

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Bernice Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Reeves Street Bernice, LA 71222	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>18118</p> <p>Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 2 (#51 and #70) of 5 (#35, #51, #65, #70, and #78) residents' rooms observed. The failed practice was evidenced by resident's air/heating units needed cleaning.</p> <p>Findings:</p> <p>Resident 51</p> <p>On 03/17/2025 at 12:27 p.m. observation of the air/heating unit in resident #51's room revealed the vents contained a black substance.</p> <p>On 03/18/2025 at 1:00 p.m. observation of the air/heating unit in resident #51's room with S1Executive Director confirmed the vents contained a black substance and needed to be cleaned.</p> <p>Resident 70</p> <p>On 03/17/2025 at 12:28 p.m. observation of the air/heating unit in resident #70's room revealed the vents contained a buildup of dust and grime.</p> <p>On 03/18/2025 at 1:10 p.m. observation of the air/heating unit in resident #70's room with S1Executive Director confirmed the vents contained a buildup of dust and grime and needed to be cleaned.</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on observations, record reviews and interviews the facility failed to ensure a resident's comprehensive plan of care was implemented for 2 (#2 and #34) of 2 residents reviewed for care plans by, not providing heel protectors and /or a palm protector as ordered by the physician.</p> <p>Findings:</p> <p>Resident 34</p> <p>Review of the record for resident #34 revealed an admitted [DATE] with diagnoses including cerebral infarction, contracture to right and left hand, diabetes mellitus, chronic obstructive pulmonary disease, dysphagia, heart disease, anemia, schizophrenia, right below the knee amputation, hyperlipidemia, and diabetic neuropathy.</p> <p>Review of the physician's orders revealed an order dated 11/04/2024 to ensure heel protectors in place every shift related to diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #34 was independent with cognition for daily decision making. Resident #34 was totally dependent on staff for mobility, transfers and toilet use and required extensive assistance with eating.</p> <p>Review of the current care plan revealed resident #34 had an activities of daily living (ADL) self-care performance deficit related to activity intolerance. The interventions included to use heel protectors while in the bed.</p> <p>On 03/17/2025 at 1:00 p.m., and 3:00 p.m. observations of resident #34 revealed she was in the bed without a heel protector on her left foot.</p> <p>On 03/17/2025 at 3:05 p.m. S16Licensed Practical Nurse (LPN) confirmed resident #34 should have on a heel protector on the left foot while in the bed.</p> <p>On 03/19/2025 at 2:00 p.m. S2Director of Nursing (DON) was notified that resident #34 did not have the heel protector on while in the bed on 03/17/2025.</p> <p>32231</p> <p>Resident #2</p> <p>Review of the medical record revealed resident #2 was admitted to the facility on [DATE] with diagnoses that included in part, hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side, and Schizophrenia.</p> <p>Review of the March 2025 medication administration record revealed an order dated 02/20/2025 at 6:00 p.m. , to monitor placement for palm protectors to left hand contractures each shift.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/17/2025 1:43 p.m., 03/18/2025 at 8:45 a.m., and 03/18/2025 at 1:45 p.m., observations revealed resident #2 was lying in bed with a contracture observed to his left hand. Further observation revealed there was no type of splint device in place to the resident's hand.</p> <p>On 03/18/2025 1:49 p.m., an observation revealed resident #2 was lying in bed with a contracture observed to his left hand with no type of splint device in place. S5Registered Nurse (RN) / Wound Care Nurse (WCN) was present and observed resident #2's contracted hand. She confirmed that resident #2 did not have any type of splint device in place at that time. After reviewing the March 2025 physician's orders with S5RN/WCN, she confirmed resident #2 was to have a palm protector to the left hand contracture and be monitored for placement every shift.</p> <p>On 03/18/2025 at 10:34 a.m., S1Registered Nurse/Unit Manager was notified the above findings regarding resident #2's contracted hand.</p> <p>On 03/19/2025 at 3:30 p.m., S1Executive Director, S2Director of Nursing, and S3Clinical Operations were notified of the above findings.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out Activities of Daily Living (ADL) receives the necessary services to maintain good personal hygiene for 1 (#73) of 6 (#15, #26, #27, #56, #65, and #73) residents reviewed for ADL care. The provider failed to ensure resident #73's fingernails were trimmed and cleaned.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #73 was admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer's disease and dementia.