

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Natchitoches Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 781 Highway 494 Natchitoches, LA 71457	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004</p> <p>Based on observations, interviews, and record review the facility failed to ensure that each Resident was treated with respect and dignity in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 2 (#19, and #32) out of 34 sampled residents. The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the privacy of Resident #19 while staff provided wound care. 2. Ensure staff did not stand while assisting Resident #32 during a meal service. <p>Findings:</p> <p>Review of the facility's policy titled Dignity dated 02/2021 read in part . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times.</p> <p>Review of the facility's policy titled Assistance with Meals dated 03/2022 read in part . Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals.</p> <p>Resident #19</p> <p>Record Review revealed Resident #19 was admitted to the facility on [DATE]. Resident #19 had diagnoses that included in part . Chronic Kidney Disease, Stage 5, Type 2 Diabetes Mellitus, Congestive Heart Failure, Unspecified Protein Calorie Malnutrition, Dependence on Renal Dialysis, Chronic Pulmonary Edema, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #19's Quarterly MDS with an ARD of 04/10/2024 revealed Resident #19 had a BIMS of 15(cognition intact). Resident #19 required Substantial/Maximal assistance from staff for toileting, showering/bathing, dressing, and personal hygiene.</p> <p>Review of Resident #19's Active Orders revealed in part .</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Clean Stage 2 Pressure Ulcer to coccyx with normal saline or wound cleanser, apply calazinc, apply collagen, and apply foam border dressing. Order date: 07/15/2024</p> <p>Observation on 07/17/2024 at 10:04 a.m. revealed S9 Treatment Nurse and S13 Treatment nurse provided wound care to Resident #19. Upon entering Resident #19's room the window blinds was observed open, with a person outside of window cutting the lawn. S9 Treatment Nurse and S13 Treatment Nurse uncovered and undressed Resident #19's bottom half with window blinds opened, and Resident #19 remained exposed. Surveyor intervened and closed window blinds for resident's privacy. S9 Treatment Nurse stated she forgot to close the blinds prior to wound care treatment.</p> <p>Interview on 07/17/2024 at 1:33 p.m. with Resident #19 revealed she always kept her window blinds open. Resident #19 stated she did not realize that her blinds were open while she was undressed during wound care. Resident #19 stated I hope the man on the lawn [NAME] didn't see. Resident #19 revealed she would not have wanted anyone to see her undressed.</p> <p>Resident #32</p> <p>Observation on 07/15/2024 at 12:10 p.m. of dining service revealed S12 LPN assisted Resident #32 with meal service in resident's room. S12 LPN was observed standing over the left side of Resident #32's bed while she fed resident. There were 2 chairs observed in resident's room.</p> <p>Interview on 07/15/2024 at 12:11 p.m. with S12 LPN confirmed she stood to assist Resident during meal service and stated she did not know she could not stand to assist residents with meals.</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20604</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure services were provided to meet professional standards of quality, by failing to accurately transcribe and implement recommendations from the Registered Dietician, and failing to notify the physician when a resident complained of hunger, nausea, and requested to have her tube feeding rate increased for 1 (#26) of a total of 5 (#4, #16, #26, #96, and #98) residents receiving nutrition by PEG tube feedings in the facility; and failing to perform and document a Comprehensive Skin Assessment for 1 (Resident #19) of 3 (Resident #19, Resident #28, Resident #101) Residents reviewed for Pressure Ulcers. The total Sample Size was 34.</p> <p>Findings:</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #26 on 07/05/2024 at 3:02 p. m., when S4 RN Clinical Coordinator incorrectly entered a physician's order for a nutritional feeding rate at 25 ml/hr instead of the recommended rate of 45 ml/hr. S19RD's Progress Notes dated 07/05/2024, revealed recommendations for Diabetisource AC (nutritional feeding) at 45 ml/hr. Review of Resident #26's medical record revealed she had received Diabetisource AC at 25 ml/hr from 07/05/24 to 07/15/2024, instead of the recommended Diabetisource AC at 45 ml/hr. Review of Resident #26's progress notes dated 07/13/2024 revealed, Resident #26, who was cognitively intact, and able to communicate by typing messages on her phone, communicated to S6 LPN that she wanted her feedings increased because she was hungry, nauseated, and felt like she was losing too much weight. During an interview on 07/15/2024 at 10:26 a.m. with Resident #26, she typed on her phone that she was hungry and losing weight. Observations at that time revealed Diabetisource AC infusing via her PEG tube at 25 ml/hr. In an interview with S4 RN on 07/16/2024 at 2:49 p.m., she stated she misread the RD recommendation, and put in the order as Diabetisource 25 ml/hr, instead of the recommended 45 ml/hr. Resident #26 had a significant weight loss of 9.6 pounds (7.79% body weight), between 07/05/2024 and 07/16/2024.</p> <p>S1Administrator and S2 DON were notified of the Immediate Jeopardy situation on 07/17/2024 at 4:21 p.m.</p> <p>The Immediate Jeopardy was removed on 07/18/2024 at 4:45 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>This deficient practice continued at a potential for more than minimal harm for any resident on PEG tube feeding in the facility that may receive new dietary recommendations.</p> <p>Findings:</p> <p>Resident #26</p> <p>Review of the facility's policy titled, Medication Orders (Revised November 2014), revealed the following, in part: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. A current list of orders must be maintained in the clinical record for each resident.</p> <p>Review of the facility's policy titled, Emergency and/or Alternate Physician Care (Revised April 2013), revealed the following, in part .All residents shall be provided with emergency and/or alternative physician care.</p> <p>2. Should an emergency arise, and the resident's attending physician is not available, the emergency physician on-call must be contacted .</p> <p>5. The staff will use appropriate procedures to contact physicians, depending on arrangements and the urgency of the situation .</p> <p>6. If a physician and his/her backup coverage do not respond timely or appropriate manner to the facility notification of medical issues, the nursing staff will contact the medical director for assistance.</p> <p>Review of the facility's Info: Orders Communication Methods Explained (Updated January 31, 2024), revealed the following, in part: When adding a new order, users may select any of the following communication methods:</p> <p>Phone - means the physician called on the phone and communicated an order to the user, and it will pend signature.