

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|---|---|
| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48912</p> <p>Based on record review and interviews, the facility failed to initiate and resolve grievances voiced for 1 (#17) of 33 sampled residents reviewed for grievances.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Grievance Policy and Procedure, dated 10/10/2022 revealed the following, in part:</p> <p>Follow Up/Resolution:</p> <p>1. The grievance official/compliance liaison or designee will follow up with the complainant with a resolution within 5 business days of the date that the grievance was filed.</p> <p>Review of Resident #17's Admission MDS with an ARD of 03/18/2024 revealed BIMS of 14 which indicated she was cognitively intact. Further review revealed she was dependent on staff for bathing.</p> <p>Review of the Completed Care record dated 04/01-04/31/2024 revealed Resident #17 only had a bath on 04/04/2024 and 04/15/2024. Completed Care Record dated 05/01-05/31/2024 revealed Resident #17 only had a bath on 05/08/2025 and 05/22/2023.</p> <p>Review of the facility's grievance logs dated December 2023-current revealed on 04/03/2024 Resident #17 had a complaint for nursing. Further review revealed, Resident #17 stated she had not had a bath in 5 days. Corrective Action: Immediately after making this statement to a staff member the bath aid entered the room and performed a complete bed bath.</p> <p>On 06/05/2024 at 8:18 a.m., an observation and interview was conducted with Resident #17. Resident #17 appeared unkempt, dandruff was around perimeter of her head and in hair, her hair was oily, and her skin was noted to be flaky and dry. Resident #17 stated it had been seven days since she had a bath or had her hair washed. Resident #17 stated prior to this stint of no baths it was five days before she had her last bath.</p> <p>On 06/05/2024 at 8:49 a.m., an interview was conducted with S6ADON. She stated Resident #17 did complain in April of not getting bathed. She stated she bathed Resident #17 herself. S6ADON confirmed she did not have anything in place to prevent the occurrence from happening again.</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 |
|---|-------|-----------|

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50093</p> <p>Based on interviews and record review, the facility failed to ensure a resident's assessment accurately reflected the resident's status for 1 (#10) of 33 residents reviewed in the final sample.</p> <p>Findings:</p> <p>Review of the facility's policy MDS Policy and Procedure, with an effective date of 6/25/2015, revealed, in part, the following:</p> <p>Policy:</p> <p>All MDS are to be completed and transmitted according to the most current Resident Assessment Instrument (RAI) manual.</p> <p>Procedure:</p> <p>The Interdisciplinary Team will assess the resident and document during the 7 day look back and accurately complete the MDS according to the RAI manual.</p> <p>Review of Resident #10's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed Resident #10 had a diagnosis of Localized Edema with an onset date of 08/23/2011.</p> <p>Review of Resident #10's current Physician Orders revealed the following:</p> <p>Start Date: 02/19/2024</p> <p>Lasix 40 mg tablet by mouth daily for localized edema</p> <p>Review of Resident #10's MAR for March 2024, April 2024, May 2024, and June 2024 revealed, in part, Resident #10 received Lasix 40 mg by mouth daily as prescribed.</p> <p>Review of Resident #10's Quarterly MDS with an ARD of 05/15/2024 revealed Localized Edema was not coded as an active diagnosis in Section I.</p> <p>An interview was conducted on 06/07/2024 at 1:45 p.m. with S10MDS. S10MDS confirmed Resident #10's MDS with an ARD of 05/15/2024 was not coded for the diagnosis of Localized Edema. S10MDS also confirmed Resident #10's MDS should have been coded for the diagnosis of Localized Edema since it was an active diagnosis and she was receiving medication for it.</p> <p>An interview was conducted on 06/07/2024 at 2:00 p.m. with S2DON. She stated if a resident had an active diagnosis in which they were receiving medication for, the MDS should have been coded for the diagnosis.</p> |  |  |

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
|--|--|
