

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Forest Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 Ochsner Blvd Covington, LA 70433	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on record review and interviews, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1(#106) of 31 sampled residents by failing to ensure Resident #106 was coded correctly for a urinary tract infection (UTI).</p> <p>Findings:</p> <p>Review of Resident #106's Clinical Record revealed admitted [DATE], with diagnoses which included History of UTI.</p> <p>Review of Resident #106's Annual MDS with an Assessment Reference Date (ARD) of 12/30/2024, revealed Section I: Infections, Line I2300-UTI in last 30 days coded No by S4LPN on 12/31/2024.</p> <p>Review of Resident #106's Physician's Orders revealed Doxycycline 100 mg by mouth twice a day for 5 days related to History of UTI with an onset date of 12/23/2024.</p> <p>Review of Resident #106's Nurse's Notes revealed on 12/23/2024 the writer noted new order Doxycycline 100 mg by mouth twice a day for 5 days.</p> <p>Review of Resident #106's Physician's Progress note dated 12/23/2024 History of Present Illness section revealed, in part: Resident #106 presented to local hospital emergency department on 12/20/2024 after nursing staff reported patient was having uncontrolled shaking and had altered mental status. Labs obtained unremarkable, urine analysis consistent with acute cystitis. Patient placed on Meropenem for UTI and left lower extremity cellulitis. Resident #106 was instructed to discharge on Doxycycline.</p> <p>Review of Resident #106's Hospital Discharge Summary dated 12/22/2024 revealed, in part: Resident #106 was hospitalized with a primary diagnosis of UTI. Further review revealed Resident #106 was to start Doxycycline 100 mg one capsule by mouth every 12 hours for 5 days.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/29/2025 at 11:58 a.m., an interview was conducted with S5CM. She stated the process was to utilize nurse's notes and hospital discharge paperwork to complete MDS assessments. She stated for an Annual Assessment some sections required a 30 day look back period which was 30 days prior to ARD. She confirmed she was aware Resident #106 was diagnosed with an UTI on 12/23/2024. S5CM reviewed Resident #106's Annual MDS with ARD of 12/30/2024, and confirmed Section I: Infections -Line I2300 asked UTI in last 30 days was coded as No on MDS. She stated the coding was not stating Resident #106 did not have a UTI in the last 30 days she was using her own discretion by coding no because of not having enough documentation.</p> <p>On 01/30/2025 at 1:56 p.m., an interview was conducted with S1DON. She stated she expected staff to accurately code and complete MDS Assessments. S1DON reviewed Resident #106's Annual MDS with ARD of 12/30/2024, and confirmed Section I: Infections -Line I2300 which asked UTI in last 30 days was coded No. S1DON reviewed Section I: Infections-LineI2300 instructions from Resident Assessment Instrument manual with surveyor and confirmed the above MDS should not have been coded No, because of staff's own discretion for not having enough documentation. S1DON then reviewed Resident #106's 12/23/2024 Nurse's Note, Progress Note, and Hospital Discharge Summary, and confirmed Line I2300 should have been coded as Yes, and was not.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on observations, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet the needs of 1 (#134) resident out of 31 total sampled residents. The facility failed to ensure Resident #134 was care planned for nutritional assistance in which she required supervision with meals.</p> <p>Findings:</p> <p>Review of Resident #134's Clinical Record revealed she was admitted on [DATE] with diagnoses which included Parkinson's Disease and Dysphagia.</p> <p>Review of Resident #134's Quarterly MDS with ARD of 12/06/2024 revealed Section GG: Eating was coded as supervision or touching assistance with one person physical assistance.</p> <p>Review of Resident #134's most recent Care Plan failed to reveal any interventions for activities of daily living related to eating nor any interventions for nutritional assistance needed.</p> <p>Review of Resident #134's Speech Therapy (ST) Discharge Summary dated 01/24/2025 revealed in part ST educated Resident #134 and staff on how to implement compensatory strategies with Resident #134 during meals to improve safety, as Resident #134 was unable to implement strategies independently.</p> <p>Review of #134's Occupational Therapy (OT) Discharge Summary dated 01/24/2025 revealed, in part: Resident #134 feeding was self-feeding with stand by assistance due to upper extremity muscle weakness limiting independence in self-feeding. Self-feeding was impacted by lack of postural alignment during meals.