

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Healthcare of Hammond		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure residents with Pressure Ulcers received care consistent with professional standards of practice by failing to ensure: 1. The nurse documented the date and their initials on the dressings of each treatment performed for 2 (#3 and #4) of 4 (#3, #4, #5, and #6) residents reviewed with Pressure Ulcers; and 2. The nurse applied dressings large enough to fully cover and protect the wounds for 1 (#4) of 4 (#3, #4, #5, and #6) residents reviewed with Pressure Ulcers. Findings: Review of the facility's Wound Care Policy and Procedure, effective 11/26/2014, revealed, in part, the following: Treatment Orders: After observation/evaluation of the affected skin area, implement standing orders. Applying Treatment: 1. Date and Initial each Dressing Nursing Interventions: 1. Local Care a. Cleansing and dressing as ordered and appropriate 2. Keep resident clean and dry Resident #3 Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Pressure Ulcer, Unspecified Stage, Bacterial Infection, Spastic Quadriplegic, and Cerebral Palsy. Review of Resident #3's Current Physician Orders revealed the following: Start date- 09/02/2025. Pressure ulcer right anterior hip clean with normal saline/wound cleanser, pat dry apply Dakin soaked dressing, apply barrier of choice, and cover with clean dry dressing daily. Start date- 09/08/2025. Pressure Ulcer to left hip to sacral clean with normal saline/wound cleanser, pat dry apply medical/honey, apply barrier of choice, and cover with clean dry dressing daily. An observation was conducted on 09/08/2025 at 08:55 a.m. of Resident #3's sacrum dressing not fully covering pressure wound area. An observation was conducted on 09/08/2025 at 10:30 a.m. of Resident #3's dressings to the bilateral heels, sacrum, and right ischium. The dressings were observed without the date the treatment was performed or the initials of the person who performed the treatment. An observation and interview was performed on 09/08/2025 at 11:20 a.m. with S6LPN. S6LPN confirmed she was the facility's Wound Treatment Nurse and performed wound treatments Monday through Friday. S6LPN confirmed she did not perform Resident #3's wound treatment on 08/06/2025 or 08/07/2025 and was not aware who served as the treatment nurse on those dates. S6LPN confirmed Resident #3's dressings did not contain the date the treatment was performed or the initials of the person who performed the treatment, and should have. S6LPN confirmed this information was important to have on the dressing to indicate it was performed on time as ordered and to be used as a point of reference to determine the amount of drainage present from a specific timeframe. An interview was conducted with S11CNA on 09/08/2025 at 11:30 a.m. S11CNA confirmed Resident #3's dressing did not have date and initials on dressing prior to being removed. Resident #4 Review of Resident #4's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis which included Pressure Ulcer of Sacral Region, Stage 4. Review of Resident #4's Current Physician Orders revealed the following: Start date- 09/02/2025. Pressure ulcer to sacral wound area- clean with normal saline/wound cleanser pat dry apply mesalt and calcium alginate apply barrier of choice and cover with clean dry dressing daily. An observation was conducted on 09/08/2025 at 10:40 a.m. of Resident #4's dressing to the sacrum. The dressing did not extend past the edges of the wound, leaving a 3 inch x 3 inch portion of her sacral wound open to air with no protective covering. Observation also revealed the dressing did not contain the date the treatment was performed or the initials of the person who performed it. An observation and interview was performed on 09/08/2025 at 11:20 a.m. with S6LPN. S6LPN confirmed Resident #4's sacral dressing did not extend beyond the edges of her wound which left an area 3 inches x 3 inches exposed to contaminants and this should not happen. S6LPN confirmed all wounds with orders to cover with a dressing should have a dressing in place which extended beyond the edges of the wound to fully cover it and prevent anything from coming in contact with the wound. S6LPN further confirmed Resident #4's dressing did not contain the date the treatment was performed or the initials of the person who performed the treatment and should have. An interview was conducted on 09/09/2025 at 10:30 a.m. with