STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Manor Nursing and Rehab Ctr, LLC	9919 Jefferson Hwy. Baton Rouge, LA 70809

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 0583

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Keep residents' personal and medical records private and confidential.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45270

Based on observations, interviews, and record review, the facility failed to provide privacy to residents when receiving assistance with personal care for 3 (#2, #R1 and #R5) of 5 (#2, #3, #R1, #R3, and #R5) residents observed during Activities of Daily Living. The facility failed to ensure:

1. Privacy curtains were pulled and the room door was closed prior to staff providing incontinence care to Resident #2 and Resident #R1; and

2. Resident #R5 had privacy curtains around his bed and were pulled prior to staff providing incontinence care.

Findings:

1.

Resident #2

Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of Urinary Tract Infections and Cerebral Infarction.

On 08/13/2024 at 5:10 a.m., an observation was made of S11CNA performing incontinence care for Resident #2. Resident #2 shared a room with one other resident, and Resident #2's bed was located closest to the door/entrance into the room. Resident #2's roommate was present in the room. S11CNA did not close the door or pull the privacy curtain before providing care to Resident #2. During the care, S11CNA exited the room, left the room door open and Resident #2's buttocks and legs were exposed.

Resident #R1

Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-dominant Side.

(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: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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F 0583

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 08/13/2024 at 5:02 a.m., an observation was made of S11CNA performing care for Resident #R1. The room door was open and S11CNA was observed in Resident #R1's room from the hallway. Resident #R1 shared a room with one other resident, and Resident #R1's bed was located closest to the door/entrance into the room. The privacy curtains were not pulled between Resident #R1 and the door, or between the resident and his roommate who was awake watching television. Resident #R1 was in bed, brief exposed, and was removing his soiled shirt.

On 08/13/2024 at 5:15 a.m., an interview was conducted with S11CNA. S11CNA confirmed the aforementioned observations. S11CNA confirmed she did not close the door or pull the privacy curtains in Resident #R1's room and he could be visualized during care to anyone who entered the room and to his roommate. S11CNA confirmed she did not close the door or pull the privacy curtains in Resident #2's room and she could be visualized during care to anyone who entered her room and to her roommate.

2.

Resident #R5

Review of Resident #R5's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia without Behavioral Disturbance and Alzheimer's Disease with Late Onset.

On 08/13/2024 at 5:33 a.m., an observation was made of S12CNA performing incontinence care for Resident #R5. Resident #R5 shared a room with one other resident, who was awake, alert and sitting in a wheelchair in the room. Further observation revealed there were no privacy curtain attached to the track on the ceiling. S12CNA provided incontinence care and dressed Resident #R5 with his roommate present in the room.

On 08/13/2024 at 5:55 a.m., an interview was conducted with S12CNA. S12CNA stated Resident #R5 was incontinent. S12CNA confirmed there was no privacy curtain in Resident #R5's room. S12CNA stated the privacy curtain was taken down about one month ago to be washed and was never put back up. S12CNA confirmed there was no barrier to keep Resident #R5 from being visualized during care to anyone who entered his room or to his roommate who was in the room during the care provided.

On 08/13/2024 at 6:15 a.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. S2DON stated for a residents' privacy, the CNAs should close the resident's room door and pull the privacy curtains prior to performing care. S2DON stated she would not expect staff to provide care with the residents' room door open, privacy curtains not pulled and the residents being visualized by their roommate. S2DON stated she was not aware the privacy curtain had been removed out of Resident #R5's room. S2DON stated S1ADM had been working with S13MS to get the facility's privacy curtains cleaned and replaced.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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Jefferson Manor Nursing and Rehab Ctr, LLC	9919 Jefferson Hwy. Baton Rouge, LA 70809

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/2024 at 6:27 a.m., an interview was conducted with S1ADM. S1ADM stated S13MS had been taking down, cleaning and rehanging the privacy curtains. S1ADM stated the facility was swapping out the old privacy curtains and replacing them with new ones. S1ADM stated if a resident did not have a privacy curtain in their room, staff should try and make it as private as possible. S1ADM stated the curtains were to provide privacy and dignity to the residents. S1ADM was made aware of the above findings. S1ADM stated the CNA should not have provided care to Resident #R5 where he was visible to his roommate. S1ADM stated the CNAs should pull the privacy curtains and close room doors prior to providing care to provide as much privacy as possible for the residents. On 08/13/2024 at 7:45 a.m., an interview was conducted with S13MS. S13MS stated he took down and threw away Resident #R5's privacy curtain because it was dry rotted. S13MS stated he could not recall exactly when he took down Resident #R5's privacy curtain, but it had been more than one week ago.