</p> <p>Verbal - means the physician was present and verbally communicated an order to the user, and it will pend signature.</p> <p>Prescriber Written - means the physician wrote the order on a prescription pad and signed it, then handed it to the user. There is no electronic signature trail of a prescriber written order. It is assumed the facility scanned the hard copy with a signature on it.</p> <p>Review of Resident #26's medical record revealed an admitted [DATE], with diagnoses that included in part . Cerebral Infarction, Retention of Urine, Gastrostomy Status, Ileus, Neuromuscular Dysfunction of the Bladder, Aphasia, Dysphasia, and Type 2 Diabetes Mellitus.</p> <p>Review of Resident #26's MDS with an ARD of 06/22/2024, revealed she had a BIMS score of 13, which indicated she was cognitively intact.</p> <p>Review of Resident #26's physician's orders read in part as follows:</p> <p>07/05/2024 - Enteral feed order: Continuous diabetic source 25 ml/hour 150 ml water flush q6hrs .</p> <p>Review of Resident #26's current care plan with a problem onset date of 06/21/2024, revealed a problem of I require tube feeding, I receive Diabetisource 250ml every 8 hours with 150ml flush every 8 hours. Interventions included: I am dependent with tube feeding and water flushes. I will have a RD to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The care plan had not been updated to reflect the 07/05/2024 RD recommendations for Diabetisource AC at 45 ml/hr + 150 ml q 6hrs (or 25 ml/hr. flushes if continuous).</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of an email correspondence revealed the following was sent to several employees including S2 DON, S7 ADON and S4 RN Clinical Coordinator:</p> <p>07/04/2024 at 2:03 p.m. - S19 Registered Dietician sent recommendations to increase Diabetisource from 250 ml every 8 hours, to Diabetisource 250 ml every 6 hours.</p> <p>07/05/2024 at 8:52 a.m. - S7 ADON responded to S19 RD, and requested the continuous rate for a feeding pump.</p> <p>07/05/2024 at 10:23 a.m. - S19 RD responded with recommendation for Diabetisource AC at 45 ml/hr + 150 ml q 6 hrs (or 25 ml/hr. flushes if continuous). Will provide 1296 Kcals, 65 gm protein, 883 mls free water (1422 mls TFW).</p> <p>Review of Resident #26's Electronic Medication Administration Record (EMAR) for July 2024, revealed she received Diabetisource 25 ml/hr from 07/05/2024 through 07/15/2024.</p> <p>Review of Resident #26's medical record revealed the following weights which represented a significant weight loss of 7.79% between 07/05/2024 and 07/16/2024:</p> <p>06/19/2024 125.8 lbs Wheelchair</p> <p>07/02/2024 125.8 lbs Wheelchair</p> <p>07/05/2024 123.2 lbs Wheelchair</p> <p>07/16/2024 113.6 lbs Wheelchair</p> <p>Review of Resident #26's progress notes revealed that on 07/13/2024 at 12:41 p.m. S6 LPN wrote Resident states that she is feeling hungry and nauseated and feels like she is losing too much weight. Gave her Zofran and it was ineffective. She is requesting to have her feedings increased. Called and left message for the physician. Will continue to monitor.</p> <p>An observation and interview on 07/15/2024 at 10:26 a.m., revealed Resident #26 had a feeding pump infusing Diabetisource AC at 25 ml/hr., with the water flush set at 150 ml/6hrs. At that time, Resident #26 typed I'm hungry, I'm losing weight on her phone, then typed I'm getting one capful of feeding an hour. During that time, Resident #26's daughter entered the room, and said her mother's tube feeding was not enough, and she had lost weight. Resident #26's daughter explained she was here today to talk to someone about her mother's tube feeding, and being hungry.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview on 07/16/2024 at 2:49 p.m. with S4 RN Clinical Coordinator, revealed she was responsible for carrying out dietary recommendations for Resident #26 on 07/05/2024. She indicated that Resident #26 was NPO with tube feedings, and getting bolus feedings of Diabetisource AC 250ml every 8 hours, and flush with 150ml of water every 8 hours. S4 RN Clinical Coordinator said that Resident #26 was assessed by S19 RD on 07/04/2024, with recommendations to increase Diabetisource to 250ml carton every 6 hours, and flush with 150 ml of water every 6 hours, to increase Resident #26's caloric intake from 900Kcals to 1200Kcals. S4 RN Clinical Coordinator stated that on 07/05/2024, S7 ADON requested S19 RD give her the rate for continuous feeding on a pump because Resident #26 was staying long-term. She stated that the S19 RD sent an email on 7/05/2024 recommending Diabetisource AC at 45 ml/hr. S4 RN Clinical Coordinator stated that she called S10 NP and misread the recommendation to S10 NP. S4 RN Clinical Coordinator indicated that she entered the order as 25 ml/hr., instead of the recommended 45 ml/hr. S4 RN Clinical Coordinator stated I read the recommendation wrong.</p> <p>During an observation and interview of Resident #26 on 07/16/2024 at 3:12 p.m., when asked how she was feeling today, Resident #26 typed I feel better. Before I was hungry and nauseous after taking medicine on an empty stomach. Resident #26 then typed It felt like they were starving me and there was nothing I could do. I asked the nurse practitioner if I'm gonna die.</p> <p>An interview on 07/16/2024 at 4:00 p.m. with S2 DON and S20 QI Nurse, revealed there was not one standard facility process for obtaining, communicating and carrying out dietary recommendations. S2 DON stated the clinical coordinator for each house was responsible for obtaining and carrying out the dietary recommendations for their residents. S2 DON reported that the facility did not have a system for ensuring recommendation from the Registered Dietician were accurately communicated and accurately entered. S20 QI Nurse, stated We don't have one, but we will have one today.</p> <p>An interview on 07/16/2024 at 4:55 p.m. with S7 ADON revealed that she was the direct supervisor for S4 RN Clinical Coordinator. S7 ADON reported she amended the order for Resident #26 on 07/09/2024 to reflect on the EMAR for the day and night shift. However, she reported that she did not review the rate of the infusion, and did not compare the order to the dietary recommendations. S7 ADON confirmed Resident #26 should have been getting 45 ml/hr of Diabetisource instead of the 25 ml/hr she received from 07/05/2024 through 07/15/2024.</p> <p>A telephone interview on 07/17/2024 at 8:38 a.m. with S10 NP, revealed that he typically follows the Registered Dietician's recommendations. He stated That's what she specializes in. He reported he did not remember talking to S4 RN Clinical Coordinator about Resident #26's PEG feeding. He revealed that he would have followed the RD's recommendations for the 45ml per hour infusion rate.