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50093</p> <p>Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered care plan to meet the needs of 1 (#1) of 33 residents reviewed in the final sample. The facility failed to develop a care plan with interventions for a resident with diabetes who frequently refuses blood glucose monitoring.</p> <p>Findings:</p> <p>Review of the facility's policy Care Plan Policy and Procedure, with an effective date of 05/22/2017, revealed, in part, the following:</p> <p>Policy:</p> <p>A comprehensive plan of care will be used to communicate and address care issues that are relevant to the resident's individual needs.</p> <p>Procedure:</p> <p>4. The care plan will be revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving.</p> <p>6. Consider:</p> <p>f) Respecting the resident's right to decline treatment.</p> <p>Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus with Unspecified Complications and Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified.</p> <p>Review of Resident #1's current Physician's Orders revealed the following, in part:</p> <p>(Start date: 08/21/2023) Accu Check ACHS cover with Humalog 100 unit/ml Kwikpen per sliding scale.</p> <p>Review of Resident #1's MAR for March 2024, April 2024, and May 2024, revealed Resident #1's Accu Checks were not administered at 6:00 a.m. on the following dates: 03/03/2024, 03/08/2024, 03/09/2024, 03/10/2024, 03/11/2024, 03/12/2024, 03/13/2024, 03/14/2024, 03/15/2024, 03/16/2024, 03/17/2024, 03/22/2024, 03/29/2024, 03/30/2024, 04/03/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/10/2024, 04/12/2024, 04/13/2024, 04/14/2024, 04/19/2024, 04/20/2024, 04/22/2024, 04/26/2024, 04/27/2024, 04/28/2024, 04/29/2024, 05/03/2024, 05/04/2024, 05/05/2024, 05/06/2024, 05/10/2024, 05/11/2024, 05/12/2024, 05/14/2024, 05/17/2024, 05/18/2024, 05/19/2024, 05/20/2024, 05/24/2024, 05/25/2024, and 05/26/2024.</p> <p>(continued on next page)</p> |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #1's MAR for March 2024, April 2024, and May 2024, revealed Resident #1's Accu Checks were not administered at 11:00 a.m. on the following dates: 03/07/2024, 03/08/2024, 03/11/2024, 03/12/2024, 03/13/2024, 03/17/2024, 03/21/2024, 03/22/2024, 03/28/2024, 04/19/2024, 05/03/2024, 05/10/2024, 05/16/2024, 05/17/2024, 05/23/2024, 05/24/2024, 05/30/2024, and 05/31/2024.</p> <p>Further review of Resident #1's detailed Administration Record revealed documentation of Resident #1's Accu Checks not being administered on all of the above dates and times in March 2024, April 2024, and May 2024 due to being refused by Resident #1.</p> <p>Review of Resident #1's Care Plan revealed no care plan developed related to Resident #1's refusals of Accu Checks.</p> <p>On 06/06/2024 at 5:25 p.m., an interview was conducted with S10MDS nurse. She confirmed she was responsible for updating residents' care plans. She stated morning meets are held to discuss changes in residents' behavior. She stated if a resident requires a care plan change based on information received in the morning meeting, she will update the care plan. She stated she does not recall if Resident #1's frequent refusal of Accu Checks were discussed in daily morning meetings. She confirmed Resident #1 did not have a care plan developed for frequent refusals of Accu Checks. She stated she was not aware of Resident #1's frequent refusals of Accu Checks. She confirmed Resident #1 should have had a care plan developed for frequent refusals of Accu Checks.</p> <p>On 06/06/2024 at 5:50 p.m., an interview was conducted with S2DON. She stated morning meets are held to discuss changes in residents' behavior. She stated if a resident requires a care plan change based on information received in the morning meeting, S10MDS will update the care plan. She stated Resident #1's frequent refusals of Accu Checks have been discussed in daily morning meetings with S10MDS nurse was present and aware of this. She confirmed Resident #1 did not have a care plan developed for refusals of Accu Checks and Resident #1 should have had a care plan developed for refusals of Accu Checks.</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48912</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure resident's received the necessary services to maintain personal hygiene for 1 (#17) of 2 (#17 and #45) residents reviewed for Activities of Daily Living.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Bath, Tub Policy and Procedure, dated 09/04/2014 revealed the following, in part:</p> <p>Policy: Tub Baths are to be given as scheduled and/or as needed.</p> <p>Procedure:</p> <p>5. Assist resident into tub and assist with bath as needed.</p> <p>Review of the facility's policy titled, Bath, Shower Policy and Procedure, dated 09/04/2014 revealed the following, in part:</p> <p>Policy: Showers are to be given as scheduled and/or as needed.</p> <p>Procedure:</p> <p>1. Place resident in shower chair and cover with appropriate drape.</p> <p>4. Wash face and shampoo hair; rinse well.</p> <p>Review of Resident #17's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Morbid Obesity and Chronic Diastolic Heart Failure.</p> <p>Review of Resident #17's Admission MDS with an ARD of 03/18/2024 revealed BIMS of 14 which indicated she was cognitively intact. Further review revealed Resident #17 required substantial/maximum assistance with bathing.</p> <p>On 06/05/2024 at 10:00 a.m., an interview was conducted with S1NFA. She provided April and May 2024 Completed Care AHT bath logs for Resident #17. She stated these are from April 1st-30th and May 1st-31st. S1NFA confirmed these were the reports for the entire month and the only documentation she had.</p> <p>Review of the Completed Care record dated 04/01/2024-04/31/2024 revealed Resident #17 received baths on 04/04/2024 and 04/15/2024. Completed Care Record dated 05/01/2024-05/31/2024 revealed Resident #17 received baths on 05/08/2025 and 05/22/2023.</p> <p>(continued on next page)</p> |  |  |

