STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195464	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellington	308 Amelia Street Rayne, LA 70578

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on observations and interview, the facility failed to maintain and clean, comfortable, and homelike environment by failing to ensure clean bed linen was provided to 1 (#46) out of 2 (#24 and #46) residents investigated for homelike environment. Findings: On 06/26/2024, a review of the facility's policy titled Bed Making - Unoccupied Bed with a last reviewed date of 04/29/2024 read in part . Purpose: To provide a clean and comfortable bed for the residents . Essential Points . Change any soiled or dirty linen . Review of Resident #46's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Muscle Wasting and Atrophy, Lack of Coordination, and Spondylosis without Myelopathy. On 06/24/2024 at 12:15 p.m. an observation was made of Resident #46's room. Resident #46 was sitting in his wheelchair. The bed was observed not made and the resident's pillow case revealed a medium size yellow stain, and multiple areas of small light brown stains on the resident's bed linen. On 06/24/2024 at 2:19 p.m. a second observation was made of Resident #46's bed. The bed was observed and was made. The resident's pillow case revealed a medium size yellow stain, and multiple areas of small light brown stains on the resident's bed linen. On 06/24/2024 at 2:22 p.m. an interview and observation of Resident #46's room was conducted with S3LPN (Licensed Practical Nurse). She confirmed that Resident #46's bed was made. S3LPN confirmed the stains on pillow case and bed linens and she confirmed there should not be any stains on linen and it should have been changed before the bed was made. On 06/26/2024 at 2:24 p.m. an interview was conducted with S1DON (Director of Nursing). S1DON confirmed bed linens should be clean at all times and if stains are noted on linens they should be changed.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observations, interviews, and record review, the facility failed to follow a physician's order and care plan for 1 (#95) of 40 sampled residents by failing to ensure the resident's TED (Thrombo-Embolic Deterrent) hoses were applied as ordered. Findings: Resident #95 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Chronic Obstructive Pulmonary Disease, Essential Primary Hypertension, and Unspecified Atrial Fibrillation. A review of quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/26/2024, revealed Resident #95 had a BIMS (Brief Interview of Mental Status) score of 15, indicating her cognition was intact. A review of Resident #95's physician orders revealed an order written on 03/01/2024 to apply TED hose in the AM (morning) and remove at night. A review of Resident #95's June 2024 care plan revealed she had Hypertension r/t (related to) dx (diagnosis) of Essential Primary Hypertension and Atrial Fibrillation with a goal to remain free of complications related to Hypertension. Interventions in part .Compression stockings on in the AM, off in PM (afternoon). On 06/24/2024 at 12:23 p.m., an observation was made of Resident #95 in her room. The resident was sitting in her reclining chair. Further observation revealed she was wearing black slippers with no TED hoses on. On 06/25/2024 at 9:04 a.m., an observation and interview was conducted with Resident #95. She was sitting in her chair and no TED hoses were on her legs. When asked, Resident #95 stated that the nurse did not offer to put her TED hose on yesterday (06/24/2024) or today (06/25/2024). On 06/25/2024 at 9:09 a.m., an observation and interview of Resident #95 was conducted with S4LPN (Licensed Practical Nurse). She confirmed that the resident was not wearing her TED hoses and stated that she did not put them on the resident yesterday (06/24/2024) or today (06/25/2024).

