STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195362	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zachary Manor Nursing and Rehabilitation Center	6161 Main Street Zachary, LA 70791

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 3 (#12, #54 and #66) residents out of a total of 21 sampled residents. The facility failed to ensure: 1. Resident #12 was coded correctly for PASRR (Pre-admission Screening and Resident Review); 2. Resident #54 was coded correctly for vision; and 3. Resident #66 was coded correctly for discharge. Findings: Resident #12 Review of Resident #12's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #12's OBH-Level II Evaluation Summary & Determination Notice dated 08/02/2024 revealed under recommendations: The individual has a serious mental illness and nursing home admission was recommended. Review of Resident #12's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2024 revealed Section A1500 PASRR: Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, was coded as 0. No. On 01/07/2025 at 1:02 p.m., an interview was conducted with S4MDS. She stated she was responsible for completing resident's MDS assessments. She reviewed Resident #12's PASRR Level II dated 08/02/2024 indicating she had a serious mental illness. She reviewed Resident #12's Annual MDS with an ARD of 09/04/2024. She confirmed Resident #12 was not coded accurately for having a serious mental illness and should have been. On 01/07/2025 at 1:13 p.m., an interview was conducted with S2DON. She reviewed Resident #12's information listed above. She confirmed Resident #12 was not coded accurately for having a serious mental illness and should have been. Resident #54 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #54's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Legal Blindness. Review of Resident #54's Quarterly MDS with an ARD of 12/09/2024 revealed she had a BIMS of 12, which indicated she was moderately cognitively impaired. Further review revealed Section B1000 Vision was coded as Adequate. On 01/08/2025 at 9:00 a.m., an interview was conducted with Resident #54. She stated she was legally blind. On 01/08/2025 at 10:00 a.m., an interview was conducted with S4MDS. S4MDS reviewed Resident #54's Quarterly MDS with an ADR of 12/09/2024 and verified Section B1000 was coded for Adequate Vision. S4MDS confirmed Resident #54 was legally blind, which made the entry incorrect. On 01/08/2025 at 11:30 a.m., an interview was conducted with S2DON. She confirmed Resident #54 had a diagnosis of legal blindness. She reviewed the Quarterly MDS with an ADR 12/09/2024 and confirmed Section B1000 Vision was coded as Adequate, which was not correct. Resident #66 Review of Resident #66's Clinical Record revealed she was admitted to the facility on [DATE] and transferred to a local hospital for shortness of breath on 11/02/2024. Review of Resident #66's Discharge MDS with an ARD of 11/02/2024 revealed Section A2105 Discharge Status: Inpatient Rehabilitation Facility. Review of Resident #66's Nurse's Note dated 11/02/2024 at 2:49 p.m. revealed the following, in part: Resident was complaining of shortness of breath and coughing up mucous, wheezing was heard upon auscultation, contacted doctor. Order given to send to emergency room for evaluation and treatment. Signed, S9LPN. Review of Resident #66's Physician Order dated 11/02/2024 revealed the following, in part: Send to ER. On 01/08/2025 at 2:00 p.m., an interview was conducted with S5MDS and S2DON. They reviewed the above documentation and confirmed Resident #66 should have been coded as having a discharge location for a Short Term General Hospital and not an Inpatient Rehabilitation Facility. 47732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47732 Based on record review and interviews the facility failed to ensure a resident's plan of care was revised by failing to update vision interventions for 1 (#54) of 19 residents reviewed in the final sample for Care Plans. Findings: Review of Resident #54's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included Legally Blind. Review of Resident #54's Quarterly MDS, with ARD of 12/09/2024, revealed a BIMS of 12, which indicated she was moderately cognitive impaired. Further review revealed Section B: Hearing, Speech, and Vision, line B100-Vision was coded as Adequate, and Corrective Lenses was coded as No. Review of Resident #54's Care Plan dated 12/22/2023 revealed: Care Plan Description: Visual deficit related to Blindness to Bilateral Eyes Interventions: Assist resident to maintain eyeglasses. Encourage to wear glasses. Ensure adequate lighting for tasks. Keep eyeglasses within reach. Keep pathways clear. Provide assistance with ambulation as needed. On 01/08/2025 at 9:00 a.m., an interview was conducted with Resident #54. She stated she was legally blind, unable to distinguish light from dark, and does not wear corrective lenses. She confirmed she was non-ambulatory and bed bound. On 01/08/2025 at 9:10 a.m., an interview was conducted with S15CNA. She confirmed Resident # 54 is blind, does not ambulate, requires lift with 2 people, and does not have corrective glasses. On 01/08/2025 at 9:15 a.m., an interview was conducted with S6LPN. She stated Resident #54 