

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Rosewood Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 534 15th Street Lake Charles, LA 70601	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>44418</p> <p>Based on observations and interviews, the facility failed to provide a clean, comfortable, and homelike environment for 1 (#33) out of 35 sampled residents. The deficient practice had the potential to affect a census of 63.</p> <p>Findings:</p> <p>On 12/08/2024 at 10:19 a.m., an observation was conducted of Resident #33's room. The room had a silver pole on wheels that held the TF (Tube Feeding) machine, it had dry white substance(s) running down the pole and a tan , crusty substance covering almost the entire wheel base. Further observation revealed the oxygen concentrator had dried white and tan crusty splattered substance and drip spots on the front and top of the concentrator.</p> <p>On 12/08/2024 at 10:20 a.m., resident stated they should clean that machine and pole, it is dirty and they don't even attempt to clean it.</p> <p>On 12/08/2024 at 10:43 a.m., an observation of Resident #33's room and interview was conducted with S5RN (Registered Nurse). She confirmed the findings from above, and stated they should have been cleaned.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</p> <p>Based on interview and record review, the facility failed to ensure RD (Registered Dietitian) recommendations in response to identified weight loss were relayed to the physician for review and implementation for 1 (#44) of 9 (#3, #5, #23, #33, #34, #35, #44, #46, #212) residents that receive nutrition from enteral feedings.</p> <p>Findings:</p> <p>A review of Resident #44's record revealed an admitted [DATE] with diagnoses that included Dysphagia, Aphasia, Protein-Calorie Malnutrition, and Encounter for Attention to Gastrostomy (feeding/PEG tube).</p> <p>A review of Resident #44's care plan revealed a focus area for potential nutritional problem related to disease process, dysphagia, malnutrition, and has unplanned weight loss. Interventions included, provide and serve diet/provide peg (feeding) tube as per order and RD to evaluate and make diet change recommendations.</p> <p>A review of Resident #44's current physician's orders for November 2024 and December 2024 failed to reveal an order for tube feeding formula and rate.</p> <p>A review of Resident #44's November 2024 EMAR (Electronic Medication Administration Record) revealed an order that stated May substitute Isosource 1.5 for Jevity but failed to include administration instructions for rate. Review of Resident #44's December 2024 EMAR revealed an order that stated May substitute Isosource 1.5 for Jevity but also failed to include administration instructions for rate.</p> <p>Review of the RD Consultant Dietitian report Summary of Nutritional Care dated 11/15/2024 for Resident #44 revealed the following: Consult on [AGE] year old male who was eating initially by PO (by mouth) and after MBS (Modified Barium Swallow) test, he is NPO (nothing by mouth) and receiving Isosource 1.5 (liquid nutrition for tube feeding) at 50ml/hr (milliliters per hour) with 30ml/hr flush (water) He has had a 13.4 pound weight loss in past month and is currently at 134.8 pounds. BMI: 21.8 and is 90% of IBW (Ideal body weight) range: 149-180 pounds. Recommended increase to Isosource 1.5 TF (tube feeding) to 65ml/hr continuously .</p> <p>On 12/10/2024 at 10:45 a.m., an interview was conducted with S10RD. S10RD stated she assesses all residents' nutritional needs. The results, including changes and recommendations, are then emailed to the facility's administrative staff. The administrative staff is responsible for implementing the changes. She viewed her Consultant Dietitian Report dated 11/15/2024 and confirmed she had identified Resident #44's weight loss and made recommendations to increase the tube feeding rate according to the resident's estimated nutritional needs. She confirmed this report was sent to administrative staff, which included the DON (Director of Nursing), ADON (Assistant Director of Nursing), and the Administrator via e-mail.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/10/2024 at 3:03 p.m., a concurrent record review and interview was conducted with S2DON. S2DON confirmed she received the RD consultant report dated 11/15/2024 that included Resident #44's recommendations for the increased tube feeding rate. S2DON then viewed Resident #44's record and failed to identify that the recommendation had been implemented and confirmed there was no order to increase the tube feeding rate and should have been.</p> <p>On 12/10/2024 at 4:15 p.m., an additional interview was conducted with S2DON who stated that the resident's current weight is 135 lbs and has not had a weight loss from November 2024 to December 2024. During the interview, a request was made for a policy in regards to the process for reviewing and implementing Registered Dietitian recommendations. No such policy was provided by the time of survey completion.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46169</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure that residents' enteral feeding was properly labeled for 2 (#34 and #35) out of 2 (#34 and #35) sampled residents reviewed for tube feeding. The deficient practice had the potential to affect a total of 9 residents that received tube feedings.