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	04/15/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5% for 1 (#70) of 11 residents observed during medication administration. A total of 52 opportunities were observed with 20 medication errors, which resulted in a medication error rate of 38.46%. Findings: Review of the facility's policy titled Medication Administration with an effective date of 10/04/2024 revealed the following, in part:Medication Administration: Prior to administration, the Nursing staff member administering the medication shall ensure that the following steps are accomplished.d. Verify the medication is being administered at the proper time Medication Administration Times:Medication should be administered within 60 minutes before or after the scheduled time. Review of Resident #70's Clinical Record revealed Resident #70 was admitted to the facility on [DATE] and had diagnoses, which included Essential (Primary) Hypertension; Hypertensive Heart Disease Without Heart Failure; Hyperlipidemia; Chronic Kidney Disease; Heart Failure; Atrial Fibrillation. Review of Resident #70's Physician Orders and MAR for 04/2026 revealed the following medications were scheduled for administration at 8:00 a.m.: Amiodarone HCl Oral Tablet 200 MG. Give 1 tablet by mouth one time a day.Amlodipine Besylate Oral Tablet 10 MG. Give 1 tablet by mouth one time a day.Clopidogrel Bisulfate Oral Tablet 75 MG. Give 1 tablet by mouth one time a day.Lovenox Injection Solution Prefilled Syringe 40 MG/0.4ML. Inject 0.4 ml subcutaneously one time a day.Furosemide Oral Tablet 20 MG. Give 1 tablet by mouth one time a day.Potassium Chloride ER Oral Tablet Extended Release 10 MEQ. Give 1 tablet by mouth one time a day.Pantoprazole Sodium Oral Tablet Delayed Release 40 MG. Give 1 tablet by mouth one time a day.Sitagliptin Oral Tablet 100 MG. Give 1 tablet by mouth one time a day.Rosuvastatin Calcium Oral Tablet 10 MG. Give 1 tablet by mouth one time a day.Zoloft Oral Tablet 50 MG. Give 1 tablet by mouth one time a day.Suzetrigine Oral Tablet 50 MG. Give 1 tablet by mouth two times a day.Precose Oral Tablet 25 MG. Give 1 tablet by mouth with meals.Linaclotide Oral Capsule 72 MCG. Give 1 capsule by mouth one time a day.Aspirin EC Oral Tablet Delayed Release 81 MG. Give 1 tablet by mouth one time a day.Fish Oil Oral Capsule 1000 MG. Give 2 capsule by mouth one time a day.Ferrous Sulfate Oral Tablet 325 MG. Give 1 tablet by mouth one time a day.Cholecalciferol Oral Tablet 125 MCG. Give 1 tablet by mouth one time a day.Oyster Shell Calcium/D Oral Tablet 250-3.125 MG-MCG. Give 1 tablet by mouth one time a day. On 04/13/2026 at 9:39 a.m., an observation was made of S3ADON preparing to pass the above listed medications to Resident #70. S3ADON stated the medications administered to Resident #70 were scheduled to be administered at 8:00 a.m. When she went to find Resident #70 to administer the medications, Resident #70 had left the facility for a Doctor's appointment. On 04/13/2026 at 10:06 a.m., an interview was conducted with S3ADON. S3ADON stated if a resident had a medication scheduled for 8:00 a.m., the medication should be administered between 7:00 a.m. to 9:00 a.m. S3ADON confirmed she attempted to pass the above listed medications to Resident #70 after 9:00 a.m., but Resident #70 was not in the facility. She stated the oncoming nurse would administer the medications when Resident #70 returned to the facility. On 04/13/2026 at 4:12 p.m., an interview was conducted with S9LPN. S9LPN confirmed she did not administer Resident #70's daily medications when Resident #70 returned from her doctor's appointment and should have. She stated Resident #70 (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	returned from her Doctor's appointment at 1:30 p.m. On 04/15/2026 at 11:15 a.m., an interview was conducted with S2DON. S2DON stated medications should be given as ordered by the physician.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure a resident's call light was within reach for 1 (#29) of 31 residents reviewed during the initial pool. Findings: Review of the facility's policy titled Resident Call Light System Policy and Procedure with an effective date of 09/14/2022, revealed the following, in part:Purpose:1. To provide a communication system with audible or visual signals to allow residents to call for staff assistance from their bedside . Procedure:6. When providing care to residents, be sure to position the call light conventionally within reach for the resident to use. Review of Resident #29's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Generalized Muscle Weakness, Difficulty In Walking, and Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of Resident #29's Quarterly MDS with an ARD of 02/25/2026, revealed she had a BIMS of 11, which indicated she was moderately cognitively impaired. Further review revealed Resident #29 was always incontinent of bowel and bladder and required substantial/maximal assistance for toileting hygiene. Review of Resident #29's current Care Plan revealed the resident was at risk for falls. Interventions included to be sure the resident's call light is within reach. On 04/12/2026 at 10:53 a.m., an observation was made of Resident #29 in her room. She was lying in bed with her soft touch call light on the nightstand out of reach. An interview was conducted at this time and Resident #29 stated she needed to be changed. She stated she wanted to call the CNA for assistance, but her call light was moved out of reach sometime during the night. She stated she used her call light often and confirmed she could not reach her call light. On 04/12/2026 at 10:55 a.m., an observation and concurrent interview was conducted with S4LPN. S4LPN stated Resident #29 used her call light often to call staff for assistance. S4LPN observed and confirmed Resident #29's soft touch call light was on the nightstand and out of the resident's reach. On 04/14/2026 at 2:57 p.