STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195359	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Continuing Care Center	2301 Sterlington Road Monroe, LA 71203

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record reviews and interviews the facility failed to inform the resident's responsible party of a resident's change in condition for 2 (#5 and #6) of 4 (#4, #5, #6 and #7) records reviewed for resident rights. The facility failed to notify 1) resident #5's responsible party when she expired on [DATE], and 2) resident #6's responsible party when the facility had to reschedule 2 psychiatric appointments. Findings: Review of the facility's Change in Condition Policy and Procedure with a revised date of [DATE] revealed: Policy: To identify and evaluate a change in condition and notify the Physician and Responsible Party when indicated. A significant change in Resident's status is any sign or symptom that is: Acute or sudden onset A marked change (i.e., more severe) in relation to usual signs and symptoms New or worsening symptom Examples include but are not limited to the following: cardiovascular, respiratory, behavioral, fall with major injury, infection, dehydration, altered mental status, pressure injury, and any other condition based on professional judgment. Procedures: When a change in condition occurs, the Licensed Nurse will: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Document date, time, Physician, Responsible Party was notified of findings from the evaluation and any new orders obtained. Resident #5 Review of the medical record for resident #5 revealed an admitted [DATE] with diagnoses of heart disease, chronic kidney disease, atrial fibrillation, anxiety, polyneuropathy, thyrotoxicosis, gout, hypertension, pain, edema, and depression. Further review of the medical record revealed resident #5 had a Do Not Resuscitate code status. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a BIMS score of 14 which indicated the resident was cognitively intact and required assistance with activities of daily living. Review of the nurses' notes dated [DATE] revealed at approximately 9:20 a.m. the Certified Nursing Assistant (CNA) called the floor nurse to come into the resident's room immediately. Upon entering the room, the resident had blue appearance around her mouth. The resident was lying flat in the bed. The nurse raised the head of the bed and her oxygen saturation was 85%, and oxygen at 2 liters per nasal cannula was started. Resident #5's radial pulse was still detectable, sternal rub administered, and the resident did not respond. No audible heart beat noted and at 9:22 a.m., the hospice company was notified. At approximately 10:00 a.m. the hospice nurse and hospice chaplain arrived to the resident's room and the physician was notified at 10:24 a.m. On [DATE] at 7:45 a.m., interview with S6Licensed Practical Nurse (LPN) revealed she took care of resident #5 on [DATE]. She revealed she wasn't sure if she called the responsible party to inform her of her mother's change in condition but if she did notify the responsible party, she probably did not document it in the medical record. On [DATE] at 9:40 a.m., interview with S2Director of Nursing (DON) revealed the LPNs should notify the family with a change in the resident's condition even if the resident receives hospice. S2DON revealed there was no documented evidence of the responsible party being notified of resident #5's change in condition. Resident #6 Review of the medical record for resident #6 revealed an admitted [DATE] with diagnoses including anemia, acute bronchitis, edema, anxiety, chronic kidney disease, schizoaffective disorder, dementia, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact for daily decision making. Further review of the MDS revealed the resident required assistance with activities of daily living. Review of the care plan revealed resident #6 currently takes psychotropic medications as evidenced by depression, anxiety and insomnia, and to obtain a psychiatric consult as needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's appointment calendar revealed resident #6 had an appointment on [DATE] at 8:00 a. m. at a psychiatric clinic. Further review of the calendar revealed on [DATE] resident #6 had a psychiatric appointment and an ambulance company was to take resident #6 to the appointment. On [DATE] at 12:00 p.m., interview with S5Transportation Driver revealed she drove resident #6 to an appointment out of town on [DATE]. S5Transporatation Driver revealed she was given an incorrect address, she was late arriving to the appointment, and the office informed her they had to reschedule resident #6's appointment. On [DATE] at 1:30 p.m., S2DON confirmed she did not notify resident #6's responsible party that the resident missed her appointment on [DATE] and they rescheduled the appointment for [DATE]. On [DATE] at 11:35 a.m., interview with S1Administrator revealed on [DATE] one of the facility's vans was out of commission for a couple of days. S1Administrator revealed the facility was unable to transport resident #6 to the appointment. The facility contacted the ambulance company to transport the resident and they were unable to transport and the facility had to reschedule the appointment again. On [DATE] at 4:00 p.m., interview with S1Administrator revealed there was no documented evidence regarding the responsible party being notified that resident #6's appointment on [DATE] had to be reschedule.