STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195393	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Nursing & Rehabilitation Center	522 Main Street Delhi, LA 71232

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43405 Based on observations, interviews, and record reviews, the facility failed to ensure failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 2 (#12 and #38) of 4 (#12, #26, #38, and #59) sampled residents reviewed for activities of daily living (ADLs). Findings: Review of the facility's policy and procedure related to nail care, (revision date 02/01/2024), revealed the following, in part: General Guidelines 1. Nail care includes daily cleaning and regular trimming; 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments; 7. Diabetic nail care to be performed by a Registered Nurse or Provider Resident #12 Review of the record revealed an admitted [DATE] with diagnoses including myelopathy, chronic obstructive pulmonary disease, enlarged and hypertrophic nails, hammer toe, hyperlipidemia, hypertension, glaucoma, fusion of spine lumbar region, pressure ulcer of sacral region stage 4,and type 2 diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident #12 has a Brief Interview of Mental Status (BIMS) score of 12 indicating mild cognitive impairment. Further review of the MDS revealed resident requires assistance with ADLs. Review of the careplan dated 09/26/2023 revealed musculoskeletal: requires assistance with ADL's due to decreased mobility: related to occasional incontinence episodes, recent back surgery, chronic pain syndrome, muscle weakness. The interventions included 1-2 person assist with ADLs including hygiene, bathing, and transfers as needed, assist with positioning transfers, and ambulation as necessary 1-2 person assist with transfers. (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: 195393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview/observation on 04/08/2024 at 2:45 p.m. revealed resident #12 had long, jagged fingernails on bilateral hands. Resident #12 reported she has asked staff to cut her nails. An observation of resident #12 on 04/09/2024 at 8:10 a.m. revealed long, jagged fingernails noted to bilateral hands. An interview on 04/11/2024 at 1:45 p.m. with S2DON (Director of Nursing) confirmed that resident #12 is unable to trim her own nails and a Registered Nurse should have trimmed fingernails. Resident #38 Review of the chart revealed an admitted [DATE] with diagnoses including unspecified dementia without behavioral disturbance, nicotine dependence, major depressive disorder, alzheimer's disease, chronic obstructive pulmonary disease, history of amputation of right thumb and index finger, other visual disturbances, and type 2 diabetes mellitus. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating mild cognitive impairment. Further review of the MDS revealed resident required assistance with ADLs. Observations of resident #38 on 04/08/2024 at 10:05 a.m., 04/09/2024 at 8:10 a.m., and 04/11/2024 at 9:00 a.m. revealed resident had long, jagged, and dirty fingernails on both hands. An interview with resident #38 on 04/09/2024 at 8:10 a.m. revealed he is unable to trim his own nails. Review of the resident #38's careplan dated 02/08/2022 revealed potential for altered neurological function: Interventions included may use 1-2 person assist with ADLs, hygiene, bathing, and transfers as needed. An interview/observation with resident #38 on 04/11/2024 at 9:00 a.m. revealed resident's fingernails were long, dirty, and jagged on both hands. Resident #38confirmed he was unable to trim his own nails due to amputation of thumb and 1st finger to right hand. An interview on 04/11/2024 at 1:45 p.m. with S2DON confirmed resident #38 was unable to trim his own nails and a Registered Nurse should have trimmed his fingernails.