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
|--|--|
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 06/05/2024 at 8:18 a.m., an observation and interview was conducted with Resident #17. Resident #17 observed to be unkempt with oily hair, dandruff around the perimeter of her head and in her hair, and her skin noted to be flaky and dry. Resident #17 stated it had been seven days since she had a bath or had her hair washed. Resident #17 stated prior to this stent of no baths it was five days before she had her last bath. She confirmed her bath days were Mondays, Wednesdays, and Fridays. She stated she normally washed her hair twice a week and would like her hair washed a minimum of two times a week. She stated she preferred to be bathed via showers or whirlpool over a bed bath.</p> <p>On 06/05/2024 at 8:49 a.m., an interview was conducted with S6ADON. She stated Resident #17 had difficulty getting in the shower chair and the bath aide needed assistance getting her on the shower chair on bath days. She confirmed Resident #17 was supposed to be bathed on Mondays, Wednesdays, and Fridays. S6ADON confirmed no accommodations were made.</p> <p>On 06/05/2024 at 10:49 a.m., an interview was conducted with S8CNA. She stated she did not provide showers for Resident #17 because she had difficulty getting her on a shower chair, so she gave her bed baths. She stated she could shower Resident #17 if she had assistance, but often times there was no one available to help her. She confirmed there were times Resident #17 did not receive a shower or bed bath before the end of her shift and should have.</p> |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48872</p> <p>48912</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards of practice. The facility failed to ensure oxygen tubing was labeled for 2 of 2 (#5, and #17) residents reviewed for oxygen therapy.</p> <p>Findings:</p> <p>Resident #5</p> <p>Review of Resident #5's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Obstructive Sleep Apnea.</p> <p>Review of the Quarterly MDS with an ARD of 03/20/2024 revealed Resident #5 had a BIMS of 15, which indicated she was cognitively intact.</p> <p>Review of Resident #5's current Physician Orders revealed the following, in part:</p> <p>03/29/2024-Change Oxygen tubing and humidified water weekly. Label with date.</p> <p>04/16/2024-Oxygen at 2 LPM via nasal cannula as needed for shortness of breath, and to relieve Hypoxia.</p> <p>Review of Resident #5's current Care Plan revealed the following, in part:</p> <p>Onset: 03/20/2024</p> <p>Problem: I have Respiratory Failure.</p> <p>Intervention: I wear oxygen as ordered.</p> <p>On 06/04/2024 at 8:43 a.m., an interview was conducted with Resident #5. She stated she wore oxygen continuously while in bed because her oxygen levels would decrease.</p> <p>On 06/03/2024 at 10:25 a.m., an observation was made of Resident #5 lying in bed with oxygen in use via nasal cannula at 2 liters per minute. There was no date noted on the oxygen tubing.</p> <p>On 06/03/2024 at 9:30 a.m., an interview was conducted with S3LPN. S3LPN observed Resident #5's oxygen tubing, and confirmed the oxygen tubing was not dated and it should have been.</p> <p>On 06/03/2024 at 2:58 p.m., an observation was made of Resident #5 lying in bed with oxygen in use via nasal cannula at 2 liters per minute. There was no date noted on the oxygen tubing.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 06/04/2024 at 8:43 a.m., an observation was made of Resident #5 lying in bed with oxygen in use via nasal cannula at 2 liters per minute. There was no date noted on the oxygen tubing.</p> <p>Resident #17</p> <p>Review of Resident #17's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.</p> <p>Review of Resident #17's current Physician Orders revealed the following, in part:</p> <p>03/20/2024-Change Oxygen tubing and humidified water weekly. Label with date.</p> <p>04/16/2024-Oxygen at 2 LPM via NC as needed to relieve hypoxia.</p> <p>Review of Resident #17's current Care Plan revealed the following, in part:</p> <p>Onset: 03/14/2024</p> <p>Problem: I require oxygen therapy.</p> <p>Intervention: Administer oxygen as ordered.</p> <p>On 06/03/2024 at 8:55 a.m., an observation was made of Resident #17 lying in bed with oxygen in use via nasal cannula at 2 liters per minute. There was no date noted on the oxygen tubing.</p> <p>On 06/03/2024 at 10:24 a.m., an observation was made of Resident #17 lying in bed with oxygen in use via nasal cannula at 2 liters per minute. There was no date noted on the oxygen tubing.