S7NP. S7NP confirmed Residents #3 and #4 had orders to keep pressure ulcer wound covered. S7NP confirmed importance of wound dressings to be dated and timed to determine the amount of drainage present at a specific timeframe. S7NP confirmed if the treatment order called for the wound to be covered with a dressing, she expected the dressing to be large enough to fully cover wound, leaving no openings to air or exposure to contaminants. S7NP confirmed leaving a wound open to air that should be covered greatly increased the risk of the wound becoming infected and should not occur. An interview was conducted on 09/10/2025 at 2:47 p.m. with S2DON S2DON</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, and interviews, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (#4) of 2 (#4 and #R1) residents reviewed for enteral feedings. The facility failed to ensure the enteral feeding bag was appropriately labeled with a date, time, and nurse initials. Based on record review, observations, and interviews, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (#4) of 2 (#4 and #R1) residents reviewed for enteral feedings. The facility failed to ensure the enteral feeding bag was appropriately labeled with a date, time, and nurse initials. Findings: Review of the facility's policy titled, Enteral Nutritional Therapy, dated 01/14/2016 revealed the following: Enteral Nutritional Therapy is to be given as ordered by the physician. 11. Change formula container per facility procedure. Review of the clinical record for Resident #4 revealed she was re-admitted to the facility on [DATE] (original admission date to facility 12/18/2020) with diagnoses which included Gastrostomy Status. Review of the current Physician Orders for Resident #4 revealed, in part, the following: Start date: 05/30/2025 - Enteral Nutrition via feeding pump- Diabetisource via Peg (percutaneous enteral gastrostomy) at 60 ml (milliliter) per hour continuous secondary to dysphagia. Start date: 09/12/2024 - Closed system container- Change feeding administration set with each new bottle; label the formula container, syringe, and administration set with the resident's name, date, time, and nurse's initials. An observation was made on 09/08/2025 at 10:15 a.m. of Resident #4. Resident #4's enteral feeding solution was infusing at 60 ml/hour with no labeling of date, time or nurse initials noted on the formula container. An interview was conducted on 09/08/2025 at 10:40 a.m. with S5LPN. S5LPN confirmed Resident #4's hanging bag of enteral feeding should have been labeled with a date, time, and nurse's initials and was not. An interview was conducted on 09/10/2025 at 2:20 p.m. with S2DON. S2DON confirmed an enteral feeding bag should be labeled with the date, time, and nurse's initials at the start of infusion. An interview was conducted on 09/10/2025 at 2:25 p.m. with S1ADM. S1ADM confirmed expectation was for staff to follow physician orders and facility policy for administration of enteral feedings.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews, the facility failed to ensure there was sufficient numbers of direct care staff to provide timely assistance with baths/showers for 4 of 4 (#5, #8, #9, and #10) residents reviewed for baths/showers. This deficient practice had the potential to affect any of the 81 residents residing in the facility. Findings: Review of the facility's Bath, Shower Policy and Procedure, effective 09/04/2014, revealed, in part, the following:Policy: Showers are to be given as scheduled and/or as needed. Procedure: NOTE: Never leave the resident alone in the shower room. Review of the facility's Resident Council Meeting Minutes, dated 09/09/2025, revealed, in part, Resident #5, #8, #9, and #10 participated in the meeting. Further review revealed the residents in attendance agreed the new bath/shower process was not working and no one received their baths/showers at their scheduled times. An observation was conducted on 09/09/2025 at 8:25 a.m. of Resident #8 and 2 other residents, seated in wheelchairs in the hallway outside of the bath/shower room waiting to receive their bath/shower. An observation was conducted on 09/09/2025 at 9:05 a.m. of Resident #8 and the same 2 residents, seated in wheelchairs in the hallway outside of the bath/shower room waiting to receive their bath/shower. An observation was conducted on 09/09/2025 at 9:35 a.m. of Resident #8, #10, and one other resident seated in wheelchairs in the hallway outside