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NAME OF PROVIDER OR SUPPLIER Deerfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 522 Main Street Delhi, LA 71232	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on observations, record reviews, and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 (#23) of 1 resident reviewed for edema, 2 (#6 & #26) of 3 (#6, #26, #50) residents reviewed for Oxygen, and 1 (#6) of 1 resident observed during a Percutaneous Endoscopic Gastrostomy (PEG) tube medication administation. The facility failed to: 1. Apply compression stockings as ordered by the physician for resident #23, 2. Administer Oxygen as ordered by the physician for resident #6 and resident #26, and 3. Administer a 30 cubic centimeters (cc) water flush prior to the administration of resident #6's medications as ordered by the physician. Findings: Resident #23 Review of the medical record for resident #23 revealed the resident was admitted on [DATE] with diagnoses including hypertension, dementia with behavioral disturbance, ventricular septal defect following acute myocardial infarction, disorder of kidney and ureter, Alzheimer's disease, and edema. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severely impaired cognitive skills for daily decision making. The resident required maximal assistance with toileting hygiene and moderate assistance with transfers. The resident was incontinent of bowel and bladder. Review of the physician orders revealed an order dated 10/13/2023 to apply compression stockings every morning and remove compression stockings before bedtime. Review of the medical record revealed a careplan for impaired cardiac output. Further review of the careplan revealed an intervention to apply compression stockings every morning and remove every bedtime as ordered. Observations on 04/09/2024 at 8:40 a.m., 1:55 p.m., and 4:00 p.m. and on 04/11/2024 at 8:20 a.m. revealed resident #23 was sitting in her wheelchair in a common area. Further observation revealed the resident's feet and ankles were edematous and the resident did not have her compression stockings applied. Observation on 04/11/2024 at 11:15 a.m. revealed resident #23 was sitting in her wheelchair in the secondary dining room. Further observation revealed the resident's feet and ankles were edematous and the resident did not have her compression stockings applied. An interview with S5Certified Nursing Assistant (CNA) on 04/11/2024 at 12:00 p.m. revealed she was not aware that resident #23 required compression stockings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with S4Licensed Practical Nurse (LPN) on 04/11/2024 at 12:17 p.m. revealed the resident had an order for compression stockings and she confirmed the resident was not wearing her compression stockings. An interview with S2Director of Nursing (DON) on 04/11/2024 at 1:30 p.m. confirmed resident #23 did not have her compression stockings on as ordered by the physician. 43405 Resident #6 Review of the record for resident #6 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, cerebrovascular accident, chronic obstructive pulmonary disease (COPD), diabetes mellitus, tardive dyskinesia, and hypertension. Review of the Physician's Orders for April 2024 revealed the following orders dated: -01/28/2015 Oxygen (O2) at 2 Liters (L)/minute (min) via nasal cannula (NC) as needed (prn) ; and -11/14/2022 Give all medications via gastrostomy tube (G-tube), flush port with 30 cc of tap water before and after medications. An observation of the administration of G-tube medications for resident #6 on 04/09/2024 at 12:00 p.m. with S9Licensed Practical Nurse (LPN) revealed she did not flush the G-tube with 30 cc of tap water before the administration of medications. An interview with S9LPN confirmed she did not flush G-tube with 30 cc of tap water before medication administration. Observations of resident #6 on 04/08/2024 at 9:21 a.m. and 04/09/2024 at 8:05 a.m. revealed resident had O2 at 3.5 L/minute via NC. Review of the careplan updated on 02/09/2024 revealed resident had the potential for impaired respiratory function related to COPD, chronic bronchitis, cough, nasal congestion, and COVID (COronaVIrus Disease)-19. Interventions included to administer O2 therapy as ordered including O2 at 2L/min via NC prn. Observations of resident #6 on 04/08/2024 at 9:21 a.m. and 04/09/2024 at 8:05 a.m. revealed resident had O2 at 3.5 L/min via N/C. An interview on 04/11/2024 at 1:45 p.m. with S2DON confirmed that resident #6 had an order for 30 cc of tap water flush to be administered prior to medication administration and S9LPN should have flushed the G-tube with 30 cc of tap water prior to administering medications. S2DON confirmed that resident #6's O2 should have been at 2L/min via NC prn. S2DON confirmed that staff did not follow physician's orders for resident #6 by failing to flush the G-tube with 30 cc tap water prior to administration of medications and by not ensuring the O2 was at 2L/min via NC. Resident #26 (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the record revealed an admitted [DATE] with diagnoses including cellulitis of right lower limb, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, hypertension, unspecified dementia, chronic obstructive pulmonary disease, and acute respiratory failure with hypoxemia. Review of the Physician's Orders for April 2024 revealed an order dated 11/28/2023 for Oxygen at 2 Liters/minute (L/min) via nasal cannula (NC) continuous. Observations of resident #26 during the survey revealed the following: 1.) on 04/08/2024 at 9:28 a.m.