| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195359 | A. Building<br>B. Wing | 12/11/2025 |

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| St. Joseph Continuing Care Center | 2301 Sterlington Road<br>Monroe, LA 71203 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assess residents for self-administration of medications for 2 (#46 & #109) of 2 sampled residents observed for medications available at the bedside. Findings:Facility's Self-Administration Medications policy dated 06/14/2006 revealed, in part.<br><br>Policy:<br><br>A Patient may self-administer medications if the Patient is determined safe for the Patient and other Patients of the Facility by the Facility's Interdisciplinary Team.<br><br>Procedure:<br><br>An Assessment for Self-Administration of Medications) See [NAME] Form CFS 1-14HH) must be completed on each Patient requesting to self-administer medications and quarterly thereafter. An Assessment for Self-Administration of Medications is kept with the Patient's medical record under the Assessments tab.<br><br>Resident #46<br><br>Record review revealed Resident #46 was admitted to the facility 11/10/2023 with diagnoses that included polyosteoarthritis, unspecified; morbid (severe) obesity due to excess calories; diabetes mellitus due to underlying condition with unspecified complications; chronic obstructive pulmonary disease, unspecified; and functional quadriplegia.<br><br>Review of annual Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #46 was cognitively intact.<br><br>On 12/08/2025 at 10:06 a.m., 12/09/2025 at 8:35 a.m. and 12/09/2025 at 12:45 p.m., observations revealed a Ventolin inhaler at the Resident's bedside.<br><br>On 12/08/2025 at 8:35 a.m., an interview with Resident #46 revealed she self-administered the Ventolin inhaler.<br><br>On 12/09/2025 at 12:45 a.m., an interview with Resident #46 revealed staff replaces her inhaler when she runs out.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/09/2025 a record review revealed an order for Proventil HFA inhalation aerosol solution 108 (90 Base) mcg/act (albuterol sulfate) 2 puffs inhale orally every 6 hours as needed for SOB. Further record review revealed no facility assessment for Resident #46 to self-administer medications.<br><br>On 12/09/2025 at 1:00 p.m., an observation with S2Director of Nursing (DON) confirmed Resident #46 had a Ventolin inhaler at bedside and was self-administering the inhaler without a facility assessment for the self-administering of medications.<br><br>Resident #109<br><br>Review of Resident #109's diagnoses revealed in part aggressive periodontitis, anemia, type 2 diabetes, with diabetic chronic kidney disease, need for assistance for personal care, and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side.<br><br>Review of Resident #109's admission MDS dated [DATE] revealed a BIMS score of 11, which indicated Resident #109 had moderate cognitive impairment.<br><br>Review of Resident #109's record revealed no documented evidence Resident #109 had been assessed to be appropriate to self- administer medications.<br><br>Observation on 12/08/2025 at 8:45 a.m. revealed Resident #109 lying in bed, while alone in her room with Chlorohexidine Gluconate oral rinse on her bedside table. The prescription label indicated the oral rinse had been prescribed for her.<br><br>During an interview on 12/08/2025 at 8:45 a.m., Resident #109 stated she did use the mouthwash by herself.<br><br>During an interview on 12/08/2025 at 8:49 a.m., S5LPN confirmed Resident #109 should not have the oral rinse in her room on the bedside table.<br><br>During an interview on 12/10/2025 at 11:28 a.m., S2DON confirmed Resident #109 had not been assessed to self- administer medication and should not have the Chlorohexidine Gluconate oral rinse at bedside. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on record review and interview, the facility failed to ensure the SNF ABN Form, CMS-10055 was provided to the resident and/or the resident's responsible party prior to the discontinuation of Medicare Part A services for 2 (#116, #117) of 3 residents reviewed for Beneficiary Notification who required the notification. Findings: Resident #116Record review revealed Resident #116's Medicare Part A skilled services episode start date was 06/24/2025. The last covered day of Part A services was 07/21/2025. The facility initiated the discharge from Medicare Part A services with benefit days remaining. Resident #116 was discharged home. Further review revealed no documented evidence Resident #116 was provided the SNF ABN, Form CMS-10055 prior to being discharged from Medicare Part A Services. On 