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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** 49176 Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was stored appropriately when not in use for 1 (Resident #97) out of 2 (Resident #83, Resident #97) sampled residents reviewed for respiratory care. Findings: Review of Resident #97's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Atrial Fibrillation, Atherosclerotic Heart Disease of Native Coronary Artery, and COVID-19. Review of Resident #97's June 2024 physician's orders revealed an order dated 04/08/2024 for O2 (oxygen) at 2L/MIN/NC (liters per minute per Nasal Cannula) PRN (as needed) to relieve hypoxia. Review of Resident #97's care plan read in part .Resident has oxygen therapy as needed for SOB (shortness of breath). Interventions included: Oxygen Settings: 02 at 2L per nasal cannula as needed. On 06/24/2024 at 12:04 p.m., an observation was made of Resident #97's room. An oxygen concentrator was observed near the resident's wall while not in use. The nasal cannula tubing was draped over the oxygen concentrator open to air, with the nose piece of the tubing making contact with the machine. On 06/24/2024 at 12:11 p.m., S3LPN (Licensed Practical Nurse) was asked to enter Resident #97's room. S3LPN observed the oxygen concentrator machine and confirmed the nasal cannula tubing was open to air and not stored appropriately. S3LPN stated the nursing staff was responsible for storing nasal cannula tubing in a bag when not in use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm 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** 47965 Based on observations, interviews and record reviews, the facility failed to ensure the nursing staff demonstrated specific competencies and skill sets necessary to provide care to meet the residents' needs safely to attain or maintain the highest practicable physical well-being for 1 (#95) of 40 sampled residents. This was evidenced by S4LPN (Licensed Practical Nurse) leaving Resident #95's medication at the bedside. Findings: On 06/25/2024, a review of the facility's policy titled Medication Administration - Oral with a revision date of 04/29/2024 read in part, It is the policy of the _____ to administer medications in a safe manner .The person administering medication must remain with the resident until all medication has been swallowed. Resident #95 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Chronic Obstructive Pulmonary Disease, Essential Primary Hypertension, and Unspecified Atrial Fibrillation. A review of Resident #95's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/26/2024, a BIMS (Brief Interview of Mental Status) score of 15 indicating her cognition was intact, but the resident had no documents in her medical records that she was able to self administer her medications. A review of Resident #95's physician orders revealed the following orders: -1/19/2024 Pantropazole Sodium Oral Tablet Delayed Release 40 mg (milligram) give 1 tablet by mouth 2 times a day -1/19/2024 Venlafaxine HCL (Hydrochloride) Oral Tablet 25 mg give 1 tablet by mouth three times a day. -1/20/2024 Allopurinol Oral tablet 100 mg give 1 tablet by mouth one time a day. -1/20/2024 Amiodarone HCL oral tablet 200 mg give 1 tablet by mouth one time a day. -1/20/2024 Icar-C Oral Tablet 100-250 mg give 1 tablet by mouth one time day. -1/20/2024 Levothyroxine Sodium Oral Tablet 75 MCG (Microgram) give 1 tablet by mouth one time a day. -1/20/2024 Metoprolol Succinate ER Oral Tablet Extended release 24 hour 25 mg give 0.5 tablet by mouth one time a day. -1/20/2024 Multivitamin Oral Tablet give 1 tablet by mouth one time a day. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/21/2024 Prednisone oral tablet 5 mg give 1 tablet by mouth one time a day every other day. -6/08/2024 Folic Acid Oral Tablet Give 1 mg by mouth one time a day related to anemia -6/10/2024 by Lasix Oral Tablet 20 mg (Furosemide) Give 20 mg by mouth one time a day. A review of Resident #95's Medication Audit Report revealed the following medications were administered by S4LPN (Licensed Practical Nurse) on 06/25/2024 at 6:29 a.m.: -Levothyroxine Sodium Oral Tablet 75 MCG. Give 1 tablet by mouth one time a day. -Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 25 MG. Give 0.5 tablet by mouth one time a day. -Allopurinol Oral Tablet 100 MG Give one tablet by mouth one time a day. -Pantoprazole Sodium Oral Tablet Delayed Release 40 mg. Give 1 tablet by mouth two times a day. -Icar-C Oral Tablet 100-250 MG Give 1 