

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  Our Lady of Wisdom Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5600 General Degaulle Dr New Orleans, LA 70131	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46361</p> <p>49259</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a resident was treated with dignity when staff did not provide incontinence care to a resident as requested prior to meal service. This deficient practice was identified for 2 (Resident #3, Resident #4) of 4 (Resident #1, Resident #2, Resident #3, Resident #4) sampled residents reviewed for resident rights.</p> <p>Findings:</p> <p>Review of the facility's Resident Rights policy statement, revised on 10/2016, revealed, in part, employees should treat residents with respect and dignity. Further review revealed federal and state laws guaranteed certain basic rights to all residents of this facility.</p> <p>Observation on 04/09/2025 at 11:40AM of the Hall z nurse's station revealed, in part, the call light monitor was alarming for Resident #3 and Resident #4 rooms. Further observation revealed at 11:41AM S3Licensed Practical Nurse (LPN) made an announcement on the facility speaker system that staff assistance was needed for Resident #3 and Resident #4 rooms. Further observation of the call system monitor revealed at 11:42AM, Resident #3's call light was no longer alarming, and Resident #4's call light remained activated.</p> <p>Resident #3</p> <p>Review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/2025 revealed, in part, Resident #3 had a Brief Interview for Mental Status (BIMS) of 15 which indicated Resident #3's cognition was intact. Further review revealed Resident #3 was dependent for transfers and toileting, and was incontinent (loss of bladder or bowel control) of both bladder and bowel.</p> <p>Review of Resident #3's care plan revealed, in part, Resident #3 had a self-care deficit related to mobility impairment and weakness and required total assistance with toileting. Further review revealed Resident #3 was incontinent of bowel and staff was to check Resident #3 for incontinence as needed and provide incontinence care after each incontinent episode.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/09/2025 at 11:42AM revealed Resident #3's call light above the doorway of his room was not activated. Further observation revealed he was sitting in his wheelchair in his room with his wife present.</p> <p>In an interview on 04/09/2025 at 11:42AM, Resident #3 indicated the call light had been activated because Resident #3 wanted to be changed before lunch was served.</p> <p>In an interview on 04/09/2025 at 11:43AM Resident #3's wife indicated that a staff member had entered the room, turned off the call light, and stated she would get Resident #3 some help and did not provide incontinence care.</p> <p>Observation on 04/09/2025 at 1:21PM revealed S9Certified Nursing Assistnat (CNA) entered multiple resident rooms to remove lunch meal trays. Further observation revealed S9CNA entered Resident #3's room, removed the lunch trays, and did not provide incontinence care.</p> <p>In an interview on 04/09/2025 at 1:40PM, S6MDS Clinical Coordinator indicated she had entered Resident #3's room to address the call light before lunch. S6MDS Clinical Coordinator further indicated Resident #3 had asked to be changed and she then notified Resident #3's nurse and S9CNA per Resident #3's request.</p> <p>In an interview on 04/09/2025 at 1:41PM S9CNA indicated she had been notified by S6MDS Clinical Coordinator of Resident #3's request for personal care, but was informed of the request after the lunch trays had already been passed out to all the residents. S9CNA further indicated incontinence care was not provided to residents during meal service.</p> <p>Resident #4</p> <p>Review of Resident #4's Admission MDS with an ARD of 01/23/2025 revealed Resident #4 had a BIMS Score of 13 which indicated Resident #4's cognition was intact, and Resident #4 required substantial/maximum assistance with toilet hygiene.</p> <p>Review of Resident #4's care plan revealed, in part, Resident #4 had a self-care deficit related to limited mobility and was total dependent on staff for toilet use. Further review revealed Resident #4 was incontinent of bowel and bladder and staff was to check Resident #4 for incontinence as needed and provide incontinence care after each incontinent episode.</p> <p>Observation on 04/09/2025 at 11:57AM, S8CNA approached Resident #4 who was sitting outside his room in his wheelchair. Resident #4 stated to S8CNA that he still needed to be changed and S8CNA responded with, I am about to push you to the table. Further observation revealed S8CNA pushed Resident #4 to a dining table next to other residents waiting for lunch meal to be served.</p> <p>Observation on 04/09/2025 at 12:15PM revealed Resident #4 was sitting at Hall z dining table with multiple residents eating lunch without receiving incontinence care.