of the bath/shower room waiting to receive their bath/shower. An observation was conducted on 09/09/2025 at 9:45 a.m. Resident #8 and #10, and one other resident seated in wheelchairs in the hallway outside of the bath/shower room waiting to receive their bath/shower. Resident #5Review of Resident #5's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included, in part, Unspecified Congestive Heart Failure (CHF).Review of Resident #5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/2025, revealed, in part, a BIMS of 14, which indicated she was cognitively intact. Review of Resident #5's Plan of Care, as of 08/06/2025, revealed, in part, the following:Resident required staff assistance for ADL care. Resident required limited to moderate assistance with ADL's. Resident needs met per herself and staff.Interventions:Assist resident with bathing.An interview was conducted on 09/10/2025 at 8:35 a.m. with Resident #5. Resident #5 stated she had to clean herself up in her sink in the mornings when her CNA was not available to give her a bath/shower. She stated the facility had a bath/shower situation and she was not receiving regular baths or was having to wait hours for a bath/shower. She stated there were not enough CNAs to get everything done. Resident #8Review of Resident #8's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included, in part, Chronic Obstructive Pulmonary Disorder (COPD), Severe Morbid Obesity, Generalized Muscle Weakness, Abnormalities of Gait and Mobility, and Hidradenitis Suppurativa (HS). Review of Resident #8's quarterly MDS with an ARD of 07/30/2025, revealed, in part, the resident was assessed by the facility to have a BIMS of 15, which indicated he was cognitively intact. Review of Resident #8's Plan of Care, as of 09/10/2025, revealed, in part, the following:Resident diagnosed with HS.Resident required staff assistance for ADL care.Resident required limited to extensive assistance with ADL's. Resident needs met per himself and staff.Interventions:Assist resident with bathing.An observation and interview was conducted on 09/09/2025 at 9:10 a.m. with Resident #8 in line outside of the bath/shower room. He stated he had a skin condition, HS, which required him to take a bath/shower first thing every morning to prevent further outbreak and control the odor it caused. He confirmed he got in line for his bath/shower this morning a little after 8:00 a.m. and was still waiting. He stated he was the Resident Council President and called a meeting today due to resident complaints of long wait times for baths/showers since the facility no longer utilized Shower Aides. He stated almost two weeks ago the facility removed 2 shower aides from the daily assignments Monday through Friday. He stated since that time, he had waited in excess of two to three hours each morning to receive his daily bath. He stated there was almost never less than three residents waiting in line in the hallway for a bath/shower. He confirmed he required staff assistance to take his bath/shower and could not perform the task independently. He confirmed he had missed some activities within the facility because he was waiting in line to receive his bath. He confirmed the facility's Administration was aware of the delays and had not done anything to improve it. Resident #8 stated he blamed the facility for not having enough staff.An interview was conducted on 09/09/2025 at 10:30 a.m. with S7NP. S7NP confirmed due to Resident #8's diagnosis of HS, he had numerous open lesions on his body which caused a noticeable odor. S7NP confirmed Resident #8 required a bath first thing every morning 7 days a week to remove the bacteria on his</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, interviews, and record reviews, the facility failed to have a measurable evaluation system in place to ensure nursing staff were trained and competent to perform wound treatments as ordered prior to being allowed to independently perform them. This deficient practice was evidenced by failure to ensure: 1. The nurse documented the date and their initials on the dressing of each treatment performed for 1 (#3 and #4) of 4 (#3, #4, #5, and #6) residents present in the facility who were reviewed for wounds; and 2. The nurse applied a dressing large enough to fully cover and protect the wound for 1 (#4) of 4 (#3, #4, #5, and #6) residents present in the facility who were reviewed for wounds. This deficient practice had the potential to affect any of the