</p> <p>On 01/29/2025 at 7:48 a.m., an observation was made of Resident #134. Resident #134 could not been seen from doorway because privacy curtain was pulled. Once around privacy curtain, Resident #134 was noted sitting up in wheel chair, and feeding herself breakfast with no staff nor family present.</p> <p>On 01/29/2025 at 7:59 a.m., an observation was made Resident #134 sitting up in wheel chair, and feeding herself breakfast with no staff nor family present.</p> <p>On 01/29/2025 at 8:20 a.m., an observation was made Resident #134 sitting up in wheel chair, and feeding herself breakfast with no staff nor family present.</p> <p>On 01/29/2025 at 8:46 a.m., an interview was conducted with S14CNA. She stated she was currently Resident #134's aide. She stated Resident #134 was not a resident that required to be fed but required supervision of meals, so she does not stay the entire meal, but monitor's resident periodically. S14CNA was informed of multiple aforementioned observations of Resident #134 not having anyone supervising her while she ate. S14CNA confirmed she was supposed to have someone observing her eat and did not.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/30/2025 at 11:09 a.m., an interview was conducted with S16CNA. She stated she took care of Resident #134 often, and she required monitoring during meals. She stated she referenced to the Kiosk to learn the level of assistance a resident required and intervention for meals/nutrition. She attempted to show surveyor where the level of care was in kiosk, but was not successful and asked S14CNA for help. S16CNA nor S14CNA, who was working the same hall, could find the documentation. S16CNA stated in this case she would go talk with the nurse to determine the level of assistance a resident required for meals/nutrition.</p> <p>On 01/29/2025 at 3:09 p.m., an interview was conducted with S17LPN. She stated she was Resident #134's nurse. She stated to find a resident's level of assistance required and intervention for meals/nutritional she referred to the care plan.</p> <p>On 01/30/2025 at 11:02 a.m., an interview was conducted with S11LPN. He stated he was Resident #134's nurse. He stated to find a resident's level of assistance required and interventions for meals/nutritional he referred to the care plan.</p> <p>On 01/29/2025 at 11:31 a.m., an interview was conducted with S15TD. She stated Resident #134 was discharged from ST services last week. She stated Resident #134 could feed herself, but required assistance with set up and meal supervision. She stated staff was made aware by resident's nutritional assistance need by the ST and OT Discharge Summary. She reviewed Resident #134's ST and OT Discharge Summary dated 01/24/2025, and confirmed stand by assistance meant a person could perform a task independently but required support or supervision in case of difficulty.</p> <p>On 01/29/2025 at 11:36 a.m., an interview was conducted with S5CM. She confirmed she was responsible for care plans. She stated activities of daily living interventions related to eating was not something she usually care planned. She stated at this facility they do not generally care plan level of assistance for feeding. She stated staff was made aware of level of assistance a resident required via verbal report. She reviewed Resident #134's Quarterly MDS with ARD of 12/06/2024, and confirmed Section GG: Eating was coded as supervision or touching assistance with one person physical assist. She stated Resident #134 did not require that level of assistance with meals anymore. She was informed of the aforementioned observations of Resident #134 eating breakfast without supervision, OT & ST Discharge Summary dated 01/24/2025 recommendations, and inconsistency with staff interviews. She reviewed Resident #134's most recent Care Plan, and confirmed she was not care planned for nutritional assistance, and should have been.</p> <p>On 01/30/2025 at 1:56 p.m., an interview was conducted with S1DON. She was informed of the aforementioned observations of Resident #134 eating breakfast without supervision, OT & ST Discharge Summary dated 01/24/2025 recommendations, and inconsistency with staff interviews. S1DON could not provide documentation of Resident #134 ever being care planned for nutritional assistance.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure</p> <p>accuchecks were completed timely and insulin was administered before meals as ordered for 2 (#81, #93) of 4 (#8, #76, #81, and #93) residents reviewed for insulin administration.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Administration of Medications revealed the following, in part:</p> <p>Purpose: To administer medications in accordance with best practice.</p> <p>Procedure:</p> <p>2. Administration of any drug requires a physician's order.</p> <p>Resident #81</p> <p>Review of Resident #81's Clinical Record revealed he was readmitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Neuropathy.