

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER The Woodlands Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 144 Thad Bailes Rd Leesville, LA 71446	

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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>20604</p> <p>Based on observation, interview, and record review the facility failed to maintain a medication error rate below 5% by failing to give two medications as ordered, and administering a discontinued medication for 1 (#37) of 3 (#37, #96, and #101) residents observed during medication administration. A total of 30 opportunities were observed which included 3 medication errors for a medication error rate of 10%.</p> <p>Findings:</p> <p>Review of the facility's policy on 06/25/2024 titled, Administering Medications with revision date April 2019 revealed the following, in part: . 3. Medications are administered in accordance with prescriber orders, including any required time frame. 9. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication</p> <p>Observation on 06/24/2024 at 8:31 a.m. revealed S4 LPN prepared and administered the following medications for Resident #37:</p> <p>Aspirin 81mg 1 tablet by mouth</p> <p>Zyrtec 10mg 1 tablet by mouth</p> <p>Docusate Sodium 100mg 1 tablet by mouth</p> <p>Ferrous Sulfate 325mg 1 tablet by mouth</p> <p>Potassium 10meq 1 tablet by mouth</p> <p>Lasix 10mg 1/2 tablet by mouth</p> <p>Lasix 20mg 1 tablet by mouth</p> <p>Coreg 3.125mg 1 tablet by mouth</p> <p>Oxycodone 10mg 1 tablet by mouth</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>8.5 tablets were administered to Resident #37 by S4 LPN.</p> <p>Record review of the current physician orders for Resident #37 revealed the following medication orders:</p> <p>Lasix (Diuretic) Oral Tablet 20 mg. Give 1 tablet by mouth one time a day. Order date 06/09/2024</p> <p>Lasix Oral Tablet 10 mg. Give 1/2 tablet by mouth one time a day. Discontinue date 06/08/2024</p> <p>Ticagrelor (Antiplatelet) Oral Tablet 90 mg. Give 1 tablet by mouth two times a day. Order date 05/29/2024.</p> <p>Lansoprazole (Antacid) Oral Capsule Delayed Release 30 mg. Give 1 capsule by mouth one time a day. Order date 05/29/2024.</p> <p>Record review of Resident #37's 06/2024 EMAR revealed the following medications were documented as administered on 06/24/2024 during surveyor observation:</p> <p>Ticagrelor 90 mg</p> <p>Lansoprazole 30 mg</p> <p>Lasix 10mg was not documented as administered on the EMAR.</p> <p>Observation on 06/24/2024 at 8:31 a.m. of medicine administered to Resident #37 by S4 LPN revealed Ticagrelor and Lansoprazole were not administered as ordered, and Lasix 30 mg (1.5 tablets) was administered.</p> <p>Interview on 06/24/2024 at 9:30 a.m. with S4 LPN confirmed that she did not administer to Resident #37, Ticagrelor 90 mg and Lansoprazole 30 mg as ordered, but should have. S4 LPN confirmed she administered Lasix 20 mg, and Lasix 10 mg to Resident #37. S4 LPN stated she was unaware Lasix 10 mg was discontinued on 06/08/2024, and confirmed Lasix 10 mg should not have been administered to Resident #37.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20604</p> <p>Based on observation, record review, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development of communicable diseases and infections for 1 of 1 resident reviewed for pressure ulcers (#292), and 1 (#292) of 43 residents reviewed for Enhanced Barrier Precautions.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Perform proper hand hygiene during wound care for Resident #292; and 2. Ensure signage was used to communicate to staff those residents who required the use of Enhanced Barrier Precautions (EBP) and Personal Protective Equipment (PPE) before high contact care activities were provided for Resident #292. <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy on 06/25/2024 titled Wound Care, with a revision date 11/2017, read in part . 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. 6. Put on Gloves . <p>Review of Resident #292's medical record revealed Resident #292 was admitted to the facility on [DATE], and had diagnoses that included in part .Lack of Coordination, Age Related Debility, and Generalized Muscle Weakness.</p> <p>Review of Resident #292's Admission MDS with an ARD of 05/24/2024, revealed Resident #292 had a BIMS of 13 (Cognition intact).</p> <p>Review of Resident #292's Comprehensive Person Centered Care Plan revealed the following in part . Pressure ulcers to right heel and right lateral malleolus. Interventions included in part . EBP care should be maintained for resident's entire stay, or until wounds have healed. Post clear signage on the door or wall outside of room indicating the type of precautions and required PPE.</p> <p>Review of Resident #292's 06/2024 physician orders revealed the following:</p> <p>Right heel pressure wound: cleanse with wound cleanser, apply Santyl ointment then calcium alginate to wound bed, apply Xeroform gauze to peri wound skin, then wrap with kerlix and secure with paper tape daily.</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 - Some</p>	<p>Observation on 06/25/2024 at 9:41 a.m. revealed S1 Treatment Nurse performed wound care to Resident #292's right heel. S1 Treatment Nurse put on gloves and removed Resident #292's old dressing to her right heel. S1 Treatment Nurse held Resident # 292's right foot off the bed with her left hand and discarded the soiled dressing with her right hand. S1 Treatment Nurse continued to hold Resident #292's right foot with her left hand, then reached into the clean field with her right hand to grab supplies, and proceeded to clean Resident #292's wound. S1 Treatment Nurse did not remove gloves or sanitize her hands after removing the soiled dressing, before cleaning the wound.</p> <p>Interview on 06/25/2024 at 9:53 a.m. with S1 Treatment Nurse, revealed she should remove gloves and sanitize hands after removing the old dressing, and before cleaning the wound.</p> <p>Interview on 06/25/2024 at 10:30 a.m. with S2 DON, confirmed gloves should be changed and hands sanitized after removing a dressing, and before cleaning the wound.</p> <p>2. Review of the facility's policy on 06/25/2024 titled Implementation of Standard and Transmission-Based Precautions, dated 03/2024 read in part . 3. Enhanced Barrier Precautions (EBP) . I. Examples of Enhanced-Barrier Precaution Residents: Wounds-Include chronic wounds, but are not limited to pressure ulcers, diabetic ulcers, unhealed surgical wounds and venous stasis ulcers; . Signage will be used to communicate to staff which residents require the use of EBP and PPE before high contact care activities are provided.</p> <p>Observation on 06/24/2024 at 10:52 a.m. revealed Resident #292 with a dressing on her right foot. Interview with Resident #292 at that time revealed she had a wound on her right foot for a while (unable to determine how long). Observation revealed no Enhanced Barrier Precaution signage in or outside of Resident # 292's room.</p> <p>Observation on 06/25/2024 at 9:35 a.m. revealed no EBP signage in or outside of Resident # 292's room.</p> <p>Interview on 06/25/2024 at 10:14 a.m. with S3 Infection Preventionist, revealed she was responsible to ensure staff was aware of residents who require EBP. S3 Infection Preventionist stated that residents with Peg tubes, Foley Catheters, and wounds should be on Enhanced Barrier Precautions. S3 Infection Preventionist stated she puts EBP signage next to the resident's door to indicate to staff that Enhanced Barrier Precautions was required, so that direct care staff would be aware and take the necessary precautions before high contact care activities are provided to residents.</p> <p>Observation of Resident #292's room on 06/25/2024 at 10:20 a.m., with S3 Infection Preventionist, revealed no EBP signage. S3 Infection Preventionist confirmed there was no signage to alert direct care staff that Resident #292 was on Enhanced Barrier Precautions. S3 Infection Preventionist confirmed Resident #292 should have signage alerting staff to use Enhanced Barrier Precautions.</p>		