</p> <p>On 06/03/2024 at 10:33 a.m., an interview was conducted with S9LPN. S9LPN confirmed Resident #17 wore continuous oxygen. S9LPN observed Resident #17's oxygen tubing, and confirmed the oxygen tubing was not dated and it should have been.</p> <p>On 06/04/2024 at 3:18 p.m., an interview was conducted with S7ADON. She stated the protocol for oxygen tubing changes occurred weekly and as needed on night shift by the nurse. S7ADON confirmed oxygen tubing should be dated.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Post nurse staffing information every day.</p> <p>50093</p> <p>Based on observations and interviews, the facility failed to post nurse staffing data on a daily basis which included the total resident census number for 2 of 2 areas reviewed for nurse staffing data.</p> <p>Findings:</p> <p>An observation was made on 06/04/2024 at 9:46 a.m. of the Daily Nursing Assignment sheet dated 06/04/2024 posted at Nursing Station A with no resident census included. The Daily Nursing Assignment sheet at Nursing Station A revealed it did not include the resident census.</p> <p>An observation was made on 06/04/2024 at 9:50 a.m. of the Daily Nursing Assignment sheet dated 06/04/2024 posted on the bulletin board at the end of Hall B. The Daily Nursing Assignment sheet at Hall B revealed it did not included the resident census.</p> <p>An interview was conducted on 06/04/2024 at 9:55 a.m. with S2DON. She stated S6ADON was responsible for posting the Daily Nursing Assignment sheet. S2DON confirmed the resident census number was not included on the Daily Assignment sheet that was posted on Hall B and it should have been.</p> <p>An interview was conducted on 06/04/2024 at 10:00 a.m. with S6ADON. She stated she was responsible for positing the Daily Nursing Assignment sheet. The Daily Nursing Assignment sheet dated 06/04/2024 which was posted on the bulletin board at the end of Hall B was reviewed. S6ADON confirmed the resident census number was not included on the Daily Assignment sheet that was posted on Hall B She confirmed the resident census number was not included on the Daily Nursing Assignment sheets and stated she was not aware it needed to be included.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48184</b></p> <p>Based on interviews and record reviews, the facility failed to ensure residents' drug regimens were free from unnecessary psychotropic medications for 2 (#4 and #7) of 6 (#1, #4, #7 #10, #35 and #43) residents reviewed for unnecessary psychotropic medications. The facility failed to ensure Resident #4 and Resident #7 had PRN orders for psychotropic drugs that were limited to 14 days.</p> <p>Findings:</p> <p><b>Resident #4</b></p> <p>Review of the clinical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses, which included Dementia, Unspecified Severity with Agitation, Anxiety Disorder, Major Depressive Disorder with Severe Psych Symptoms, Unspecified Mood Defective Disorder, and Alzheimer's Disease, Unspecified. Further review revealed Resident #4 was admitted to Hospice Services on 09/16/2023.</p> <p>Review of Resident #4's active Physician Orders revealed the following, in part:</p> <p>Start Date: 12/14/2023- Ativan 1mg tablet give one tablet by mouth every 4 hours as needed for Agitation.</p> <p>Start Date: 06/03/2024- Lorazepam 1mg give one tablet by mouth every 4 hours as needed for agitation related to Anxiety Disorder, Unspecified.</p> <p>Further review of Resident #4's active Physician Orders revealed the orders for Ativan and Lorazepam did not have a documented stop date.</p> <p><b>Resident #7</b></p> <p>Review of Resident #7's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Senile Degeneration of Brain, not elsewhere classified, Unspecified Dementia, Other Bipolar Disorders, and Major Depressive Disorder, Recurrent, In Remission. Further review revealed Resident #7 was admitted to Hospice services on 05/24/2024.</p> <p>Review of Resident #7's active Physician Orders revealed the following, in part:</p> <p>Start Date: 06/03/2024- Lorazepam 1mg give one tablet by mouth every 4 hours as needed for Target Behaviors: Restlessness, Agitation. Hold if sedated. Related to Generalized Anxiety Disorder.</p> <p>Further review of Resident #7's active Physician Orders revealed the orders for Lorazepam did not have a documented stop date.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 06/04/2024 at 10:51 a.m., an interview was conducted with the Hospice Registered Nurse. She confirmed Resident #7, and all residents receiving Hospice care with their company, had a PRN standing order for Lorazepam with no stop date or duration listed on the order.</p> <p>On 06/04/2024 at 11:40 a.m., an interview was conducted with the Hospice Physician. He stated he wrote the order for the Lorazepam medication as a PRN order for Resident #7, and he confirmed there was no duration or stop date on the order. He stated he was not aware that a duration or stop date was needed on the orders for PRN Lorazepam.