</p> <p>A telephone interview on 07/17/2024 at 09:09 a.m. with S19 RD, revealed she made recommendations to increase Resident #26's PEG feeding from Diabetisource 250ml every 8 hours to provide 900 Kcals, to Diabetisource 250ml every 6 hours to provide 1200 Kcals to increase her caloric intake. S19 RD reported that S7 ADON emailed her and requested a continuous rate recommendation on 07/05/2024. S19 RD reported she recommended Diabetisource AC to be infused at 45 ml/hr, and flushed with 150 ml of water every 6 hours, or flush at 25 ml/hr if Resident #26 was on a continuous infusion. S19 RD confirmed that Resident #26 should have received 45 ml/hr instead of 25 ml/hr, as recommended on 07/05/2024. S19 RD confirmed that receiving 25 ml/hr contributed to Resident #26's weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview on 07/17/2024 at 12:05 p.m. with S2 DON revealed she was told by S6 LPN on 07/14/2024 about Resident #26 being hungry. S2 DON reported that she emailed S19 RD on 07/14/2024 about Resident #26's PEG feeding and complaints of hunger. S2 DON stated that S19 RD responded on 07/15/2024, and recommended to increase the tube feeding by 10ml every 4 hours until Resident #26 reached 45 ml/hr. S2 DON stated she was not aware of the issue with Resident #26's tube feeding rate until it was brought to her attention by the surveyor.</p> <p>A telephone interview on 07/17/24 at 12:15 p.m. with S6 LPN revealed that Resident #26 told her on 07/13/2024 around lunch time that she was hungry, losing weight and wanted her tube feeding to be increased. S6 LPN reported that she called Resident #26's attending physician and left a message, but never received a call back. S6 LPN stated that on 07/14/2024, towards the end of her shift, she saw S2 DON at the facility and reported to her what Resident #26 had said.</p> <p>A telephone interview on 07/18/2024 at 1:18 p.m. with S10 NP revealed that he did not remember any nurse calling him about the recommendations for Diabetisource to be infused at 25 ml/hr, and he did not sign any order for Diabetisource to be infused at 25 ml/hr. He reported that he thought 25ml/hour was a low rate.</p> <p>In an interview on 07/18/2024 at approximately 1:30 p.m., S2 DON reported she was not notified by S6 LPN about Resident #26's complaints of hunger and weight loss until the afternoon of 07/14/2024. S2 DON reported she emailed the S19 RD at that time and received an email the following morning on 07/15/2024 at 10:02 a.m. from the S19 RD to increase Resident #26's tube feedings. S2 DON acknowledged S6 LPN should have continued attempting to reach a medical provider when she did not hear back from the physician on 07/13/2024.</p> <p>47004</p> <p>Resident #19</p> <p>Review of the facility's current policy titled Wound Care dated 01/09/2022 read in part . A comprehensive skin assessment is completed within 24 hours of admit/readmit to facility. Comprehensive skin assessment includes completion of the Braden Risk Assessment. The Braden Risk Assessment is completed by the nursing staff: Within 24 hours of admission, weekly x4 after admit/readmit, quarterly and annually.</p> <p>Record Review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses that included in part . Chronic Kidney Disease, Stage 5, Type 2 Diabetes Mellitus, Congestive Heart Failure, Unspecified Protein Calorie Malnutrition, Dependence on Renal Dialysis, Chronic Pulmonary Edema, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #19's Quarterly MDS with an ARD of 04/10/2024, revealed Resident #19 had a BIMS of 15(cognitively intact). Resident #19 required Substantial/Maximal assistance from staff for toileting, showering/bathing, dressing, and personal hygiene.</p> <p>Record review revealed Resident #19 was hospitalized with a diagnosis of Congestive Heart Failure on 06/27/2024 and returned to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review revealed a Braden Scale for Predicting Pressure Sore Risk assessment was completed on 07/08/2024, instead of 24 hours after return from the hospital.</p> <p>Interview on 07/16/2024 at 9:13 a.m. with Resident #19 revealed when she returned to the facility from being hospitalized from 06/27/2024 - 07/04/2024, she had a sore on her butt. Resident #19 revealed the facility did not treat her butt until 07/15/2024.</p> <p>Interview on 07/16/2024 at 11:10 a.m. with S9 Treatment Nurse, revealed nursing staff perform weekly skin inspections on residents and notify her of any changes. S9 Treatment Nurse stated on 07/14/2024, staff reported a break in Resident #19's skin, on her bottom. S9 Treatment Nurse stated she assessed Resident #19 on 07/14/2024, and staged the wound as a Stage 2 pressure ulcer to the resident's coccyx. S9 Treatment Nurse stated she notified S10 NP and received wound care orders to treat Resident #19's wound. S9 Treatment Nurse revealed Resident #19 was hospitalized , but she was not notified of Resident#19 returning to the facility with a wound.</p> <p>Interview on 07/16/2024 at 3:15 p.m. with S10 NP revealed he was made aware Resident #19 developed a stage 2 pressure ulcer to her coccyx on 07/14/2024, and provided wound care orders.</p> <p>Interview on 07/17/2024 at 9:08 a.m. with S9 Treatment Nurse, revealed she was responsible for performing Comprehensive Skin Assessments on residents. S9 Treatment Nurse confirmed a Comprehensive Skin Assessment was required to be completed and documented when a resident was readmitted following hospitalization . S9 Treatment Nurse confirmed a Braden Scale for Predicting Pressure Sore Risk should have been completed and documented within 24hrs of Resident #19's return from the hospital on 07/04/2024, but it had not been completed until 07/08/2024.</p> <p>Review of Resident #19's Active Orders revealed in part .</p> <p>Clean Stage 2 Pressure Ulcer to coccyx with normal saline or wound cleanser, apply calazinc, apply collagen, and apply foam border dressing. Order date: 07/15/2024</p> <p>Weekly Skin Inspection. One time a day, every Monday. Order date: 07/17/2023.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</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** 47004</p> <p>Based on observation, interview, and record review, the facility failed to ensure Residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene for 2 (#33 and #77) of 7 (#4, #5, #26, #30, #33, #42, and #87) Residents reviewed for ADL's. The facility failed to ensure a Resident (#33) received nail and oral care, and failed to ensure a Resident (#77) received incontinent care. The total Sample Size was 34.</p> <p>Findings:</p> <p>Review of the facility policy titled: Activities of Daily Living (ADLs), Supporting dated 03/2018 read in part . Appropriate care and services will be provided for Residents who are unable to carry out ADLs independently, with the consent of the Resident and in accordance with the plan of care including: a. Hygiene (bathing, dressing, grooming, and oral care.) c. Elimination (toileting).</p> <p>Resident #33</p> <p>Review of Resident #33's Electronic Health Record revealed Resident #33 was admitted to the facility on [DATE]. Resident #33 had diagnoses that included in part . Alzheimer's Disease, Parkinson's Disease with Dyskinesia, Generalized Muscle Weakness, Anxiety Disorder, Dementia, and Epilepsy.</p> <p>Review of Resident #33's Quarterly MDS with ARD of 05/15/2024 revealed Resident #33 had a BIMS of 06 (Severe Cognitive Impairment). Resident #33 required Substantial/Maximal Assistance from staff for Eating, Oral Hygiene, Toileting, Showering/Bathing, Dressing, and Personal Hygiene.