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	07/30/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview the facility failed to ensure grievances were investigated for 1 (#1) of 3 (#1, #2, #3) sampled residents. The facility failed to investigate a grievance by Resident #1's RP (responsible party) promptly.Findings:Review of the facility's grievance policy dated November 2017 revealed in part:The patient or patient representative has a right to voice grievances to the facility or other entity that hears grievances without fear of discrimination or reprisal. Grievances include those with respect to care and treatment, the behavior of staff and other concerns.Guidelines:3. When the facility is made aware of a problem or concern voiced by a Patient or on behalf of the Patient, the facility must make every effort for prompt resolution of all grievances regarding the residents' rights.4. The following steps should be taken for concern resolution:a. Attempt to solve the problem yourself and check back with the Patient to see if they are satisfied with the outcome.b. Involve your Executive Director or Director of Nursing Services.5. A grievance form must be completed and turned in to the department head supervisor.Review of Resident #1's medical record revealed an initial admit date of 06/17/2021 and a readmission date of 06/20/2024 with a diagnosis of but not limited to, schizophrenia, chronic kidney disease, depression, anxiety, dysphagia and schizoaffective disorder.Review of Resident #1's most recent quarterly MDS (Minimum Data Set) dated 07/05/2025 revealed Resident #1 had a BIMS (Brief Interview Mental Status) of 7 indicating severely impaired cognition. During a phone interview on 07/30/2025 at 10:00 a.m. Resident #1's responsible party stated he reported the theft of Resident #1's phone charger to S2 ADON (assistant director of nurses) when visiting about two weeks ago. Resident #1's RP further reported no one at the facility had followed-up with him about this theft. Review of the facility grievance and complaint logs failed to reveal an entry related to Resident #1.During an interview on 07/30/2025 at 10:30 a.m. S2 ADON confirmed Resident #1's RP had reported the theft of Resident #1's phone charger to her about a week ago S2 ADON also confirmed a grievance investigation was not done. S2 ADON stated, I did not follow up with Resident #1's RP and should have.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interview and record review the facility failed to use infection control standards of practice for 1(#2) of 3 (#1, #2 and #3) sampled residents by not properly storing a resident's Foley catheter bag preventing an increased risk of contamination and infection. Resident #2's Foley catheter bag was improperly stored on the floor. Findings:Review of the facility's Catheter Care, Urinary policy (revised September 2014) presented by S1 DON (Director of Nursing) revealed in part:Purpose: The purpose of this procedure is to prevent catheter-associated UTI (urinary tract infections).Infection Control: Be sure the catheter tubing and drainage bag is kept off the floorObservation on 7/29/2025 at 11:25 a.m. with S2 ADON (Assistant Director of Nursing) revealed resident #2's Foley catheter noted to be lying on the floor. Resident #2 noted to be on enhanced barrier precautions according to the sign on her door.Observation on 07/30/2025 at 10:30 a.m. revealed resident #2's Foley catheter bag positioned on the floor at the side of the bed. Review of resident #2's medical record revealed diagnoses including but not limited to unstable dementia, severe, with psychotic disturbance, posterior reversible encephalopathy, gastrostomy status, folate deficiency anemia, essential hypertension, cognitive communication deficit, and urinary tract infection. Review of resident #2's most recent Quarterly MDS (minimum data set) dated 06/11/2025 section H bladder and bowel, revealed the use of an indwelling catheter.Review of resident #2's Comprehensive Plan of Care revealed resident #2 had a Foley catheter. Some of the interventions was to position the Foley catheter bag and tubing below the level of the bladder and away from entrance room door. Check tubing for kinks each shift.Review of resident #2's Physician Progress notes dated 07/02/2025 revealed in part.Reason for visit:Follow up visit. Nursing request, familyAssessment and Plan: Urinary tract infection, site unspecified with E. coli. Augment 875/125 mg (milligram) BID (twice a day) times 10 days. Seen 06/13/2025 and evaluated. Nurse had reported some increased agitation, and a urinalysis obtained. Has urinary tract infection with E. coli and plan to start on Augmentin 875/125 mg BID times 10 days. Neuromuscular dysfunction of bladder, unspecified. Foley.During an interview on 7/29/2025 at 112:25 a.m. S2 ADON confirmed resident #2's Foley catheter bag was on the floor and should not have been. Reported residents' bed was in the lowest position and confirmed the catheter should not be on the floor. Further review of resident #2's records revealed she had received treatment for a urinary tract infection on 04/18/2025 and 07/15/2025.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record reviews and interview the facility failed to ensure nurses started a medication that had been ordered by the physician for 1(#2) of 3 (#1, #2 and #3) sampled residents. The facility failed to start the medication Naltrexone for resident #2. Findings: Review of resident #2's record revealed in part, a Psych Evaluation, date of service July 3, 2025. Chief complaint and history of present illness, history of dementia and insomnia.Case Conceptualization: Speech unintelligible. Information obtained from staff. They describe resident #2 as being 'hypersexual' and gave examples on behavior. Resident #2 is not aggressive. Resident #2 has a PEG (percutaneous endoscopic gastrostomy) tube for nutrition. Resident #2 does sleep well. Will make recommendations below and will re-assess in 1 month, sooner if needed. -Recommendations: Start trial of Naltrexone 25 mg (milligram) daily. Rationale: Naltrexone shown to reduce inappropriate behavior. Review of resident #2's July 2025 MAR (medication administration record) failed to reveal the medication Naltrexone had been started as ordered.Review of resident #2's records revealed diagnoses that included but not limited to unstable dementia, severe, with psychotic disturbance, posterior reversible encephalopathy, acute neurologic view, gastrostomy status, essential hypertension, and cognitive communication deficit. During an interview on 07/30/2025 at 12:40 p.m. with S1 DON (Director of Nursing) reported the medication Naltrexone was never started and it should have been.