STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195356	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Bernard Nursing & Rehab	4021 Roneagle Way New Orleans, LA 70122

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 50452 Based on record reviews and interviews, the facility failed to ensure a resident received specialized psychological service recommendations for 1 (Resident #65) of 1 (Resident #65) sampled residents reviewed for PASRR (Preadmission Screening and Resident Review). Findings: Review of Resident #65's Electronic Medical Record (EMR) revealed, in part, Resident #65's was admitted to the facility 03/01/2024, and had medical diagnosis of Bipolar, and Major Depressive Disorder upon admission. Further review revealed no documented evidence that a Level II PASSR recommendations was completed for Resident #65. Review of Resident #65's Social Services' Note dated 06/05/2024 at 11:29 a.m., revealed, in part, S2Social Services received Resident #65's Level II PASSR recommendations on 06/05/24 from the Louisiana Office of Behavioral Health. Review of Resident #65's EMR revealed Resident #65's approved for admission by Level II Authority for a temporary period effective 09/10/2023 through 09/08/2024. Review of Resident #65's Level II PASSR Recommendations and Determination Notice dated 9/11/2023 revealed, in part, recommendations that Resident #65 receive Community Psychiatric Support & Treatment (CPST) and/or psychiatric/psychosocial/psychological evaluation. There was no documented evidence, and the facility did not present any documented evidence, Resident #65 received CPST and/or psychiatric/psychosocial/psychological evaluation. In a telephone interview on 06/05/2024 at 1:33 p.m., the facility's psychiatric services provider's Practice Manager indicated Resident #65 had not received CPST and/or psychiatric/psychosocial/psychological evaluation since her admission into the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2024 at 1:50 p.m., S2Social Services indicated the facility did not have evidence of Resident #65's Level II PASSR recommendations upon the survey team's request, and had to get the documentation from the Louisiana Office of Behavioral Health. S2Social Services further indicated Resident #65's Level II PASSR recommendations were not followed, and Resident #65 had not received CPST and/or psychiatric/psychosocial/psychological evaluation since her admission to the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 17453 Based on record reviews, observations and interviews, the facility failed to: 1. ensure a resident's water, used for jejunostomy tube (J-tube is a soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine. The tube delivers food and medicine) flushes, was labeled properly; and, 2. ensure a resident's feeding syringe was labeled, dated and clean. This deficient practice was identified for 1 (Resident #72) of 3 (Resident #57, Resident #64, and Resident 72) sampled residents investigated for enteral feeding. Findings: Review of Resident #72's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/2024 revealed, in part, a Brief Interview for Mental Status exam score of 13. A score of 13 which indicated Resident #72 was cognitively intact. Further review of Section K revealed Resident #72 had a feeding tube. Observation on 06/03/2024 at 9:45 a.m. revealed Resident #72's feeding syringe was not labeled and was not dated and the feeding syringe had a pink liquid in the tip. Observation on 06/03/2024 at 9:45 a.m. revealed Resident #72's water bag, used for j tube flushes, was not labeled and was not dated. Observation on 06/04/2024 at 9:30 a.m. revealed Resident #72's water bag, used for j tube flushes, was not labeled and was not dated. Observation on 06/05/2024 at 8:45 a.m. revealed Resident #72's feeding syringe was not labeled and was not dated. Observation on 06/05/2024 at 8:45 a.m. revealed Resident #72's water bag, used for j tube flushes, was not labeled and was not dated. In an interview on 06/05/2024 at 8:50 a.m., S6Licensed Practical Nurse (LPN) confirmed Resident #72's feeding syringe and water bag was not labeled and was not dated. In an interview on 06/05/2024 at 12:47 p.m., S1Director of Nursing (DON) indicated feeding syringes should be labeled with the resident's name, date and time opened. S1DON further indicated the water, used for