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed that resident #73 was severely impaired with his daily decision making skills and he required substantial/maximal assistance with personal hygiene.</p> <p>Review of the medical record revealed resident #73 was care planned for an ADL self-care deficit and he required extensive assistance with ADLs related to Alzheimer's disease. The documented approaches included in part, bathing/showering: check nail length, trim and clean on bath days and as necessary.</p> <p>On 03/17/2025 at 9:40 a.m., and 03/18/2025 at 9:54 a.m., observations revealed resident #73 sitting in a wheelchair in front of the nurse's station. Further observation revealed resident #73 had long fingernails to both hands, they were long, untrimmed and had thick buildup of grime underneath the nail beds of both hands.</p> <p>On 03/18/2025 at 9:55 a.m., S15Certified Nursing Assistant (CNA) was notified of the observations of resident #73's fingernails being long, untrimmed with a buildup of grime underneath the nail beds of both hands. After observing resident #73's hands, S15CNA confirmed that resident #73's fingernails needed to be trimmed and cleaned.</p> <p>On 03/18/2025 at 11:04 a.m., S10Registered Nurse (RN), Unit Manager was notified of the above findings. After observing resident #73's hands, she confirmed that resident #73's fingernails needed to be trimmed and cleaned.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the Licensed Practical Nurse (LPN) must have the appropriate competencies to provide nursing and related services necessary to care for resident's needs as identified and described in the plan of care for 1 (#2) of 7 (#2, #4, #12, #15, #43, #44, and #50) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #2 was admitted to the facility on [DATE] with diagnoses that included in part, hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side, and schizophrenia.</p> <p>Review of the March 2025 Medication Administration Record (MAR) revealed an order dated 02/20/2025 to monitor placement for palm protector to left hand contractor each shift every day and night shift. Further review of the March 2025 MAR revealed S9LPN had initialed on the MAR on 03/18/2025 (day shift), to indicate that resident had been monitored for the palm protector placement to resident #2's left hand.</p> <p>On 03/17/2025 at 1:43 p.m., and 03/18//2025 at 8:45 a.m., observations revealed resident #2 was lying in bed with a contracture observed to his left hand. Further observation revealed there was no type of splint device in place to the resident's hand.</p> <p>On 03/18/2025 at approximately 2:35 p.m., S9LPN was notified of resident #2's physician's order to monitor placement for palm protector to resident #2's left hand contracture on the day shift. She was further notified of the observations of resident #2 not having the palm protector in place during the observations. S9LPN confirmed that she had initialed the monitoring of the device. She further confirmed that she did not actually observe the hand protector in resident #2's left palm at the time she documented the monitoring on 03/18/2025 for the day shift.</p> <p>On 03/18/2025 at 10:34 a.m., S1Registered Nurse/Unit Manager was notified the above findings regarding resident #2's contracted hand.</p> <p>On 03/19/2025 at 3:30 p.m., S1Executive Director, S2Director of Nursing, and S3Clinical Operations were notified of the above findings.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, review of the Order Listing Report, and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, by 1) having exposed and unlabeled food items in the freezer and refrigerator, 2) placing contaminated food preparation utensils on top of and in direct contact with resident foods, and 3) testing the dishwasher sanitizer level with expired test strips. According to the Order Listing Report provided by S11Dietary Manager (DM), there was a total of 79 residents that received a meal tray from the kitchen.</p> <p>Findings:</p> <p>On [DATE] at 8:30 a.m., an observation of the kitchen with S11Dietary Manager (DM) revealed there was one upright freezer that had one opened box of riblet pork patties and one opened box of hamburger patties that were exposed to air and not labeled with an open date. Further observation of the upright freezer revealed one opened box of chicken bread that was not labeled with an open date. Further observation of the kitchen revealed one refrigerator that had an opened box of pie dough and a second refrigerator that had one opened box of sausage patties that were not labeled with an open date. S11DM confirmed the opened, air exposed, unlabeled food items should not have stored inside of the freezer and refrigerator and available for resident consumption.</p> <p>Observation of the kitchen further revealed S11Dietary Manager testing the dishwasher for the sanitizer level. After she had completed the testing, an observation of the test strip bottle revealed an expiration date of ,d+[DATE]. S11Dietary Manager was present and confirmed the bottle of test strips was expired.