12/11/2025 at 8:45 a.m. an interview with S6SW and S7Business Office Manager, confirmed a SNF ABN, Form CMS-10055 was not provided to the resident or their responsible party as required prior to the resident's discharge from Medicare Part A Services. Resident #117Record review revealed Resident #117's Medicare Part A skilled services episode start date was 06/17/2025. The last covered day of Part A services was 08/01/2025. The facility initiated the discharge from Medicare Part A services with benefit days remaining. Resident #117 was discharged home. Further review revealed no documented evidence Resident #117 was provided the SNF ABN, Form CMS-10055 prior to the resident's discharge from Medicare Part A Services. On 12/11/2025 at 11:02 a.m. an interview with S6SW and S7Business Office Manager confirmed a SNF ABN, Form CMS-10055 was not provided to the resident or their responsible party prior to the resident's discharge from Medicare Part A Services. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the discharge notices were sent to the Office of the State Long-Term Care Ombudsman for 2 (#107, #108) of 2 residents sampled for discharges. Findings:Resident #108<br><br>Review of the MDS assessments revealed Resident #108 was admitted on [DATE] and the resident left the facility Against Medical Advice which was a voluntary discharge on [DATE].<br><br>Review of the monthly emergency transfer log revealed it only included notifications for the month of December 2025. On 12/20/2025 at 2:40 p.m., interview with S3RN revealed the facility did not have access to the monthly emergency transfer logs prior to December 2025.<br><br>Resident #107<br><br>Review of the MDS assessments revealed Resident #107 was admitted on [DATE] and was discharged to the hospital on [DATE]. The MDS assessments also revealed resident #107 was readmitted to the nursing facility on 10/14/2025 and discharged home on [DATE].<br><br>Review of the monthly emergency transfer log revealed it only included the month of December 2025. On 12/20/2025 at 2:40 p.m., interview with S3RN revealed the facility did not have access to the monthly emergency transfer logs prior to December 2025. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice by failing to clean and store piston syringes in accordance with facility policy for 1 (# 74) of 1 residents reviewed for enteral feedings.Findings:Review of the medical record revealed resident #74 had an admission date of 10/22/2025 with diagnoses which included diabetes, encephalopathy, muscle weakness and communication deficits. Review of the December 2025 physician orders revealed the resident received medications and nutritional support by way of a PEG tube.On 12/08/2025 at 1:34 p.m., observation of Resident #74's syringe at the bedside revealed the tip was filled with a yellowish fluid. The syringe was capped and the plunger was in the syringe.Review of the facility policy on piston syringe use dated May 2012 read in part.syringes used for liquids other than clear water must be rinsed appropriately, dried, and replaced in a proper storage bag or other approved container. Store syringe and plunger separately in the bag.On 12/10/25 at 3:40 p.m., interview with S2DON confirmed staff should have cleaned and stored the syringe properly after use for Resident #74. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure residents were assessed for the risk of entrapment from bedrails prior to installation for 2 (#53 and #77) of 3 residents identified for having side rails in use.Findings:Review of the facility's Proper Use of Side Rails Policy and Procedure, revised December 2016, revealed the following, in part:General Guidelines3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's:c. Risk of entrapment from the use of side rails.Resident #77Review of Resident #77's record revealed an admission date of 09/11/2025 with diagnoses including acute and chronic respiratory failure with hypoxia, hypertension, heart failure, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia, depression, unspecified dementia, and metabolic encephalopathy. Review of Resident #77's current physician's orders revealed an order dated 10/07/2025 for quarter assist rails in place as an enabler as desired or needed, alert physician of any noted complications or quarter assist rail use, responsible party aware and in agreement of use.Observations on 12/08/2025 at 8:48 a.m. and 12/09/2025 at 9:45 a.m. revealed Resident #77 was lying in bed with bilateral quarter rails in the up position. Review of Resident #77's Medicare 5 day MDS assessment dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment. Further review