</p> <p>In an interview on 04/09/2025 at 1:14PM, Resident #4 indicated he needed his adult brief to be changed and he had asked the CNA to provide incontinence care to him right before he was brought to lunch, as he preferred not to go to lunch without being changed. Resident #4 further indicated that the CNA did not change his adult brief at that time.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/09/2025 at 1:50PM, S6MDS Clinical Coordinator indicated she had entered Resident #4's room before lunch to answer an activated call light. S6MDS Clinical Coordinator further indicated Resident #4 had asked for his adult brief to be changed and she then notified Resident #4's nurse and S8CNA of Resident #4's request.</p> <p>In an interview on 04/09/2025 at 2:15PM, S2Interim Director of Nursing (DON) indicated staff normally did not provide incontinence care to residents during meal times due to infection control concerns.</p> <p>In an interview on 04/09/2025 at 3:33PM, S8CNA acknowledged she heard Resident #4 state he was still waiting to be changed when she was pushing him to Hall z dining room, but did not address him or respond to his needs at that time because he caught me off guard there was too much going on. S8CNA indicated residents were rounded on every 2 hours and CNAs don't typically change residents during meal time. When asked if she would want to sit in stool or urine for 2 or more hours, S8CNA shook her head no in response.</p> <p>In an interview on 04/09/2025 at 3:53PM, S1Administrator indicated he, himself, would not want to sit in stool or urine for 2 hours and/or eat a meal while he, himself, was sitting in stool or urine. S1Administrator indicated staff should have provided incontinence care to Resident #3 and Resident #4 regardless if it was during meal service.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46361</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure only licensed personnel administered medications for 1 (Resident #3) of 4 (Resident #1, Resident #2, Resident #3, Resident #4) sampled residents reviewed for nursing services.</p> <p>Findings:</p> <p>Review of the facility's Administering Medications policy revised on 04/2019 revealed, in part, only persons licensed or permitted by the state to prepare, administer and document the administration of medication may do so.</p> <p>Observation on 04/08/2025 at 11:06AM with S10Certified Nursing Assistant (CNA) present revealed an unmarked cup with no identifying information on it was filled to three-quarters capacity which contained a clear ointment located on the shelf inside a cabinet on Hall z.</p> <p>In an interview on 04/08/2025 at 11:10AM, S11CNA indicated she placed the above mentioned medication cup of ointment in the cabinet on Hall z after she obtained the ointment from S4LPN. S11CNA indicated she had applied the ointment in the past to Resident #3's chest, abdomen, and groin.</p> <p>In an interview on 04/08/2025 at 11:23PM, S4Licensed Practical Nurse (LPN) indicated he gave S11CNA Resident #3's ointment so she could apply the ointment topically to Resident #3's dry and itching skin. S4LPN identified the above mentioned ointment was Mometasone Furoate Ointment 0.1% (a steroid cream used to treat skin conditions) and confirmed the ointment was medicated. S4LPN further indicated the facility allowed CNAs to apply medicated ointments.</p> <p>Review of Resident #3's April 2025 Physician Orders revealed, in part, Resident #3 had an order dated 11/15/2023 for Mometasone Furoate External Ointment 0.1% apply topically one time a day for psoriasis (a skin condition that causes dry and itchy skin).</p> <p>In an interview on 04/08/2025 at 12:30PM, S2Interim Director of Nursing (DON) indicated it was not the facility's standard of practice to allow CNAs to apply medicated ointments to residents.</p> <p>In an interview on 04/08/2025 at 12:35PM, S5Minimum Data Set Clinical Coordinator stated CNAs were absolutely not allowed to apply medicated ointments to residents.</p> <p>In an interview on 04/08/2025 at 3:53PM, S1Administrator indicated S4LPN should not have given S11CNA Resident #3's medicated ointment to apply.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46361</p> <p>49259</p> <p>Based on observations, interviews and record reviews the facility failed to provide timely incontinence care for 2 (Resident #3, Resident #4) of 4 (Resident #1, Resident #2, Resident #3, Resident #4) sampled residents reviewed for incontinence.</p> <p>Findings:</p> <p>Review of the facility's Resident Rights policy statement, revised on 10/2016, revealed, in part, employees should treat residents with respect and dignity. Further review revealed federal and state laws guaranteed certain basic rights to all residents of this facility.