has diagnosis of Legally Blind. She stated Resident #54 is unable to ambulate and transferred to the Geri chair daily using lift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/2025 at 11:00 a.m., an interview was conducted with S4MDS. S4MDS reviewed the Care Plan dated 12/22/2023 for Resident #54. S4MDS confirmed the current interventions for Resident #54 related to Visual Deficit Blindness Bilateral Eyes included intervention for eye glasses, adequate lighting, glare free environment, clear pathways, and ambulation assistance did not reflect the status of Resident #54 on admission, or currently. She stated that care plan revisions should be updated as often as needed, and with 3 month assessments done by the MDS Staff and was not. 01/08/2025 at 11:30 a.m., an interview was conducted with S2DON. She confirmed Resident #54 had a diagnosis of Legal Blindness. She reviewed the Care Plan dated 12/22/2023 for Resident #54. S2DON confirmed the interventions listed for Resident #54 related to Visual Deficit Blindness Bilateral Eyes did not reflect the status of Resident #54. S2DON confirmed the care plan should be updated with each assessment conducted by MDS staff, and was not.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on an observation, interviews, and record review, the facility failed to ensure there was a system in place for facility residents to receive routine dental care by an outside dentist as requested for 1 of 1 (#16) resident reviewed for dental services. This deficient practice had the potential to affect any of the 67 residents residing in the facility. Findings: A review of Resident #16's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Mild Protein-Calorie Malnutrition. A review of Resident #16's Quarterly MDS with an ARD of 12/26/2024 revealed he had a BIMS of 11, which indicated he was moderate cognitively impaired. A review of the In House Facility Dental notes revealed the following: 05/29/2024 Resident #16 refused dental services today. Resident #16 told S11MR he only wants to see an outside dentist. 08/29/2024 Resident #16 refused dental services today. On 01/07/2025 at 2:25 p.m., an observation and interview was conducted with Resident #16. He was observed in the dining room with multiple broken bottom teeth noted. Resident #16 stated he only wanted to see an outside dentist and did not want to see the dentist which came to the facility. On 01/08/2025 at 8:14 a.m., an interview was conducted with S12ST. She stated Resident #16 liked to attend appointments at his normal places where he was from. She stated Resident #16's last appointment with his outside dentist was on 02/07/2022. She confirmed she made all outside facility appointments and was not made aware of 05/29/2024's dental note where Resident #16 requested an appointment with the outside dentist; therefore, she did not schedule Resident #16 an appointment. On 01/08/2025 at 8:35 a.m., an interview was conducted with a representative at Resident #16's outside dental office. She confirmed Resident #16's last scheduled appointment was on 02/07/2022. On 01/08/2025 at 8:59 a.m., an interview was conducted with S11MR. She stated on 05/29/2024, Resident #16 told her he only wanted to see his outside dentist. She confirmed she did not tell the nurse because she thought S3ADON reviewed the dental notes. On 01/08/2025 at 9:06 a.m., an interview was conducted with S3ADON. She stated residents had the option to see an outside dentist if requested. She stated S13RN and S14SW reviewed the onsite dental notes when the dentist came to the facility. She confirmed S12ST was responsible for scheduling outside appointments. She reviewed the dental note dated 05/29/2024, and confirmed Resident #16 should have had an outside dental appointment scheduled. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #16's Nurses Note, dated 06/04/2024 revealed the following: Resident #16 was to be seen by in house dentist, Resident #16 refused and stated he wanted to be seen by an outside dentist. Signed by S13RN On 01/08/2025 at 9:11 a.m., an interview was conducted with S14SW. She stated she thought she reviewed the note on 05/29/2024, an appointment was made, and Resident #16 refused to go. She was unable to provide documentation of the scheduled appointment or Resident #16's refusal. On 01/08/2025 at 4:31 p.m., an interview was conducted with S2DON. She stated she thought Resident #16 was scheduled for an appointment and refused to go. She was unable to provide documentation of the scheduled appointment or Resident #16's refusal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on record review and interviews, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 2 (#14 and #65) of 2 (#14 and #65) residents reviewed for accurate documentation. The facility failed to ensure: 1. The medical record of Resident #65 contained accurate documentation of Coroner Notification with Permission to Release the Body; and 2. The medical record of Resident #14 contained a documented nurse assessment upon return from dialysis. This deficient practice had the potential to affect a current census of 67 residents. Findings: Review of the facility's undated policy, titled Documentation Guidelines: General, revealed the following: Nursing Service documentation will include, but shall not be limited to the following: 4. Baseline data such as weight, vital signs, etc. 5. Follow up care of resident's incidents and accidents Documentation in the nursing record will be made when a change in resident condition occurs. This includes all nursing interventions and follow up. Documenting information on the resident in the medical record provides: 1. A means of communication between the physician and other professionals contributing to the resident's care. 4. A way to record the care received by the resident. Review of the facility's undated policy, titled Fistula Maintenance: Post Dialysis Care, revealed the following: B. Documentation: 1. Documentation in the medical record regarding the fistula site may occur on the MAR, flowsheets, in the nurses' notes or any other part of the medical record. The following are examples of items to include in the documentation: b. condition of site; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Presence/absence of bleeding and/or any other abnormalities noted; and d. Complaints from resident regarding the site. 1. A review of Resident #65's Clinical Record revealed he was admitted to the facility on [DATE], with diagnosis, which included Chronic Obstructive Pulmonary Disease and Neoplasm of the Digestive System. Further review revealed he expired in the facility on [DATE]. A review of Resident #65's Physician Orders revealed the following: [DATE] at 11:00 a.m. by S3ADON - Ok to call Coroner, [DATE] at 10:30 a.m. by S3ADON - Ok to release body to a local funeral home. A review of Resident #65's MDS, with an ARD of [DATE], revealed the following: Section F: Entry/Discharge Reporting: 12. Death in Facility; and A2105: Discharge Status: 13. deceased A review of Resident #65's Nurse's Note revealed in part, [DATE] at 12:15 p.m. by S7LPN - Resident found at 8:12 a.m. in his wheelchair unresponsive, skin cold to touch, and had no pulse or respiration. Cardiopulmonary Resuscitation (CPR) was started at 8:15 a.m. and continued until 8:58 a.m. Local paramedics were called and arrived at 8:26 a.m. and placed a call to the Emergency Physician at 8:56 a.m. obtaining permission to stop CPR. On [DATE] at 9:00 a.m., an interview was conducted with S7LPN. S7LPN confirmed she was working day shift on [DATE]. S7LPN stated Resident #65 was found unresponsive in his wheel chair in the dining room, and CPR was started. She stated she was the scribe for the incident, and did not place any of the notification phone calls following his death. On [DATE] at 9:30 a.m., an interview was conducted with S3ADON. S3ADON confirmed she was working on [DATE]. S3ADON stated when the paramedics arrived, they worked on Resident #65 until they called the local emergency department physician and received an order for OK to stop CPR. S3ADON stated the facility's procedure for notification of the coroner was for a nurse to call. S3ADON stated she initiated a medical order, ok to call the coroner at [DATE] at 11:00 a.m. S3ADON stated she called the Coroner's Office to notify them Resident #65 had expired. S3ADON stated she spoke to a female on the phone, but was unable to recall her name. S3ADON stated the female on the phone said OK. She stated the Coroner's Office did not come to the facility prior to the body being released to the funeral home. S3ADON confirmed she did not document the time she called the coroner, who she spoke with, and permission to release the body was obtained. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:00 a.m., an interview was conducted with the Chief of Investigations for the local Coroner's office. He confirmed when a resident expired in a nursing home, even if EMS was present on the scene at the time of death, the funeral home was required to contact the coroner's office to report the death. He confirmed his office was open on [DATE] and if the nursing home had called to report a death, a staff member would have taken the call, written a report, and due to the circumstances of a sudden unexpected death in the facility, an investigator would have been sent out to the facility. He confirmed the Coroner's office did not receive a phone call regarding Resident #65's death until the funeral home called to request permission to cremate his body. He confirmed when the funeral home called, there was no active case for Resident #65 because they were never made aware of his passing and should have been. On [DATE] at 1:00 p.m., an interview was conducted with S2DON. S2DON confirmed she was present in the building on [DATE] when Resident #65 expired. S2DON confirmed the facility was responsible for notifying the coroner's office when a resident expired in the facility. S2DON confirmed an order to call the coroner was initiated by S3ADON on [DATE] at 11:00 a.m., and there was no further documentation regarding his death notification to the coroner or obtaining permission to release the body present in Resident #65's medical record and should be. 2. A review of Resident #14's Clinical Record revealed he was admitted on [DATE] with diagnoses, which included Dependence of Renal Dialysis. A review of Resident #14's current Physician Orders revealed the following: 11//2024- Dialysis