</p> <p>Review of Resident #33's Care Plan with a target completion date of 08/14/2024 revealed in part . ADL self-care deficit related to Cerebrovascular Disease and Parkinson's. Interventions included: Extensive assistance by (1) staff with personal hygiene and oral care. I will have oral care routinely: brush teeth, rinse mouth with wash.</p> <p>Observation on 07/15/2024 at 10:54 a.m. of Resident #33 revealed a thick white substance in her mouth and on teeth, with strong mouth odor. Resident #33 revealed staff did not help her brush her teeth. Resident #33 stated I have to do all that, they do not help me. Resident #33 was observed with long, dirty finger nails with brown substance beneath nail beds.</p> <p>Observation on 07/16/2024 at 10:03 a.m. of Resident #33 revealed a thick white substance in her mouth and on teeth, with strong mouth odor. Resident #33 stated staff did not brush her teeth, or clean her face today. Resident #33 observed with long length nails, with brown substance beneath the nail beds. Resident #33 stated she liked her nails trimmed short, and would like staff to clean them.</p> <p>Interview on 07/16/2024 at 10:07 a.m. with S12 LPN revealed Resident #33 was bathed on Tuesdays, Thursdays, and Saturdays, and CNA's were to perform personal and oral hygiene on resident's daily. S12 LPN stated it was the responsibility of the night shift CNA's to get Resident #33 up, ready, and perform personal/oral hygiene. S12 LPN observed Resident #33 and confirmed Resident #33 was in need of oral and nail care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>44844</p> <p>Resident #77</p> <p>Review of Resident #77's Electronic Health Record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses that included in part .Paroxysmal Atrial Fibrillation, Secondary Malignant Neoplasm of other Digestive Organs, Restless Leg Syndrome, Major Depressive Disorder, Muscle Wasting and Atrophy Left and Right Shoulder, Other Lack of Coordination, Unspecified Osteoarthritis, Shortness of Breath and Urinary Tract Infection.</p> <p>Review of Resident #77's Annual MDS with an ARD of 06/26/2024, revealed a BIMS score of 12 (moderately impaired cognition). Resident #77 was dependent with toileting and bathing, and required the assistance of 2 or more staff. Resident #77 had impairment on both sides of lower extremities and was incontinent of both bowel and bladder.</p> <p>Review of Resident #77's Care Plan with a target date of 09/26/2024, revealed in part .ADL self-care performance related to muscle weakness. Approaches included: Toilet Use - I am not toileted. I am dependent on staff for incontinence care of bowel and bladder.</p> <p>Interview on 07/15/2024 at 10:47 a.m. with Resident #77 revealed staff did not change her incontinent brief while she was in her wheelchair. Resident #77 revealed staff had to use a mechanical lift to transfer her from the bed to wheelchair, and vice versa. Resident #77 revealed the 7:00 a.m. to 3:00 p.m. staff assisted her up to her wheelchair in the mornings, and the evening shift assisted her back to bed between 3:30p.m. - 4:00 p. m. Resident #77 revealed staff assisted her up to her wheelchair between 8:30 a.m. - 9:00 a.m. this morning. Resident #77's sister was in the room and stated she was worried that Resident #77 would develop a Urinary Tract Infection from sitting in her urine for long periods of time.</p> <p>Observation and interview on 07/15/2024 at 1:00 p.m. revealed Resident #77 in therapy. Resident #77 stated she had not been changed.</p> <p>Observation and interview on 07/15/2024 at 2:25 p.m. revealed Resident #77 sitting in a wheelchair in her room. Resident #77 stated staff had not offered to change her. Resident #77 revealed she had called for assistance to be changed in the past, but it made her feel uncomfortable to ask, because staff knew they were suppose to change her every 2 hours.</p> <p>Interview on 07/16/2024 at 10:00 a.m. and 10:30 a.m., with S14 [NAME] Clerk, revealed Resident #77 left the facility around 9:10 a.m. that morning for an appointment, and returned to the facility around 10:15 a.m.</p> <p>Observation and interview on 07/16/2024 at 11:00 a.m. with Resident #77 revealed she was in therapy in a wheelchair. Resident #77 revealed she had not received incontinent care since she returned from her appointment around 10:00 a.m. today. Resident #77 stated she asked S15 CNA to change her before she went to therapy this morning, but S15 CNA told her she would change her after therapy. Resident #77 stated on yesterday (07/15/2024), 3:00 p.m. to 11:00 p.m. staff assisted her to bed at 3:30 p.m. Resident #77 revealed she did not receive incontinent care from 9:00 a.m. until 3:30 p.m. on 07/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 07/16/2024 at 1:00 p.m. with S15 CNA, revealed she was the CNA assigned to Resident #77 on 07/15/2024 and 07/16/2024, on the 7:00 a.m. to 3:00 p.m. shift. S15 CNA revealed she assisted Resident #77 to her wheelchair yesterday (07/15/2024) between 8:00 a.m. and 9:00 a.m., and confirmed she did not provide incontinent care to Resident #77 for the remainder of her shift. S15 CNA stated the evening shift staff (3:00 p.m. to 11:00 p.m.), would assist Resident #77 back to bed. S15 CNA revealed Resident #77 was a heavy wetter and she should have provided incontinent care for Resident #77. S15 CNA revealed on 07/16/2024 she assisted Resident #77 up to her wheelchair (didn't remember the exact time). Resident #77 left the facility around 9:10 a.m. for an appointment. S15 CNA stated Resident #77 asked her to be changed, and she told Resident #77 to wait until after therapy. S15 CNA revealed she was aware that incontinent residents should be changed at least every 2 hours.</p> <p>Interview on 07/16/2024 at 1:05 p.m. with S8 RN Clinical Coordinator, revealed residents should be checked by staff at least every 2 hours for incontinent episodes, and changed as needed. S8 RN Clinical Coordinator confirmed Resident #77 was assisted to her wheelchair between 9:00 a.m. and 10:00 a.m., and assisted back to bed between 3:00 p.m. and 4:00 p.m. on 07/16/2024. S8 RN Clinical Coordinator revealed when Resident #77 returned from her appointment this morning she should have been given incontinent care. S8 RN Clinical Coordinator stated S17 CNA Household Coordinator was responsible for ensuring staff were providing incontinent care to dependent residents.</p> <p>Interview on 07/16/2024 at 1:11 p.m. with S17 CNA Household Coordinator revealed she was responsible for ensuring staff provided incontinent care for dependent residents. S17 CNA Household Coordinator revealed Resident #77 should have received incontinent care at least every 2 hours. S18 CNA stated she was unaware that Resident #77 was not provided incontinent care timely.</p> <p>Observation on 07/16/2024 at 1:30 p.m., revealed S15 CNA, S16 CNA and S17 CNA Household Coordinator assisted Resident #77 to bed using a mechanical lift. Resident #77 had on 2 adult briefs which were wet, and had a strong urine odor.</p> <p>Interview on 07/16/2024 at 1:39 p.m. with S8 RN Clinical Coordinator revealed Resident #77 wore 2 adult briefs because she was a heavy wetter.