STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195509	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Wisdom Community Care Center	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49562 Based on record review and interview the facility failed to ensure the Resident's right to formulate an advanced directive was properly reflected in the Resident's medical record for 1 (Resident #335) of 28 (Resident #5, Resident #15, Resident #20, Resident #27, Resident #32, Resident #35, Resident 37, Resident #40, Resident #41, Resident #46, Resident #49, Resident #58, Resident #59, Resident #63, Resident #82, Resident #83, Resident #88, Resident #89, Resident #93, Resident #94, Resident #95, Resident #102, Resident #103,Resident #104, Resident #205, Resident #255, Resident #355) sampled residents reviewed for advanced directives. Findings: Review of Resident #355's EMR (electronic medical record) revealed Resident #355 was admitted to the facility on [DATE]. Review of Resident #355's [DATE] Physician's Orders revealed, in part, a copy of a signed order in the medical record dated [DATE] for Cardio Pulmonary Resuscitation (CPR). Review of Resident #355's [DATE] Physician's Orders in the Electronic Medical Record (EMR) revealed, in part, an order dated [DATE] for Do Not Resuscitate (DNR). In an interview on [DATE] at 10:57 a.m., S3MDS Nurse confirmed there was an order dated [DATE] for Resident #355 to be Full Code in the physical chart, while there was an order dated [DATE] in the EMR for Resident #355 to be DNR. S3MDS further indicated there should not be a discrepancy in Resident #355's code status orders. In an interview on [DATE] at 11:47 a.m., S2Director of Nursing (DON) agreed there should not have been a discrepancy in Resident #355's code status orders.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195509	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Wisdom Community Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46361 Based on record reviews, observations, and interviews, the facility failed to: 1. Ensure food was not expired and stored in a sanitary manner. 2. Ensure a carton of nutritional supplement was stored per manufacturer's guidelines and was not available for consumption. Findings: 1. Observation on [DATE] at 9:42 a.m. of storage pantry revealed, in part, the following: two 27-ounce (oz.) packages of refried beans with an expiration date of [DATE]; a one-gallon container of taco sauce with an expiration date of [DATE]; one 24 oz. container of bread crumbs with an expiration date of [DATE]; and one-gallon container of red enchilada sauce with an expiration date of [DATE]. In an interview on [DATE] at 9:42 a.m., S7Food Service Manager confirmed the two packages of refried beans; breadcrumbs, enchilada sauce, and taco sauce were all expired. Observation on [DATE] at 9:45 a.m., revealed an opened undated one-gallon container of blue cheese dressing. Further observation revealed the rim and the outside of the blue cheese-dressing container had an unidentified creamy substance with an unidentified green fuzzy substance. Observation also revealed an undated open box of small pastries which was not labeled. In an interview [DATE] at 9:45 a.m., S7Food Service Manager confirmed the presence of the unidentified substance and confirmed it was not stored in a sanitary manner. S7Food Service Manager further confirmed there should not have been expired food on the shelves. S7Food Service Manager also confirmed the box of pastries should have been properly dated and labeled. In an interview on [DATE] at 9:50 a.m., S1Administrator confirmed there should not have been any expired food in the kitchen area. 2. In an interview on [DATE] at 12:21 p.m., S5Licensed Practical Nurse (LPN) indicated the Med Pass 2.0 nutritional supplement was already opened on Medication cart X when she arrived for her shift today at 7:00 a.m. S5LPN further indicated she was unaware of the time the Med Pass 2.0 nutritional supplement on medication cart X was opened. Observation on [DATE] at 12:53 p.m. revealed an opened unrefrigerated carton of Med Pass 2.0 nutritional supplement on medication cart X. Further observation revealed the carton had an opened date of [DATE] but did not indicate a time the carton was opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195509	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Wisdom Community Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Med Pass 2.0 nutritional supplement's directions revealed, in part, the product should be used within 4 hours of opening if not refrigerated. In an interview on [DATE] at 12:53 p.m., S5LPN confirmed the Med Pass 2.0 nutritional supplement on medication cart X had not been refrigerated. In an interview on [DATE] at 1:47 p.m., S2Director of Nursing (DON) confirmed the carton of Med Pass 2.0 nutritional supplement on medication cart X should have been labeled with a date and time the supplement was opened. S2DON further indicated the nursing staff should ensure the Med Pass 2.0 nutritional supplement was discarded 4 hours after being opened if not refrigerated. S2DON confirmed the opened and unrefrigerated Med Pass 2.0 nutritional supplement should not have been on medication cart X and available for use. 49753

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195509	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Wisdom Community Care Center	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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 46361 Based on record reviews, observations and interviews, the facility failed to ensure a resident's percutaneous endoscopic gastrostomy (PEG) tube (a tube that goes directly into the stomach to receive nutrition) feeding pole was in safe operating condition for 1 (Resident #46) of 3 (Resident #15, Resident #37, and Resident #46) sampled residents reviewed for environment. Findings: Review of Resident #46's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/28/2024 revealed, in part, Resident #46 was dependent on staff for all Activities of Daily Living (ADL's) and received all nutrition per PEG tube. Observation on 06/24/2024 at 09:50 a.m., revealed Resident #46 was in bed and Resident #46's PEG tube was attached to the feeding pump and pole which held a bag of formula and a bag of water. Further review revealed the PEG tube feeding pole, the feeding pump, and the bags of formula and water leaned to the side and swayed back and forth when touched. In an interview on 06/25/2024 at 11:11 a.m., S10CNA indicated broken equipment should be placed out of service. Observation on 06/25/2024 at 12:15 p.m. revealed Resident #46 was in bed and Resident #46's PEG tube was attached to the feeding pump and pole which held a bag of formula and a bag of water. Further review revealed the PEG tube feeding pole, the feeding pump, and the bags of formula and water leaned to the side and swayed back and forth when touched. Observation on 06/26/2024 at 10:45 a.m. revealed Resident #46 was in bed and Resident #46's PEG tube was attached to the feeding pump and pole which held a bag of formula and a bag of water. Further review revealed the tube feeding pole, the feeding pump, and the bags of formula and water leaned to the side and swayed back and forth when touched. Observation on 06/27/2024 at 1:45 p.m. revealed Resident #46 was in bed and Resident #46's PEG tube was attached to the feeding pump and pole which held a bag of formula and a bag of water. Further review revealed the tube feeding pole, the feeding pump, and the bags of formula and water leaned to the side at an angle and swayed back and forth when touched. In an interview on 06/27/2024 at 2:40 p.m., S2Director of Nursing (DON) confirmed Resident #46's PEG tube feeding pole leaned to the side significantly and should not have been leaning. S2DON further indicated the nursing staff should have removed Resident #46's PEG tube feeding pole. S2DON further indicated Resident # 46's PEG tube feeding pole was unstable and had the potential to fall over.