tablet by mouth one time a day. -Multivitamin Oral tablet. Give 1 tablet by mouth one time a day. -Venlafaxine HCL Oral tablet 25 MG Give 1 tablet by mouth 3 times a day. -Folic Acid Oral Tablet. Give 1 MG by mouth one time a day. -Lasix Oral Tablet 20 mg. Give 20 MG by mouth one time a day. -Amiodarone HCL Oral Tablet 200 MG. Give one tablet by mouth one time a day. -Prednisone Oral Tablet 5 MG. Give 1 tablet by mouth one time a day every other day. On 06/25/2024 at 9:04 a.m., an observation was conducted of Resident #95 in her room. A clear plastic medicine cup containing 11 pills was observed on the resident's over bed table. On 06/25/2024 at 9:09 a.m., an observation was made of Resident #95's room with S4LPN (Licensed Practical Nurse) followed by an interview. She confirmed that she left the medications in the clear plastic cup at the resident's bedside. On 06/25/2024 9:45 a.m., an interview was conducted with S1DON (Director of Nursing). She stated according to the facility's policy that nurses are not supposed to leave medications at residents' bedside.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47540 Based on observations and interview, the facility failed to store, distribute, and serve food in accordance with professional standards for food service safety by failing to follow appropriate food handling practices as evidenced by: 1. Two opened packages of hamburger buns not labeled with the date. 2. Food storage: A. Cooler: 1. One opened Liquid Protein container not labeled with the date. 2. One opened Chocolate Desert Topping not labeled with the date and an expiration date of [DATE]. B. Walk-in freezer: 1. One opened bag of garlic bread not labeled with the date. 2. One opened bag of sweet potato fries not labeled with the date. The total amount of residents that ate out of the kitchen was 112 residents. Findings: On [DATE] at 9:50 a.m., an initial tour of the facility's kitchen was conducted with S5DC (Dietary Cook). S5DC confirmed the two opened packages of hamburger buns were not labeled with the date. On [DATE] at 9:57 a.m., an interview and observation was conducted with S2DM (Dietary Manager). S2DM confirmed the above findings were opened and not labeled and should have been. She also stated the expired item should not be in the cooler.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39319 Based on interviews and record review, the facility failed to maintain accurately documented medical record in accordance with accepted professional standards and practices. The facility failed to accurately document on the TAR (Treatment Administration Record) for 1 (#98) out of 1(#98) sampled resident reviewed for urinary catheter or UTI (Urinary tract infection) in a final sample of 40 residents. Findings: Review of Resident #98's April 2024 Treatment Administration Record (TAR) revealed the nursing staff failed to initial suprapubic catheter site care and treatment on the resident's left toe and malleolus were performed on the following dates: 04/07/2024, 04/09-04/10-2024, 04/12/2024, 04/15-04/16/2024 and 04/21/2024. Review of Resident #98's May 2024 Treatment Administration Record (TAR) revealed the nursing staff failed to initial that treatment on the resident's left toe were performed on the following dates: 05/01/2024, 05/04-05/05/2024, 05/11-05/12/2024. Further review of the May 2024 TAR revealed the nursing staff failed to initial that suprapubic catheter care was performed every shift on the following dates: Day shift: 05/04-05/05/2024, 05/11-05/12/2024, 05/18-05/19/2024, and 05/25-05/26/2024; Evening shift: 05/06-05/07/2024, 05/11-05/14/24, 05/20-05/21/2024, and 05/25-05/28/2024; Night shift: 05/01/2024, 05/07/2024, 05/11-05/12/2024, and 05/25/2024. Review of Resident #98's June 2024 Treatment Administration Record (TAR) revealed the nursing staff failed to initial that suprapubic catheter care was performed every shift on the following dates: Day shift: 06/01-06/02/2024, 06/07-06/08/2024, and 06/21-06/22/2024; Evening shift: 06/01-06/04/2024, 06/07/2024, 06/09-06/11/2024, 06/15/2024, 06/17-06/18/2024, and 06/23-06/24/2024; Night shift: 06/06/2024, 06/20-06/21/2024, and 06/24-06/25/2024. On 06/27/2024 at 2:09 p.m., an interview and review of the resident's April, May and June 2024 TARs was conducted with S1DON (Director of Nursing). She confirmed there were multiple days on the April, May and June 2024 TARs that were not initialed by the nursing staff. She stated that the treatment nurse and/or the nurse should initial the TAR when they conduct a treatment.