facility's 31 wounds with active treatment orders. Findings: Review of the facility's Wound Care Policy and Procedure, effective 11/26/2014, revealed, in part, the following: Treatment Orders: After observation/evaluation of the affected skin area, implement standing orders. Applying Treatment: 1. Date and Initial each Dressing Nursing Interventions: 1. Local Care a. Cleansing and dressing as ordered and appropriate 2. Keep resident clean and dry Review of the facility's Staff Assignments, dated 09/06/2025 through 09/07/2025, revealed, in part, the following: 09/06/2025 (Saturday): Wound Treatment Nurse - S4MDS; and 09/07/2025 (Sunday): Wound Treatment Nurse - S4MDS. Review of S4MDS's Personnel File revealed she was a Licensed Practical Nurse who was hired to work at the facility on 09/27/2018 and currently served as the facility's Minimum Data Set (MDS) and Care Plan Nurse. Review of S4MDS's Annual Training and Competency Evaluation, dated 08/29/2025, revealed, in part, S3SD initialed indicating she observed S4MDS perform the following tasks with competency demonstrated: Skin Integrity Program - Treatments and Documentation. 1. An observation was conducted on 09/08/2025 at 10:30 a.m. of Resident #3's dressings to the bilateral heels, sacrum and right ischium. The dressings were observed without the date treatment was performed and/or the initials of the person who performed the treatment. An observation and interview was performed on 09/08/2025 at 11:20 a.m. with S6LPN. S6LPN confirmed she was the facility's Wound Treatment Nurse and performed wound treatments Monday through Friday. S6LPN confirmed the facility utilized various nursing staff from all areas of the facility to perform treatments on Saturdays and Sundays and the person performing them varied from week to week. S6LPN confirmed she did not perform Resident #3's wound treatment on 09/06/2025 or 09/07/2025 and was not aware who served as the treatment nurse on those dates. S6LPN confirmed she did not conduct any training or evaluation of competency in regards to wound treatments for floor nurses or the nurses who filled in as Weekend Treatment Nurse. S6LPN confirmed Resident #3's dressings did not contain the date the treatment was performed and/or the initials of the person who performed the treatment and should have. S6LPN confirmed this information was important to have on the dressing to indicate it was performed on time as ordered and to be used as a point of reference to determine the amount of drainage present from a specific timeframe. 2. An observation was conducted on 09/08/2025 at 10:40 a.m. of Resident #4's dressing to the sacrum. The dressing did not extend past the edges of the wound, leaving a 3inch x 3 inch portion of her sacral wound open to air with no protective covering. The dressing did not contain the date the treatment was performed and/or the initials of the person who performed it. An observation and interview was performed on 09/08/2025 at 11:20 a.m. with S6LPN. S6LPN confirmed she did not perform Resident #4's wound treatment on 09/06/2025 or 09/07/2025 and was not aware who did. S6LPN confirmed Resident #4's sacral dressing did not extend beyond the edges of her wound which left an area 3 inches x 3 inches exposed to contaminants and this should not happen. S6LPN confirmed all wounds with orders to cover with a dressing should have a dressing in place which extended beyond the edges of the wound to fully cover it and prevent anything from coming in contact with the wound. S6LPN confirmed Resident #4's dressing did not contain the date the treatment was performed and/or the initials of the person who performed the treatment and should have. An interview was conducted on 09/09/2025 at 8:50 a.m. with S4MDS. S4MDS confirmed she was the facility's MDS and Care Plan Nurse but due to the facility no longer utilizing agency staff, the administrative nurses were assigned to be on-call to cover shifts at least 5 days a month and could be called in to work direct care when and where they were needed. S4MDS confirmed when she arrived to start her shift on 09/06/2025, she thought she would be working as a floor nurse on 09/06/2025 and 09/07/2025 but was told she would be performing wound treatments. S4MDS confirmed she had never been a Wound Treatment Nurse and prior to 09/06/2025, she had not performed wound treatments in over a year. S4MDS confirmed on 09/06/2025 after she found out she would be performing wound treatments she printed the</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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A Self-Administration of Medication Assessment will be completed as indicated. 