</p> <p>On 06/04/2024 at 09:46 a.m., an interview was conducted with S2DON. She stated she was responsible for assessing all PRN psychotropic medications. She confirmed the Lorazepam order for Resident #7 did not have a stop date or duration. She confirmed PRN Lorazepam orders for residents receiving Hospice care, including Resident #4, are not required to have a stop date or duration.</p> <p>On 06/04/2024 at 10:45 a.m., an interview was conducted with S1NFA. She confirmed the Lorazepam medication was a PRN order for Resident #7 and did not have a stop date or duration. She confirmed PRN Lorazepam orders for residents receiving Hospice, including Resident #4, are not required to have a stop date or duration.</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49343</p> <p>Based on interviews and record review, the facility failed to ensure residents were free of significant medication errors for 1(#78) of 33 residents reviewed in the final sample. The facility failed to ensure Resident #78 received Eliquis as ordered by the physician.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation for Resident #78, a resident with a history of Pulmonary Embolism and Acute Embolism and Thrombus of the Lower Extremity, on [DATE] at 08:00 a. m. when S5LPN discontinued his order for Eliquis without a physician's order. Resident #78 did not receive Eliquis as ordered from [DATE] through [DATE]. Resident #78 was found on [DATE] at 12:00 a.m., lying on the right side of the floor, unresponsive, pulseless and not breathing. The coroner's report read causes of death: Acute Myocardial Infarction vs Pulmonary Embolism; Hypertension' changes of Aging.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>S1NFA and S2DON were notified of the Past Noncompliance Immediate Jeopardy on [DATE] at 3:38 p.m.</p> <p>Findings:</p> <p>Review of the medication Black Box Warning for Eliquis revealed the following, in part: Warning: Premature discontinuation of Eliquis increases the risk of thrombotic events: Premature discontinuation of any oral anticoagulant, including ELIQUIS, increases the risk of thrombotic events. To reduce this risk, consider coverage with another anticoagulant if Eliquis is discontinued for a reason other than Pathological bleeding or completion of a course of therapy. Eliquis is indicated for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy.</p> <p>Review of the clinical record revealed Resident #78 was admitted to the facility [DATE] with diagnoses which included, Acute Embolism and Thrombosis of Right Distal Lower Extremity and Pulmonary Embolism without Acute cor Pulmonale.</p> <p>Review of the Care Plan dated [DATE] for Resident #78 revealed the following, in part:</p> <p>Problem: I am at risk for deep vein thrombosis.</p> <p>Interventions: Administer my anticoagulant as ordered .</p> <p>Review of the Hospital Discharge orders, dated [DATE] revealed in part, the following:</p> <p>Eliquis 5 mg tablet for a clot in the lung, take 2 tablets by mouth 2 times daily for 30 days, then 1 tablet (5 mg total) 2 times daily on [DATE].</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of the Physician Orders dated [DATE] for Resident #78 revealed on [DATE] at 8:00 p.m. an order was implemented for Eliquis 5 mg tablet by mouth twice daily and on [DATE], the Eliquis was discontinued. Further review revealed no order to discontinue Eliquis 5 mg tablet by mouth twice daily.</p> <p>Review of the Medication Administration Record dated [DATE] for Resident #78 revealed Eliquis 5 mg tablet by mouth twice daily was not on the MAR to be administered from [DATE] to [DATE] per physician orders.</p> <p>Review of the nurse's note dated [DATE] revealed the following:</p> <p>[DATE] at 12:00 a.m.: Summons to room by CNA when arrived observed resident lying on right side on floor nonresponsive. No pulse, no breathing noted. Charge nurse verified code status as DNR. Notified Acadian who came out and did an EKG which showed asystole. Acadian paramedics advised to leave body on floor until coroner review body.</p> <p>Review of the Coroner's Report for Resident #78 revealed the following, in part:</p> <p>I, Coroner, certify the following report of death:</p> <p>Date and time of death: [DATE] at 00:15</p> <p>Causes of death: Acute Myocardial Infarction vs Pulmonary Embolism; Hypertension' changes of Aging.</p> <p>On [DATE] at 10:21 a.m., a telephone interview was conducted with S14NP. She stated she would not discontinue Resident #78's Eliquis due to his history of Pulmonary Embolism and an active blood clot. She stated Resident #78 not receiving the Eliquis for ten days could have contributed to his death. She stated Resident #78 did not have any procedures that would have caused a physician to hold the Eliquis for a period of time.</p> <p>On [DATE] at 10:35 a.m., an interview was conducted with S2DON. She stated Resident #78 had a history of a cerebrovascular accident, traumatic brain injury, and was admitted to the facility in [DATE] with a blood clot. She stated S5LPN discontinued Resident #78's Eliquis on [DATE] without a physician's order.