</p> <p>Review of Resident #81's current Physician Orders revealed the following, in part:</p> <p>Novolog Flex Pen U-100 Insulin Apart 100 units/mL subcutaneous Pen-injector: administer 4 units subcutaneously before each meal as per sliding scale 201-250.</p> <p>An observation was made on 01/28/2025 at 11:38 a.m. of meal trays being delivered by direct care staff to residents on Hall 600. S10LPN was observed performing Resident 81's blood sugar check without administering insulin.</p> <p>An interview with S10LPN and documentation of Medication Administration Record revealed Resident #81's accucheck was 220 at 01/28/2025 11:38a.m.</p> <p>Review of Medication Administration Audit Report dated 01/28/2025 revealed Insulin was administered subcutaneously at 12:09 p.m. to Resident #81 by S10LPN.</p> <p>Resident #93</p> <p>Review of Resident #93's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus.</p> <p>Review of Resident #93's January 2025 Physician Orders revealed the following, in part:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Novolog Pen Injector administer 6 Units subcutaneously per Sliding Scale for 251-300 blood glucose before each meal.</p> <p>An observation was made on 1/28/2025 at 12:12 p.m. of S10LPN. S10LPN administered 6 Units of Novolog insulin medication to Resident #93, who was observed to be seated in hallway with her lunch meal already 95% eaten.</p> <p>An interview was conducted with S10LPN on 01/28/2025 at 12:15 p.m. She stated Resident #81 and Resident #93's Novolog insulin was ordered to be administered before meals. She confirmed she administered Resident #81 and Resident #93's insulin after they had consumed lunch and should have administered the insulin before lunch as ordered.</p> <p>An interview and observation was conducted 01/30/25 11:35 a.m. with S12LPN on 500 Hall. S12LPN stated she had 8 residents on the hall who required blood sugar checks and insulin prior to meals. She stated meals were delivered to Residents' rooms between 11:00 a.m. - 11:30 a.m. S12LPN stated it was not possible to complete blood sugar checks and administer insulin prior to meals.</p> <p>An interview was conducted with S1DON on 01/30/2025 at 12:08 p.m. S1DON confirmed Resident #81 and Resident #93 had orders for insulin subcutaneously before meals per sliding scale. S1DON stated Residents #81 and #93's insulin should have been administered before meals as ordered. S1DON confirmed untimely blood sugar checks and insulin administration was not an acceptable nursing staff practice. S1DON further stated that sliding scale insulin should have been given prior to meals, per physician orders.</p>

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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>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5% for 3 (#88, #81 and #93) of 7 (#7, #8, #13, #76, #88, #81, and #93) residents observed during medication administration. A total of 26 opportunities were observed with 3 medication errors, which resulted in a medication error rate of 11.54%. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #88's Eliquis was given as ordered; and 2. Resident #81's Insulin was administered before meals as ordered. 3. Resident #93's Insulin was administered before meals as ordered. <p>Findings:</p> <p>Review of the facility's policy titled, Administration of Medications revealed the following, in part:</p> <p>Purpose: To administer medications in accordance with best practice.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 2. Administration of any drug requires a physician's order. 3. Drugs and biologicals are administered nor more than one hour before and no more than one hour after dosage time on order. <p>Resident #88</p> <p>Review of Resident #88's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Chronic Systolic Congestive Heart Failure.</p> <p>Review of Resident #88's current Physician Orders revealed the following, in part:</p> <p>Eliquis oral tablet by mouth two times a day related to paroxysmal atrial fibrillation. Start date 06/03/2024.</p> <p>An observation was made of S11LPN administering medications to Resident #88 on 01/29/2025 at 9:11 a.m. Resident #88 had an order for Eliquis oral tablet by mouth two times a day at 8:00 a.m. S11LPN did not administer Resident #88's Eliquis.</p> <p>An interview was conducted with S11LPN on 01/29/2025 at 9:35 a.m. S11LPN stated Resident #88's Eliquis was missing and not available for administration. S11LPN confirmed Resident #88 missed her morning 8:00 a.m. dose of Eliquis.</p> <p>Resident #81</p> <p>(continued on next page)</p>		