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NAME OF PROVIDER OR SUPPLIER Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9919 Jefferson Hwy. Baton Rouge, LA 70809	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 Based on observations, interviews and record reviews the facility failed to ensure a resident who was unable to carry out Activities of Daily Living (ADL's) received the necessary services to maintain good hygiene for 3 (#2, #R1, and #R3) of 6 (#1, #2, #3, #R1, #R3, and #R5) residents reviewed for ADL's. The facility failed to ensure: 1. Resident #2 and Resident #R1 received incontinence care timely; and 2. Resident #2 and #R3 received oral care daily. Findings: 1. Resident #2 Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI's and Cerebral Infarction. Review of Resident #2's Quarterly MDS with an ARD of 06/21/2024 revealed she had a BIMS of 6, which indicated she was severely cognitively impaired. Further review revealed she required substantial/maximum assistance for toileting. Review of Resident #2's Care Plan revealed the following, in part: Problem: 03/27/2024: Toileting deficit: needs assistance related ho history of Cerebral Infarction. Is unaware of the urge to toilet. Interventions: Provide assist with toileting as needed; perineal care every 2 hours and as needed Problem: 03/27/2024: Self-care ADL deficit: needs assist with toileting, bathing and hygiene Interventions: Assist with hygiene Review of Resident #2's Physician Orders dated August 2024 revealed the following, in part: Start date: 03/26/2024. Incontinence care. Check for incontinence at least every 2 hours. Cleanse periarea/buttock with perifresh, pat dry, apply periguard as a preventative measure. On 08/13/2024 at 5:10 a.m., an observation was made of S11CNA performing incontinence care for Resident #2. S11CNA confirmed Resident #2's incontinence brief and incontinence pad were wet with urine. Resident #R1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9919 Jefferson Hwy. Baton Rouge, LA 70809	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-dominant Side. Review of Resident #R1's Quarterly MDS with an ARD of 05/06/2024 revealed Resident #R1 was always incontinent of urine. Further review revealed he required substantial/max assist with dressing, personal hygiene, transfers, and toilet transfers. Review of Resident #R1's Care Plan revealed the following, in part: Problem: 01/11/2024: Resident will remain free of altered skin integrity. Interventions: Incontinence care: check for incontinence at least every 2 hours. Cleanse periarea/buttocks with Perifresh, pat dry. On 08/13/2024 at 5:02 a.m., an observation was made S11CNA performing care for Resident #R1. Resident #R1 was observed in bed removing his soiled shirt. S11CNA stated she had just completed changing Resident #R1's soiled brief. There was a strong urine odor in his room. S11CNA removed a wet pad from underneath the resident, along with his shirt and jacket, which S11CNA stated were soiled with urine. On 08/13/2024 at 5:15 a.m., an interview was conducted with S11CNA. S11CNA stated she worked 10:00 p.m. to 6:00 a.m. and was assigned to Resident #2 and Resident #R1. S11CNA stated the last time she rounded on her assigned resident's, including Resident #2 and Resident #R1 was around 1:00 a.m. S11CNA stated she was supposed to round on the resident's every 2 hours. On 08/13/2024 at 6:15 a.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. S2DON stated CNAs should round on the residents every 2 hours and as needed. S2DON stated she would not expect the CNAs to wait more than 3 hours to make rounds and provide incontinence care. 2. Review of the facility's undated policy titled, Care: A.M. revealed the following, in part: Procedure: 6. If resident has teeth, proceed with oral hygiene. 7. If resident has had dentures soaking overnight, remove from denture cup, rinse in cool water. Have resident rinse mouth with water or mouthwash. A soft toothbrush can be used to stimulate gum and tongue circulation by gentle brushing. Insert the dentures. Review of the facility's undated policy titled, Care: P.M. revealed the following, in part: Procedure: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. If the resident has dentures, remove them. Clean the dentures appropriately. Provide water or mouthwash for resident to rinse mouth. Place resident's cleaned dentures in a covered denture cup of water with the resident's name on it. A soft toothbrush can be used to stimulate gum and tongue circulation by gentle brushing. Resident #2 Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI's and Cerebral Infarction. Review of Resident #2's Quarterly MDS with an ARD of 06/21/2024 revealed she had a BIMS of 6, which indicated she was severely cognitively impaired. Further review revealed she required partial/moderate assistance for oral hygiene. Review of Resident #2's Care Plan revealed the following, in part: Problem: 03/27/2024: Self-care ADL deficit: needs assist with toileting, bathing and hygiene Interventions: Assist with hygiene Review of Resident #2's Resident Care Details dated from 07/17/2024-08/13/2024 revealed no oral care was documented on the dates of 07/27/2024, 07/28/2024, 07/30/2024-08/10/2024, and 08/13/2024. On 08/13/2024 at 10:34 a.m., an interview was conducted with Resident #2. She was oriented to person and place. She stated staff did not perform oral care to her daily. On 08/14/2024 at 11:07 a.m., an interview was conducted with S9CNA. She stated she worked the 6:00 a.m. -2:00 p.m. shift and was assigned to Resident #2 when she worked. She stated each CNA was responsible ensure oral care was performed on their assigned residents. She stated there was a place to document oral care in the kiosk system. She was notified of the findings on Resident #2's Detail Summary Sheet and stated if she did not document oral care on Resident #2, she did not do it. Resident #R3 Review of Resident #R3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI and Pressure Ulcer of Sacral Region. Review of Resident #R3's Quarterly MDS with an ARD of 06/17/2024 revealed she had a BIMS of 15, which indicated she was cognitively intact. Further review revealed she required setup or clean-up assistance with oral care. Review of Resident #R3's Resident Care Details from 07/16/2024-08/13/2024 revealed no oral care was documented on the dates of 07/18/2024-07/22/2024, 07/24/2024-07/29/2024, and 07/31/2024-08/10/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 9919 Jefferson Hwy. Baton Rouge, LA 70809	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/2024 at 12:41 p.m., an interview was conducted with Resident #R3. She stated staff did not provide oral care to her daily. She stated she wore dentures, and had asked staff to clean them but they never did. She stated if she was given the supplies, she could clean them herself. She stated she did not eat with her dentures in place anymore and did not try to wear them unless she had a visitor because she did not want them to get dirty. At that time, upper and lower dentures were to be observed lying on her torso, and Resident #R3 was observed to not have any dentures in her mouth. On 08/14/2024 at 12:53 p.m., an interview was conducted with S8CNA. She stated she was assigned to Resident #R3 on several occasions. She stated she worked both the 6:00 a.m.-2:00 p.m. shift and the 2:00 p.m.-10:00 p.m. shift. She stated cleaning dentures was part of oral care and should be performed each morning and night. She confirmed she never cleaned Resident #R3's dentures. She was notified of the findings on Resident #R3's Detail Summary Sheet, and stated if she did not document oral care on Resident #R3, she did not do it. On 08/14/2024 at 2:03 p.m., an interview was conducted with S2DON. She stated oral care was part of the CNA's a.m. care they were to provide to their assigned residents. She stated oral care was to be performed daily and included cleaning resident's dentures. She stated she reviewed both Resident #2 and #R3's Resident Care Detail Sheets and confirmed oral care was not documented as being performed daily and should have been. 46975