</p> <p>Interview on 07/16/2024 at 1:44 p.m. with S2 DON confirmed Resident #77 should have been changed when she asked to be changed, and should have been offered incontinent care at least every 2 hours.</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20604</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with a PEG tube maintained acceptable parameters of nutritional and hydration status consistent with the resident's comprehensive assessment for 1 (#26) of a total of 5 (#4, #16, #26, #96, and #98) residents receiving nutrition by PEG tube feedings in the facility.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #26 on 07/05/2024 at 3:02 p. m., when S4 RN Clinical Coordinator incorrectly entered a physician's order for a nutritional feeding rate at 25 ml/hr instead of the recommended rate of 45 ml/hr. S19 RD's Progress Notes dated 07/05/2024, revealed recommendations for Diabetisource AC (nutritional feeding) at 45 ml/hr. Review of Resident #26's medical record revealed she had received Diabetisource AC at 25 ml/hr from 07/05/24 to 07/15/2024, instead of the recommended Diabetisource AC at 45 ml/hr. Review of Resident #26's progress notes dated 07/13/2024 revealed, Resident #26, who was cognitively intact, and able to communicate by typing messages on her phone, communicated to S6 LPN that she wanted her feedings increased because she was hungry, nauseated, and felt like she was losing too much weight. During an interview on 07/15/2024 at 10:26 a.m. with Resident #26, she typed on her phone that she was hungry and losing weight. Observations at that time revealed Diabetisource AC infusing via her PEG tube at 25 ml/hr. In an interview with S4 RN on 07/16/2024 at 2:49 p.m., she stated she misread the RD recommendation, and put in the order as Diabetisource 25 ml/hr, instead of the recommended 45 ml/hr. Resident #26 had a significant weight loss of 9.6 pounds (7.79% body weight), between 07/05/2024 and 07/16/2024.</p> <p>S1Administrator and S2 DON were notified of the Immediate Jeopardy situation on 07/17/2024 at 4:21 p.m.</p> <p>The Immediate Jeopardy was removed on 07/18/2024 at 4:45 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>This deficient practice continued at a potential for more than minimal harm for any resident receiving PEG tube feeding in the facility that may receive new dietary recommendations.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Weight Assessment and Intervention (Revised March 2022), revealed the following, in part:</p> <p>5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe . Interventions for undesirable weight loss are based on careful consideration of the following: a. Resident choice and preferences. b. Nutrition and hydration needs of the resident . The use of supplementation and/or feeding tubes;</p> <p>Review of the facility's policy titled, Dietician (Revised October 2017) revealed the following, in part:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>1. A qualified Dietician or other clinically qualified nutrition professional will help oversee food and nutritional services provided to the residents .</p> <p>9. Our facility's Dietician is responsible for, but not necessarily limited to: a. Assessing nutritional needs of residents;</p> <p>Review of Resident #26's medical record revealed an admitted [DATE] with diagnoses that included in part . Cerebral Infarction, Retention of Urine, Gastrostomy Status, Ileus, Neuromuscular Dysfunction of the Bladder, Aphasia, Dysphasia, and Type 2 Diabetes Mellitus.</p> <p>Review of Resident #26's MDS with an ARD of 06/22/2024 revealed she had a BIMS score of 13, which indicated she was cognitively intact.</p> <p>Review of Resident #26's physician's orders revealed in part the following:</p> <p>07/05/2024 - Enteral feed order: Continuous Diabetisource 25 ml/hour with 150 ml water flush every 6 hours .</p> <p>Review of Resident #26's current care plan with a problem onset date of 06/21/2024, revealed a problem of I require tube feeding, I receive Diabetisource 250ml every 8 hours with 150ml flush every 8 hours. Interventions included: I am dependent with tube feeding and water flushes. I will have a RD to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The care plan had not been updated to reflect the 07/05/2024 RD recommendations for Diabetisource AC at 45 ml/hr + 150 ml q 6hrs (or 25 ml/hr. flushes if continuous).</p> <p>Review of Resident #26's clinical record revealed a Registered Dietician Nutritional Assessment: Summary Note: dated 07/04/2024, which read in part: NPO w/ tube feedings: Diabetisource 250ml q 8 hrs + 150ml flush q 8 hrs. Providing: 900 kcals, . Recommend: To more closely meet estimated nutrition needs increase Diabetisource to 250ml carton q 6 hrs + 150 ml flush q 6 hrs. Will provide 1200 kcals, 60 gm protein and 818 mls free water (1418 mls TFW). Signed by S19 RD.</p> <p>Review of an email correspondence revealed the following was sent to several employees including S2 DON, S7 ADON and S4 RN Clinical Coordinator:</p> <p>07/04/2024 at 2:03 p.m. - S19 RD sent recommendations to increase Diabetisource from 250 ml every 8 hours, to Diabetisource 250 ml every 6 hours.</p> <p>07/05/2024 at 8:52 a.m. - S7 ADON responded to S19 RD, and requested the continuous rate for a feeding pump.</p> <p>07/05/2024 at 10:23 a.m. - S19 RD responded with recommendation for Diabetisource AC at 45 ml/hr + 150 ml q 6 hrs (or 25 ml/hr. flushes if continuous). Will provide 1296 Kcals, 65 gm protein, 883 mls free water (1422 mls TFW).</p> <p>Review of Resident #26's Electronic Medication Administration Record (EMAR) for July 2024 revealed she received Diabetisource 25 ml/hr from 07/05/2024 through 07/15/2024.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #26's medical record revealed the following weights which represented a significant weight loss of 7.79% between 07/05/2024 and 07/16/2024:</p> <p>06/19/2024 125.8 lbs Wheelchair</p> <p>07/02/2024 125.8 lbs Wheelchair</p> <p>07/05/2024 123.2 lbs Wheelchair</p> <p>07/16/2024 113.6 lbs Wheelchair</p> <p>Review of Resident #26's progress notes revealed that on 07/13/2024 at 12:41 p.m. S6 LPN wrote Resident states that she is feeling hungry and nauseated and feels like she is losing too much weight. Gave her Zofran and it was ineffective. She is requesting to have her feedings increased. Called and left message for the physician. Will continue to monitor.</p> <p>An observation and interview on 07/15/2024 at 10:26 a.m., revealed Resident #26 had a feeding pump infusing Diabetsource AC at 25 ml/hr., with the water flush set at 150 ml/6hrs. At that time, Resident #26 typed I'm hungry, I'm losing weight on her phone, then typed I'm getting one capful of feeding an hour. During that time, Resident #26's daughter entered the room, and said her mother's tube feeding was not enough, and she had lost weight. Resident #26's daughter explained she was here today to talk to someone about her mother's tube feeding, and being hungry.</p> <p>An observation on 07/16/2024 at 9:04 a.m. revealed Resident #26 in her room with a tube feeding pump infusing Diabetsource AC at 45 ml/hr with the water flush set at 150 ml every 6 hours. Resident #26 was smiling and typed feeling better.