STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195410	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Place Nursing Care Center	333 Lee Drive Baton Rouge, LA 70808

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on interviews and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences by failing to respond to call lights in an appropriate time frame for 2 of 2 (#27 and #33) residents reviewed for call light response. Findings: Resident #27 Review of Resident #27's clinical record revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Parkinson's Disease, Muscle Weakness (Generalized), and Unsteadiness on Feet. Review of Resident #27's Annual MDS with an ARD of 03/27/2024 revealed the resident had a BIMS of 15 which indicated the resident had intact cognition. Further review revealed Resident #27 required partial/moderate to substantial/maximum assistance with ADLs with the exception of eating. Review of the call light log for Resident #27 from 03/28/2024 to 05/28/2024 revealed the following, in part: 03/28/2024 Occurred: 4:31p.m. Responded: 5:20 p.m. Response Time: 48 minutes 04/01/2024 Occurred: 10:23 p.m. Responded: 11:42 p.m. Response Time: 78 minutes 04/05/2024 Occurred: 12:44 p.m. Responded: 1:29 p.m. Response Time: 44 minutes 05/16/2024 Occurred: 10:22 p.m. Responded: 10:59 p.m. Response Time: 37 minutes 05/17/2024 Occurred: 6:27 p.m. Responded: 7:06 p.m. Response Time: 39 minutes 05/17/2024 Occurred: 9:06 p.m. Responded: 9:54 p.m. Response Time: 48 minutes 05/19/2024 Occurred: 7:58 p.m. Responded: 8:44 p.m. Response Time: 45 minutes (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/2024 at 9:54 a.m., an interview was conducted with Resident #27. Resident #27 stated sometimes she has to wait up to an hour for a call light response. Resident #27 stated this has happened several times a day. Resident #33 Review of Resident #33's clinical record revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Repeated Falls, Personal History of TIA, and CVA. Review of Resident #33's Quarterly MDS with an ARD of 04/10/2024 revealed a BIMS of 11 which indicated the resident had moderate cognitive impairment. Further review revealed Resident #33 was dependent or required substantial/maximum assistance with all ADLs with the exception of eating. Review of Resident #33's current Care Plan revealed the following, in part: Problem: ADL Function and Rehab: Mobility, Impaired physical Interventions: Instruct Resident #33 frequently to use the pull cord for assistance. Review of the call light log for Resident #33 from 03/28/2024 to 05/28/2024 revealed the following, in part: 03/29/2024 Occurred: 5:53 p.m. Responded: 6:56 p.m. Response Time: 62 minutes 04/01/2024 Occurred: 4:00 p.m. Responded: 4:45 p.m. Response Time: 45 minutes 04/01/2024 Occurred: 9:41 p.m. Responded: 11:43 p.m. Response Time: 121 minutes 04/02/2024 Occurred: 1:51 p.m. Responded: 2:33 p.m. Response Time: 41 minutes 04/12/2024 Occurred: 8:32 p.m. Responded: 9:14 p.m. Response Time: 41 minutes 04/15/2024 Occurred: 6:33 p.m. Responded: 7:17 p.m. Response Time: 44 minutes 04/26/2024 Occurred: 5:36 p.m. Responded: 6:13 p.m. Response Time: 37 minutes 04/27/2024 Occurred: 10:25 a.m. Responded: 11:20 a.m. Response Time: 54 minutes 04/28/2024 Occurred: 9:01 a.m. Responded: 9:37 a.m. Response Time: 36 minutes 04/28/2024 Occurred: 10:21 a.m. Responded: 11:39 a.m. Response Time: 77 minutes 05/04/2024 Occurred: 11:24 a.m. Responded: 12:34 p.m. Response Time: 70 minutes 05/05/2024 Occurred: 4:47 a.m. Responded: 5:52 a.m. Response Time: 65 minutes 05/11/2024 Occurred: 8:52 p.m. Responded: 9:57 p.m. Response Time: 64 minutes (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/14/2024 Occurred: 3:57 a.m. Responded: 5:23 a.m. Response Time: 85 minutes 05/17/2024 Occurred: 12:21 p.m. Responded: 1:23 p.m. Response Time: 61 minutes 05/17/2024 Occurred: 8:16 p.m. Responded: 9:14 p.m. Response Time: 58 minutes 05/21/2024 Occurred: 4:29 a.m. Responded: 5:16 a.m. Response Time: 47 minutes 05/28/2024 Occurred: 8:22 p.m. Responded: 9:16 p.m. Response Time: 54 minutes On 05/28/2024 at 11:13 a.m., an interview was conducted with Resident #33. Resident #33 stated the call light wait is more than 30 minutes for response. On 05/31/2024 at 12:23 p.m., an interview was conducted with S2DON. S2DON stated call lights should be answered timely and within 15 minutes. S2DON stated a 20 minute response time would be unreasonable but things happen. S2DON reviewed and confirmed the aforementioned findings for Resident #27 and #33. S2DON confirmed the call light response was horrible and the response times were not appropriate.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on interviews and record reviews, the facility failed to ensure nursing staff communicated a significant change in status to the resident's physician or family for 2 (#48, #46) of 4 (#6, #32, #46, and #48) residents reviewed for notification of change. The facility failed to ensure: 1. Nursing staff notified Resident #48's physician after low blood glucose readings were obtained, a change in breath sounds was noted, or a change in level of consciousness occurred; and 2. Nursing staff notified Resident # 46's family after a low blood glucose readings were obtained This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 5:15 a.m., when S4LPN failed to implement the standing orders for Hypoglycemic Protocol when Resident #48's blood glucose level was 49 mg/dL. S4LPN administered approximately 2 ounces of sugar water via oral swab to the resident. Upon rechecking Resident #48's blood glucose level, the reading was 53 mg/dL. S4LPN did not notify the physician of the low readings. On [DATE] at 6:00 a.m., S5LPN observed Resident #48 and found the resident had gurgled breathing and was unable to be aroused. S5LPN failed to notify Resident #48's physician or assess vital signs to include a blood glucose reading at that time. At 6:30 a.m., S5LPN found Resident #48 unresponsive, without a pulse or breath sounds. S1ADM and S2DON were notified