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on observations, interviews, and record reviews the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers. This deficient practice was evidenced by failing to ensure a resident with orders for heel protectors failed to have pressure reducing interventions implemented per Physician's Orders for 1 (#2) of 9 (#1, #2, #3, #R1, #R2, #R3, #R4, #R5, and #R6) sampled residents. Findings: Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI's and Cerebral Infarction. Review of Resident #2's Quarterly MDS with an ARD of 06/21/2024 revealed she had a BIMS of 6, which indicated she was severely cognitively impaired. Review of Resident #2's Physician's Order dated 07/01/2024 revealed an order for heel protectors to bilateral heels. On 08/13/2024 at 10:34 a.m., an observation was made of Resident #2. No heel protectors were observed to her heels, and her heels were not floated off the bed. On 08/13/2024 at 12:57 p.m., an observation was made of Resident #2. No heel protectors were observed to her heels, and her heels were not floated off the bed. On 08/13/2024 at 2:40 p.m., an observation was made of Resident #2. No heel protectors were observed to her heels, and her heels were not floated off the bed. On 08/14/2024 at 8:15 a.m., an observation was conducted with Resident #2. No heel protectors were observed to her heels, and her heels were not floated off the bed. On 08/14/2024 at 10:57 a.m., an observation was made of Resident #2. No heel protectors were observed to her heels, and her heels were not floated off the bed. On 08/14/2024 at 11:07 a.m., an interview was conducted with S9CNA. She stated Resident #2 did not have heel protectors, or if she did, she had never seen them. She stated she usually put a pillow behind Resident #2's ankles to float her heels off the bed. At that time, an observation was made with S9CNA of Resident #2's. She confirmed there were no heel protectors in place, nor were her heels elevated off the bed. She was notified of the observations on 08/13/2024, and confirmed she was assigned to Resident #2 on 08/13/2024 and did not float her heels or place bilateral heel protectors. On 08/14/2024 at 11:25 a.m., an interview was conducted with S5LPN. She was notified of the observations made of Resident #2 on 08/13/2024 and 08/14/2024. She stated wound care was responsible for ensuring heel protectors were in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/2024 at 11:30 a.m., an interview was conducted with S4LPN. She stated it was the CNA's responsibility to ensure heel protectors were in place. She was notified of the observations of Resident #2 not having bilateral heel protectors in place on 08/13/2024 and 08/14/2024, and stated she should have had them on. She stated the last time she observed Resident #2's heel boots on her heels was on 08/12/2024 at 10:00 a.m. when she performed the resident's body audit. She stated Resident #2 was at risk for skin breakdown. She confirmed the heel boots were supposed to be worn at all times while Resident #2 was in bed. On 08/14/2024 at 2:03 p.m., an interview was conducted with S2DON. She was made aware of the observations on 08/13/2024 and 08/14/2024 of Resident #2 not having bilateral heel protectors in place. She reviewed Resident #2's Physician Orders and stated staff should have ensured the resident had the heel protectors in place since there was an order for them. She stated Resident #2 was at risk for skin breakdown.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 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 for 4 (#2, #3, #R1 and #R3) of 9 (#1, #2, #3, #R1, #R2, #R3, #R4, #R5, and #R6) resident's reviewed in the sample. The facility failed to ensure: 1. Staff wore proper Personal Protective Equipment (PPE) while providing care to Resident #3 and Resident #R3, who were on Enhanced Barrier Precautions (EBP); and 2. Staff performed appropriate infection control practices, hand hygiene, and proper glove use for Resident #2 and Resident #R1 observed for incontinence care. Findings: 1. Review of the Enhanced Barrier Precautions sign posted on resident doors revealed the following, in part: Enhanced Barrier Precautions: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter. Resident #3 Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of Paraplegia, Neuromuscular Dysfunction of Bladder, and Urinary Tract Infection. Review of Resident #3's Care Plan revealed the following, in part: Problem: 08/21/2021-Potential for UTI and/or complications related to use of Suprapubic Catheter Placement. Review of Resident #3's Physician Orders dated August 2024 revealed the following, in part: Order date: 05/02/2024-Enhanced Barrier Precautions utilized when performing high-contact resident care activities related to suprapubic catheter. On 08/13/2024 at 6:52 a.m., an observation was made of S2DON assessing Resident #3's suprapubic catheter and brief. S2DON did not don a gown prior to removing Resident #3's bed linens, unfastening her brief, and assessing the suprapubic catheter and brief. On 08/13/2024 at 7:00 a.m., an observation was made of S7CNA and S8CNA perform catheter care and pericare for Resident #3. S7CNA and S8CNA did not don a gown prior to performing catheter care and pericare for Resident #3. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Immediately following Resident #3's catheter care and pericare an interview was conducted with S7CNA and S8CNA. S7CNA and S8CNA stated Resident #3 was on Enhanced Barrier Precautions. S7CNA and S8CNA confirmed they should have been wearing a gown while performing catheter care and pericare for Resident #3. Upon exiting Resident #3's room, a sign was observed on Resident #3's door, which read: Enhanced Barrier Precautions Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter.