</p> <p>Observation on 04/09/2025 at 11:40AM of the Hall z nurse's station revealed, in part, the call light monitor was alarming for Resident #3 and Resident #4 rooms. Further observation revealed at 11:41AM S3Licensed Practical Nurse (LPN) made an announcement on the facility speaker system that staff assistance was needed for Resident #3 and Resident #4 rooms. Further observation of the call system monitor revealed at 11:42AM, Resident #3's call light was no longer alarming, and Resident #4's call light remained activated.</p> <p>Resident#3</p> <p>Review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/2025 revealed, in part, Resident #3 had a Brief Interview for Mental Status (BIMS) of 15 which indicated Resident #3's cognition was intact. Further review revealed Resident #3 was dependent for transfers and toileting, and was incontinent (loss of bladder or bowel control) of both bladder and bowel.</p> <p>Review of Resident #3's care plan revealed, in part, Resident #3 had a self-care deficit related to mobility impairment, weakness and required total assistance with toileting. Further review revealed Resident #3 was incontinent of bowel and staff was to check Resident #3 for incontinence as needed and provide incontinence care after each incontinent episode.</p> <p>Observation on 04/09/2025 at 11:42AM revealed Resident #3's call light above the doorway of his room was not activated. Further observation revealed he was sitting in his wheelchair in his room with his wife present.</p> <p>In an interview on 04/09/2025 at 11:42AM, Resident #3 indicated the call light had been activated because Resident #3 wanted to be changed before lunch was served.</p> <p>In an interview on 04/09/2025 at 11:43AM, Resident #3's wife indicated that a staff member had entered the room, turned off the call light, and stated she would get Resident #3 some help. Resident #3's wife stated because Resident #3 required a total lift for transfers in and out of bed, the staff often took a long time to change Resident #3 after incontinent episodes.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/09/2025 at 12:09PM, Resident #3 indicated he had not been changed since he activated the call light at 11:40AM and he had a bowel movement.</p> <p>In an interview on 04/09/2025 at 12:35PM, Resident #3 indicated he had not been changed since he activated the call light at 11:40AM.</p> <p>Observation on 04/09/2025 at 1:21PM revealed S9 Certified Nursing Assistant (CNA) entered multiple resident rooms to remove lunch meal trays. Further observation revealed S9CNA entered Resident #3's room, removed the lunch trays, and did not provide incontinence care.</p> <p>In an interview on 04/09/2025 at 1:40PM, S6MDS Clinical Coordinator indicated she had entered Resident #3's room to address the call light before lunch. S6MDS Clinical Coordinator further indicated Resident #3 had asked to be changed and she then notified Resident #3's nurse and S9CNA per Resident #3's request.</p> <p>In an interview on 04/09/2025 at 1:41PM S9CNA indicated she had been notified by S6MDS Clinical Coordinator of Resident #3's request for personal care, but was informed of the request after the lunch trays had already been passed out to all the residents. S9CNA further indicated incontinence care was not provided to residents during meal service.</p> <p>Observation on 04/09/2025 at 1:50PM revealed Resident #3 was provided incontinence care by S9CNA. Further observation revealed Resident #3 had a bowel movement in his adult brief.</p> <p>Resident #4</p> <p>Review of Resident #4's Admission MDS with an ARD of 01/23/2025, revealed Resident #4 had a BIMS Score of 13 which indicated that Resident #4's cognition was intact and Resident #4 required substantial/maximal assistance from staff with toilet hygiene.</p> <p>Review of Resident #4's care plan revealed, in part, Resident #4 had a self-care deficit related to limited mobility and was total dependent on staff for toilet use. Further review revealed Resident #4 was incontinent of bowel and bladder and staff was to check Resident #4 for incontinence as needed and provide incontinence care after each incontinent episode.</p> <p>Observation on 04/09/2025 at 11:57AM revealed S8CNA approached Resident #4 who was sitting outside his room in his wheelchair. Resident #4 stated to S8CNA that he still needed to be changed and S8CNA responded with I am about to push you to the table. Further observation revealed S8CNA pushed resident to a dining table next to other residents waiting for lunch meal to be served.</p> <p>Observation on 4/09/2025 at 12:15PM revealed Resident #4 sitting at Hall z dining table with multiple residents eating lunch.</p> <p>In an interview on 04/09/2025 at 1:14PM, Resident #4 indicated he needed his brief to be changed and he had asked the CNA to change his brief right before he was brought to lunch, as he preferred not to go to lunch without being changed. Resident #4 further indicated the CNA did not change his brief at that time and stated they (CNAs) will change me when they get around to it, I have just learned to live with it.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/09/2025 at 1:38PM revealed Resident #4 activated his call light and the light came on above the doorway to his room.