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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>Review of Resident #81's Clinical Record revealed he was readmitted to the facility on [DATE] and had diagnoses which included Type 2 Diabetes Mellitus with Diabetic Neuropathy.</p> <p>Review of Resident #81's current Physician Orders revealed the following, in part:</p> <p>Novolog Flex Pen U-100 Insulin Aspart 100 units/mL subcutaneous Pen-injector: administer 4 units subcutaneously before each meal as per sliding scale 201-250.</p> <p>An observation was made of Resident #81 on 01/28/2025 at 12:07 p.m. He was in his room and had completely finished eating his lunch.</p> <p>An interview was conducted with S10LPN on 01/28/2025 at 12:09 p.m. She stated she would administer Resident #81's sliding scale insulin after lunch, based on her previous accu-check reading of 220 she performed at 11:30 a.m. S10LPN stated Resident #81's 11:30 a.m. accucheck reading was 220, and she would administer his insulin after lunch.</p> <p>Resident #93</p> <p>Review of Resident #93's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Type 2 Diabetes Mellitus and Dementia.</p> <p>Review of Resident #93's current Physician Orders revealed the following, in part:</p> <p>Novolog Flex Pen U-100 Insulin Aspart 100 units/mL subcutaneous: administer 6 units subcutaneously before. Novolog Pen Injector 6 Units per Sliding Scale for 251-300 blood glucose before each meal.</p> <p>An observation was made of Resident #93 seated in wheelchair with lunch tray 95% consumed 01/29/2025 at 12:12 p.m. S10LPN administered Resident #93's insulin. S10LPN stated Resident #93's 11:30 a.m. accucheck reading was within 251-300 blood glucose range, and she would administer her insulin after lunch.</p> <p>An interview was conducted with S10LPN on 01/29/2025 at 12:15 p.m. S10LPN stated Resident #81 and Resident #93's Novolog insulin was ordered before meals. She confirmed she administered Resident #81 and Resident #93's insulin after they had consumed lunch and should have administered the insulin before lunch as ordered.</p> <p>An interview was conducted with S1DON on 01/30/2025 at 12:08 p.m. S1DON confirmed Resident #88 had an order to administer Eliquis tab twice daily and it should have been administered as ordered. S1DON further confirmed a medication not given within one hour prior to or one hour following scheduled administration time was a medication error. S1DON confirmed Resident #81 and Resident #93 had an orders for Novolog insulin subcutaneously before meals per sliding scale. S1DON stated Residents' #81 and 93's Novolog insulin should have been administered before meals as ordered. S1DON confirmed omission of Eliquis and administration of insulin after a meal when ordered before meals were medication errors.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615</p> <p>Based on observations, interviews and record review, the facility failed to ensure it was free of significant medication errors for 3 (#88, #81 and #93) of 7 (#7, #8, #13, #76, #88, #81, and #93) residents reviewed for medications. The deficient practice had the potential to effect the 158 residents residing in the facility who received medications.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Administration of Medications revealed the following, in part:</p> <p>Purpose: To administer medications in accordance with best practice.</p> <p>Procedure:</p> <p>2. Administration of any drug requires a physician's order.</p> <p>3. Drugs and biologicals are administered no more than one hour before and no more than one hour after dosage time on order.</p> <p>Resident #88</p> <p>Review of Resident #88's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Chronic Systolic Congestive Heart Failure.</p> <p>Review of Resident #88's January 2025 Physician Orders revealed the following, in part:</p> <p>Eliquis 5mg one tablet by mouth two times a day related to Paraoxymal Atrial Fibrillation. Start date 06/03/2024.</p> <p>Review of Resident #88's current Medication Administration Record revealed the following, in part:</p> <p>Eliquis 5mg one tablet by mouth two times a day timed for 8:00 a.m. and 8:00 p.m.</p> <p>Review of Medication Administration Audit Report for Resident #88 dated 01/27/2025 - 01/30/2025 revealed documented administration of Eliquis 5mg one tablet by mouth on 01/29/2025 at 9:57 a.m.</p> <p>Resident #81</p> <p>Review of Resident #81's Clinical Record revealed he was readmitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Neuropathy.</p> <p>Review of Resident #81's current Physician Orders revealed the following, in part:</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Novolog FlexPen U-100 Insulin Aspart 100 units/mL subcutaneous Pen-injector: administer 4 units subcutaneously before each meal as per sliding scale 201-250.</p> <p>An observation was made of Resident #81 on 01/28/2025 at 12:07 p.m. He was in his room and had completely finished eating his lunch.</p> <p>Review of Medication Administration Audit Report dated 01/28/2025 revealed Insulin was administered subcutaneously at 12:09 p.m. to Resident #81 by S10LPN.