</p> <p>On [DATE] at 12:36 p.m., a telephone interview was conducted with S5LPN. She confirmed she discontinued Resident #78's Eliquis, but did not know why. She stated she believed Resident #78 had an upcoming procedure and that was why she discontinued the Eliquis.</p> <p>On [DATE] at 12:45 p.m., an interview was conducted with S2DON. She stated when a medication order was modified or discontinued the nurse should document a note in the electronic chart stating who discontinued or modified the medication and why. She reviewed Resident #78's clinical record and confirmed there was no documentation or order to discontinue Eliquis. She stated if there was no order to discontinue Resident #78's Eliquis, then the medication should not have been stopped. She confirmed S5LPN discontinued Resident #78's Eliquis on [DATE] without a physician's order. She confirmed Eliquis was removed from the MAR on [DATE] after the order was discontinued and there was no documentation Resident #78 received the medication from [DATE] through [DATE] when Resident #78 expired.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On [DATE] at 5:20 p.m., an interview was conducted with S13LPN. She explained S2DON or the floor nurse would place orders in the resident's chart and then initiate the order in the electronic system. She stated each day she would review the telephone order slips or order discontinuation forms from the previous day to ensure the orders were implemented accurately. She confirmed if there was not an order to discontinue a medication, she would not have known to review it for accuracy. She reviewed Resident #78's physician's orders and confirmed Eliquis 5 mg twice a day was discontinued on [DATE] at 3:52 p.m., by S5LPN, without a physician's order. S13LPN stated beginning the last week of each month, administrative staff should print reports and verify all orders in the resident's charts were accurate. She stated the facility would not have known Resident #78's Eliquis was discontinued without an order until the end of the month of [DATE]. She confirmed the facility did not include Resident #78's chart check in the [DATE] review because he had already expired. She stated she received in-service training on the new chart check process and verifying order entry and discontinuation during the end of [DATE] through May because the facility switched of computer systems.</p> <p>On [DATE] at 11:00 a.m., an interview was conducted with S2DON. She stated she was not aware Resident #78's Eliquis was discontinued without a physician's order until yesterday. She stated the facility implemented a new computer system on [DATE]. She stated with the implementation of the new system, the facility implemented corrective actions to ensure orders accuracy. She stated the new process was all current resident's orders would be verified against written orders and checked for accuracy. She stated all nursing staff were in-serviced on order entry and discontinuation in the new computer system on [DATE]. She stated on [DATE], after surveyors entered the facility, nursing staff compared the resident's paper MARs to the orders in the new computer system and to the Medication Card instructions during med passes to ensure proper administration of medications as ordered. She stated since [DATE], each morning, Data Entry compared carbon copies of new written orders and a report of newly discontinued orders generated from the computer data to ensure residents received medications as ordered. She stated the facility reeducated nurses on the importance of entering medication orders into the electronic record and comparing the medication cards to the eMAR during med pass for order accuracy on [DATE]. She stated going forward the facility will have e-signature available for physician use to sign orders. She stated on [DATE] education and ongoing completion of order validation began and continues to date with no issues identified. S2DON read the written plan of removal, which stated substantial compliance was attained and maintained effective [DATE]. She stated the facility was in complete compliance on [DATE].</p> <p>The facility has implemented the following actions to correct the deficient practice:</p> <p>On [DATE] the following plan of correction was completed and included the following:</p> <p>Issue/Concern:</p> <p>Administer anticoagulant medications as ordered. (J.[NAME] documentation of Eliquis being administered as ordered incomplete per review of the MAR beginning [DATE]- [DATE])</p> <p>Areas/Systems/Programs Affected:</p> <p>- On admission a data entry error into computer system Physician's Order module for Eliquis frequency and a D/C of Eliquis on [DATE] resulted in prior non-compliance for no or inaccurate electronic documentation of administration of Eliquis to J. [NAME].</p> <p>(continued on next page)</p> |  |  |