of the Immediate Jeopardy situation on [DATE] at 5:37 p.m. The Immediate Jeopardy was removed on [DATE] at 3:53 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. The deficient practice continued at more than minimal harm for the remaining 49 residents residing in the facility. Findings: 1. Resident #48 Review of the facility document presented as the Hypoglycemic Protocol titled Signs and Symptoms of Hypoglycemia In Adults signed by S16MD on [DATE] revealed the following, in part: Whenever hypoglycemia is suspected the following steps are to be taken: 2. Follow hypoglycemia treatment, notify physician of CBG value unless otherwise ordered. Review of the facility policy titled Diabetes Mellitus Resident Care revised ,d+[DATE] revealed the following, in part: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Guidelines and Procedures: Monitoring of blood sugar levels is done as ordered by MD, and PRN per nursing judgement. MD is notified for any change in condition. Review of Resident #48's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #48's Physician orders revealed the following, in part: [DATE] Hypoglycemia Protocol: follow hypoglycemia protocol as listed then notify MD if CBG is less than 74 mg/dL or unless otherwise instructed by physician. Review of Resident #48's Care Plan revealed the following, in part: Problem: Nutrition - Resident #48 has a diagnosis of Diabetes. Interventions: accu checks as ordered, notify MD of abnormals and treat as ordered Review of Resident #48's Nurse's Notes revealed the following, in part: [DATE] at 7:06 a.m. by S4LPN: [DATE] at 05:15 a.m. routine blood sugar checked initial result was 49 fasting resident was given sweetener on sponge to tongue and cheeks. Blood sugar rechecked after 30 minutes results 53 will alert AM nurse to result again in 30 minutes. [DATE] at 6:43 a.m. by S5LPN: 6:30 a.m.: Upon entering resident's room, resident was found lying in her bed. O2 via nasal cannula at 2 Liters/min. Resident was not breathing, resident had no pulse, O2 sats unobtainable. No heart sounds upon auscultation. On [DATE] at 9:01 a.m., an interview was conducted with S20CNA. S20CNA stated her shift started at 6:00 p.m. on [DATE]. S20CNA stated Resident #48 did not have gurgled breathing during her shift. On [DATE] at 2:42 p.m., an interview was conducted with S4LPN. S4LPN confirmed Resident #48 was a Diabetic. S4LPN stated on [DATE] at approximately 5:15 a.m., Resident #48's blood glucose reading was 49 and she administered about a teaspoon of sugar on and under the tongue and placed the remaining sugar in approximately 2 ounces of water and administered about ,d+[DATE] of the solution to the resident's mouth using a pink sponge stick. S4LPN stated she rechecked Resident #48's blood sugar 20 - 25 minutes later and it was 53. S4LPN stated once the blood sugar came up to 53, Resident #48 was more alert. S4LPN stated she did not notify the doctor because the blood glucose was not super low, and she was attempting to get it up with sugar water. S4LPN stated there were standing orders to notify the doctor if a blood glucose was under a certain value but she did not know the value. S4LPN stated she had not looked at the standing order for hypoglycemia. S4LPN confirmed blood glucose readings of 49 and 53 were abnormal. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:59 a.m., an interview was conducted with S5LPN. S5LPN confirmed Resident #48 was a Diabetic. S5LPN stated she observed Resident #48 on [DATE] at approximately 6:00 a.m. and again around 6:15 a.m. S5LPN said Resident #48 was unresponsive with gurgled breathing. She stated the resident would not wake up to verbal stimulation when her name was called or when she physically shook her.S5LPN stated she received report that Resident #48 was declining, so she was not concerned when the resident was unresponsive with gurgled breathing. S5LPN stated when she next observed Resident #48 at 6:30 a.m., the resident was unresponsive, without a pulse, and stopped breathing. She explained she did not call the doctor to notify them of Resident #48's status at either 6:00 a.m. or 6:15 a.m. because the resident expired before she got a chance to. On [DATE] at 10:35 a.m., an interview was conducted with S16MD. S16MD stated there was a Hypoglycemic Protocol in place for nurses to follow when a blood glucose reading was less than 60. S16MD stated the nurse should have called the on-call physician immediately when Resident #48's blood glucose reading of 49 was received. On [DATE] at 11:13 a.m., an interview was conducted with S2DON. S2DON confirmed S4LPN did not follow the Hypoglycemic Protocol. S2DON confirmed the physician should have been notified as soon as there was a change in Resident #48's condition. S2DON stated the physician should have been notified upon receipt of the 49 blood glucose reading. S2DON stated when Resident #48 was unresponsive to verbal and physical stimuli and had gurgled respirations, S5LPN should have assessed the resident, obtained vital signs and notified the physician. S2DON stated S5LPN should have automatically sent the resident to the hospital and notified the physician of the reason. 2. Resident #46 Review of Resident #46's clinical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #46's Nurse's Notes revealed the following, in part: [DATE] at 4:20 a.m. Resident #46's blood glucose was noted to be 24 mg/dL. Further review revealed there was no documentation Resident #46's family was notified of the blood glucose level. A telephone interview was conducted on [DATE] at 11:54 a.m. with Resident #46's Responsible Party. He stated he was not notified when Resident #46 had a low blood sugar. An interview was conducted on [DATE] at 11:28 a.m. with S2DON. S2DON stated family should be notified of low blood sugar levels once treatment was provided and the blood sugar was stable. A telephone interview was conducted on [DATE] at 12:07 p.m. with S18LPN. S18LPN stated on [DATE] when Resident #46's blood sugar was 24 mg/dL and she did not call the family. 47500