</p> <p>Findings:</p> <p>Resident #34</p> <p>Review of Resident #34's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Gastrostomy Status, Dysphagia Pharyngeal Phase, Moderate Protein Calorie Malnutrition, and Vascular Dementia.</p> <p>Review of Resident #34's physician's orders revealed an order dated 11/26/2024 that read: Enteral feed every night shift for supplement r/t (related to) Mod (moderate) PCM (Protein Calorie Malnutrition), and Dysphagia. Administer Isosource 1.5 via peg tube at 45 ml (milliliters)/hr. (per hour) continuous and flush of 60 ml/hr. Total volume to be infused 1080 ml in 24 hours.</p> <p>On 12/08/2024 at 10:46 a.m., an observation of Resident #34's tube feeding administration set revealed the formula label read, Isosource 1.5, the resident's name, a date of 12/08/2024, 1:00 a.m., and nurse's initials. There was no rate listed on the administration set. Further observation of the tube feeding administration set revealed the flush bag was not labeled.</p> <p>On 12/09/2024 at 10:24 a.m., a second observation was conducted of Resident #34's tube feeding administration set revealed the flush bag was not labeled.</p> <p>On 12/09/2024 at 10:48 a.m., an observation of Resident #34's tube feeding administration set was conducted with S7LPN (Licensed Practical Nurse). S7LPN confirmed the flush bag of the tube feeding administration set was not labeled and it should have been labeled with the resident's name, contents, rate, date, time, room number, and initials.</p> <p>Resident #35</p> <p>Review of Resident #35's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses including Hemiplegia following Cerebrovascular Disease, Type II Diabetes Mellitus, Dementia, Gastrostomy Status, Dysphagia, and Aphasia.</p> <p>Review of Resident #34's physician's orders revealed an order dated 11/27/2024 that read: Enteral feed Diabetisource via peg tube at 45ml/hr. with flush of 80 mls per 4 hours.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/08/2024 at 9:25 a.m., an observation of Resident #35's tube feeding administration set was conducted revealed the formula label read, Diabetisource AC, the resident's name, a date of 12/08/2024, 1:00 a.m., and the nurse's initials. There was no rate listed on the administration set. Further observation of the tube feeding administration set revealed the flush bag was not labeled.</p> <p>On 12/09/2024 at 10:26 a.m., an observation of Resident #35's tube feeding administration set was conducted that revealed the flush bag was not labeled.</p> <p>On 12/09/2024 at 10:50 a.m., an observation of Resident #35's tube feeding administration set was conducted with S7LPN. S7LPN confirmed the flush bag of the tube feeding administration set was not labeled. S7LPN confirmed the flush bag should have been labeled with the resident's name, contents, rate, date, time, room number, and initials.</p> <p>On 12/10/24 at 8:44 a.m., an interview was conducted with S2DON (Director of Nursing). S2DON confirmed the tube feeding administration set to include the formula bag and the flush bag should have each been labeled with the date, time, nurse's initials, rate and contents to ensure the resident received the proper nutrition and hydration. Further interview with S2DON revealed the facility had no policy and procedure related to labeling the tube feeding administration set.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>44418</p> <p>Based on observations, interview, and record review, the facility failed to provide necessary care and services that is in accordance with professional standards of practice for 3 (#11, #33, #37) out of 3 (#11, #33, #37) residents reviewed for respiratory care, with the potential to effect 7 residents receiving oxygen therapy.</p> <p>Findings:</p> <p>Review of the facility's policy titled Oxygen Administration with an approval date of 12/2024, revealed in part: Steps in the procedure . 10. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is enough that the water bubbles as oxygen flows through. 12. Replenish water to humidifier jar as needed.</p> <p>Resident #11</p> <p>Review of the physician's orders for Resident #11 revealed an order dated 12/09/2024 - Oxygen (O2) 3L/NC (liters per nasal cannula).</p> <p>On 12/08/2024 at 9:37 a.m., an observation of Resident #11's O2 concentrator was done. The humidifier jar, attached to concentrator tubing, was on floor without H2O (water) in the humidifier jar.</p> <p>On 12/08/2024 at 9:44 a.m., during an observation and interview with S4LPN, she observed and confirmed the oxygen humidifier jar for the concentrator was on the floor and the humidifier jar was empty. She reported the tubing and canister are changed at night on Sundays and PRN. She also confirmed the oxygen was infusing at 3 L/NC as ordered.</p> <p>Resident #33</p> <p>Review of the physician's orders for Resident #33 revealed an order dated 10/21/2424 - O2 at 3L/NC as needed for SOB (Shortness of Breath)</p> <p>On 12/08/2024 at 10:21 a.m., an observation of Resident #33's O2 concentrator was done. The humidifier jar was without H2O in the humidifier jar.</p> <p>On 12/08/2024 at 10:25 a.m., an interview was conducted with Resident #33. She stated she uses supplemental oxygen through her nose all the time.</p> <p>On 12/08/2024 at 10:43 a.m., an observation and interview with S5RN (Registered Nurse) of Resident #33's O2 concentrator was conducted. She confirmed the humidifier jar for the oxygen was empty and should have been checked regularly and had water added to it as needed.