- resident had O2 at 3.5 L/min via NC; and 2.) on 04/09/2024 - resident did not have O2 in place; and 3.) on 04/11/2024 at 10:45 a.m. - resident had O2 at 3L/min via NC. Review of resident #26's careplan dated 01/31/2019 revealed impaired breathing patterns: related to COPD, anxiety, allergic rhinitis, and a history of upper respirator infections. Interventions included administer O2 therapy as ordered. An interview on 04/11/2024 at 10:40 a.m. with S7Assistant Director of Nursing (ADON) confirmed that resident #26's O2 concentrator was set at 3L/min during an observation. S7ADON further confirmed resident #26 has an order for O2 at 2L/min via NC continuously and staff were not following physcian's orders. An interview on 04/11/2024 at 1:45 p.m. with S2DON confirmed that staff did not follow physician's orders for resident #6's by failing to administer O2 at 2L/min via NC continuous.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on observations, record review and interviews, the facility failed to ensure that residents received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 (#39) of 3 (#12, #16, #39) residents reviewed for pressure ulcers. The facility failed to provide a pressure relieving device while in the wheelchair for resident #39. Findings: Review of the medical record for resident #39 revealed the resident was admitted on [DATE] with diagnoses including diabetes, depression, hypothyroidism, schizoaffective disorder, Vitamin D deficiency, dementia with behavioral disturbances, and muscle wasting with atrophy. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident #39 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severely impaired cognitive skills for daily decision making. The resident was dependent for toileting hygiene and required partial/moderate assistance with transfers. The resident was incontinent of bowel and bladder. The resident was at risk for developing pressure ulcers. Review of the pressure ulcer scale dated 02/20/2024 revealed the resident was identified as high risk for pressure ulcers. Review of the record revealed the following careplan: at risk for impaired skin integrity/pressure injury. Further review revealed an intervention to provide pressure reducing surfaces on bed and chair. Observation on 04/08/2024 at 10:40 a.m. revealed the resident was in her wheelchair in her room. The wheelchair did not have a pressure relieving device. Further observation on 04/08/2024 at 3:40 p.m. revealed the resident was in her wheelchair in the sitting area. The wheelchair did not have a pressure relieving device. Observation on 04/09/2024 at 8:40 a.m., 1:00 p.m., and 4:00 p.m. revealed the resident was in her wheelchair in the sitting area. The wheelchair did not have a pressure relieving device. Observation on 04/11/2024 at 8:20 a.m. revealed the resident was in her wheelchair in the sitting area. The wheelchair did not have a pressure relieving device. Observation on 04/11/2024 at 11:15 a.m. revealed the resident was in her wheelchair in the secondary dining room. The wheelchair did not have a pressure relieving device. Observation on 04/11/2024 at 1:10 p.m. revealed the resident was in her wheelchair in the sitting area. The wheelchair did not have a pressure relieving device. An interview with S5Certified Nursing Assistant on 04/11/2024 at 12:05 p.m. revealed she was not aware the resident's wheelchair did not have a pressure relieving device. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with S4Licensed Practical Nurse on 04/11/2024 at 1:10 p.m. confirmed the resident's wheelchair did not have a pressure relieving device. LPN further confirmed the resident should have a pressure relieving device in her wheelchair. An interview with S2Director of Nursing on 04/11/2024 at 1:35 p.m. confirmed the resident was at high risk for developing pressure ulcers and resident #39 should have a pressure relieving device in her wheelchair.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121 Based on record reviews and interviews, the facility failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure nurses documented the site of subcutaneous diabetic injections for 3 (#26, #31, and #40) of 5 (# 23, #26, #31, #40, and #48) sampled residents reviewed for unnecessary medications. Findings: resident #31 Review of the medical record for resident #31 revealed an admitted [DATE] with diagnoses that included type 1 diabetes, hperlipidemia, anemia, upper respiratory infection, heart disease, chronic kidney disease, osteoarthritis, lack of coordination, convulsions, vascular dementia, and hypertension. Review of the active April 2024 Physician's orders revealed the following orders in regards to resident #31 taking the following medications for type 1 diadetes : Humalog 100 units/ml (milliliter) cartridge inject 10 units subcutaneous before breakfast Ozempic dose pen inject 0.5 mg (milligram) subcutaneous every Friday Humalog 100 units/ml (milliliter) cartridge15 units before lunch and supper at 11:00 a.m. and 4:00 p.m. Administer 10 units of regular Insulin for blood sugars greater than 250 Monitor Blood Sugars before breakfast, before evening meal and 2 hours after evening meal (see sliding scale for Blood sugars order for Blood sugars greater than 250 Review of the March and April Medication Administration Records (MARS) revealed resident #31 received the medication as ordered with no documentation of the sites when resident #31 received a subcutaneous injection. Interview on 4/11/2024 at 8:30 a.m with S2DON (Director of Nursing) confirmed there wass no documentation of the injection sites with each dose of insulin given by the nurses. 