of the MDS revealed bed rail marked as not used. Review of Resident #77's current care plan revealed use of assist rails-quarter rails required as an enabler in order to promote as much independence as possible. Further review revealed the interventions included the resident uses bilateral quarter assist rails(s) as enabler to assist with bed mobility and transfer.Review of Resident #77's record revealed no documented evidence of an assessment for the risk of entrapment prior to the installation of bed rails/side rails.An interview on 12/10/2025 at 3:35 p.m. with S1Administrator confirmed the facility was unable to provide documented evidence of an assessment for the risk of entrapment for Resident #77 prior to the installation of bed rails/side rails. Resident #53Review of Resident #53's record revealed an admission date of 08/20/2025 with diagnoses including in part, unspecified atrial fibrillation, muscle weakness (generalize), unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, myocardial infarction, dementia and major depressive disorder. Review of Resident #53's current physician's orders revealed an order dated 08/20/2025 for quarter assist rails in place as an enabler as desired or needed. Alert physician of any noted complications of quarter assist rail use. RP aware of and in agreement with use. Observation on 12/09/2025 at 4:56 p.m. revealed Resident #53 was in her room lying in bed with quarter bed rails in an up position. Review of Resident #53's most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment with daily decision-making skills. Further review of the MDS revealed bed rail marked as not used. Review of Resident #53's current care plan revealed use of assist rails-quarter rails required as an enabler in order to promote as much independence as possible. Review of Resident #53's record revealed no documented evidence of an assessment for the risk of entrapment prior to the installation of bed rails/side rails.An interview on 12/10/2025 at 3:35 p.m. with S1Administrator confirmed the facility was unable to provide documented evidence of an assessment for the risk of entrapment for Resident #53 prior to the installation of bed rails/side rails. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents were free from unnecessary medications for 1 (#38) of 5 residents sampled for medication review. Findings:Review of Resident #38's record revealed an admission date of 07/18/2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cerebral infarction due to embolism of right middle cerebral artery, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease with heart failure, other seizures, and diabetes mellitus. Review of Resident #38's current physician's orders revealed the following orders, in part: 11/11/2025- Eliquis (anticoagulant) oral tablet 5 mg give 5 mg po 2 times a day;11/11/2025- Levetiracetam (anticonvulsant) oral tablet 500 mg give 500 mg po 2 times day; and 11/13/2025- anticoagulant side effect monitoring and anticonvulsant side effect monitoring every shift.Review of Resident #38's End of Part A stay MDS assessment dated [DATE] revealed a BIMS score of 13 indicating no cognitive impairment. Further review of the MDS revealed resident received the following high risk drug class medications- anticoagulant and anticonvulsant.Review of Resident #38's current care plan revealed the resident was on anticonvulsant therapy related to hemiparesis following cerebral infarction affecting left non-dominant side, bipolar disorder, other seizures, and seizure disorder. Interventions included to give medication as ordered, monitor for any adverse consequences, specifically increased confusion or over-sedation, observe and report any seizure activity, and monitor/document side effects and effectiveness. Review of the November 2025 TAR revealed the facility failed to have documented evidence of monitoring for anticonvulsant side effects and anticoagulation side effects 13 times beginning 11/12/2025 through 11/30/2025.Review of the November 2025 MAR revealed Resident #38 received Eliquis (anticoagulant) and Levetiracetam (anticonvulsant) beginning 11/11/2025.Review of the December 2025 TAR revealed the facility failed to document monitoring anticoagulant and anticonvulsant side effect monitoring 5 times during December 2025.Review of December 2025 MAR revealed resident #38 received Eliquis and Levetiracetam from 12/01/2025 through 12/09/2025. An interview on 12/10/2025 at 4:15 p.m. with S4RN confirmed the facility failed to document as ordered the monitoring of anticoagulant side effects and anticonvulsant side effects every shift. An interview on 12/11/2025 at 9:45 a.m. with S3RN confirmed the facility failed to document as ordered the monitoring of anticoagulant side effects and anticonvulsant side effects every shift for Resident #38 while he received Eliquis and Levetiracetam. