STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195446	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Nursing and Rehabilitation Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 45270 Based on observation, interviews, and record review, the facility failed to ensure a resident's assessment accurately reflected the residents' status. The facility failed to ensure: 1. A resident's Minimum Data Set yearly assessment was accurately coded in regards to PASRR Level II for 1 (#28) of 4 (#6, #15, #28, and #80) residents reviewed for PASRR; and 2. A resident's Minimum Data Set yearly and quarterly assessments accurately reflected the use of a bed alarm for 1 (#15) of 3 (#15, #56, and #59) residents reviewed for falls. Findings: Review of the facility's policy MDS 3.0 Completion, with no effective date, revealed, in part, the following: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Care Plan Team Responsibility for Assessment Completion: 1. Interdisciplinary Responsibility for Completion of MDS Sections: c. Persons completing part of the assessment must attest to the accuracy of the section they completed. Review of the facility's policy MDS - Conducting an Accurate Resident Assessment, with no effective date, revealed, in part, the following: Policy: The purpose of this policy is to assure that all residents receive an accurate assessment of relevant care areas. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: 1. Accurate assessments addressing each resident's status, needs, strengths and areas of decline must be conducted by a qualified staff that are knowledgeable about the resident and correctly documented in the medical record. 2. The appropriate, qualified health professional correctly documents the resident's . psychosocial problems and identifies resident strengths to maintain or improve . psychosocial status. 5. The physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dieticians and other professionals, such as developmental disabilities specialists, in assessing the resident and in correcting resident assessments. Involvement of other disciplines is dependent upon individual resident status and needs. 1. Resident #28 Review of Resident #28's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Schizophrenia (onset 03/08/2023) and Paranoid Schizophrenia (onset 03/28/2023). Review of Resident #28's most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2024, revealed the following: A1500: Resident Evaluated by PASRR - 0. No. A15010A: Serious Mental Illness - Blank. Review of Resident #28's BHSF Form 142, dated 09/27/2023, revealed, in part, the following: Section II: Approved for admission by Level II Authority, effective 10/02/2023 through 09/30/2024. An interview was conducted on 04/25/2024 at 11:55 a.m. with S3MDS. She confirmed Resident #28 was not coded for PASRR Level II or for having a serious mental illness on the most recent yearly MDS, dated [DATE], and should have been. An interview was conducted on 04/25/2024 at 11:58 a.m. with S4MDS. She confirmed Resident #28 was not coded for PASRR Level II or for having a serious mental illness on the most recent yearly MDS, dated [DATE], and should have been. An interview was conducted on 04/25/2024 at 1:20 p.m. with S2DON. She confirmed Resident #28 was not coded for PASRR Level II or for having a serious mental illness on the most recent yearly MDS, dated [DATE], and should have been. She confirmed she would expect all residents to be coded correctly in their MDS Assessments. 2. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Assessment Instrument 3.0 User's Manual dated October 2023 revealed the following in part: Section P0200 Alarms Coding Instructions Identify all alarms that were used at any time (day or night) during the 7-day look-back period. After determining whether or not an item listed in P0200 was used during the 7-day look-back period, code the frequency of use: o Code 0, not used: if the device was not used during the 7-day look-back period. o Code 1, used less than daily: if the device was used less than daily. o Code 2, used daily: if the device was used on a daily basis during the look-back period. Resident #15 Review of Resident #15's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Unspecified Dementia Unspecified Severity with Anxiety, Generalized Anxiety Disorder, Insomnia, Delusional Disorders, Cognitive Communication Deficit, Unsteadiness of Feet, and Difficulty in Walking. Review of Resident #15's most recent Annual MDS, with