</p> <p>Resident #93</p> <p>Review of Resident #93's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus.</p> <p>Review of Resident#93's Clinical Record Quarterly MDS with ARD 11/20/2024, section N revealed Resident #92 required insulin medication administration.</p> <p>Review of Resident #93's January 2025 Physician Orders revealed the following, in part:</p> <p>Novolog FlexPen U-100 Insulin Aspart 100 units/mL subcutaneous: administer 6 units. Novolog Pen Injector administer 6 Units subcutaneously per Sliding Scale for 251-300 blood glucose before each meal.</p> <p>An observation was made on 1/28/2025 at 12:12 p.m. of S10LPN. S10LPN administered 6 Units of Novolog insulin medication to Resident #93, who was observed to be seated in hallway with her lunch meal already 95% eaten.</p> <p>An interview was conducted with S10LPN on 01/28/2025 at 12:15 p.m. She stated Resident #81 and Resident #93's Novolog insulin was ordered to be administered before meals. She confirmed she administered Resident #81 and Resident #93's insulin after they had consumed lunch and should have administered the insulin before lunch as ordered.</p> <p>An interview was conducted with S1DON on 01/28/25 at 2:11 p.m. S1DON stated late medication administration of insulin was not acceptable practice for nursing. She confirmed blood glucose checks and insulin ordered prior to meals should be performed in conjunction with Medication Administration Review and physician orders.</p> <p>An interview was conducted with S1DON on 01/30/2025 at 12:08 p.m. S1DON confirmed Resident #88 had an order to administer Eliquis one tab twice daily by mouth and it was not administered timely as ordered. S1DON further confirmed a medication not given within one hour prior to or one hour following scheduled administration time was a medication error. S1DON confirmed Resident #81 and Resident #93 had orders for Novolog insulin subcutaneously before meals per sliding scale. S1DON stated Residents' #81 and #93's Novolog insulin should have been administered before meals as ordered. S1DON confirmed medications were not administered in a timely manner and as ordered by the physician.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Forest Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 Ochsner Blvd Covington, LA 70433	
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 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** 47191</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. A resident's catheter remained off of the floor for 1(#91) of 3 (#24, #91, and #407) residents observed with an indwelling catheter; and 2. Staff properly utilized Enhanced Barrier Precaution (EBP) Personal Protective Equipment (PPE) during care for 4 of 4 (#24, #91, #407, and #409) residents whom required EBP. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Review of Resident #91's Clinical Record revealed she was readmitted to the facility on [DATE] with diagnoses, which included the following, in part: Personal History of Urinary Tract Infections, Retention of Urine, and Urgency of Urination.</p> <p>Review of Resident #91's current Physician Orders revealed Catheter-Foley 18F with an onset date of 05/31/2024.</p> <p>On 01/27/2025 at 12:24 p.m., an observation was made of Resident #91's indwelling catheter bag on the floor.</p> <p>On 01/27/2025 at 12:27 p.m., an observation and interview was conducted with S3LPN. Upon entering Resident #91's room, S3LPN observed Resident #91's indwelling catheter bag on the floor. S3LPN confirmed the indwelling catheter bag was lying on the floor and should not have been.</p> <p>On 01/30/2025 at 1:32 p.m., an interview was conducted with S1DON. S1DON confirmed the indwelling catheter bag should be kept off of the floor as that is an increased risk of infection.</p> 2. <p>Review of the facility's policy with a revised date of 03/2024, titled Enhanced Barrier Precautions revealed the following, in part:</p> <p>Policy:</p> <p>Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes.</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>Enhanced Barrier Precautions involve gown and glove 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., residents with wounds or indwelling medical devices).</p> <p>Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities.</p> <p>Resident #24</p> <p>Review of Resident #24's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included the following, in part: Urinary Tract Infection, Extended Spectrum Beta-Lactamases Resistance and Urge Incontinence.</p> <p>Review of Resident #24's care plan revealed the following:</p> <p>Focus: The resident has history of Multiple Drug Resistance Organism</p> <p>Interventions: Enhanced Barrier Precautions</p> <p>On 01/29/2025 at 10:19 a.m., an observation was conducted of S6CNA providing incontinence care for Resident #24. An Enhanced Barrier Precautions sign was observed to be posted on the door and above the head of Resident #24's bed. S6CNA failed to don a gown prior to providing high contact resident care.