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44965 Based on record review and interview, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) to a resident or her responsible party for 1 (#6) of 3 (#6, #200 and #201) residents reviewed for Beneficiary Notification. Review of Resident #6's SNF Beneficiary Notification Review Form completed by the facility revealed the following, in part: Medicare Part A Skilled Services episode start date: 02/08/2024 Last covered day of Part A Service: 02/28/2024 How was the Medicare Part A Service Termination/Discharge determined? The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Was a NOMNC, Form CMS-10123 provided to the resident? No An interview was conducted with S2DON on 05/30/2024 at 12:32 p.m. She confirmed a NOMNC was never issued to Resident #6 and/or her responsible party and should have been.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 The facility failed to ensure a resident received treatment and care according to the resident's plan of care and physician's orders in accordance with professional standards of practice by failing to provide needed services. The facility failed to ensure: 1. S4LPN and S5LPN implemented the hypoglycemic protocol for 1 (#48) of 3 (#32, #46, and #48) residents reviewed with Diabetes; and 2. S5LPN assessed an unresponsive resident with gurgled breathing for 1 (#48) of 3 (#32, #46, and #48) residents reviewed with Diabetes. This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 5:15 a.m., when S4LPN failed to implement the standing orders for Hypoglycemic Protocol when Resident #48's blood glucose level was 49 mg/dL. S4LPN administered approximately 2 ounces of sugar water via oral swab to the resident. Upon rechecking Resident #48's blood glucose level, the reading was 53 mg/dL. S4LPN did not notify the physician of the low readings. On [DATE] at 6:00 a.m., S5LPN observed Resident #48 and found the resident had gurgled breathing and was unable to be aroused. S5LPN failed to notify Resident #48's physician or assess vital signs to include a blood glucose reading at that time. At 6:30 a.m., S5LPN found Resident #48 unresponsive, without a pulse or breath sounds. S1ADM and S2DON were notified of the Immediate Jeopardy situation on [DATE] at 5:37 p.m. The Immediate Jeopardy was removed on [DATE] at 3:53 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. The deficient practice continued at more than minimal harm for the remaining 49 residents residing in the facility. Findings: Review of the facility policy titled Diabetes Mellitus Resident Care revised ,d+[DATE] revealed the following, in part: Policy Guidelines and Procedures: Monitoring of blood sugar levels is done as ordered by MD, and PRN per nursing judgement. MD is notified for any change in condition. In the event of emergency or acute change in status, assess the resident for the following: Not able to awaken, Personality Change, Unconsciousness and obtain a blood glucose reading. In the event of low blood sugar, follow physician standing order. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If the resident who has low blood sugar remains unresponsive after initiation of standing order, activate EMS system and transfer to the emergency room . Notify MD and obtain order for transfer. Repeat blood glucose testing as indicated to monitor efficacy of emergency treatments. Notify MD of any initiation of standing order for low blood sugar, including resident response to treatment. Review of Resident #48's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #48's Physician's Orders revealed the following, in part: [DATE] Hypoglycemia Protocol: follow hypoglycemia protocol as listed then notify MD if CBG is less than 74 mg/dL or unless otherwise instructed by physician. Review of the facility document presented as the Hypoglycemic Protocol titled Signs and Symptoms of Hypoglycemia In Adults signed by S16MD on [DATE] revealed the following, in part: Whenever hypoglycemia is suspected the following steps are to be taken: 1. Verify results by repeated CBG 2. Follow hypoglycemia treatment, notify physician of CBG value unless otherwise ordered. 3. Treat according to appropriate level or protocol Level II: CBG ,d+[DATE] mg/dl with or without mild/moderate symptoms Give 8 oz of juice. If juice is not tolerated, give 16oz Skim or Low Fat milk; go to #4 4. Retest CBG after ,d+[DATE] minutes after treatment. If CBG less than 74 mg/dl, give another 4 ounces juice or 8 oz of milk. Review of Resident #48's Care Plan revealed the following, in part: Problem: Nutrition - Resident #48 has a diagnosis of Diabetes. Interventions: Notify MD of abnormal and treat as ordered. Problem: Metabolism-Diabetes- Resident #48 has a diagnosis of Diabetes and is at risk for unstable blood sugar levels. Interventions: Evaluate, assess, and monitor hypoglycemia signs and symptoms. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #48's Nurse's Notes revealed the following, in part: On [DATE] at 7:06 a.m. by S4LPN: [DATE] 5:15 a.m. routine blood sugar checked, initial result was 49 fasting and resident was given sweetener on sponge to tongue and cheeks. Blood sugar rechecked after 30 minutes results 53 will alert a.m. nurse to result again in 30 minutes. On [DATE] at 6:43 a.m. by S5LPN: 6:30 a.m. Upon entering resident's room, resident was found lying in her bed. Resident was not breathing, resident had no pulse, O2 sats unobtainable. No heart sounds upon auscultation. On [DATE] at 9:01 a.m., an interview was conducted with S20CNA. S20CNA stated her shift started at 6:00 p.m. on [DATE]. S20CNA stated Resident #48 did not have gurgled breathing during her shift. On [DATE] at 2:42 p.m., an interview was conducted with S4LPN. S4LPN confirmed Resident #48 was a Diabetic. S4LPN stated on [DATE] at approximately 5:15 a.m., Resident #48's blood glucose reading was 49 and she administered about a teaspoon of sugar on and under the tongue and placed the remaining sugar in approximately 2 ounces of water and administered