43405 Resident #26 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the record revealed an admitted [DATE] with diagnoses including cellulitis of right lower limb, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, hypertension, unspecified dementia, and chronic obstructive pulmonary disease. Review of the April 2024 Physician's Orders revealed an order dated 11/27/2023 for Novolog insulin sliding scale 6 a.m. and 4 p.m: 180-200 give 2 Units (U) subcutaneous (SQ), 201-250 give 3 U SQ, 251-300 give 4 U SQ, greater than 300 give 5 U SQ and call physician. Review of the March 2024 and April 2024 Medication Administration Records (MAR) revealed Novolog insulin had been given with no documentation of sites for the administration of Novolog insulin. An interview on 04/11/2024 at 11:25 a.m. with S7Assistant Director of Nursing (ADON) confirmed that sites should have been documented for insulin administration. S7ADON confirmed that there was no documentation of sites for administration of Novolog insulin for resident #26 for March 2024 and April 2024. An interview on 04/11/2024 at 1:45 p.m. with S2DON confirmed that there was no documentation of sites for administration of Novolog insulin for residnet #26 for March and April 2024. Resident #40 Review of the record revealed an admitted [DATE] with diagnoses including hypertension, glaucoma, acute embolism and thrombosis of unspecified deep veins of lower extremity, type 2 diabetes without complications, and angina pectoris. Review of the April 2024 Physician's Orders revealed an order dated 03/27/2024 for Mounjaro 2.5 mg/0.5 ml give 2.5 mg SQ every week (Friday) for resident #40. Review of the April 2024 MAR revealed Mounjaro SQ was administered on 04/05/2024 with no documentation of the injection site. An interview on 04/11/2024 at 11:25 a.m. with S7ADON confirmed the injection site should have been documented for the administration of Mounjaro. S7ADON confirmed that there was no documentation of site for administration of Mounjaro for resident #40 on 04/05/2024.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121 Based on record review and interview, the pharmacist failed to identify and report irregularities to the attending physician and the facility's medical director and director of nursing for 2 (#26, #31) of 5 (#23,#26, #31,#40,#48) sampled residents reviewed for unnecessary medications and insulin administration. Findings: resident #31 Review of the medical record for resident #31 revealed an admitted [DATE] with diagnosis that include type 1 diabetes, hperlipidemia, anemia, upper respiratory infection, heart disease, chronic kidney disease, osteoarthritis, lack of coordination, convulsions, vascular dementia, and hypertension. Review of the April 2024 Physician's orders revealed the following orders in regards to resident #31 taking the following medications for type 1 diadetes : Humalog 100 units/ml (milliliter) cartridge inject 10 units subcutaneous before breakfast Ozempic dose pen inject 0.5 mg (milligram) subcutaneous every Friday Humalog 100 units/ml (milliliter) cartridge15 units before lunch and supper at 11:00 a.m. and 4:00 p.m. Administer 10 units of regular Insulin for blood sugars greater than 250 Monitor Blood Sugars before breakfast, before evening meal and 2 hours after evening meal (see sliding scale for Blood sugars order for Blood sugars greater than 250 Review of the March and April Medication Administration Records (MARS) revealed no documentation of the injection sites when resident #31 received each dose of insulin given. Interview on 4/11/2024 at 8:30 a.m with S2Director of Nursing (DON) confirmed injection sites should be documented for insulin administration and there was no documentation of injection sites for insulin administration related to resident #31 for March 2024 and April 2024. An interview on 04/11/2024 at 1:50 p.m. with the S2DON confirmed that the pharmacist did not notify the facility of the irregularities in regards to the nurses not documenting the injection site when insulin was given. 