On 08/13/2024 at 7:18 a.m., an interview was conducted with S2DON. S2DON stated Resident #3 had a suprapubic catheter and was on Enhanced Barrier Precautions. S2DON stated staff should wear a gown and gloves when providing care for Resident #3. S2DON confirmed she did not don a gown prior to assessing Resident #3's suprapubic catheter and should have.

Resident #R3

Review of Resident #R3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI and Pressure Ulcer of Sacral Region.

Review of Resident #R3's Care Plan revealed the following, in part:

Problem: 03/14/2024- Altered skin integrity-has actual pressure ulcers as listed: Pressure injury to sacrum

Intervention: Enhanced Barrier Precautions utilized when performing high-contact resident care activities related to stage 4 pressure injury.

Review of Resident #R3's Physician Orders dated August 2024 revealed the following, in part:

Enhanced Barrier Precautions utilized when performing high-contact resident care activities related to stage 4 pressure injury.

On 08/14/2024 at 12:30 p.m., an observation was made of S10CNA performing catheter care and pericare for Resident #R3 with S2DON and S3CN. S10CNA did not don a gown prior to performing catheter care and pericare for Resident #R3. Upon exiting Resident #R3's room, a sign was observed on Resident #R3's door, which read: Enhanced Barrier Precautions Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter.