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
|--|--|
| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>- An audit of Eliquis supply ordered and obtained from Pharmacy from [DATE] - [DATE] compared to remaining supply of Eliquis indicates facility provided the 140 tabs required to administer Eliquis as ordered during facility stay ([DATE] - [DATE]).</p> <p>Plan of Correction:</p> <p>The following tasks/ methods were completed in to ensure medications administered as ordered by the facility:</p> <ol style="list-style-type: none"> <li>1. Administrative nursing staff were trained by the new computer system liaison on order entry including discontinued orders on [DATE] with competencies dated [DATE].</li> <li>2. From [DATE] - [DATE], Data Entry nurse reviewed current and newly received orders in computer system for accuracy and no issues were noted.</li> <li>3. From [DATE] - [DATE], data entry nurse completed audits of carbon copies of newly written orders including newly discontinued orders to ensure current medications ordered are firing properly ensure proper administration of medications.</li> <li>4. Facility completed chart audits of current resident's physician's orders and compared them to orders entered into computer system electronic order module [DATE] to [DATE] to ensure current medications ordered are firing properly in the eMAR for order validation to ensure proper administration of medications as ordered. Reviewing nurse signed/dated [DATE]'s monthly physician's orders and they were sent to MD for review and signature then filed on resident's chart.</li> <li>5. Administrative nurses and Regional QI nurses trained staff nurses on order entry including discontinuing orders on [DATE].</li> <li>6. On [DATE], facility again completed chart audits of current resident's physician's orders and compared the orders in prior computer system to ensure current medications ordered are firing properly in eMAR for order validation to ensure proper administration of medications as ordered. Reviewing nurse signed/dated [DATE]'s monthly physician's orders and they were sent to MD for review and signature then filed on resident's chart.</li> <li>7. On [DATE], data migration of orders from the prior computer system into the new system completed.</li> <li>8. From [DATE] to [DATE], Facility dual entered newly written orders including newly discontinued orders into both computer systems to ensure current medications ordered fired properly in eMAR for order validation to ensure proper administration of medications as ordered.</li> <li>9. From [DATE] to [DATE], facility completed chart audits of current resident's physician's orders, newly received orders, and newly discontinued orders compared to orders entered into the new system and the prior system's electronic orders module to ensure current medications ordered fired properly in eMAR for order validation to ensure prop administration of medications as ordered.</li> </ol> <p>(continued on next page)</p> |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>10. On [DATE], nursing staff compared prior system paper MARs/TARs to new system eMAR/eTAR to Medication Card instructions during med passes for order validation to ensure proper administration of medications as ordered.</p> <p>11. Since [DATE], each morning, Data Entry has compared carbon copies of newly written orders and a report of newly discontinued orders generated from the new system data validation to ensure residents continued to receive medications as ordered.</p> <p>12. On [DATE], Data Entry re-validated newly entered and newly discontinued orders in the new system to ensure medications are firing to system's eMAR properly from [DATE] - [DATE] for proper documentation of administration as ordered with no issues noted.</p> <p>13. The following steps will be completed for order validation to ensure proper administration of medications as ordered:</p> <ul style="list-style-type: none"> <li>- Data entry of medication orders for new admissions will be confirmed by 2 nurses</li> <li>- Monday - Friday, Data Entry or designee will compare carbon copies of newly written orders and a report of newly discontinued orders generated from the new system to the current orders in the system</li> <li>- These carbon copies of newly received orders and reports of newly discontinued orders will be retained to be reviewed again during end of month order validation</li> </ul> <p>14. [DATE], Data Entry re-educated by the DON on the order validation process to ensure administration of medications as ordered.</p> <p>15. On [DATE], facility re-educated nurses by ADON on the importance of entering medications orders into the new system and comparing the medication cards to the eMAR during med pass for order validation to ensure proper administration of medications as ordered.