43405 Resident #26 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #26`s record revealed an admitted [DATE] with diagnoses including cellulitis of right lower limb, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, hypertension, unspecified dementia, chronic obstructive pulmonary disease, and acute respiratory failure with hypoxemia. Review of the April 2024 Physician's Orders revealed an order dated 11/27/2023 for Novolog insulin sliding scale 6 a.m. and 4 p.m: 180-200 give 2 Units (U) subcutaneous (SQ), 201-250 give 3 U SQ, 251-300 give 4 U SQ, >300 give 5 U SQ and call physician, Review of the March 2024 and April 2024 Medication Administration Records (MAR) revealed no documentation of the injection sites when Novolog insulin was given as ordered. An interview on 04/11/2024 at 11:25 a.m. with S7Assistant Director of Nursing (ADON) confirmed that injection sites should be documented for insulin administration. S7ADON confirmed there was no documentation of injection sites for Novolog administration in March 2024 and April 2024 for resident #26. An interview on 04/11/2024 at 1:45 p.m. with S2DON confirmed there was no documentation of injection sites for Novolog administration in March 2024 and April 2024 for resident #26. S2DON also confirmed pharmacy consultant did not notify the facility of the irregularities in regards to the nurses not documenting the injection site when insulin was given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on interviews and record reviews, the facility failed to ensure residents were free from unnecessary medication use for 1 (#26) of 5 (#23, #26, #31, #40, and #48) sampled residents reviewed for unnecessary medications. The physician failed to ensure a psychotropic medication (Alprazolam) was not ordered to be given as needed for a time period greater than 14 days for resident #26. Findings: Resident #26 Review of the record revealed resident #26 had an admitted [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, hypertension, unspecified dementia, and chronic obstructive pulmonary disease. Review of the April 2024 Physician's Orders revealed an order dated 11/27/2023 for Alprazolam 0.25 milligrams (mg) 1 tablet by mouth (po) as needed (prn) for anxiety. Review of the Pharmaceutical Consultant Report dated 01/23/2024 revealed pharmacist recommended that Alprazolam (Xanax) prn psychotropic medication should be limited to 14 days. Physician denied the gradual dose reduction and rationale was minimally effective dose given, signed and dated by physician on 01/31/2024. Review of the March 2024 Medication Administration Record (MAR) revealed Alprazolam 0.25 mg po was administered on 03/21/2024. Review of the April 2024 MAR revealed Alprazolam 0.25 mg po was administered on 04/01/2024 and 04/02/2024. An interview on 04/11/2024 at 1:45 p.m. with S2Director of Nursing (DON) confirmed that Alprazolam (psychotropic) should not be administered as needed greater than 14 days. S2DON confirmed that the physician continued a prn psychotropic medication past 14 days for resident #26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Deerfield Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 522 Main Street Delhi, LA 71232	

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 19256 Based on observations, record reviews, and interviews, the facility failed to ensure the menus were followed for 4 (#25, #36, #55 and #113) of 4 residents who were prescribed pureed diets and 11 (#16, #18, #19, #22, #27, #40, #42, #51, #54, #58, and #363) of 11 residents who were prescribed mechanical soft diets. The facility failed to ensure the menus were followed for 8 (#14, #17, #23, #28, #39, #53, #54, and #58) of 8 residents by not providing 4 ounces of chicken during the 04/08/2024 lunch meal. Findings: Review of the lunch menu approved by the Registered Dietician dated 04/08/2024 revealed the residents receiving a pureed diet should receive pureed cornbread and the residents on a mechanical soft diet should receive moist cornbread. Further review revealed all diets should receive 4 ounces of chicken. Review of the medical records revealed residents #25, #36, #55 and #113 were ordered pureed diets and residents #16, #18, #19, #22, #27, #40, #42, #51, #54, #58, and #363 were ordered mechanical soft diets. Further review revealed residents #14, #17, #23, #28, #39, #53, #54, and #58 received meals from the facility's kitchen. Observation of the lunch meal on 04/08/2024 at 11:30 a.m. revealed residents #25, #36, #55 and #113 who were to receive pureed diets did not receive pureed cornbread. Further observation revealed residents #16, #18, #19, #22, #27, #40, #42, #51, #54, #58, and #363 who were to receive mechanical soft diets did not receive moist cornbread. Observation also revealed residents #14, #17, #23, #28, #39, #53, #54, and #58 who were to receive 4 ounces of chicken received one chicken leg not equivalent to s4 ounces. On 04/08/2024 at 12:06 p.m., an observation with S6Dietary Manager of the amount of chicken from one chicken leg revealed the chicken did not measure 4 ounces. Observation on 04/08/2024 at 12:15 p.m. revealed resident #54 had eaten her one chicken leg. An interview with resident #54 at this time revealed she would like some more chicken. An interview on 04/09/2024 at 12:30 p.m. with S6Dietary Manager (DM) confirmed the residents who received pureed diets were not served pureed cornbread and the residents who received mechanical soft diets were not served moistened cornbread as stated on the menu approved by the Registered Dietician. Further interview with S6DM confirmed one chicken leg did not provide 4 ounces of chicken as stated on the menu approved by the Registered Dietician. During an interview with the S1Administrator on 04/09/2024 at 1:05 p.m., S1Administrator was notified that the menu approved by the Registered Dietician was not followed during the lunch meal on 04/08/2024.