about ,d+[DATE] of the solution to the resident's mouth using a pink sponge stick. S4LPN stated she rechecked Resident #48's blood sugar 20 - 25 minutes later and it was 53. S4LPN stated once the blood sugar came up to 53, Resident #48 was more alert. S4LPN stated she administered Resident #48 three additional sponges of sugar water from the same cup to the resident. S4LPN stated she planned to recheck the resident's blood sugar again in ,d+[DATE] minutes but never did. S4LPN stated the resident did not have a hypoglycemic protocol to follow in her record. S4LPN explained she thought about giving the resident juice but had received report that the resident was not eating. S4LPN stated she did not consider administering glucagon. S4LPN stated she did not notify the doctor because the blood glucose was not super low, and she was attempting to get it up with sugar water. S4LPN stated there were standing orders to notify the doctor if a blood glucose was under a certain value but she did not know the value. S4LPN stated she had not looked at the standing order for hypoglycemia. On [DATE] at 8:59 a.m., an interview was conducted with S5LPN. S5LPN confirmed Resident #48 was a Diabetic. S5LPN stated she observed Resident #48 on [DATE] at approximately 6:00 a.m. and again around 6:15 a.m. S5LPN said Resident #48 was unresponsive with gurgled breathing. She stated the resident would not wake up to verbal stimulation when her name was called or when she physically shook her. She confirmed she did not assess the residents vital signs or check blood glucose levels at either 6:00 a.m. or 6:15 a.m. S5LPN stated she received report that Resident #48 was declining, so she was not concerned when the resident was unresponsive with gurgled breathing. S5LPN stated when she next observed Resident #48 at 6:30 a.m., the resident was unresponsive, without a pulse, and stopped breathing. She explained she did not call the doctor to notify them of Resident #48's status at either 6:00 a.m. or 6:15 a.m. because the resident expired before she got a chance to. She further confirmed she did not notify EMS. S5LPN stated she did not know the resident had low blood glucose readings beginning at 5:15 a.m. and would have checked her blood sugar and followed the hypoglycemic protocol if she did. On [DATE] at 10:35 a.m., an interview was conducted with S16MD. S16MD stated there was a Hypoglycemic Protocol in place for nurses to follow when a blood glucose reading was less than 60. S16MD stated the nurse should have called the on-call physician immediately when Resident #48's blood glucose reading of 49 was received. S16MD stated if Resident #48 was unable to drink the sugar water, then Glucagon would have been the better option to treat Resident #48's hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:13 a.m., an interview was conducted with S2DON. S2DON stated she expected nurses to follow the Hypoglycemic Protocol. S2DON stated the Hypoglycemic Protocol was the standing doctor's orders for a Diabetic resident and was located at the nurse's station. S2DON stated if Resident #48 was unable to drink enough sugar water, Glucagon should have been administered. S2DON confirmed S4LPN did not follow the Hypoglycemic Protocol. S2DON confirmed the physician should have been notified as soon as there was a change in Resident #48's condition. S2DON stated the physician should have been notified upon receipt of the 49 blood glucose reading. S2DON stated when Resident #48 was unresponsive to verbal and physical stimuli and had gurgled respirations, S5LPN should have assessed the resident, obtained vital signs and notified the physician. S2DON stated S5LPN should have automatically sent the resident to the hospital and notified the physician of the reason.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on observations, interviews, and record review, the facility failed to ensure a resident received adequate supervision and assistance devices to prevent accidents by failing to utilize a Hoyer Lift with the assistance of two staff members for transfers for 1 (#28) of 3 (#28, #33, and #36) residents reviewed with Hoyer Lift transfers. Findings: Review of Resident #28's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Dementia, Generalized Muscle Weakness, Other Lack of Coordination, and Abnormal Posture. Review of Resident #28's Quarterly MDS with an ARD of 03/13/2024 revealed she had a BIMS of 8, which indicated moderate cognitive impairment. Further review of the MDS revealed she was dependent on staff for transfers. Review of Resident #28's current Physician Orders revealed Hoyer Lift x 2 for transfers with a start date of 05/16/2023. Review of Resident #28's current Care Plan revealed the following, in part: Problem: Routine care needs - Resident #28 requires extensive assistance with transfers Approach: 05/16/2023 - transfer status Hoyer Lift x 2 staff members Review of Resident #28's nursing referral screen to rehab dated 05/05/2023 revealed the following, in part: Rehab comments/recommendation: Recommend Hoyer Lift transfer x 2 person for safety and proper positioning. An observation was made of S12CNA transferring Resident #28 from her bed to geri-chair on 05/29/2024 at 9:02 a.m. S12CNA transferred Resident #28 into her geri-chair independently without any lift device. An observation was made of Resident #28's care plan in her room following the above observation. Resident #28's lift care plan on the bulletin board in her room revealed she required a Hoyer Lift with two staff members for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with S12CNA on 05/29/2024 at 9:13 a.m. She stated each resident's ADL charting revealed how much assistance each resident required for a particular ADL, including transfers. She stated she was able to transfer Resident #28 independently and had never used a Hoyer Lift. She confirmed she got Resident #28 out of bed this morning independently, got her back in bed for catheter care independently, and transferred her back to her geri-chair