</p> <p>16. Going forward facility will have e-signature available for physician use to sign orders and the facility does not currently use agency staff and has not used them since the last day in [DATE]. There is no plan to reinstitute agency staff at this time.</p> <p>17. The DON or designee will monitor by reviewing completion of order validation findings twice weekly on a random sample of 10 residents to ensure continued compliance for 6 weeks and randomly monthly thereafter.</p> <p>18. All new nursing staff will be trained by staff development nurse or designee on administering medication as ordered during orientation prior to independent medication administration.</p> <p>19. On [DATE] education and ongoing completion of order validation began and continues to date with no issues identified, it is the facilities belief that substantial compliance was attained and maintained effective [DATE].</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p>46308</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infection. The facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. S3LPN and S4LPN practiced proper hand hygiene for 3 of 3 (#11, #129, #130) residents observed for medication administration; and</li> <li>2. S4LPN disinfected blood glucose meters between resident use for 1of 1 (#130) residents observed for blood glucose monitoring.</li> </ol> <p>This deficient practice had the potential to affect any of the 79 residents currently residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Hand Hygiene Policy and Procedure dated 07/01/2020, revealed the following, in part:</p> <p>Policy:</p> <ol style="list-style-type: none"> <li>3. Before and after direct resident contact for which hand hygiene is indicated by acceptable professional practice.</li> <li>1.</li> </ol> <p>On 06/03/2024 at 2:05 p.m., an observation was made of S3LPN administering medication to Resident #129. S3LPN did not sanitize her hands prior to putting Resident #129's pills in her cup. S3LPN handed the cup of pills to Resident #129. Resident #129 took her pills and gave her empty cup back to S3LPN. S3LPN discarded the pill cup into the trash. S3LPN did not perform hand hygiene before or after medication administration.</p> <p>On 06/03/2024 at 2:10 p.m., an interview was conducted with S3LPN. She confirmed she did not perform hand hygiene before or after giving Resident #129 her medications. She stated the facility's process is to perform hand hygiene before and after medication administration and she should have.</p> <p>On 06/04/2024 at 7:10 a.m., an observation was made of S4LPN during medication pass. She prepared Resident #11's medication in a pill cup. S4LPN did not sanitize her hands before preparing Resident #11's medications. S4LPN went into Resident #11's room, gave Resident #11 her pill cup, and came out of Resident #11's room without sanitizing her hands. S4LPN then prepared Resident #130's medications in a pill cup and walked into Resident #130's room and gave her pill cup to her without performing hand hygiene.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>195526  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heritage Healthcare - Hammond  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1300 Derek Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 06/04/2024 at 7:30 a.m., an interview was conducted with S4LPN. She confirmed she did not sanitize her hands before administering Resident #11's medication or between medication administration with Resident #11 and Resident #130.</p> <p>2.</p> <p>Review of the facility's policy titled, Hand Hygiene Policy and Procedure dated 07/01/2020, revealed the following, in part:</p> <p>Policy:</p> <p>4. Before and after performing any invasive procedure (e.g. fingerstick blood sampling)</p> <p>Review of the facility's policy titled, Blood Glucose Monitoring Policy and Procedure 08/24/2016, revealed the following, in part:</p> <p>Procedure:</p> <p>12. Disinfect all surfaces of the glucometer after use.</p> <p>On 06/04/2024 at 7:20 a.m., an observation was made of S4LPN. She retrieved a glucometer from the top drawer of her medication cart and proceeded to go into Resident 130's room. An observation was made of S4LPN performing a glucometer check on Resident #130. S4LPN came out of Resident #130's room and without sanitizing her glucometer, put the glucometer back in her top drawer of her medication cart.</p> <p>On 06/04/2024 at 7:30 a.m., an interview was conducted with S4LPN. She confirmed she did not sanitize her hands before performing the glucometer check on Resident #130. She further stated she should have cleaned the glucometer after using it on Resident #130 and before placing it back in her medication cart and she did not.</p> <p>On 06/04/2024 at 9:15 a.m., an interview was conducted with S2DON. S2DON confirmed nurses should use hand sanitizer before and after administering medications to each resident. S2DON further stated the glucometer should be cleaned before and after each resident use.</p> |  |  |