</p> <p>On [DATE] at 11:30 a.m., an observation of the steam table revealed one large pan of cornbread that had been cut into individualized pieces. Further observation revealed a large spatula and a pair of tongs lying inside of the pan of cornbread. During the food service, S12Dietary [NAME] was observed handling both the tongs and spatula with her bare hands. She was further observed handling and placing them on top of the cornbread with her bare hands. Both the tongs and spatula were on top of and in direct contact with the cornbread that was served to the residents. S13Dietary [NAME] was observed preparing the resident's plates for the meal service. During the observation, S13Dietary [NAME] touched the inside of the plates with her bare fingers and /or thumb.</p> <p>On [DATE] at 12:40 p.m., S11Dietary Manager and S18Regional Director of Nutritional Services were notified of the above observations and confirmed that S12Dietary [NAME] should not have placed the spatula and tongs on top of and in direct contact with the cornbread and further confirmed that S13Dietary [NAME] should not have touched the inside of the plates with bare fingers and or/hands due to cross contamination.</p> <p>On [DATE] at 3:30 p.m., S1Executive Director, S2Director of Nursing, and S3Clinical Operations were notified of the above findings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observations, record reviews and interviews the facility failed to ensure staff maintained infection control practices by not following Enhanced Barrier Precautions (EBP) for 2 (#61, #65) of 2 residents observed during care who were on EBP and by having staff personal items in the medication storage room.</p> <p>Findings:</p> <p>Review of the facility's EBP policy and procedure dated April 2024 revealed:</p> <p>Policy</p> <p>Subject: Enhanced Barrier Precautions</p> <p>Policy: Enhanced Barrier Precautions are indicated for residents with infections or colonization with a Centers for Disease Control (CDC)-targeted Multi Drug Resistant Organisms (MDRO) when contact precautions do not apply or for residents with wounds and/or indwelling medical devices without secretions/excretions that are unable to be covered/contained & are not known to be infected/colonized with any MDRO during high-contact resident care activities as these residents are at an increased risk of being infected.</p> <p>Definition</p> <ol style="list-style-type: none"> 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in Nursing Homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). 2. Enhanced Barrier Precautions only require use of gown/gloves when performing high contact resident activities: <ol style="list-style-type: none"> a. Dressing b. Bathing/showering c. Transferring (in room, shower/tub rooms, and therapy gyms) d. AM/PM Care e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy, or ventilator <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>h. wound care: any skin opening requiring a dressing</p> <p>3. Duration: Enhanced Barrier Precautions are intended to remain in effect for the duration of the resident stay or until the wound in closed/medical device removed.</p> <p>Responsibility</p> <p>All Staff</p> <p>Equipment</p> <p>1. Door sign that reads Enhanced Barrier Precautions or Visitors Must See Nurse Before Entering.</p> <p>2. Supply of gowns, gloves and plastic bags.</p> <p>Procedure</p> <p>1. A private room is not required. Residents may be out of the room, attend activities and therapies and any other activities of their choosing.</p> <p>2. Education family and/or resident on the precaution being initiated and procedures to be maintained.</p> <p>3. Apply protective equipment as indicated prior to providing any high contact resident care as listed above.</p> <p>a) Gloves- utilized during the course of providing high contact care. Remove gloves before leaving the room.</p> <p>b) Gown- apply gown before providing high contact care. Additional Personal Protective Equipment (PPE) may be indicated under Standard Precautions if splashing is anticipated such as tracheostomy care or wound irrigation.</p> <p>c) Resident Care Equipment- normal procedure of cleaning and disinfecting equipment before use on another resident.</p> <p>d) Explain all procedures to the resident before initiating care.</p> <p>e) Bag used linen(s), dispose of gown and gloves in waste receptacle after care is completed.</p> <p>f) Wash hands before leaving the room and transfer bagged linen to holding room.</p> <p>g) Sanitize hands</p> <p>Resident 61</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the record for resident #61 revealed diagnoses in part of obstructive and reflux uropathy, diabetes insipidus, benign prostatic hyperplasia without lower urinary tract symptoms, and chronic kidney disease.</p> <p>Review of the Physician's order dated 02/20/2025 revealed an order for EBP due to indwelling catheter.