flushes, should be labeled and dated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50452 Based on record reviews, interviews and observations, the facility failed to ensure a resident's oxygen equipment was dated and stored in a sanitary manner when not in use for 1 (Resident #92) of 1 (Resident #92) sampled residents reviewed for respiratory care. Findings: Review of Resident #92's Quarterly Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2024 revealed, in part, Resident #92 received oxygen therapy. Further review revealed, Resident #92 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #92 was mildly cognitively impaired. Review of Resident #92's June 2024 Physician's Orders, revealed, in part, an order for oxygen at 2 liters (L) via nasal cannula (NC) to maintain oxygen saturation above 92 % every shift and as needed. In an interview on 06/03/2024 at 09:30 a.m., Resident #92 indicated he was short of breath and used his oxygen as needed. Observation on 06/03/2024 at 9:30 a.m., revealed Resident #92's nasal cannula tubing for his oxygen was uncovered and lying on the floor. Further observation revealed the humidifier on Resident #92's oxygen concentrator was dated 04/27/2024. Observation on 06/04/2024 at 3:35 p.m., revealed Resident #92's nasal cannula tubing for his oxygen was uncovered and lying on the floor. Further observation revealed the humidifier on Resident #92's oxygen concentrator was dated 04/27/2024. In an interview on 06/04/2024 at 3:40 p.m., S4Licensed Practical Nurse (LPN) confirmed Resident #92's nasal cannula tubing for his oxygen was uncovered and lying on the floor. S4LPN also confirmed Resident #92's humidifier for his oxygen concentrator was dated 04/27/2024. S4LPN further indicated Resident #92's nasal cannula tubing for his oxygen should not have been uncovered and lying on the floor. S4LPN further indicated that Resident #92's humidifier should have been changed and dated each week on Sundays.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40405 Based on record reviews and interviews, the facility failed to ensure a physician was notified of a pharmacist recommendation for 2 (Resident #8 and Resident #94) of 5 (Resident #8, Resident #19, Resident #74, Resident #89, and Resident #94) sampled residents reviewed for unnecessary medications. Findings: Resident #8 Review of the facility's Psychotropic & Sedative/Hypnotic Utilization by Resident form updated in 2017 revealed, in part, Resident #8's last Gradual Dose Reduction (GDR) was completed on 03/10/2024. In a telephone interview on 06/05/2024 at 3:43 p.m., the Pharmacy Consultant for the facility indicated a GDR was recommended for Resident #8 on 03/10/2024 for Seroquel 50mg 1 tablet by mouth at bedtime. In an interview on 06/05/2024 at 3:15 p.m., S1Director of Nursing (DON) indicated the facility did not have documentation to show Resident #8's GDR was reviewed by a physician. Resident #94 Review of Resident #94's GDR revealed, in part, a pharmacist made a recommendation for a dose reduction of Resident #94's Risperdal (a medication used to treat mental disorders) 4.5 mg at bedtime. There was no documentation evidence, and the facility did not present any documented evidence, Resident #94's physician was notified of the pharmacist's recommendation for a dose reduction of Resident #94's Risperdal 4.5 mg. In an interview on 06/05/2024 at 3:55 p.m., S1DON confirmed a dose reduction was recommended for Resident #94 on 01/04/2024. S1DON further confirmed there was no documented evidence that Resident #94's physician was made aware of this recommendation. 50452

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 17453 Based on record reviews and interviews, the facility failed to have accurate documentation for the route of medication administration for 2 (Resident #64 and Resident #72) of 3 (Resident #57, Resident #64, and Resident 72) sampled residents investigated for enteral feeding. Findings: Resident #64 Review of Resident #64's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/2024 revealed, in part, Resident #64 had a Brief Interview for Mental Status (BIMS) score of 9. A Score of 9 indicated moderate cognitive impairment. Further review of Resident #64's MDS revealed she had a feeding tube. Review of Resident #64's Care Plan, revised on 04/29/2024, revealed Resident #64 received medications through a feeding