independently while surveyor was observing. She reviewed Resident #28's ADL care plan at that time and confirmed Resident #28 required a Hoyer Lift with two staff members' assistance for transfers. She stated therapy completed transfer assessments on each resident to determine how much assistance each resident required. An interview was conducted with S15LPN on 05/29/2024 at 10:25 a.m. She confirmed she was assigned to Resident #28. She stated Resident #28 should always be transferred with the Hoyer Lift and the assistance of two staff members. She stated staff should never transfer Resident #28 with any other method. An interview was conducted with S14RTD on 05/29/2024 at 12:04 p.m. She confirmed Resident #28 was assessed by therapy to need a Hoyer Lift for transfers, which was the safest way to transfer Resident #28. She stated the expectation was for staff to always use the Hoyer Lift for transfers. An interview was conducted with S2DON on 05/29/2024 at 10:44 a.m. She stated therapy was responsible for making the determination on a resident's transfer status. She stated there was a transfer list at each kiosk and each resident's room had an ADLs care plan, which alerted staff to each residents' transfer status. She confirmed Resident #28 was assessed by therapy and required a Hoyer Lift for transfers. She stated the staff should never transfer Resident #28 independently without a Hoyer Lift.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681 Based on observation, interviews, and record review, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure oxygen tubing and humidifier bottle were properly labeled for 1(#21) of 8 (#5, #18, #21, #30, #41, #46, #250, #251) residents reviewed with oxygen therapy. Findings: Review of the facility policy titled, Oxygen Administration, dated 10/2016, revealed, in part: Replace oxygen tubing, mask/cannula and humidification solution weekly. Review of clinical record for Resident #21 revealed she was admitted to the facility on [DATE] and had diagnosis which included Chronic Obstructive Pulmonary Disease, Asthma, Atrial Fibrillation, Heart Failure and Obstructive Sleep Apnea. Review of current Physicians Orders for Resident #21 revealed the following, in part: Start date: 05/15/2024 Shortness of breath with new onset of dyspnea begin on 1 liter O2, titrate to 2L to keep O2 saturation more than 92%. Start date: 05/19/2024 Change nasal cannula and label weekly on Sunday and as needed. Start date: 05/19/2024 Humidifier bottle change and label weekly on Sunday. An observation was made of Resident #21 on 05/28/2024 at 9:15 a.m., sleeping in recliner with O2 nasal cannula with humidifier in use. The oxygen tubing and humidification bottle were not labeled with a date indicating when changed. An interview was conducted with S17LPN on 05/28/2024 at 10:16 a.m. S17LPN stated Resident #21 utilized oxygen via nasal cannula often as prescribed. S17LPN confirmed Resident #21's oxygen tubing and humidification bottle was not labeled with a date and should have been. An interview was conducted with S2DON on 05/29/2024 at 1:51 p.m. S2DON confirmed all oxygen tubing and humidifiers should be changed weekly and labeled with a date when changed. An interview was conducted with S1ADM on 05/29/2024 at 1:52 p.m. S1ADM confirmed all oxygen tubing and humidification systems should be labeled with a date when changed.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on interviews and record reviews, the facility failed to ensure licensed nurses had the necessary competencies and skill sets to care for a resident's needs. The facility failed to ensure: 1. S4LPN and S5LPN implemented the hypoglycemic protocol for 1 (#48) of 3 (#32, #46, and #48) residents reviewed with Diabetes; and 2. S5LPN assessed an unresponsive resident with gurgled breathing for 1 (#48) of 3 (#32, #46, and #48) residents reviewed with Diabetes. This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 5:15 a.m., when S4LPN failed to implement the standing orders for Hypoglycemic Protocol when Resident #48's blood glucose level was 49 mg/dL. S4LPN administered approximately 2 ounces of sugar water via oral swab to the resident. Upon rechecking Resident #48's blood glucose level, the reading was 53 mg/dL. S4LPN did not notify the physician of the low readings. On [DATE] at 6:00 a.m., S5LPN observed Resident #48 and found the resident had gurgled breathing and was unable to be aroused. S5LPN failed to notify Resident #48's physician or assess vital signs to include a blood glucose reading at that time. At 6:30 a.m., S5LPN found Resident #48 unresponsive, without a pulse or breath sounds. S1ADM and S2DON were notified of the Immediate Jeopardy situation on [DATE] at 12:50 p.m. The Immediate Jeopardy was removed on [DATE] at 3:53 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. The deficient practice continued at more than minimal harm for the remaining 49 residents residing in the facility. Findings: Review of the facility policy titled Diabetes Mellitus Resident Care revised ,d+[DATE] revealed the following, in part: Policy Guidelines and Procedures: Monitoring of blood sugar levels is done as ordered by MD, and PRN per nursing judgement. MD is notified for any change in condition. In the event of emergency or acute change in status, assess the resident for the following: Not able to awaken, Personality Change, Unconsciousness and obtain a blood glucose reading. In the event of low blood sugar, follow physician standing order. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If the resident who has low blood sugar remains unresponsive after initiation of standing order, activate EMS system and transfer to the emergency room . Notify MD and obtain order for transfer. Repeat blood glucose testing as indicated to monitor efficacy of emergency treatments. Notify MD of any initiation of standing order for low blood sugar, including resident response to treatment. Review of the facility policy titled Physician Contact, revised ,d+[DATE], revealed the following, in part: Policy Summary and Objective: Effective communication with the resident's MD is necessary in order to plan for and deliver high quality resident service. Policy Guidelines and Procedures: Prior to calling a MD to report a change in condition or status update, you should have: A complete set of vital signs and any follow up vital signs to show response to interventions to this point Chief complaint of the resident including signs and symptoms Nursing assessment of resident complaint Results of lab work Report any outstanding issues to on-coming shift for continued assessment/intervention Notify the Director of Nursing or Nurse Manager on call for any unstable residents Review of Resident #48's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #48's Physician's Orders revealed the following, in part: [DATE] Hypoglycemia Protocol: follow hypoglycemia protocol as listed then notify MD if CBG is less than 74 mg/dL or unless otherwise instructed by physician. Review of the facility document presented as the Hypoglycemic Protocol titled Signs and Symptoms of Hypoglycemia In Adults signed by S16MD on [DATE] revealed the following, in part: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Whenever hypoglycemia is suspected the following steps are to be taken: 1. Verify results by repeated CBG 2. Follow hypoglycemia treatment, notify physician of CBG value unless otherwise ordered. 3. Treat according to appropriate level or protocol Level II: CBG ,d+[DATE] mg/dl with or without mild/moderate symptoms Give 8 oz of juice. If juice is not tolerated, give 16oz Skim or Low Fat milk; go to #4 4. Retest CBG after ,d+[DATE] minutes after treatment. If CBG less than 74 mg/dl, give another 4 ounces juice or 8 oz of milk. Review of Resident #48's Nurse's Notes revealed the following, in part: On [DATE] at 7:06 a.m. by S4LPN: [DATE] 5:15 a.m. routine blood sugar checked, initial result was 49 fasting and resident was given sweetener on sponge to tongue and cheeks. Blood sugar rechecked after 30 minutes results 53 will alert a.m. nurse to result again in 30 minutes. On [DATE] at 6:43 a.m. by S5LPN: 6:30 a.m. Upon entering resident's room, resident was found lying in her bed. Resident was not breathing, resident had no pulse, O2 sats unobtainable. No heart sounds upon auscultation. On [DATE] at 9:01 a.m., an interview was conducted with S20CNA. S20CNA stated her shift started at 6:00 p.m. on [DATE]. S20CNA stated Resident #48 did not have gurgled breathing during her shift. On [DATE] at 2:42 p.m., an interview was conducted with S4LPN. S4LPN confirmed Resident #48 was a Diabetic. S4LPN stated on [DATE] at approximately 5:15 a.m., Resident #48's blood glucose reading was 49 and she administered about a teaspoon of sugar on and under the tongue and placed the remaining sugar in approximately 2 ounces of water and administered about ,d+[DATE] of the solution to the resident's mouth using a pink sponge stick. S4LPN stated she rechecked Resident #48's blood sugar 20 - 25 minutes later and it was 53. S4LPN stated once the blood sugar came up to 53, Resident #48 was more alert. S4LPN stated she administered Resident #48 three additional sponges of sugar water from the same cup to the resident. S4LPN stated she did not consider administering glucagon. S4LPN stated she did not notify the doctor because the blood glucose was not super low, and she was attempting to get it up with sugar water. S4LPN stated there were standing orders to notify the doctor if a blood glucose was under a certain value but she did not know the value. S4LPN stated she did not look at the standing order for hypoglycemia. S4LPN confirmed blood glucose readings of 49 and 53 were abnormal. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:59 a.m., an interview was conducted with S5LPN. S5LPN confirmed Resident #48 was a Diabetic. S5LPN stated she observed Resident #48 on [DATE] at approximately 6:00 a.m. and again around 6:15 a.m. S5LPN said Resident #48 was unresponsive with gurgled breathing. She stated the resident would not wake up to verbal stimulation when her name was called or when she physically shook her. She confirmed she did not assess the residents vital signs or check blood glucose levels at either 6:00 a.m. or 6:15 a.m. S5LPN stated she received report that Resident #48 was declining, so she was not concerned when the resident was unresponsive with gurgled breathing. S5LPN stated when she next observed Resident #48 at 6:30 a.m., the resident was unresponsive, without a pulse, and stopped breathing. She explained she did not call the doctor to notify them of Resident #48's status at either 6:00 a.m. or 6:15 a.m. because the resident expired before she got a chance to. S5LPN stated she did not know the resident had low blood glucose readings beginning at 5:15 a.m. On [DATE] at 10:35 a.m., an interview was conducted with S16MD. S16MD stated there was a Hypoglycemic Protocol in place for nurses to follow when a blood glucose reading was less than 60. S16MD stated the nurse should have called the on-call physician immediately when Resident #48's blood glucose reading of 49 was received. S16MD stated if Resident #48 was unable to drink the sugar water, then Glucagon would have been the better option to treat Resident #48's hypoglycemia. On [DATE] at 11:13 a.m., an interview was conducted with S2DON. S2DON stated she expected nurses to follow the Hypoglycemic Protocol. S2DON stated the Hypoglycemic Protocol was the standing doctor's orders for a Diabetic resident and was located at the nurse's station. S2DON stated this information is included in orientation. S2DON stated if Resident #48 was unable to drink enough sugar water, Glucagon should have been administered. S2DON confirmed S4LPN did not follow the Hypoglycemic Protocol. S2DON confirmed the physician should have been notified as soon as there was a change in Resident #48's condition. S2DON stated the physician should have been notified upon receipt of the 49 blood glucose reading. S2DON stated when Resident #48 was unresponsive to verbal and physical stimuli and had gurgled respirations, S5LPN should have assessed the resident, obtained vital signs and notified the physician. S2DON stated S5LPN should have automatically sent the resident to the hospital and notified the physician of the reason. Review of the document titled RN / LPN Skills Orientation Check List revealed no documentation of the Hypoglycemic Protocol.