</p> <p>On 01/29/2025 at 11:15 a.m., an interview was conducted with S6CNA. She stated Resident #24 no longer required Enhanced Barrier Precautions due to indwelling device recently being removed.</p> <p>On 01/30/2025 at 1:33 p.m., an interview was conducted with S2ADON. She stated Resident #24 remained on Enhanced Barrier Precautions due to a history of Multiple Drug Resistance Organism. S2ADON stated staff should have donned PPE prior to providing high contact resident care to Resident #24.</p> <p>Resident #91</p> <p>Review of Resident #91's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included the following, in part: Personal History of Urinary Tract Infections, Retention of Urine, and Urgency of Urination.</p> <p>Review of Resident #91's current Physician Orders revealed Catheter-Foley 18F with an onset date of 05/31/2024.</p> <p>Review of Resident #91's current Care Plan revealed the following, in part:</p> <p>Focus: The resident has indwelling Foley Catheter</p> <p>Interventions: Enhanced Barrier Precautions</p> <p>On 01/29/2025 at 9:25 a.m., a sign was observed on Resident #91's door that read EBP which included instructions to wear gown and gloves during high contact resident care activity.</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>On 01/29/2025 at 3:12 p.m., an observation was made of S8CNA performing catheter care on Resident #91. S8CNA failed to properly utilize PPE by not donning a gown while performing catheter care.</p> <p>On 01/29/2025 at 3:27 p.m., an interview was conducted with S8CNA following catheter care observation. She stated an EBP sign on a resident's door indicated staff were to dress out with gloves and gown prior to performing high contact resident care. She confirmed Resident #91 had an EBP sign on her door. She stated she did not notice the sign on the door prior to entering the room to perform catheter care. S8CNA confirmed she did not don a gown prior to performing catheter care on Resident #91 and should have.</p> <p>Resident #407</p> <p>Review of Resident #407's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included the following, in part: Urinary Tract Infection, Benign Prostatic Hyperplasia, and Retention of Urine.</p> <p>Review of Resident #407's current Physician Orders revealed Catheter-Foley 16F with an onset date of 01/11/2025.</p> <p>On 01/30/2025 at 10:05 a.m., an observation was made of S13CNA performing catheter care on Resident #407. An Enhanced Barrier Precautions sign was observed on Resident#407's door. S13CNA failed to properly utilize PPE by not donning a gown while performing catheter care.</p> <p>On 01/30/2025 at 10:23 a.m., an interview was conducted with S13CNA following catheter care observation. She confirmed Resident #407 had an EBP sign on his door and stated she did not notice the sign on the door prior to entering the room to perform catheter care. She stated an EBP sign on a resident's door indicated staff were to dress out with gloves and gown prior to performing high contact resident care. S13CNA confirmed she did not don a gown prior to performing catheter care on Resident #407 and should have.</p> <p>Resident #409</p> <p>Review of Resident #409's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included the following, in part: Neuromuscular Dysfunction of Bladder and Personal History of Urinary Tract Infections.</p> <p>Review of Resident #409's current Physician Orders revealed Catheter-Foley 16F with an onset date of 01/08/2025.</p> <p>Review of Resident #409's current Care Plan revealed the following, in part:</p> <p>Focus: The resident has indwelling Foley catheter</p> <p>Interventions: Enhanced Barrier Precautions</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>On 01/29/2025 at 10:49 a.m., an observation was conducted of S7CNA providing catheter care for Resident #409. An Enhanced Barrier Precautions sign was observed on Resident#409's door and above the head of the bed. S7CNA failed to properly utilize PPE by not donning a gown prior to providing high contact resident care.</p> <p>On 01/29/2025 at 10:51 a.m., an interview was conducted with S7CNA. She stated Resident #409 was on Enhanced Barrier Precautions due to having an indwelling device. S7CNA confirmed she did not apply a gown prior to providing high contact resident care and should have.</p> <p>On 01/30/2025 at 1:32 p.m., an interview was conducted with S1DON. S1DON was notified of the above observations related to EBP. She stated if a resident had an Enhanced Barrier Precaution sign on the outside of their door, staff were required to wear proper PPE which included gloves and a gown prior to providing high contact resident care.</p> <p>48912</p> <p>49343</p>		