an ARD of 12/29/2023, revealed the following: P0200A: Bed alarm-0. Not used. Review of Resident #15's most recent Quarterly MDS, with an ARD of 03/28/2024, revealed the following: P0200A: Bed alarm-0. Not used. Review of Resident #15's current Physician Orders revealed the following: Start date: 10/18/2023: Bed alarm to bed on while resident is in bed. An observation was made on 04/23/2024 at 9:07 a.m. of Resident #15's room. A bed alarm was observed on the mattress. An interview was conducted on 04/23/2024 at 9:08 a.m. with Resident #15's family member. She stated Resident #15 had frequent falls due to getting out of bed without calling staff for assistance. She stated sometime last year, a bed alarm was added and used nightly to prevent Resident #15 from falling. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 04/24/2024 at 9:04 a.m. with S6CNA. She stated she was assigned to Resident #15, who was a fall risk. She stated Resident #15 would get out of bed unassisted and had a bed alarm for months. She stated anytime Resident #15 was in bed, the bed alarm should be used to prevent falls. An interview was conducted on 04/24/2024 at 9:33 a.m. with S7LPN. She stated she was assigned to Resident #15, who had dementia and was a fall risk. She stated since last year, when Resident #15 was in bed the staff used a bed alarm to prevent falls. A telephone interview was conducted on 04/24/2024 at 4:30 p.m. with S8CNA. She stated she was assigned to Resident #15 on the 6:00 p.m. to 6:00 a.m. shift for the last 2 months. She stated Resident #15 was a fall risk. She stated anytime Resident #15 was in bed, she used a bed alarm to prevent her from falling. An interview was conducted on 04/25/2024 at 11:55 a.m. with S3MDS. She reviewed the MDS assessments with an ARD of 12/29/2023 and 03/28/2024 for Resident #15 and confirmed under Section P Restraints, bed alarm was not checked. She confirmed Resident #15 had a bed alarm in use during both MDS assessments. She stated the corporate office directed her not to code the bed alarm under Section P for Resident #15, since the bed alarm was not used as a restraint. An interview was conducted on 04/25/2024 at 1:40 p.m. with S2DON. She stated a bed alarm was used nightly for Resident #15 since it was ordered on 10/18/2023. She reviewed the MDS assessments with an ARD of 12/29/2023 and 03/28/2024 for Resident #15 and confirmed under Section P Restraints, bed alarm was not checked. She stated the corporate office directed S3MDS to not code the bed alarm on Section P, because it was not used as a restraint for Resident #15.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 Based on record review and interviews, the facility failed to ensure a record of the Level 1 Preadmission Screening Resident Review (PASRR) form was maintained in the resident's record for 1 (#6) of 4 (#6, #15, #28, and #80) residents reviewed for PASRR. Findings: Review of the facility's policy Resident Assessment-Coordination with PASRR Program, with no effective date, revealed the following, in part: Policy: This facility coordinates assessments with the Preadmission Screening and Resident Review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 3. A record of the pre-screening shall be maintained in the resident's medical record. Resident #6 Review of Resident #6's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Unspecified Dementia Unspecified Severity with Mood Disturbance, Schizophrenia, Major Depressive Disorder, Anxiety Disorder, and Schizoaffective Disorder. Review of Resident #6's OBH-PASRR Level 1 Pre-Admission Screening and Resident Review Form was attempted with no documentation available from the facility. An interview was conducted on 04/25/2024 at 11:45 a.m. with S10SW. She stated Resident #6 was admitted from a non-local facility. She stated the facility's corporate outreach team completed the preadmission packet, including the Level 1 PASRR screening form for non-local admissions and forwarded the information to her via email. She stated Resident #6's Level 1 pre-admission screening and resident review form was not included in the preadmission packet she received. She confirmed she did not request the Level 1 pre-admission screening and resident review form to ensure the resident was accurately screened prior to admission and should have. An interview was conducted on 04/25/2024 at 11:55 a.m. with S3MDS. She stated Resident #6 was admitted from a non-local facility and the corporate outreach team completed the preadmission paperwork and approved Resident #6 for admission. She reviewed the electronic PASRR forms and the clinical record for Resident #6 and confirmed there was no documentation of the Level 1 pre-admission screening and resident review form. She stated without the Level 1 pre-admission screening and resident review form there was no way to ensure the resident was accurately screened. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/25/2024 at 1:45 p.m. with S2DON. She stated the facility's corporate outreach team and the discharging hospital were responsible for Level 1 PASSR's for any non-local new admission residents. She stated the facility relied on the corporate team to ensure the residents were accurately screened prior to admission. She stated Resident #6 was admitted from a non-local facility. She reviewed the provided documentation for Resident #6 and confirmed the Level 1 pre-admission screening and resident review form was not provided. She stated the Level 1 pre-admission screening and resident review form should have been requested to ensure the resident was screened accurately prior to admission.

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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** 45270 Based on observation, interviews, and record review, the facility failed to ensure residents received adequate supervision for 1 (#15) of 3 (#15, #56, and #59) residents reviewed for falls. The facility failed to ensure staff rounded on Resident #15 every 2 hours to prevent falls. Findings: Review of the facility's policy titled, Routine Resident Checks, with no effective date, revealed the following, in part: Policy: Staff shall make routine resident checks to help maintain resident safety and well-being. Policy Interpretation and Implementation: 1. CNA's will check each resident at least every 2 hours. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. Review of the facility's policy titled, Fall Prevention, with no effective date, revealed the following, in part: Assessment and Care Planning Process: Individualized interventions will be planned as needed based on root cause analysis. 7. Increased monitoring by staff. Review of Resident #15's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Unspecified Dementia Unspecified Severity with Anxiety, Generalized Anxiety Disorder, Insomnia, Delusional Disorders, Cognitive Communication Deficit, Unsteadiness of Feet, and Difficulty in Walking. Review of Resident #15's most recent Quarterly MDS with an ARD of 03/28/2024, revealed she had a BIMS of 5, which indicated she was severely cognitively impaired. Further review of the MDS revealed she required staff assistance with toileting and transfers. Review of Resident #15's current Care Plan revealed the following, in part: Problem onset of 02/15/2023 Problem: Falls: At risk for falls (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: Start date: 04/10/2023 Resident noted to have a fall in her room. Resident states she was attempting to go to the bathroom. Intervention is to toilet every 2 hours. Review of the incident log dated November 2023-April 2024 revealed the following, in part: Resident #15 had falls on the following dates: 11/06/2023, 11/18/2023, 12/21/2023, 12/24/2023, 12/28/2023, 02/29/2024, 03/02/2024, 03/16/2024, 03/20/2024, 03/27/2024, and 04/01/2024. Review of Resident #15's Grievance Form dated 04/23/2024 revealed the following, in part: Grievance/Concern details: Resident #15 was not attended to within a reasonable time frame. Action taken: Reviewed surveillance and showed S8CNA making rounds on Resident #15 at 1:00 a.m. and 4:23 a.m. An interview was conducted on 04/24/2024 at 9:04 a.m. with S6CNA. She stated she was assigned to Resident #15, who was a fall risk and required staff assistance with transfers and toileting. She stated Resident #15 had dementia and frequent falls when she got up unassisted to go to the bathroom. She stated the staff should round on Resident #15 at least every 2 hours to prevent falls. An interview was conducted on 04/24/2024 at 9:33 a.m. with S7LPN. She stated she was assigned to Resident #15, who had dementia and required staff assistance with transfers and toileting. She stated Resident #15 had frequent falls. She stated the CNAs should round at least every 2 hours on Resident #15 to prevent falls. A telephone interview was conducted on 04/24/2024 at 4:30 p.m. with S8CNA. She stated Resident #15 was a fall risk and required assistance with toileting and