2. Interdisciplinary Team (IDT) will review assessment and determine if resident is safe to administer medication. 3. IDT will determine who will be responsible (resident or nursing staff) for storage and documentation of the administration of drugs, as well as the location of the drug administration. 1. If resident is deemed safe: a. Physician order will be written b. Nursing will monitor weekly and as needed. 2. Care plan will be updated. Equipment: 1. Self-Administration of Medication Assessment 2. High Risk Meeting 3. Care Plan An observation was conducted 09/08/2025 at 8:40 a.m. of Resident #2's Albuterol Sulfate Inhaler lying on the bedside table next to her bed with no staff present. Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with Chronic Obstructive Pulmonary Disorder (COPD); Cognitive Communication Deficit; Lack of Coordination; Weakness; and a Disorder of Brain. Review of Resident #2's Quarterly Minimum Data Set (MDS) with a modification Assessment Record Date (ARD) of 06/25/2025 revealed she was assessed by the facility to have a Brief Interview of Mental Status (BIMS) of 15 which indicated she was cognitively intact. Further review of Section G - Functional Status revealed, in part, the following: Eating: Supervision or touching assistance; Oral Hygiene: Partial/Moderate Assistance; Toileting: Substantial/Maximal Assistance; Shower/Bathe: Substantial/Maximal Assistance; Dressing: Substantial/Maximal Assistance; Footwear: Dependent. Review of Resident #2's active Physician Orders, as of 09/08/2025 at 9:50 a.m., revealed no active orders for Resident #2 to self-administer medications or to have medications left at bedside. Further review revealed, in part, an order written on 06/03/2024 for Albuterol Sulfate Inhaler 108 micrograms (mcg)/actuation (act). Inhale 2 puffs every 6 hours as needed for wheezing related to COPD. Review of Resident #2's Care Plan, as of 09/08/2025 at 9:53 a.m., revealed she was not currently care planned to self-administer medications or to have medications left at bedside. Review of Resident #2's MAR, dated 08/01/2025 through 09/08/2025, revealed, in part, no documented evidence of Resident #2's Albuterol Sulfate Inhaler being administered at any time during the aforementioned period. An interview and observation was conducted on 09/08/2025 at 8:42 a.m. with S5LPN. S5LPN confirmed Resident #2's Albuterol Sulfate Inhaler was left unattended on her bedside table in her room. S5LPN confirmed Resident #2 did not have an order for the inhaler to remain at bedside or to self-administer her own medications. S5LPN confirmed an assessment for safe self-administration of medications was required for a resident to have medications left at bedside and Resident #2 had not received this assessment. S5LPN confirmed a physician's order was also required for a resident to keep medications at bedside in order to self-administer and Resident #2 did not have such an order. S5LPN confirmed Resident #2's medications should remain locked in the medication cart at all times when a nurse was not actively administering it to the resident. S5LPN reviewed Resident #2's Medication Administration Record (MAR) and confirmed the last time a nurse documented administering her Albuterol Sulfate Inhaler was in July 2025. S5LPN confirmed the MAR documentation could not be accurate because Resident #2 required frequent use of her inhaler to treat her shortness of breath. An interview was conducted on 09/10/2025 at 2:30 p.m. with S2DON. S2DON confirmed any resident who wished to self-administer their own medications and have them left at bedside would require an assessment to determine if they were safe to do so along with a physician's order indicating they were approved to self-administer medications and if they were allowed to have the medication left at bedside. S2DON confirmed Resident #2 had not been assessed for safe self-administration of medications and did not have a physician's order to self-administer so her Albuterol Sulfate Inhaler should not have been left at bedside. S2DON confirmed Resident #2's medications should remain locked in the medication cart at all times when a nurse was not actively administering it to her. S2DON confirmed even when a resident was allowed to self-administer the date/time</p>		