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957 Based on record reviews and interviews the facility failed to protect the resident's right to be free from sexual abuse by a resident for 2 (#2 and #3) of 3 (#1, #2, #3) residents reviewed for abuse. The facility failed to protect Resident #2 and Resident #3 from inappropriate sexual advances by Resident #1. Findings: Review of the facility's Abuse Prohibition Protocol dated April 2019 revealed the following, in part: 1. The Patient has the right to be free from abuse, neglect, mistreatment of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the Patient's symptoms. 7. e. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault, or any nonconsensual sexual contact of any type with the Patient. Resident #1 A review of Resident #1's medical record revealed an admitted [DATE] with diagnoses of acute kidney failure, COPD (Chronic Obstructive Pulmonary Disease), type II diabetes, emphysema, and insomnia. Review of Resident #1's MDS (Minimum Data Set) dated 05/31/2024 revealed a BIMS (brief interview of mental status) score of 14 which would indicate Resident #1 was cognitively intact. Review of a nurse's note from 04/11/2024 revealed the following: Resident #1 is being monitored as one on one for incident with previous roommate (Resident #2). Accusation of this resident (Resident #1) of sexual misconduct, taking his penis and masturbating in front of his roommate (Resident #2), asking his roommate how big is his penis and do he let men suck it. This resident denies this behavior. S2 DON (Director of Nursing) is aware . The review of the facility's incident investigation report dated 04/11/2024 revealed Resident #2 was immediately removed from the shared room with Resident #1. Resident #1 was placed on one on one monitoring. Resident #2 was placed a new room per his request. Review of a nurse's note from 06/05/2024 revealed the following: CNA (certified nursing assistant) reported to this nurse that resident's roommate (Resident #3) reported to her that this resident (Resident #1) ask him if he would suck his penis. His roommate (Resident #3) told him no, and he does not engage in such activity, he (Resident #1) in turn ask if he could suck his (Resident #3) penis instead, upon investigation and talking to patient's roommate (Resident #3), he (Resident #3) explained the same story to this nurse . Resident #1 was discharged from the facility on 06/06/2024 after a resident initiated discharge. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An attempt to contact Resident #1 on 06/13/2024 at 4:25 p.m. was unsuccessful. Resident #2 A review of Resident #2's medical record revealed an admitted [DATE] with diagnoses of COPD, hypertension, hyperlipidemia, pain, and dysphagia. Review of the Quarterly MDS assessment, for Resident #2, dated 04/10/2024 revealed the resident scored a 14 on the BIMS which indicated the resident was cognitively intact. The resident had no behaviors noted. Review of the nurse's note dated 04/11/2024 at 9:26 p.m. revealed the following: 6:30 p.m.: incident: writer in to give resident (Resident #2) his medication this evening and resident stated, I'm going to knock the hell out of that son of a b____. Writer asked resident what's the matter? What's going on? Resident replied: He (Resident #1) took his penis out and was jerking off in front of me and asked me how big is mine and do I let men suck mine? Resident seemed very upset, resident was in room by his self when telling this to writer. During an interview on 06/13/2024 at 9:00 a.m., Resident #2 reported Resident #1 came into the room and said that he could give good blow jobs. Resident #2 indicated he didn't go that way to Resident #1. Then Resident #1 pulled his penis out and started choking it (masturbating). Surveyor asked where Resident #1 was when he (Resident #1) did that and he said where you are standing. Surveyor was approximately three feet away from Resident #2's bed. Surveyor then asked if Resident #1 ejaculated and Resident #2 said yes. Surveyor asked where the ejaculate went and Resident #2 said Resident #1 put it in his own hand. Surveyor asked Resident #2 how he felt after Resident #1 masturbated in front of him and Resident #2 said he wanted to whoop Resident #1's a__. Resident #3 A review of Resident #3's medical record revealed an admitted [DATE] with diagnoses of dementia, pneumonia, atherosclerotic heart disease, heart failure, end stage renal disease, dialysis, hypertension, and anemia. Review of the 5 day MDS assessment for Resident #3 dated 06/05/2024 revealed the resident scored an 11 on the BIMS which indicated the resident had moderately impaired cognitive skills for daily decision making. The resident had no behaviors noted. Review of the nurses note dated 06/05/2024 at 6:30 p.m. revealed the following: Certified Nursing Assistant (CNA) reported to this nurse that this resident (Resident #3) reported to her that his roommate (Resident #1) asked him if he would suck his d___, he told him no that he does not engage in such activity, he (Resident #1) in turned asked if he could suck his (Resident #3) instead . During an interview on 06/13/2024 at 4:00 p.m. Resident #3 was asked if he was propositioned by Resident #1. Resident #3 did not remember right away and then he said yes that guy (Resident #1) said let me see your d___ and then Resident #1 asked Resident #3 if he wanted him to suck his d___. Resident #3 indicated he told Resident #1 that he did not do stuff like that. Then Resident #3 told Resident #1 that he would bust his a__ if he didn't quit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/2024 at 10:05 a.m. S2 DON confirmed the first incident of sexual abuse with Resident #1 was on 04/11/2024 when Resident #2 reported Resident #1 pulled his penis out and started masturbating in front of him. The second event was on 06/05/2024 when Resident #3 told staff that Resident #1 asked Resident #3 if he would suck his penis. Resident #3 said no and then Resident #1 then asked Resident #3 if he wanted his penis sucked. During an interview with S2 DON and S1 Administrator on 06/13/2024 at 2:20 p.m. S2 DON verified Resident #1 was immediately separated from Resident #2 after the first incident. Resident #1 was removed from Resident #3's room after the second incident. Resident #1 was discharge on 06/06/2024 due to a resident initiated discharge.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review and interviews the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene by, not having documented evidence that residents received baths as scheduled for 1 (#6) of 3 (#5, #6 and #7) records reviewed for Activities of Daily Living (ADLs). Findings: Review of the medical record for resident #6 revealed an admitted [DATE] with diagnoses including anemia, acute bronchitis, edema, anxiety, chronic kidney disease, schizoaffective disorder, dementia, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact for daily decision making. Further review of the MDS revealed the resident required extensive assistance with personal hygiene. Review of the care plan revealed a problem regarding ADL functions with interventions to encourage independence, praise when attempts are made and set up assistance with showers, shaving, oral, hair, and nail care per schedule and as needed. Review of the ADL Verification Worksheet for May 1, 2024 - May 21, 2024 revealed no documented evidence that the resident received baths as scheduled. On 06/17/2024 at 12:10 p.m., interview with S3Certified Nursing Assistant (CNA) revealed resident #6 is scheduled to receive a bed bath every Monday, Wednesday, Friday and on the other days they give resident #6 a partial bath. On 06/18/2024 at 11:25 a.m., interview S2DON revealed on the days the residents are not scheduled for full bath the CNAs should perform a partial bath and document the type of bath the resident received on the computer system. S2DON confirmed there was no documented evidence that resident #6 received baths as scheduled.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observation, record review, and interviews, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (#6) of 3 (#4, #6 and #7) residents reviewed for limited range of motion. Findings: Review of the medical record for resident #6 revealed an admitted [DATE] with diagnoses including anemia, acute bronchitis, edema, anxiety, chronic kidney disease, schizoaffective disorder, dementia, and dysphagia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact for daily decision making. Further review of the MDS revealed the resident required assistance with activities of daily living. Review of the care plan revealed resident #6 was at risk for skin integrity and for a soft brace to be worn while in the bed. Review of the physician orders revealed an order dated 11/08/2022 to place a brace on every evening and remove when out of the bed. Review of the therapy department notes revealed a date of service for 04/26/2024 to place Multi Podus boots on bilateral feet. On 06/18/24 at 8:20 a.m., observation of resident #6 revealed she was in the bed and with the resident's approval, S3CNA removed the covers from resident #6's feet. Further observation revealed resident #6 had foot drop to bilateral feet and she was not wearing the soft braces to her bilateral feet while in the bed. At that time, interview with S3CNA revealed the resident should have been wearing soft braces to bilateral feet when in the bed. On 06/18/2024 at 8:30 a.m., observation of resident #6 with S2Director of Nursing (DON) revealed the resident was in the bed. S2DON removed the covers from resident #6's feet and noticed the braces were not on her bilateral feet while in the bed. On 06/18/2024 at 8:40 a.m., interview with S4Therapy Director revealed resident #6 should have been currently wearing the soft braces while in the bed and the metal braces when she is in a wheelchair. On 06/18/2024 at 11:25 a.m., interview with S2DON confirmed on 06/18/2024 at 8:30 a.m. resident #6 should have been wearing the soft boots on her bilateral feet while she was in the bed.