On 08/14/2024 at 2:26 p.m., an interview was conducted with S10CNA. S10CNA confirmed she did not don a gown prior to performing catheter care and pericare for Resident #R3 and should have. She verified she was aware Resident #R3 was on EBP. She confirmed when a resident was on EBP, a gown and gloves needed to be worn when providing any kind of contact care to the resident.

On 08/14/2024 at 12:45 p.m., an interview was conducted with S2DON and S3CN. S2DON and S3CN stated Resident #R3 was on Enhanced Barrier Precautions. S2DON and S3CN confirmed S10CNA should have worn a gown while performing catheter care and pericare for Resident #R3 and did not.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9919 Jefferson Hwy. Baton Rouge, LA 70809	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's undated policy titled, Incontinence Care: Bladder revealed the following, in part: Procedure: 2. Perform handwashing or use alcohol gel. 8. Put on disposable gloves. 9. For female perineal care 10. For male perineal care 11. Remove and discard gloves. 12. Perform handwashing or use alcohol gel. Resident #R1 Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-dominant Side. On 08/13/2024 at 5:02 a.m., an observation was made of S11CNA performing care for Resident #R1. S11CNA was observed in Resident #R1's room wearing gloves and holding a shirt. Resident #R1 was observed in bed, wearing a clean brief and removing his soiled shirt. S11CNA stated she had already changed Resident #R1's soiled brief. A strong urine odor was noted. S11CNA removed a wet pad from underneath the resident, along with his shirt and jacket, which S11CNA stated were soiled with urine. While wearing soiled gloves, S11CNA was observed placing the soiled pad and clothing on the floor, assisted Resident #R1 to put on a clean shirt, repositioned him in bed, repositioned the bed linens, pulled the string to turn off the light, grabbed the bedside table of Resident #R1's roommate and moved it next to the roommates bed, picked up the soiled linens and bag of trash, walked out of the room into the hallway, opened the lid to the yellow soiled linen barrel, placed the soiled clothing inside, walked down the hall, removed the soiled gloves and placed the bag of trash and gloves in the grey trash barrel and replaced the lid. S11CNA did not perform hand hygiene, and walked down the hall toward Resident #2's room. Resident #2 Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of UTI's and Cerebral Infarction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Manor Nursing and Rehab Ctr, LLC	9919 Jefferson Hwy. Baton Rouge, LA 70809

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/2024 at 5:10 a.m., an observation was made of S11CNA performing incontinence care for Resident #2. Without performing hand hygiene, S11CNA was observed entering Resident #2's room, and turned on the light above the bed. S11CNA applied a pair of clean gloves, and was observed pulling back Resident #2's bed linens and unfastened her brief. Resident #2 turned to her right side. S11CNA touched the pad underneath Resident #2 and stated it was wet with urine. S11CNA removed the glove from her left hand, opened the room door, exited the room, removed a pink pad from the clean linen cart in the hall, and reentered Resident #2 room. S11CNA applied a clean glove to her left hand, placed a clean pad and clean brief underneath Resident #2. S11CNA used a perineal wipe to clean the resident's buttocks and perineal area, Resident #2 turned on her back, S11CNA cleansed the resident with a perineal wipe, fastened the left side of the clean brief, the resident turned on her left side, S11CNA fastened the right side of the clean brief, and removed the soiled pad and brief. Without removing her gloves or performing hand hygiene, S11CNA adjusted Resident #2's gown and bedside table. S11CNA removed her soiled gloves, applied clean gloves, repositioned the bed linen, picked up a remote and adjusted the bed, picked up the bag of trash and soiled linen, took off her right glove, walked into the hallway, opened the lid on the yellow linen barrel and placed the soiled linen, walked down the hall, opened the lid on the grey trash barrel, placed the bag of trash and gloves, and replaced the lid. S11CNA did not perform hand hygiene, applied a pair of clean gloves and walked down the hall. On 08/13/2024 at 5:15 a.m., an interview was conducted with S11CNA. S11CNA stated hand hygiene should be performed in between resident rooms. S11CNA stated she performed hand hygiene and changed gloves depending on the situation, and what resident care she was providing. S11CNA confirmed the aforementioned observations. On 08/13/2024 at 6:15 a.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. S2DON stated CNAs should perform hand hygiene before providing care, when going from dirty to clean, and at the end of care. S2DON stated CNAs should not touch items in a resident's room with soiled gloves or prior to performing hand hygiene. 46975