</p> <p>An interview on 07/16/2024 at 2:49 p.m. with S4 RN Clinical Coordinator, revealed she was responsible for carrying out dietary recommendations for Resident #26 on 07/05/2024. She indicated that Resident #26 was NPO with tube feedings, and getting bolus feedings of Diabetsource AC 250ml every 8 hours, and flushed with 150ml of water every 8 hours. S4 RN Clinical Coordinator said that Resident #26 was assessed by S19 RD on 07/04/2024, with recommendations to increase Diabetsource to 250ml carton every 6 hours, and flush with 150 ml of water every 6 hours, to increase Resident #26's caloric intake from 900Kcals to 1200Kcals. S4 RN Clinical Coordinator stated that on 07/05/2024, S7 ADON requested S19 RD give her the rate for continuous feeding on a pump because Resident #26 was staying long-term. She stated that the S19 RD sent an email on 7/05/2024 recommending Diabetsource AC at 45 ml/hr. S4 RN Clinical Coordinator stated that she called S10 NP and misread the recommendation to S10 NP. S4 RN Clinical Coordinator indicated that she put in the order as 25 ml/hr., instead of the recommended 45 ml/hr. S4 RN Clinical Coordinator stated I read the recommendation wrong.</p> <p>During an observation and interview of Resident #26 on 07/16/2024 at 3:12 p.m., when asked how she was feeling today, Resident #26 typed I feel better. Before I was hungry and nauseous after taking medicine on an empty stomach. Resident #26 then typed It felt like they were starving me and there was nothing I could do. I asked the nurse practitioner if I'm gonna die.</p> <p>An observation on 07/16/2024 at 3:32 p.m. revealed Resident #26 being weighed in the Therapy room in her wheelchair. Resident #26's weight was 113.6 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview on 07/16/2024 at 4:00 p.m. with S2 DON and S20 QI Nurse, revealed there was not one standard facility process for obtaining, communicating and carrying out dietary recommendations. S2 DON stated the clinical coordinator for each house was responsible for obtaining and carrying out the dietary recommendations for their residents. S2 DON reported that the facility did not have a system for ensuring recommendation from the Registered Dietician were accurately communicated and accurately entered. S20 QI Nurse, stated We don't have one, but we will have one today.</p> <p>An interview on 07/16/2024 at 4:55 p.m. with S7 ADON revealed that she was the direct supervisor for S4 RN Clinical Coordinator. S7 ADON reported she amended the order for Resident #26 on 07/09/2024 to reflect on the EMAR for the day and night shift. However, S7 ADON stated that she did not review the rate of the infusion, and did not compare the order to the dietary recommendations. S7 ADON confirmed Resident #26 should have been getting 45 ml/hr of Diabetisource instead of the 25 ml/hr she received from 07/05/2024 through 07/15/2024.</p> <p>A telephone interview on 07/17/2024 at 8:38 a.m. with S10 NP, revealed that he typically follows the Registered Dietician's recommendations. He stated That's what she specializes in. He reported he did not remember talking to S4 RN Clinical Coordinator about Resident #26's PEG feeding. He revealed that he would have followed the RD's recommendations for the 45ml per hour infusion rate.</p> <p>A telephone interview on 07/17/2024 at 09:09 a.m. with S19 RD, revealed she made recommendations to increase Resident #26's PEG feeding from Diabetisource 250ml every 8 hours to provide 900 Kcals to Diabetisource 250ml every 6 hours to provide 1200 Kcals to increase her caloric intake. S19 RD reported that S7 ADON emailed her and requested a continuous rate recommendation on 07/05/2024. S19 RD reported she recommended Diabetisource AC to be infused at 45 ml/hr, and flushed with 150 ml of water every 6 hours, or flush at 25 ml/hr if Resident #26 was on a continuous infusion. S19 RD confirmed that Resident #26 should have been receiving 45 ml/hr instead of 25 ml/hr, as recommended on 07/05/2024. S19 RD confirmed that receiving 25 ml/hr contributed to Resident #26's weight loss.</p> <p>An interview on 07/17/2024 at 12:05 p.m. with S2 DON revealed she was told by S6 LPN on 07/14/2024 about Resident #26 being hungry. S2 DON reported that she emailed S19 RD on 07/14/2024 about Resident #26's PEG feeding and complaints of hunger. S2 DON stated that S19 RD responded on 07/15/2024, and recommended to increase the tube feeding by 10ml every 4 hours until Resident #26 reached 45 ml/hr. S2 DON stated she was not aware of the issue with Resident #26's tube feeding rate until it was brought to her attention by the surveyor.</p> <p>A telephone interview on 07/17/24 at 12:15 p.m. with S6 LPN revealed that Resident #26 told her on 07/13/2024 around lunch time that she was hungry, losing weight and wanted her tube feeding to be increased. S6 LPN reported that she called Resident #26's attending physician and left a message, but never received a call back. S6 LPN stated that on 07/14/2024, towards the end of her shift, she saw S2 DON at the facility and reported to her what Resident #26 had said.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004</p> <p>Based on observation, record review, and interview, the facility failed to ensure appropriate care and services had been provided for 1(Resident #19) of 1 resident reviewed for dialysis. The facility failed to ensure a Dialysis Communication Form was completed to include the resident's status prior to sending resident to dialysis facility. The total Sample Size was 34.</p> <p>Findings:</p> <p>Record Review revealed Resident #19 was admitted to the facility on [DATE]. Resident #19 had diagnoses that included in part . Chronic Kidney Disease, Stage 5, Type 2 Diabetes Mellitus, Congestive Heart Failure, Unspecified Protein Calorie Malnutrition, Dependence on Renal Dialysis, Chronic Pulmonary Edema, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #19's Quarterly MDS with an ARD of 04/10/2024 revealed Resident #19 had a BIMS of 15 (cognition intact).</p> <p>Review of Resident #19's Care Plan with target completion date of 10/15/2024 revealed the following in part . I have chronic Kidney disease. I have a Catheter site to Right Chest Wall. Interventions included in part . Hemodialysis Tuesday, Thursday, Saturday.</p> <p>Interview on 07/16/2024 at 9:13 a.m. with Resident #19 revealed she received dialysis service Tuesday, Thursday, and Saturday. Resident #19 was observed with a right upper chest wall catheter for dialysis services. Resident #19 stated the nurses send her to dialysis with a binder.</p> <p>Review of Resident #19's Dialysis communication binder on 07/16/2024 at 9:35 a.m. revealed on 05/02/2024, 05/04/2024, 05/07/2024, 05/16/2024, 05/18/2024, 05/25/2024, 05/30/2024, 06/04/2024 and 06/18/2024 the dialysis communication forms were not completed by facility staff to include in part .problems or concerns noted since last visit, current diet, current fluid restrictions, and vital signs.