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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195526	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare of Hammond	1300 Derek Drive Hammond, LA 70403

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46981 Based on observation, record review, and interview, the facility failed to ensure all complaint surveys since the last annual survey were available for resident review. This deficient practice had the potential to affect the 88 residents who currently resided in the facility. Findings: An observation was made on 02/24/2025 at 9:45 a.m. of the facility's folder Survey results located on the bulletin board of the facility. Review of the Survey results folder revealed the last survey posted in the binder was dated 06/07/2024. Further review revealed no documented evidence of the survey results from complaint survey dated 11/13/2024 for review. An interview was conducted on 02/24/2025 at 9:45 a.m. with S1ADM. She reviewed the facility's folder Survey results. She confirmed the only survey results located in the folder was the annual recertification survey dated 06/07/2024. She confirmed the survey results from complaint survey dated 11/13/2024 were not located in the folder.

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on observations, interviews, and record review, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure oxygen was administered as ordered by the physician for 1 (#3) of 2 (#2 and #3) residents reviewed for oxygen therapy. Findings: Review of Resident #3's clinical record revealed resident was admitted to the facility on [DATE] with diagnoses, which included Congestive Heart Failure and Chronic Respiratory Failure. Review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2025 revealed he had a BIMS of 14, which indicated Resident #3 was cognitively intact. Review of Resident #3's February 2025 Physician Orders revealed the following: 01/24/2025: Oxygen at 2 Liters (L) via nasal cannula. On 02/25/2025 at 9:45 a.m., an observation was made of Resident #3 resting in his bed with no oxygen in use. At that time an interview was conducted with Resident #3. He stated he did not wear oxygen and never had since living at the facility. On 02/25/2025 at 11:45 a.m., an interview was conducted with S3LPN. S3LPN reviewed the current Physician's orders for Resident #3. S3LPN confirmed Resident #3 had an active order to administer 2L of O2 via nasal cannula. S3LPN confirmed she failed to follow the Physician's order to administer 2L O2 via nasal cannula for Resident #3. On 02/25/2025 at 12:23 p.m., an interview was conducted with the S2DON. S2DON reviewed Resident #3's active Physician Orders and confirmed he had an order for 2L of O2 nasal cannula. S2DON stated nursing staff did not follow the current Physician Orders for Resident #3 and should have.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on record review and interview, the facility failed to ensure accurate weekly skin assessments were completed for 2 (#2 and #3) of 2 sampled residents. The deficient practice had the potential to affect any of 88 residents residing in the facility. Findings: Resident #2 Review of Resident #2's clinical record revealed resident was admitted to the facility on [DATE]. Review of Resident #2's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/2025 revealed she had a risk of pressure ulcers. Review of Resident #2's current Physician Orders revealed the following: 12/31/2024: Weekly Body Audit. Resident #3 Review of Resident #3's clinical record revealed resident was admitted to the facility on [DATE]. Review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2025 revealed he had a risk of pressure ulcers. Review of Resident #3's current Physician Orders revealed the following: 01/24/2025: Weekly Body Audit. On 02/24/2025 at 1:45 p.m., an interview was conducted with S3LPN. She stated she was required to perform weekly skin audits for Resident #2 and Resident #3. She stated when she conducted weekly skin audits she only assessed the skin which was visible to her eyes and not under any clothing. She stated it was up to the CNA or shower aid to report any skin breakdown in the area covered by clothing. On 02/24/2025 at 4:15 p.m., an interview was conducted with S2DON. She stated weekly skin audits were the responsibility of the LPN caring for the resident. She stated education was provided upon hire on how to conduct complete skin audits. She stated educated provided on skin audits included how to check the residents' cracks and crevices, behind the ears, and etc., but that she did not realize that some nurses did not understand that they should be checking even the big areas of skin located under clothing. She stated she expected the assigned nurse to assess all skin, including under clothing, and document on the MAR.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on interviews and record review, the facility failed to maintain accurate documentation for 2 (#1 and #3) of 3 (#1, #2, and #3) sampled residents. The facility failed to ensure: 1. Resident #1's daily wound care was accurately documented; and 2. Resident #3's oxygen use was accurately documented. Findings: Resident #1 Review of Resident #1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses, which included Unspecified Fracture of Left Femur, Subsequent Encounter For Closed Fracture with Routine Healing. Review of Resident #1's December 2024 - January 2025 Physician Orders revealed in part, the following: Clean surgical incision to left hip with normal saline/wound cleanser, pat dry, apply dry dressing of choice daily and as needed until healed, start date: 12/18/2024. Review of Resident #1's January 2025 TAR (Treatment Administration Record) revealed in part, the following: Wound care to surgical incision wound on 01/01/2025 was blank. An interview was conducted on 02/24/2025 at 2:00 p.m. with S4LPN. She reviewed Resident #1's January 2025 TAR. She confirmed the TAR was blank for 01/01/2025 wound care on Resident #1's surgical incision wound and should have been filled out. An interview was conducted on 02/24/2025 at 3:05 p.m. with S2DON. She reviewed Resident #1's January 2025 TAR. She confirmed the TAR was blank for 01/01/2025 wound care on Resident #1's surgical incision wound and should have been filled out. Resident #3 Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Chronic Respiratory Failure. Review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2025 revealed he had a BIMS of 14, which indicated he was cognitively intact. Review of Resident #3's current active Physician Orders revealed in part, the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxygen at 2L via nasal cannula, start date 01/24/2025. Review of Resident #3's February 2025 MAR (Medication Administration Record) revealed Oxygen at 2L via nasal cannula was documented as administered by S3LPN on 02/04/2025, 02/05/2025, 02/06/2025, 02/12/2025, 02/13/2025, 02/18/2025, 02/19/2025, 02/20/2025, and 02/24/2025. An observation was made on 02/25/2025 at 9:45 a.m. of Resident #3 with no oxygen in use. At that time an interview was conducted with Resident #3. He stated he did not wear oxygen and never had since living at the facility. An interview was conducted on 02/25/2025 at 11:45 a.m. with S3LPN. She reviewed the February 2025 MAR for Resident #3 and confirmed she had documented Resident #3 receiving Oxygen at 2L via nasal cannula on the following dates: 02/04/2025, 02/05/2025, 02/06/2025, 02/12/2025, 02/13/2025, 02/18/2025, 02/19/2025, 02/20/2025, and 02/24/2025. She confirmed Resident #3 did not use Oxygen at 2L via nasal cannula, and she had documented in error. An interview was conducted on 02/25/2025 at 12:23 p.m. with S2DON. She stated she expected staff to document completed medications/treatments on the MAR. She confirmed staff should not document administering medications or treatments if it had not been completed/performed. 47173