</p> <p>Observation on 04/09/2025 at 1:41PM revealed S8CNA entered Resident #4's room and Resident #4 asked S8CNA to change him. Further observation revealed S8CNA told Resident #4 that she had to go get help and left the room.</p> <p>In an interview on 04/09/2025 at 1:50PM, S6MDS Clinical Coordinator indicated she had entered Resident #4's room before lunch to answer an activated call light. S6MDS Clinical Coordinator further indicated Resident #4 had asked for his adult brief to be changed and she then notified Resident #4's nurse and S8CNA of Resident #4's request.</p> <p>Observation on 04/09/2025 of Hall z revealed Resident #4 was within Surveyor's eyesight from 11:40AM - 2:25PM and was not provided incontinence care until 2:10pm.</p> <p>In an interview on 04/09/2025 at 2:15PM, S2Interim Director of Nursing (DON) indicated staff normally did not provide incontinence care to residents during meal times due to infection control concerns.</p> <p>In an interview on 04/09/2025 at 3:33PM, S8CNA acknowledged she heard Resident #4 state he was still waiting to be changed when she was pushing him to Hall z dining room, but did not address him or respond to his needs at that time because he caught me off guard there was too much going on. S8CNA indicated residents were rounded on every 2 hours and CNAs don't typically change residents during meal. When asked if she would want to sit in stool or urine for 2 or more hours, S8CNA shook her head no in response.</p> <p>In an interview on 04/09/2025 at 3:53PM, S1Administrator indicated he, himself, would not want to sit in stool or urine for 2 hours and/or eat a meal while he, himself, was sitting in stool or urine. S1Administrator indicated staff should have provided incontinence care to Resident #3 and Resident #4 regardless if it was during meal service.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46361</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medicated ointments and/or lotions were stored in a locked compartment and only accessible to authorized personnel for 2 random observations made 1 of 2 days while onsite.</p> <p>Findings:</p> <p>Review of the facility's Medication Storage policy and procedure revised on 11/2020 revealed, in part, drugs and biologicals used in the facility are stored in locked compartments and only persons authorized to prepare and administer medications have access to locked medications.</p> <p>Observation on 04/08/2025 at 10:27AM revealed a bottle of Ammonium Lactate Lotion 12% (a medicated lotion used to treat skin conditions) was found sitting on a shelf, inside of an unlocked supply cabinet on Hall y, that was accessible to residents, visitors and unauthorized personnel. Further observation revealed parts of the prescription label had been removed and there was no identifiable resident specific information or prescription number.</p> <p>In an interview on 04/08/2025 at 10:28AM, S7MDS Clinical Coordinator indicated she could not say why the bottle of Ammonium Lactate Lotion 12% was placed in the unlocked supply cabinet on Hall y.</p> <p>Observation on 04/08/2025 at 11:06AM with S10Certified Nursing Assistant (CNA) present revealed a medication cup 3/4 filled with a clear ointment located on the shelf inside an unlocked cabinet on Hall z. Further observation revealed there was no identifying information on the medication cup containing the clear ointment.</p> <p>In an interview on 04/08/2025 at 11:06AM, S10CNA indicated she did not know why the medication cup containing ointment was placed into the supply cabinet on Hall z. S10CNA further indicated the medication cup containing ointment should not have been placed inside the unlocked and unattended supply cabinet on Hall z.</p> <p>In an interview on 04/08/2025 at 11:10AM, S11CNA indicated she placed the medication cup of ointment in the cabinet on Hall z. S11CNA further indicated she placed the ointment in the cabinet because she wasn't able to apply the ointment to the resident at the time and she thought the unlocked cabinet on Hall z was a safe place to store the ointment.</p> <p>In an interview on 04/08/2025 at 11:23PM, S4Licensed Practical Nurse (LPN) indicated he gave S11CNA Resident #3's ointment to be applied topically. S4LPN indicated the ointment was Mometasone Furoate Ointment 0.1% (a steroid cream used to treat skin conditions) and confirmed the ointment was medicated.</p> <p>Review of Resident #3's April 2025 Physician Orders revealed, in part, Resident #3 had an order dated 11/15/2023 for Mometasone Furoate External Ointment 0.1% apply topically one time a day for psoriasis (a skin condition that causes dry and itchy skin).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/09/2025 at 3:53PM, S1Administrator indicated the medicated ointment and lotion mentioned above should have been in a locked compartment and should not have been stored in a supply cabinet on the halls</p>