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 47500 Based on observations and interviews, the facility failed to post the required nurse staffing information on a daily basis for 4 of 4 (Nurse's Station a, b, c, and d) Nurse's Stations reviewed for nurse staffing information. Findings: An observation of the staffing data posted at Nursing Station a revealed it did not include the resident census, the total number and the actual hours worked for resident care per shift for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants on the following dates and times: 05/28/2024 at 8:45 a.m., 05/28/2024 at 1:40 p.m., and 05/29/2024 at 8:25 a.m. An observation of the staffing data posted at Nursing Station b revealed it did not include the resident census, the total number and the actual hours worked for resident care per shift for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants on the following dates and times: 05/28/2024 at 11:15 a.m., 05/28/2024 at 3:20 p.m., and 05/29/2024 at 11:15 a.m. An observation of the staffing data posted at Nursing Station c revealed it did not include the resident census, the total number and the actual hours worked for resident care per shift for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants on the following dates and times: 05/28/2024 at 9:00 a.m., 05/28/2024 at 1:43 p.m., and 05/29/2024 at 9:00 a.m. An observation of the staffing data posted at Nursing Station d revealed it did not include the resident census, the total number and the actual hours worked for resident care per shift for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants on the following dates and times: 05/28/2024 at 9:05 a.m., 05/28/2024 at 1:45 p.m., and 05/29/2024 at 9:20 a.m. An interview was conducted on 05/31/2024 at 11:05 a.m. with S8SD. S8SD stated she was responsible for posting the staffing assignment sheet. S8SD confirmed she did not include the resident census, the total number and the actual hours worked for resident care per shift for Registered Nurses, Licensed Practical Nurses, and CNAs when she posted the staffing assignment sheet. An interview was conducted on 05/31/2024 at 11:08 a.m. with S1ADM. S1ADM stated he was not aware of the required data that should have been posted regarding the staffing assignment sheet.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500 Based on record review and interview, the facility failed to ensure adequate monitoring for side effects with the use of anticoagulant medication was completed for 2 (#32 and #250) of 5 (#11, #32, #36, #47, and #250) residents reviewed for unnecessary medications. Findings: Resident #32 Review of Resident #32's clinical record revealed, in part, Resident #32 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Cognitive Communication Deficit, Type 2 Diabetes, Vascular Dementia, and Chronic Embolism. Review of Resident #32's MDS with an ARD of 05/14/2024 revealed, in part, Resident #32 received anticoagulant medication in the previous 7 days. Review of Resident #32's physician orders dated May 2024 revealed, in part, an order dated 05/08/2024 for Xarelto 15 mg at dinner for acute embolism. There was no documentation of monitoring for anticoagulant side effects for Resident #32 and the facility failed to provide documentation. Resident #250 Review of Resident #250's medical record revealed, Resident #250 was admitted to the facility on [DATE] with diagnoses, in part, bipolar disorder and heart condition. Review of Resident #250's physician orders revealed, in part, an order dated 05/21/2024 for Eliquis 5 mg by mouth twice daily for unspecified atrial fibrillation. Review of Resident #250's MAR dated 05/2024 revealed, in part, Eliquis administered as ordered for atrial fibrillation. Further review revealed there was no documentation of monitoring for side effects of Eliquis. An interview was conducted on 5/31/2024 at 10:18 a.m. with S2DON. S2DON confirmed there was no documentation of monitoring for side effects of the anticoagulant medication for Resident #32 and Resident #250. She confirmed monitoring for side effects of the anticoagulant medication should have been completed every shift.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500 Based on interview and record review, the facility failed to ensure residents' drug regimens were free from unnecessary psychotropic medications by failing to ensure an antipsychotic medication was used only when there was an acceptable diagnosis; and ensure adequate monitoring for effectiveness and side effects of psychotropic medication was completed for 2 (#32 and #250) of 5 (#11, #32, #36, #47, and #250) residents reviewed for unnecessary medications. Findings: Resident #32 Review of Resident #32's clinical record revealed, in part, Resident #32 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Cognitive Communication Deficit, Type 2 Diabetes, Vascular Dementia, and Chronic Embolism. Review of Resident #32's MDS with an ARD of 05/14/2024 revealed, in part, Resident #32 received antipsychotic medication, antianxiety medication, and antidepressant medication in the previous 7 days. Review of Resident #32's physician orders dated May 2024 revealed, in part, an order dated 05/08/2024 for Clonazepam 2mg tablet at bedtime for Radiculopathy, Quetiapine 25 mg twice daily for Vascular Dementia, and Viibryd 20mg every morning before breakfast for Depressive Episode. Review of Resident #32's MAR dated May 2024 revealed, in part, Resident #32 received the above medications as ordered. There was no documentation of monitoring for target behaviors or side effects of psychotropic medication for Resident #32 and the facility