

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Lakeview Manor Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Hospital Road New Roads, LA 70760	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270</p> <p>Based on record review and interviews, the facility failed to ensure nursing staff notified the resident representative when a resident had a significant change in condition for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Change in a Resident's Condition or Status revealed the following, in part:</p> <p>Policy Statement: Our facility shall promptly notify the .representative of changes in the resident's medical/mental condition and/or status.</p> <p>Policy Interpretation and Implementation:</p> <p>3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when:</p> <p>b. There is a significant change in the resident's physical, mental, or psychosocial status.</p> <p>Review of Resident #1's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction Due To Embolism of Right Middle Cerebral Artery and Cardiomegaly.</p> <p>Review of Resident #1's Annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/29/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) of 04, which indicated the resident had severe cognitive impairment.</p> <p>Review of Resident #1's Nurses' Notes dated August 2024 revealed no documentation the residents' representative was notified of Resident #1's change in condition on 08/27/2024.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/24/2024 at 1:25 p.m., an interview was conducted with S4LPN. She confirmed she was assigned to Resident #1 on 08/27/2024. She stated during her shift on 08/27/2024, Resident #1 vomited after breakfast and lunch and reported not feeling well. She stated she could not recall if she notified Resident #1's representative of the resident's change in condition on 08/27/2024. She stated she should notify the responsible party (RP) any time a resident demonstrated a change in condition. She reviewed the August 2024 Nurses' Notes for Resident #1 and confirmed there was no documentation to indicate she notified Resident #1's representative of the change in condition.</p> <p>On 09/24/2024 at 2:20 p.m., an interview was conducted with S5CNA. She confirmed she was assigned to Resident #1 on 08/27/2024. She stated during her shift on 08/27/2024, Resident #1 vomited after breakfast and lunch and reported her stomach was hurting. She reported Resident #1's change in condition to S4LPN.</p> <p>On 09/25/2024 at 8:50 a.m., a telephone interview was conducted with Resident #1's representative. The representative confirmed she was not notified of a change in Resident #1's condition on 08/27/2024.</p> <p>On 09/25/2024 at 9:05 a.m., a telephone interview was conducted with Resident #1's family member. The family member confirmed she was not notified of a change in Resident #1's condition on 08/27/2024.</p> <p>On 09/25/2024 at 10:55 a.m., an interview was conducted with S2DON. She stated S4LPN notified her on 08/27/2024 Resident #1 had a decreased appetite and had vomited. She reviewed Resident #1's Nurse's Notes and confirmed there was no documentation to indicate Resident #1's representative or family was notified of her change in condition on 08/27/2024. She stated she expected the nurses to notify a residents' representative of any changes in condition.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270</p> <p>Based on record review and interviews, the facility failed to maintain complete and accurate records in accordance with accepted professional standards and practices for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed. The facility failed to ensure nursing staff documented a resident's change in condition, provider notification of a resident's change in condition, and administration of Zofran.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Documentation revealed the following, in part:</p> <p>The purpose of charting and documentation is to provide:</p> <ol style="list-style-type: none"> 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., for continuity of care, treatment decisions . <p>Procedure:</p> <ol style="list-style-type: none"> 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medications, etc . 2. Document all notifications of resident status to physicians .Document all responses to notifications. 6. Document medication administration, treatments, vital signs, etc. <p>Review of the facility's undated policy titled, Routine Standing Orders revealed the following, in part:</p> <ol style="list-style-type: none"> 7. Standing orders are utilized by licensed nurses who must use professional judgement in the initiation and administration of standing orders. 