tube. Review of Resident #64's June 2024 Physician Orders revealed, in part, the following: 1. Zinc 50 milligram (mg) tablet give 1 tablet orally one time a day to aid in wound healing and prevention; 2. Vitamin d3 50 microgram (mcg) tablet give 1 tablet orally one time a day; 3. Vitamin C 500mg 1 tablet by mouth once a day; 4. Multivitamin take 1 tablet by mouth daily; 5. Promod 30 milliliter (ml) by mouth daily; 6. Megestrol 40mg/ml liquid give 10 ml orally one time a day for appetite stimulant; and, 7. Losartan potassium 50 mg tablet give 1 tablet orally in the morning In an interview on 06/05/2024 at 1:30 p.m., S1Director of Nursing (DON) indicated Resident #64 received all of her medications through her feeding tube. S1DON confirmed the above mentioned medications were transcribed incorrectly on Resident #64's June 2024 Physician Orders Resident #72 Review of Resident #72's MDS with an ARD of 04/25/2024 revealed, in part, a BIMS score of 13. A score of 13 indicated Resident #72 was cognitively intact. Further review of Resident #72's MDS revealed he had a feeding tube. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #72's June 2024 Physician Orders revealed, in part, the following: 1. Ondansetron Tablet 4mg give 1 tablet by mouth every 6 hours as needed for nausea and vomiting; 2. Sucralfate Suspension 1gram/10ml give 1 gram by mouth four times a day for gastric protection; 3. Pantoprazole sodium oral packet 40mg give 40mg by mouth two times a day for prophylaxis; 4. Metoclopramide oral tablet 5mg by mouth before meals for nausea and vomiting; 5. Aspirin enteric coated delayed release give 81mg by mouth one time a day for heart health; 6. Losartan Potassium oral tablet 100mg give 1 tablet by mouth one time a day for hypertension; and, 7. Cardura tablet 4mg give 1 tablet by mouth at bedtime for hypertension. In an interview on 06/05/2024 at 8:45 a.m., Resident #72 indicated he received all of medications through his feeding tube. In an interview on 06/05/2024 at 1:30 p.m., S1DON indicated Resident #72 received all of his medications through his feeding tube. S1DON confirmed the above mentioned medications were transcribed incorrectly on Resident #72's June 2024 Physician Orders.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47487 Based on observation, interview, and record review the facility failed to ensure a functional call bell was available for 1 (Resident #77) of the 4 (Resident #23, Resident #47, Resident #72, and Resident #77) investigated for environmental issues. Findings: Review of Resident #77's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/19/2024 revealed, in part, resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he was cognitively intact, and Resident #77 required substantial/maximal assistance with personal hygiene. In an interview on 06/04/2024 at 10:00 a.m., Resident #77 indicated his call bell was broken. Resident #77 further indicated because his call bell does not work, he had to go out into the hall to get assistance. Resident #77 further indicated he would use his call bell if it was functioning. A test of Resident #77's call bell was conducted on 06/04/2024 at 10:00 a.m., which revealed Resident #77's call bell was not functioning, and the indicator light did not illuminate on wall of Resident #77's room or outside of Resident #77's room above the door. A test of Resident #77's call bell was conducted on 06/05/2024 at 9:00 a.m., which revealed Resident #77's call bell was not functioning, and the indicator light did not illuminate on wall of Resident #77's room or outside of Resident #77's room above the door. In an interview on 06/05/2024 at 9:50 a.m., S5Certified Nursing Assistant (CNA) indicated Resident #77 was capable of using his call bell, but often came out into the hall to holler for assistance. Observation on 06/05/2024 at 9:51 a.m., revealed S5CNA tested Resident #77's call bell and found that the call bell was not functioning. In an interview on 06/05/2024 at 9:52 a.m., S5CNA confirmed Resident #77's call bell was not functioning and should be functioning. In an interview on 06/05/2024 at 9:57 a.m., S4Licensed Practical Nurse (LPN) indicated Resident #77's call bell should have been functioning. In an interview on 06/05/2024 at 10:12 a.m., S3Assistant Director of Nurses (ADON) indicated Resident #77's call bell should have been functioning.