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #61 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Further review of the MDS revealed resident #61 required partial/moderate assistance with toileting hygiene.</p> <p>Review of the current plan of care revealed resident #61 was at risk for injury/infection. Resident #61 had a Foley catheter due to diagnosis of benign prostatic hypertrophy. Further review of the current plan of care revealed resident #61 required EBP.</p> <p>On 03/17/2025 at 9:20 a.m. observation of the outside of resident #61's door revealed a sign that indicated resident #61 was on EBP. Further observation revealed gloves and gowns were available for use.</p> <p>On 03/17/2025 at 9:22 a.m. S9Licensed Practical Nurse (LPN) was observed going into resident #61's room and only applied gloves. Further observation revealed S9LPN touched the indwelling Foley catheter.</p> <p>On 03/17/2025 at 9:53 a.m., an interview with S9LPN confirmed she only wore gloves when she went in resident #61's room and handled the indwelling catheter.</p> <p>Resident 65</p> <p>Review of the record for resident #65 revealed diagnoses in part of Alzheimer's disease, dysphagia, seborrheic dermatitis and aphasia.</p> <p>Review of the Physician's order dated 02/03/2025 revealed an order for EBP due to Percutaneous Endoscopic Gastrostomy (PEG) tube.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #65 had a BIMS that was unable to be assessed. Resident #65 required substantial or maximal assistance with all activities of daily living skills.</p> <p>Review of the current plan of care revealed resident #65 required assistance with activities of daily living due to his cognitive impairment related to Alzheimer's.</p> <p>On 03/19/2025 at 8:40 a.m. observation of resident #65's door revealed a sign that indicated resident #65 was on EBP. Further observation revealed there was a supply of gloves and gowns in a cart hanging on the resident's door.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/19/2025 at 8:45 a.m. observation of resident #65 during a shower revealed S6Certified Nursing Assistant (CNA) and S7CNA transferred resident #65 from the wheelchair to the shower chair only wearing gloves. S6CNA and S7CNA did not wear a gown. Further observation of the shower performed by S6CNA revealed she only wore gloves and no gown during the shower.</p> <p>Observation of transferring resident #65 from a shower chair to the wheelchair revealed S8CNA and S6CNA transferred resident #65 back to the wheelchair only wearing gloves. S6CNA and S8CNA did not wear a gown.</p> <p>S6CNA then placed a shirt on resident #65, a clean brief and put on his pants. S7CNA assisted S6CNA with standing resident #65 to pull up his pants. S6CNA and S7CNA only wore gloves and no gown.</p> <p>On 03/19/2025 at 9:43 a.m., an interview with S6CNA, S7CNA and S8CNA confirmed they only used gloves and did not put on a gown while performing the resident's shower or transferring the resident. S7CNA further stated that she was unaware that she had to use a gown when she assisted resident #65 in the shower.</p> <p>On 03/19/2025 at 2:30 p.m. S2Director of Nursing (DON) and S3Clinical Operations were notified that S6CNA, S7CNA and S8CNA did not use appropriate personal protective equipment (PPE) when providing care to resident #65.</p> <p>32231</p> <p>Medication Storage Room</p> <p>On 03/18/2025 at 11:10 a.m., an observation of the medication storage room with S5Registered Nurse (RN)/Wound Care Nurse (WCN) revealed two large purses lying on top of and in direct contact with the medication preparation countertop.</p> <p>On 03/18/2025 at 11:13 a.m., S10Registered Nurse (RN) Unit Manager was notified of the above findings. She confirmed that the purses should not have been stored inside of the medication storage room and on the top of and in direct contact with the countertop due to cross contamination.</p> <p>On 03/19/2025 at 3:25 p.m., S1Executive Director, S2Director of Nursing, and S3Clinical Operations were notified of the findings regarding the purses being stored in the medication storage room.</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>32231</p> <p>Based on observations and interview the facility failed to ensure all mechanical equipment was maintained in safe operating condition by having a can opener in the kitchen with a large buildup of metal shavings and by having the deep fryer with grease buildup in lower compartment.</p> <p>Findings:</p> <p>On 03/17/2025 at 8:30 a.m. observation of the kitchen with S11Dietary Manager revealed the large commercial can opener had a large buildup of metal shavings underneath the blade.</p> <p>Further observation of the kitchen area with S11Dietary Manager of the deep fryer revealed there was an oil spill and buildup of thick greasy particles on the inside of the fryer's lower compartment.</p> <p>On 03/19/2025 at 3:25 p.m. S1Executive Director, S2Director of Nursing (DON) and S3Clinical Operations were notified of the above findings.</p>