10. Documentation of the situation requiring the use of standing order is placed in the Nursing Notes section of the resident's medical record prior to initiation of the order. Resident response, i.e. whether the medication was effective, is documented following the procedure for prn orders. <p>Review of the facility's Hospital Medicine Group Nursing Home Standing Orders with a revision date of 01/10/2020, revealed the following, in part:</p> <p>Common Symptoms/Complaints</p> <ol style="list-style-type: none"> 4. Nausea/Vomiting <ol style="list-style-type: none"> a. Zofran 4mg by mouth every 4 hours prn x 24 hours. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction Due To Embolism of Right Middle Cerebral Artery and Cardiomegaly.</p> <p>Review of Resident #1's Annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/29/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) of 04, which indicated the resident had severe cognitive impairment.</p> <p>Review of Resident #1's MAR (Medication Administration Record) dated August 2024 revealed no evidence Resident #1 received Zofran on 08/27/2024.</p> <p>Review of Resident #1's Nurses' Notes dated August 2024 revealed no documentation of the following: Resident #1's change in condition on 08/27/2024; the nurse practitioner was notified of Resident #1's change in condition on 08/27/2024; or evidence Resident #1 was administered Zofran on 08/27/2024.</p> <p>On 09/24/2024 at 1:25 p.m., an interview was conducted with S4LPN. She confirmed she was assigned to Resident #1 on 08/27/2024. She stated during her shift on 08/27/2024, Resident #1 vomited after breakfast and lunch and reported not feeling well. She stated she notified S6NP of Resident #1's change in condition who ordered a onetime dose of Zofran. She confirmed she administered a dose of Zofran to Resident #1 on 08/27/2024. She reviewed the August 2024 MAR and Nurses Notes for Resident #1 and confirmed she did not document the administration of Zofran to Resident #1 on 08/27/2024 and should have. She confirmed there was no documentation to indicate Resident #1's change in condition or notification of the resident's change in condition to S6NP and there should have been.</p> <p>On 09/25/2024 at 10:55 a.m., an interview was conducted with S2DON. She stated S4LPN notified her on 08/27/2024, Resident #1 had a decreased appetite and had vomited. She stated S4LPN reported she notified S6NP of Resident #1's change in condition. She stated each resident had standing orders which included Zofran. She stated when a nurse administered a onetime dose of an as needed medication on the standing orders, she expected the nurses to document the medication was administered in the nurses' notes. She stated when a resident had a change in condition the expectation was for the nurses to document the residents change in condition and notification to the provider in a nurses' note. She reviewed Resident #1's August 2024 Nurses' Notes and MAR and confirmed there was no documentation to indicate the Resident #1's change in condition, notification to the physician or nurse practitioner, or administration of Zofran to Resident #1 on 08/27/2024 and there should have been.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47732</p> <p>Based on a record review, observations, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) for 1(#2) resident who was on Enhanced Barrier Precautions (EBP).</p> <p>Findings:</p> <p>Review of the undated facility policy titled Enhanced Barrier Precautions, revealed the following:</p> <p>It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDRO).</p> <p>3. Implementation of Enhanced Barrier Precautions</p> <p>a. Gowns and gloves will be available</p> <p>4. High Contact resident care activities include:</p> <p>g. device care or use: urinary catheters.</p> <p>Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses of Urinary Tract Infection and Retention of Urine.</p> <p>Review of Resident #2's Admission MDS with ARD 08/13/2024 revealed Resident #2 had a BIMS of 3. Review of Section 6. Urinary Incontinence and Indwelling Catheter is checked yes.</p> <p>An observation was made on 09/24/2024 at 11:00 a.m. of the Enhanced Barrier Precautions sign posted on Resident #2's door. Signage indicated the following:</p> <p>Wear gloves and a gown for the following High-Contact Resident Care Activities.</p> <p>Device Care or use: Urinary Catheter.</p> <p>An observation was made on 09/24/2024 at 12:20 p.m. of S3LPN, without a gown, as she performed urinary catheter care and dressing change.</p> <p>An interview was conducted with S3LPN on 09/24/2024 at 12:25 p.m. S3LPN stated she was unclear if she should wear a gown for catheter care. After review of the Enhanced Barrier Precautions posted on Resident #2's door, S3LPN confirmed that the directions included catheter care. S3LPN confirmed she did not wear a gown when providing urinary catheter care and dressing change to Resident #2, and should have.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 09/25/2024 at 8:45 a.m. with S2DON. S2DON confirmed Resident #2 was on EBP and S3LPN should have worn a gown when she performed Resident #2's catheter care and dressing change.</p>