</p> <p>Interview on 07/16/2024 at 9:41 a.m. with S12 LPN revealed nursing staff was responsible to complete a dialysis communication form to send with residents prior to dialysis. S12 LPN revealed any medications, vitals, and changes resident had since last dialysis treatment was to be documented on the dialysis communication form.</p> <p>Interview on 07/16/2024 at 10:40 a.m. with S2 DON revealed nursing staff assessed residents prior to sending the resident out for dialysis. S2 DON revealed the nurse was to document vitals and any necessary information that needed to be communicated to the dialysis center on the Dialysis Communication form. S2 DON revealed that Dialysis Communication form was sent with the resident to dialysis. S2 DON reviewed Resident #19's 05/2024- 07/2024 Dialysis communication forms. S2 DON confirmed on 05/02/2024, 05/04/2024, 05/07/2024, 05/16/2024, 05/18/2024, 05/25/2024, 05/30/2024, 06/04/2024 and 06/18/2024 dialysis communication forms were not completed prior to sending Resident #19 to dialysis, but should have been.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Natchitoches Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 781 Highway 494 Natchitoches, LA 71457	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Telephone interview on 07/17/2024 at 9:44 a.m. with RN at contracted Dialysis Facility revealed she reviewed communication binder for all residents who present to dialysis. RN stated she reviewed the form to review vitals when residents present to dialysis. RN stated the dialysis staff documented vitals and any other pertinent information post treatment on the same communication form. RN stated the facility frequently did not complete the dialysis communication form prior to sending residents for dialysis.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to adequately monitor 1 (#18) resident out of 5 (#1, #18, #58, #71, & #82) reviewed for unnecessary medications. The facility failed to adequately monitor Resident #18 for edema while on a diuretic and for side effects and effectiveness while on an antidepressant. Findings:</p> <p>Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses that included in part . Alzheimer's Disease, Heart Failure, Hypertension, and Other Depressive Disorders.</p> <p>Review of Resident #18's Quarterly MDS with an ARD of 06/26/2024 revealed a BIMS score of 4, which indicated severe cognitive impairment. Review of the MDS revealed the resident required partial to moderate assistance with eating, substantial to maximal assistance with toilet hygiene and sitting to standing, and partial to moderate assistance with sitting to lying and lying to sitting on side of bed.</p> <p>Review of Resident #18's current physician's orders revealed the following orders:</p> <p>09/29/2023: Furosemide (a diuretic) Tablet 40 mg-Give 40 mg by mouth one time a day for edema</p> <p>09/28/2023: Lexapro (an antidepressant) Tablet 5 mg-Give 5 mg by mouth one time a day for depression</p> <p>Review of Resident #18's current care plan revealed in part the following .</p> <p>I have depression related to Dementia. Interventions included .I will remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood by/through review date. I will have administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>I have hypertension related to Congestive Heart Failure. Interventions included .Administered my anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. I will be monitored for and document any edema. Notify MD.</p> <p>Review of the July 2024 MAR revealed no documentation for monitoring for edema related to Lasix or monitoring for effectiveness or side effects related to the use of Lexapro.</p> <p>In an interview on 07/17/2024 at 3:35 p.m., S8 Clinical Coordinator confirmed there was no documentation in Resident #18's medical record of monitoring for edema, monitoring for side effects of Lexapro, or monitoring for effectiveness of Lexapro and confirmed there should be.</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>20604</p> <p>Based on observations, interviews and record reviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's Administration failed to ensure an adequate system was in place to ensure RD recommendations for PEG tube feedings were accurately transcribed into the medical record, failed to provide adequate nutrition to maintain weight, and failed to notify the physician when a resident complained of hunger, nausea, and requested to have her tube feeding rate increased for 1 (#26) of a total of 5 (#4, #16, #26, #96, and #98) residents who received nutrition by PEG tube feedings in the facility.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #26 on 07/05/2024 at 3:02 p. m., when S4 RN Clinical Coordinator incorrectly entered a physician's order for a nutritional feeding rate at 25 ml/hr instead of the recommended rate of 45 ml/hr. S19's RD Progress Notes dated 07/05/2024, revealed recommendations for Diabetisource AC (nutritional feeding) at 45 ml/hr. Review of Resident #26's medical record revealed she had received Diabetisource AC at 25 ml/hr from 07/05/24 to 07/15/2024, instead of the recommended Diabetisource AC at 45 ml/hr. Review of Resident #26's progress notes dated 07/13/2024 revealed, Resident #26, who was cognitively intact, and able to communicate by typing messages on her phone, communicated to S6 LPN that she wanted her feedings increased because she was hungry, nauseated, and felt like she was losing too much weight. During an interview on 07/15/2024 at 10:26 a.m. with Resident #26, she typed on her phone that she was hungry and losing weight. Observations at that time revealed Diabetisource AC infusing via her PEG tube at 25 ml/hr. In an interview with S4 RN Clinical Coordinator on 07/16/2024 at 2:49 p.m., she stated she misread the RD recommendation, and entered the order as Diabetisource 25 ml/hr., instead of the recommended 45 ml/hr. Resident #26 had a significant weight loss of 9.6 pounds (7.79% body weight), between 07/05/2024 and 07/16/2024.</p> <p>S1Administrator and S2 DON were notified of the Immediate Jeopardy situation on 07/17/2024 at 4:21 p.m.</p> <p>The Immediate Jeopardy was removed on 07/18/2024 at 4:45 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>This deficient practice continued at a potential for more than minimal harm for any resident on PEG tube feeding in the facility that may receive new dietary recommendations.</p> <p>Findings:</p> <p>Cross Reference F658</p> <p>Cross Reference F692</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's policy titled, Medication Orders (Revised November 2014) revealed the following, in part: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders.</p> <p>2. A current of orders must be maintained in the clinical record for each resident.</p> <p>Review of the facility's Info: Orders Communication Methods Explained (Updated January 31, 2024) revealed the following, in part: When adding a new order, users may select any of the following communication methods:</p> <p>Phone-means the physician called on the phone and communicated an order to the user and it will pend signature.</p> <p>Verbal-means the physician was present and verbally communicated an order to the user and it will pend signature.