transfers. She stated Resident #15 had frequent falls and should be rounded on at least every 2 hours to prevent falls. She verified she worked on 04/22/2024 from 6:00 p.m. and 6:00 a.m. and was assigned to Resident #15. She stated during her shift on 04/22/2024, she was busy providing care to other residents and confirmed she did not round every 2 hours on Resident #15. She stated she did not ask any of the other staff on the hall to assist her with rounding on Resident #15 and should have. Review of video footage without audio was conducted with S1ADM and S9CNAS on 04/24/2024 at 1:30 p.m. and revealed the following: Location: Hall A 04/22/2024 from 5:00 p.m. until 6:00 a.m. No staff were observed entering Resident #15's room from 6:48 p.m. - 9:02 p.m. and from 1:00 a.m. - 4:18 a.m. An interview was conducted on 04/24/2024 at 2:08 p.m. with S9CNAS. She verified S8CNA was assigned to Resident #15 on 04/22/2024 from 6:00 p.m. to 6:00 a.m. She stated Resident #15 was a fall risk and the CNAs should round every 2 hours on Resident #15 to prevent falls. She confirmed Resident #15 was not rounded on every 2 hours by S8CNA on 04/22/2024 from 6:48 p.m. until 9:02 p.m. and from 1:00 a.m. until 4:18 a.m., and should have been. (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 on 04/24/2024 at 2:10 p.m. with S1ADM. She stated Resident #15 was a fall risk. She stated her expectation was for the CNAs to round at least every 2 hours on Resident #15 to prevent falls. She confirmed Resident #15 was not rounded on every 2 hours by S8CNA on 04/22/2024 from 6:48 p. m. until 9:02 p.m. and from 1:00 a.m. until 4:18 a.m., and should have been. She stated if S8CNA was busy providing care to other residents and was unable to round every 2 hours she should have asked one of the other staff on the hall to round on Resident #15. An interview was conducted on 04/24/2024 at 2:30 p.m. with S2DON. She stated Resident #15 was a fall risk and had multiple falls since her admission to the facility. She stated most of Resident #15's falls were at night when she tried to go to the bathroom unassisted. She stated she expected staff to round on Resident #15 no less than every 2 hours to prevent falls. She stated Resident #15's family member reported to her on 04/23/2024, the staff were not making rounds on Resident #15 at night. She stated S8CNA was assigned to Resident #15 on 04/22/2024 from 6:00 p.m. to 6:00 a.m. She stated she reviewed the facility's video footage from 12:00 a.m. to 6:00 a.m. during S8CNAs shift on 04/22/2024. She confirmed S8CNA did not round on Resident #15 every 2 hours during her shift on 04/22/2024 from 1:00 a.m. until 4:23 a.m., and should have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43133 Based on observations, interviews, and record review, 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 S5CNA wore proper Personal Protective Equipment (PPE) while providing care for 1 (#42) of 8 (#21,#24, #33, #42, #61, #69, #193 and #194) residents on Enhanced Barrier Precautions (EBPs). Findings: Review of the facility's undated policy Enhanced Barrier Precautions revealed: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmissions of multidrug-resistant organisms. Definitions: Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., resident with wounds or indwelling medical devices. 4. High-contact Resident Care activities include: f. Changing briefs or assisting with toileting. Review of the Clinical Record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses which included Congenital Stenosis and Stricture of Esophagus. Review of the current care plan revealed Resident #42 was care planned for Peg Tube feeding related to esophageal stricture. On 04/25/24 at11:35 a.m., an observation was conducted of Resident #42's Peg tube. On 04/25/2024 at 09:18 a.m., an observation was conducted of incontinent care performed by S5CNA. S5CNA performed incontinent care without wearing a gown. On 04/25/2024 at 09:18 a.m., an interview was conducted with S5CNA immediately following the above observations. S5CNA stated Resident #42 was on Enhanced Barrier Precautions. She confirmed she did not wear a gown during incontinent care on a resident with a peg tube. 04/25/2024 09:38 a.m., an interview was conducted with S2DON. She stated Resident #42 had a peg tube and was on EBPs for direct contact care of the resident. She stated direct care staff should wear the appropriate PPE including a gown when preforming incontinent care on a resident with a peg tube.