

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 06/25/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's pressure ulcer treatment plan was carried out in accordance with the resident's care plan and physician's orders for 1 (Resident #332) of 2 (Resident #87, Resident #332) sampled residents investigated for pressure ulcers.</p> <p>Findings:</p> <p>Review of Resident #332's clinical record revealed, in part, Resident #332 was admitted to the facility on [DATE].</p> <p>Review of Resident #332's physician order dated 06/18/2025 revealed, in part, an order for bilateral heel protectors while in bed.</p> <p>Review of Resident #332's Minimum Data Set with an Assessment Reference Date of 06/07/2025 revealed, in part, Resident #332 had a Brief Interview for Mental Status score of 13, which indicated Resident #332 was cognitively intact. Further review revealed Resident #332 was dependent on staff for lower body foot wear.</p> <p>Review of Resident #332's care plan created on 06/05/2025, revealed, in part, Resident #332 had a deep tissue injury to the bilateral heels and staff was to apply bilateral heel protectors while in bed.</p> <p>Review of Resident #332's electronic Medication Administration Record for June 2025 revealed, in part, no documented evidence heel protectors were applied to Resident #332's bilateral heels while in bed.</p> <p>Record review revealed there was no documented evidence, and the facility did not present any documented evidence, heel protectors were applied to Resident #332's bilateral heels while in bed as ordered.</p> <p>Observation on 06/23/2025 at 10:34AM revealed Resident #332 was lying in bed and bilateral heel protectors were not applied.</p> <p>Observation on 06/24/2025 at 9:40AM revealed, Resident #332 was lying in bed and bilateral heel protectors were not applied. Further observation revealed Resident #332's bilateral heel protectors were on a shelf in Resident #332's room.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/24/2025 at 9:42AM, Resident #332 indicated staff had not applied his bilateral heel protectors.</p> <p>Observation on 06/24/2025 at 1:40PM revealed Resident #332 lying in bed and bilateral heel protectors were not applied. Further observation revealed Resident #332's bilateral heel protectors were on a shelf on in Resident #332's room.</p> <p>In an interview on 06/25/2025 at 9:31AM, Resident #332 indicated the facility staff had not been putting his heel protectors on.</p> <p>In an interview on 06/24/2025 at 1:26PM, S2Director of Nursing (DON) indicated Resident #332 should have had bilateral heel protectors on as ordered.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interviews and record reviews, the facility failed to ensure medications were administered timely for 1 (Resident #3) of 4 (Resident #3, Resident #13, Resident #45, Resident #51) sampled residents interviewed for medication administration.</p> <p>Findings:</p> <p>Review of the facility's Medication Administration policy, revised April 2019, revealed, in part, medications are administered in accordance with the prescribers orders; and within 1 hour of the prescribed time, unless otherwise specified. Further review revealed the individual administering the medication records the date and time the medication was administered.</p> <p>Review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2025 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #3 was cognitively intact.</p> <p>Review of Resident #3's clinical record revealed, in part, a diagnoses of insomnia (insomnia is difficulty falling asleep or staying asleep).</p> <p>Review of Resident #3's June 2025 Physician Orders revealed, in part, Doxepin HCl (a medication used to treat insomnia) 10 milligram (mg) capsule take 3 capsules by mouth at bedtime.</p> <p>Review of Resident #3's June 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #3's Doxepin HCl was scheduled for administration at 8:00PM.</p> <p>Review of Resident #3's Care Plan, with a target date of 07/01/2025, revealed Resident #3 was on sedative / hypnotic therapy due to insomnia with a documented intervention to administer medications as ordered by the physician.</p> <p>In an interview on 06/24/2025 at 10:00AM, Resident #3 indicated she often does not get her sleeping pill on time and reported her sleeping pill was often not administered until 10:30PM.</p> <p>Review of Resident #3's medication administration audit report dated 06/01/2025 through 06/24/2025, with a run date of 06/24/2025 at 1:42PM Central Standard Time, presented to the surveyor by S2Director of Nursing (DON) revealed, in part, the following:</p> <p>06/05/2025: Doxepin HCL 30mg was administered at 12:13AM;</p> <p>06/06/2025: Doxepin HCL 30mg was administered at 9:47PM;</p> <p>06/09/2025: Doxepin HCL 30mg was administered at 9:36PM;</p> <p>06/13/2025: Doxepin HCL 30mg was administered at 9:45PM;</p> <p>06/14/2025: Doxepin HCL 30mg was administered at 2:32AM;</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>06/15/2025: Doxepin HCL 30mg was administered at 10:39PM;</p> <p>06/18/2025: Doxepin HCL 30mg was administered at 4:53AM;</p> <p>06/21/2025: Doxepin HCL 30mg was administered at 9:26PM;</p> <p>06/22/2025: Doxepin HCL 30mg was administered at 11:22PM; and,</p> <p>06/23/2025: Doxepin HCL 30mg was administered at 10:38PM.</p> <p>In an interview on 06/24/2025 at 2:50PM, S2DON confirmed the above documented administration times for Resident #3's Doxepin HCL 30mg revealed the medication was administered to Resident #3 more than 1 hour after the scheduled time of 8:00PM, and should not have been.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and interviews, the facility failed to maintain a clean and sanitary environment for 1 (Hall B Mini Pantry) of 3 (Hall A Mini Pantry, Hall B Mini Pantry, Hall C Mini Pantry) of 3 Mini Pantries observed.</p> <p>Findings:</p> <p>Review of the 2022 Food Code United States Food and Drug Administration revealed, in part, heating and air conditioning system vents that are not properly designed and located may be difficult to clean and result in the contamination of food, food preparation surfaces, equipment, or utensils by dust or other accumulated soil from the exhaust vents.</p> <p>Observation of the Hall B Mini Pantry 9:40AM revealed, in part, a portable electric fan with an accumulation of a light gray unknown substance on the fan's grill.</p> <p>In an interview on 06/23/2025 at 9:45AM, S4Food Safety Manager confirmed there was an accumulation of a light gray unknown substance on the portable electric fan's grill in the Hall B Mini Pantry. S4Food Safety Manager further indicated the portable electric fan in the Hall B Mini Pantry should have been kept in a clean and sanitary manner.</p> <p>In an interview on 06/25/2025 at 10:00AM, S1Administrator indicated the portable electric fan in the Hall B Mini Pantry should have been kept in a clean and sanitary manner.</p>		