Schedule: Resident #14 to have dialysis 3 times a week on Tuesday, Thursday and Saturday at local Dialysis Center. A review of Resident #14's Nurse's Notes, dated [DATE] through [DATE], revealed no documented evidence of his nurse conducting an assessment upon his return to the facility from the local Dialysis Clinic on Tuesday [DATE], Thursday [DATE], and Saturday [DATE]. A review of Resident #14's Dialysis Communication Binder, dated [DATE] through [DATE], revealed no documented evidence of his nurse conducting an assessment upon his return to the facility from the local Dialysis Clinic on Tuesday [DATE], Thursday [DATE], and Saturday [DATE]. A review of Resident #14's MAR/TAR, dated [DATE] through [DATE], revealed no documented evidence of his nurse conducting an assessment upon his return to the facility from the local Dialysis Clinic on Tuesday [DATE], Thursday [DATE], and Saturday [DATE]. On [DATE] at 3:40 p.m., an interview was conducted with S16LPN. She stated she conducted an assessment of Resident #14 upon his return to the facility from the Dialysis Clinic and it should have been documented in her nurse's notes. She confirmed it was not documented in the nurse's notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:01 p.m., an interview was conducted with S5MDS. She stated it was a standard practice to assess a resident upon their return to the facility from the Dialysis Clinic and the assessment should be documented in the resident's medical record. She confirmed Resident #14 attended dialysis three times per week and the medical record did not have any documented evidence of his nurse conducting an assessment upon his return to the facility from the Dialysis Clinic. On [DATE] at 4:31 p.m., an interview was conducted with the S2DON. She stated the nurse should complete a resident assessment upon return to the facility from dialysis, which included an assessment of their dialysis access site. She stated the assessment should be documented on the resident's MAR/TAR. She confirmed there was no documented evidence of a completed assessment upon return from the Dialysis Clinic in Resident #14's medical record. 47732

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46981 Based on record review and interviews, the facility failed to electronically submit accurate payroll information for direct care staffing as required. This deficient practice had the potential to affect any of the 67 residents residing in the facility. Findings: Review of the PBJ (Payroll Based Journal) Staffing Data Report for Fiscal Year 2024 Quarter 4 (July 1-September 30) revealed the following: -One star staffing rating, triggered. -Excessively low weekend staffing, triggered. -No Registered Nurse hours, triggered. -Failed to have licensed nursing coverage 24 hours/day, triggered. An interview was conducted on 01/08/2025 at 10:40 a.m. with S10CHR. She stated she was responsible for submitting payroll data to a contract company who was hired to submit the facility's payroll data. She stated on 01/08/2025, the contract company identified inaccurately submitted September 2024 payroll data for direct care staffing. She stated all quarters for payroll data submission for direct care staffing should be complete and accurate. An interview was conducted on 01/08/2025 at 10:52 a.m. with S1ADM. She stated all quarters for payroll data submission for direct care staffing should be complete and accurate. 47732

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of infection for 1 (#167) of 19 resident's reviewed in the final sample. The facility failed to ensure: 1. Staff wore proper Personal Protective Equipment (PPE) while providing catheter care; and 2. Staff performed proper hand hygiene while providing catheter care. Findings: Review of Resident #167's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Urinary Tract Infection. Review of Resident #167's current Physician Orders revealed the following, in part: Enhanced Barrier Precautions utilized when performing high-contact resident care activities related to Urinary Catheter; and Catheter care with soap and water. One time every shift. On 01/07/2025 at 9:20 a.m., an observation of the Enhanced Barrier Precautions sign posted on Resident #167's door revealed the following, in part: Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Providing hygiene, changing briefs, device care or use: urinary catheter. On 01/07/2025 at 9:24 a.m., an observation was made of S8CNA performing catheter care for Resident #167 with no gown in use. S8CNA cleansed Resident #167's genitalia and catheter tubing, then applied a clean brief without changing gloves or performing hand hygiene. On 01/07/2025 at 9:42 a.m., an interview was conducted with S8CNA. She confirmed she did not wear a gown while performing catheter care for Resident #167. She confirmed she did not change gloves or perform hand hygiene between cleansing Resident #167's genitalia, catheter tubing, and applying a new, clean brief. On 01/07/2025 at 11:12 a.m., an interview was conducted with S2DON. She confirmed S8CNA should have worn a gown during catheter care. She confirmed S8CNA should have changed gloves and performed hand hygiene after cleansing the resident's genitalia and catheter tubing.