</p> <p>Resident #37</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the physician's orders for Resident #37 revealed an order dated 02/29/2024 O2 3L/NC as needed for Shortness of Breath.</p> <p>On 12/08/2024 at 10:04 a.m., an observation of Resident #33's O2 concentrator was done. The humidifier jar was empty, without H2O.</p> <p>On 12/08/2024 at 10:10 a.m., an observation and interview with S8LPN of Resident #37's O2 concentrator was conducted. She also confirmed the humidifier jar was empty, and should have water and bubbling when in use administering oxygen. Or while administering oxygen.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>31426</p> <p>Based on observation and interview, the facility failed to post nurse staffing information in a prominent place, readily accessible to residents and visitors. The information should be posted on a daily basis and include the resident census and total number of actual hours worked by RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and CNA (Certified Nurse Assistant) staff directly responsible for resident care per shift. The facility census was 63.</p> <p>Findings:</p> <p>On 12/10/2024 at 6:54 p.m., an interview with S1ADM (Administrator) and S9PM (Payroll Manager) verified that the facility did not post daily nurse staffing information that included the resident census and total number of actual hours worked by RNs, LPNs, and CNA staff directly responsible for resident care per shift anywhere in the facility.</p> <p>On 12/10/2024 at 7:30 p.m., an interview with S3RDO (Regional Director of Operations) was conducted. S3RDO was questioned regarding the posting of nurse staffing information that included resident census and total number of actual hours worked by RNs, LPNs, and CNA staff directly responsible for resident care per shift on a daily basis. S3RDO responded, We don't post the daily staffing information, but probably should.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</p> <p>Based on record review and interview the facility failed to ensure that each residents' medication regimen was free from unnecessary medications by failing to monitor for side effects for antipsychotropic medications for 1 (#42) of 5 (#11, #24, #27, #42, #47) residents reviewed for unnecessary medications. The deficient practice had the potential to affect a total census of 63.</p> <p>Findings:</p> <p>On 12/10/2024 at 1:07 p.m., a request was made for a policy regarding monitoring for antipsychotropic medications. No such policy was provided by the time of the survey conclusion.</p> <p>A review of Resident #42's record revealed an admitted [DATE] with diagnoses that included Vascular Dementia, Anxiety Disorder and Depression.</p> <p>A review of Resident #42's November 2024 and December 2024 EMAR's (Electronic Medication Administration Record) revealed Resident #42 was receiving the following medications:</p> <p>An antipsychotic, Quetiapine 200mg (milligram) twice daily with a start date of 11/14/2024,</p> <p>An antidepressant, Duloxetine 60mg 2 capsules daily with a start date of 11/15/2024,</p> <p>An antidepressant, Mirtazapine 15mg at bedtime with a start date of 11/14/2024, and</p> <p>An antianxiety, Buspirone 5mg three times daily with a start date of 11/21/2024.</p> <p>Further review of Resident #42's November 2024 and December 2024 EMAR failed to reveal side effect monitoring.</p> <p>On 12/20/2024 at 9:50 a.m., a concurrent record review and interview was conducted with S7LPN (Licensed Practical Nurse). S7LPN reviewed Resident #42's November 2024 and December 2024 EMAR and confirmed the resident was taking the Quetiapine, Duloxetine, Mirtazapine, and Buspirone and that all of the medications required monitoring for side effects and targeted behaviors. S7LPN confirmed this monitoring should be documented on the EMAR, and was not being done and should be.</p> <p>On 12/20/2024 at 1:07 p.m., a concurrent record review and interview was conducted with S2DON (Director of Nursing). S2DON reviewed Resident #42's November 2024 and December 2024 EMAR and confirmed the resident was taking the Quetiapine, Duloxetine, Mirtazapine, and Buspirone and that all of the medications required monitoring for side effects and targeted behaviors. S2DON confirmed this monitoring should be documented on the EMAR, and was not being done and should be.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41868</p> <p>Based on observation and interview, the facility failed to ensure food products were properly refrigerated after being opened. This deficient practice has the potential to effect the 56 residents that eat meals from the from the facility's kitchen.</p> <p>Findings:</p> <p>On 12/08/2024 at 8:45 a.m., an initial observation of the kitchen's dry storage room was conducted. One 48 ounce container of Concord Grape Jelly, was opened with approximately one-third of the jelly missing. Upon further inspection of the container, it read Refrigerate after opening.</p> <p>On 12/08/2024 at 11:15 a.m., a second observation of the kitchen's dry storage room was conducted with S6DM (Dietary Manager). She confirmed the container of Concord Grape Jelly had been opened, and on further review of the label, that is should be been refrigerated after opening.</p>