failed to provide documentation since the medication was started on 05/08/2024. Resident #250 Review of Resident #250's medical record revealed, Resident #250 was admitted to the facility on [DATE] with diagnoses, in part, Bipolar Disorder. Review of Resident #250's physician orders revealed, in part, an order dated 05/21/2024 for Fluoxetine 10 mg capsule by mouth daily for Depressive Disorder; Clonazepam 0.5mg by mouth hour of sleep for Spondylosis; and Risperdal 0.5 mg by mouth hour of sleep for Spondylosis. Review of Resident #250's MAR dated May 2024 revealed, in part, Resident #250 received the above medication as ordered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation of monitoring for target behaviors or side effects of psychotropic medication for Resident #250 and the facility failed to provide documentation. An interview was conducted on 5/31/2024 at 10:18 a.m. with S2DON. S2DON confirmed Vascular Dementia was not an appropriate indication for use of Quetiapine, Radiculopathy and Spondylosis was not an appropriate indication for use of Clonazepam, and Spondylosis was not an appropriate indication for use of Risperdal. She also confirmed there was no monitoring of target behaviors or monitoring of side effects for the above medications for Resident #32 and Resident #250 and there should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195410	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Place Nursing Care Center	333 Lee Drive Baton Rouge, LA 70808

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093 Based on record review, observations, and interviews, the facility failed to store food in accordance with professional standards for food service safety. This had the potential to effect the 49 residents who were served meals from the kitchen. Findings: Review of the facility's undated policy titled Food Receiving and Storage Policy revealed in part, the following: After receiving order from delivery driver, all items are to be dated and labeled with a received date. All items in the food storage areas will be labeled, whether opened or un-opened. If opened, date the opening date and then date a use-by date of no more than three days from the opening date. Remove any product that has been opened longer than three days, and remove any un-open product if it is on or passed the expiration date. On [DATE] at 8:54 a.m., an observation of Kitchen A revealed the following: 1. Five unsealed sausage patties, unlabeled and not dated in Freezer C; 2. Two uncooked hamburger patties, unlabeled and not dated in Freezer C; 3. Two pieces of uncooked chicken, unlabeled and not dated in Freezer C; 4. Two small Styrofoam containers of scooped orange sherbet, unlabeled and not dated in Freezer D; 5. Five small glass containers of scooped vanilla ice cream, unlabeled and not dated in Freezer D; 6. Three and ,d+[DATE] bunches of lettuce with portions discolored, unlabeled and not dated in Refrigerator E; 7. Two small Styrofoam containers of melted cheese, unlabeled and not dated in Refrigerator E; and 8. Two small quart size containers of tuna salad date [DATE] in Refrigerator E. On [DATE] at 9:30 a.m., an observation of Kitchen B revealed the following: 1. Five, 7 ,d+[DATE] ounce cans of cream of mushroom soup with an expiration date of in the walk-in pantry; (continued on next page)

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	195410	A. Building B. Wing	05/31/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Twenty three, 5 ounce cans of tomato juice with an expiration date of [DATE] in the walk-in pantry. On [DATE] at 10:25 a.m., an observation of the main kitchen revealed one opened, ,d+[DATE] full, gallon container of salad dressing, not dated in the walk-in cooler. On [DATE] at 9:35. a.m., an interview was conducted with S6ESC. She confirmed the findings observed on Kitchen A and Kitchen B. She stated she would expect staff to label all food in the refrigerators and freezers. She stated all food should be discarded 3 days after the open date and food with an expired date should be discarded. On [DATE] at 9:30 a.m., an interview was conducted with S7KM. He stated all stored foods should be labeled and dated once opened. He also stated food with an expired date should be removed and not available for consumption. On [DATE] at 11:26 a.m., an interview was conducted with S1ADM. He stated all stored food should be labeled and dated and food with an expired dated should be removed and not available for consumption.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195410	A. Building B. Wing	05/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47500 Based on record review, observation, and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) used Personal Protective Equipment (PPE) for a resident on Enhanced Barrier Precautions during a bed bath for 1 (#251) of 6 (#7, #24, #28, #39, #40, and #251) residents reviewed for Enhanced Barrier Precautions. Findings: Review of Resident #251's Physician Order dated 05/13/2024 revealed, in part, an order for Enhanced Barrier Precautions until discontinued by physician. An observation was made on 05/28/2024 at 9:40 a.m. of an Enhanced Barrier Precaution sign on Resident #251's door. Further review of the Enhanced Barrier Precaution sign revealed to wear a gown and gloves when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting. Further observation revealed, a hospice CNA was performing a bed bath on Resident #251 without wearing a gown. There was no documented evidence of an Enhanced Barrier Precaution Policy and the facility failed to provide any documented evidence. An interview was conducted on 05/31/2024 at 12:23 p.m. with S2DON. S2DON stated all staff, including hospice staff, providing care to residents should wear a gown and gloves when touching linens, bathing a resident, or changing a resident for residents on Enhanced Barrier Precautions. S2DON confirmed staff not wearing a gown while bathing a resident was not appropriate for a resident on Enhanced Barrier Precautions.