</p> <p>Prescriber Written-means the physician wrote the order on a prescription pad and signed it, then handed it to the user. There is no electronic signature trail of a prescriber written order. It is assumed the facility scanned the hard copy with a signature on it.</p> <p>Review of the facility's policy titled, Dietician (Revised October 2017) revealed the following, in part:</p> <p>1. A qualified Dietician or other clinically qualified nutrition professional will help oversee food and nutritional services provided to the residents .</p> <p>9. Our facility's Dietician is responsible for, but not necessarily limited to: a. Assessing nutritional needs of residents;</p> <p>An observation and interview on 07/15/2024 at 10:26 a.m., revealed Resident #26 had a feeding pump infusing Diabetsource AC at 25 ml/hr., with the water flush set at 150 ml/6hrs. At that time, Resident #26 typed I'm hungry, I'm losing weight on her phone, then typed I'm getting one capful of feeding an hour. During that time, Resident #26's daughter entered the room, and said her mother's tube feeding was not enough, and she had lost weight. Resident #26's daughter explained she was here today to talk to someone about her mother's tube feeding, and being hungry.</p> <p>An interview on 07/16/2024 at 2:49 p.m. with S4 RN Clinical Coordinator, revealed she was responsible for carrying out dietary recommendations for Resident #26 on 07/05/2024. She indicated that Resident #26 was NPO with tube feedings, and getting bolus feedings of Diabetsource AC 250ml every 8 hours, and flush with 150ml of water every 8 hours. S4 RN Clinical Coordinator said that Resident #26 was assessed by S19 RD on 07/04/2024, with recommendations to increase Diabetsource to 250ml carton every 6 hours, and flush with 150 ml of water every 6 hours, to increase Resident #26's caloric intake from 900Kcals to 1200Kcals. S4 RN Clinical Coordinator stated that on 07/05/2024, S7 ADON requested S19 RD give her the rate for continuous feeding on a pump because Resident #26 was staying long-term. She stated that the S19 RD sent an email on 7/05/2024 recommending Diabetsource AC at 45 ml/hr. S4 RN Clinical Coordinator stated that she called S10 NP and misread the recommendation to S10 NP. S4 RN Clinical Coordinator indicated that she entered the order as 25 ml/hr., instead of the recommended 45 ml/hr. S4 RN Clinical Coordinator stated I read the recommendation wrong.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an observation and interview of Resident #26 on 07/16/2024 at 3:12 p.m., when asked how she was feeling today, Resident #26 typed I feel better. Before I was hungry and nauseous after taking medicine on an empty stomach. Resident #26 then typed It felt like they were starving me and there was nothing I could do. I asked the nurse practitioner if I'm gonna die.</p> <p>An interview on 07/16/2024 at 4:00 p.m. with S2 DON and S20 QI Nurse, revealed there was not one standard facility process for obtaining, communicating and carrying out dietary recommendations. S2 DON stated the clinical coordinator for each house was responsible for obtaining and carrying out the dietary recommendations for their residents. S2 DON reported that the facility did not have a system for ensuring recommendations from the Registered Dietician were accurately communicated and accurately entered. S20 QI Nurse, stated We don't have one, but we will have one today.</p> <p>An interview on 07/16/2024 at 4:55 p.m. with S7 ADON revealed that she was the direct supervisor for S4 RN Clinical Coordinator. S7 ADON reported she amended the order for Resident #26 on 07/09/2024 to reflect on the EMAR for the day and night shift. However, she reported that she did not review the rate of the infusion, and did not compare the order to the dietary recommendations. S7 ADON confirmed Resident #26 should have been getting 45 ml/hr of Diabetisource instead of the 25 ml/hr she received from 07/05/2024 through 07/15/2024.</p> <p>A telephone interview on 07/17/2024 at 09:09 a.m. with S19 RD, revealed she made recommendations on 07/04/2024 to increase Resident #26's PEG feeding from Diabetisource 250ml every 8 hours to provide 900 Kcals, to Diabetisource 250ml every 6 hours to provide 1200 Kcals to increase her caloric intake. S19 RD reported that S7 ADON emailed her and requested a continuous rate recommendation on 07/05/2024. S19 RD reported she recommended Diabetisource AC to be infused at 45 ml/hr, and flushed with 150 ml of water every 6 hours, or flush at 25 ml/hr if Resident #26 was on a continuous infusion. S19 RD confirmed that Resident #26 should have received 45 ml/hr instead of 25 ml/hr, as recommended on 07/05/2024. S19 RD confirmed that receiving 25 ml/hr contributed to Resident #26's weight loss.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47004</p> <p>Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections. The facility failed to ensure the following:</p> <ol style="list-style-type: none"> Staff performed proper hand hygiene during meal service. Staff followed proper infection control practices during wound care. <p>This deficient practice had the potential to affect all residents who reside in the facility. The total resident census was 108.</p> <p>Findings:</p> <p>1. Observation on 07/15/2024 at 11:45 a.m. of meal service on X Hall dining room revealed S11 CNA assisted Resident #12, and Resident #33 whom were seated together at a table. Review of Resident #12's dietary card revealed she was a full assist with all meals. Review of Resident #33's dietary card revealed she required adaptive equipment: Sippy Cup, Weighted Utensils, and Divider Plate for every meal. Observation revealed S11 CNA assisted Resident #12, and Resident #33 while seated between each resident. S11 CNA physically touch assisted each resident, and did not perform hand hygiene between assisting the residents.</p> <p>Interview on 07/15/2024 at 12:00 p.m. with S11 CNA revealed Resident #12 and Resident #33 were to be assisted by staff with meals. S11 CNA revealed she did not perform hand hygiene between assisting Resident #12 and Resident #33, but should have.</p> <p>Interview on 07/15/2024 at 12:07 p.m. with S12 LPN confirmed staff were to perform hand hygiene between assisting residents during meal service.</p> <p>2. Observation on 07/17/2024 at 10:04 a.m. revealed S9 Treatment Nurse performed wound care on Resident #19 while S13 Treatment Nurse assisted. S9 Treatment Nurse and S13 Treatment Nurse donned gown and gloves as Resident #19 required Enhanced Barrier Precautions. Wound care supplies were set up on a bedside table next to Resident #19's bed. The treatment cart remained parked on X Hall, outside of Resident #19's room door. S9 Treatment Nurse performed wound care and requested S13 Treatment Nurse obtain cal zinc ointment from the treatment cart on X Hall. S13 Treatment Nurse then exited Resident #19's room and entered hallway without doffing gown and gloves that were used during high contact resident care.</p> <p>Interview on 07/17/2024 at 10:20 a.m. with S13 Treatment Nurse confirmed she should have removed gown and gloves prior to exiting Resident #19's room to gather supplies from the treatment cart on X Hall that contained clean supplies.</p>		