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on interviews and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment, and to help prevent the development and transmission of communicable diseases and infections as evidenced by: 1) failure to effectively decontaminate the environment of residents on contact isolation with confirmed or suspected C. Difficile infection and 2) failure to properly identify possible communicable diseases or infections before they spread. This deficient practice had the potential to affect 85 residents in the facility. Findings:1. On 12/09/2025 at 9:24 a.m., S9Housekeeper reported one product was used in contact isolation rooms with confirmed or suspected C. Difficile infection and the product had to sit for 2-3 minutes on surfaces.On 12/09/2025 at 9:37 a.m., S10Housekeeper reported there were two products used in contact isolation rooms with confirmed or suspected C. Difficile infection and the product had to sit for 2-3 minutes.On 12/09/2025 at 10:34 a.m., S2DON reported that S8Housekeeping Supervisor was responsible for ensuring contact isolation rooms with confirmed or suspected C. Difficile were terminally cleaned and nursing staff were responsible for direct patient care equipment. S2DON reported it was unknown if the product used on direct patient care equipment was effective against C. Difficile. On 12/09/2025 at 11:55 a.m., S8Housekeeping Supervisor reported there were two products available to use for all isolation rooms. S8Housekeeping Supervisor reported one of the products had a 3-5 minute kill time and the alternative product had a 10 minute kill time. On 12/09/2025 at 12:28 p.m., S11LPN reported direct patient care equipment used on residents in contact isolation rooms with confirmed or suspected C. Difficile infection was treated with one product. S11LPN reported this product had a contact time of 2 minutes. Review of product labels revealed no documentation the products were effective against C. Difficile. On 12/10/2025 at 12:17 p.m., S1Administrator confirmed the products reported in use by facility staff were not effective against C. Difficile infection.2. Review of the facility's August 2025 Infection Surveillance Report revealed the report should have identified infections into nine categories: gastrointestinal, genital, MDRO, neurologic, other, parasitic, respiratory, skin and soft tissue, and urinary tract/kidney. Further review revealed one resident in the genital category and the other residents in the category of other. Further review revealed the signs and symptoms portion was left blank on numerous entries. Review of the medical record for Resident #106 revealed physician documentation of confirmed C. Difficile infection on 08/08/2025. On 12/09/2025 at 10:34 a.m., S2DON reported the facility did not have a documented infection surveillance plan. On 12/11/2025 at 8:40 a.m., S1Administrator confirmed the infection surveillance data available did not demonstrate that infection surveillance was performed effectively in the facility.On 12/11/2025 at 9:00 a.m., S3RN was unable to produce documentation to demonstrate that infection surveillance was performed effectively in the facility. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>Based on interview and record review, the facility failed to implement policies and procedures for COVID-19 immunizations for 5 (#8, #20, #32, #92, & #106) of 5 residents reviewed for immunizations. The facility failed to ensure the residents' medical records included documentation that indicated the residents or resident representatives received education regarding the benefits and potential side effects of COVID-19 immunization. This deficient practice had the potential to affect 85 residents residing in facility.<br>Findings:Review of the facility's Coronavirus-COVID-19 Protocols policy dated September 2024 revealed, in part:13) All facilities must educate residents and staff on the COVID-19 vaccine (including additional doses/boosters) and offer to help get them vaccinated.Review of the medical records for Resident #8, Resident #20, Resident #32, Resident #92 and Resident #106 revealed there was no documented evidence of education regarding the benefits and potential side effects related to the COVID-19 vaccine. On 12/10/2025 at 4:00 p.m., S4RN confirmed there was no documented evidence of education regarding the benefits and potential side effects related to the COVID-19 vaccine. |