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. S2DON confirmed if a resident can use their call light, then their call lights should be kept in reach.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure services were provided by the facility to meet quality professional standards. The facility failed to ensure: 1.) Medications were administered safely and timely by leaving the medications at the bedside for 2 (#27 and #41) of 31 residents observed during the initial pool; and2.) A Physician's Order was obtained before administering medications for 1 (#27) of 34 residents reviewed in the final sample.Findings:Review of the facility's policy titled Medication Administration with an effective date of 10/04/2024, revealed the following, in part:Policy:Nursing personnel shall ensure the safe and effective administration of medications.Procedure:1. Medication Administration: Prior to administration, the Nursing staff member administering the medication shall ensure that the following steps are accomplished.a. Verify the medication selected matches the order and label.g. Administer the medication as ordered.8. Medication Preparation and Securitya. Immediate administration means the person preparing the medications take it directly to a resident for administration. c. Medications shall not be left unattended . 1.Resident #27 Review of Resident #27's Clinical Record revealed she was admitted to the facility on [DATE].Review of Resident #27's admission MDS with an ARD of 03/15/2026, revealed she had a BIMS of 15, which indicated she was cognitively intact.Review of Resident #27's current Physician Orders revealed the following, in part:Start date-04/13/2026- Melatonin Oral Tablet 5 MG (Melatonin) - Give 5 mg by mouth every 24 hours as needed for insomnia. On 04/12/2026 at 9:15 a.m., an observation was made of a bottle of Melatonin 5 mg on Resident #27's bedside table. On 04/12/2026 at 9:27 a.m., an observation and interview was conducted with S4LPN. of Melatonin 5 mg bottle on resident's bedside. S4LPN confirmed Melatonin bottle should have been returned to the medication cart and not left on Resident #27's bedside table. On 04/13/2026 at 3:45 p.m., an interview was conducted with S5LPN. She reviewed Resident #27's current MAR and stated resident did not have an order for Melatonin. S5LPN confirmed staff should not give residents medications without an order. On 04/15/2026 at 11:27 a.m., an interview was conducted with S4LPN. S4LPN confirmed she provided care for Resident #27 on the evening shift of 04/11/2026. She stated she administered Melatonin 5mg to Resident #27 at 8:00 p.m. medication pass and left the medication in the resident's room. She stated she was unaware Resident #27 did not have an order for Melatonin. S4LPN confirmed medications should not be administered without a Physician's Order and should not be left at a resident's bedside. On 04/14/2026 at 2:53 p.m., an interview was conducted with S2DON. S2DON confirmed medications should not be left at resident's bedside. She further confirmed medications should not be administered without a Physician's Order. 2. Resident #41Review of Resident #41's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Multiple Sclerosis, Unspecified Pain, Gout, Retention of Urine, Hyperparathyroidism, Hyperlipidemia, Dizziness and Giddiness, Essential Primary Hypertension, Nausea With Vomiting, Generalized Abdominal Pain, Epileptic Seizures, Fibromyalgia, Major Depressive Disorder, and Allergic Rhinitis.Review of Resident #41's Significant Change MDS with an ARD of 02/04/2026, revealed she had a BIMS of 13, which indicated she was cognitively intact.Review of Resident #41's current Physician Orders revealed the following, in part:Start date- 12/10/2025- Meclizine HCl 25 mg give 1 tablet by mouth every 6 hours as needed for dizziness; Ondansetron HCl 4 mg give 1 tablet by mouth every 6 hours as needed for nausea/vomiting; Simethicone 80 mg give 1 tablet by mouth every 4 hours as needed for complaint of gas; and Topiramate 100 mg give 1 tablet by mouth two times a day. Start date-12/11/2025- Allopurinol 100 mg give 1 tablet by mouth one time a day; Cinacalcet HCl 30 mg give 1 tablet by mouth one time a day; Fenofibrate 145 mg give 1 tablet by mouth one time a day; Metoprolol Tartrate 25 mg give 1 tablet by mouth one time a day; Zoloft 100 mg give 1 tablet by mouth one time a day; and Cetirizine HCl 10 mg give 1 tablet by mouth one time a day.Start date-12/12/2025- Phenazopyridine HCl give 1 tablet by mouth every 24 hours as needed for pain.Start (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date- 03/18/2026- Tramadol HCl 50 mg give 1 tablet by mouth every 6 hours as needed for pain.Start date- 03/25/2026- Vitamin C give 1000 mg by mouth one time a day.Start date- 04/11/2026- Pyridium give 95 mg by mouth one time a day for bladder spasms. On 04/13/2026 at 8:55 a.m., an observation and interview was conducted with Resident #41. An observation was made of one plastic medication cup containing 2 tablets and a second plastic medication cup containing 8 pills were observed on the bedside table with a cup of water. Resident #41 verified the medications in the two plastic cups were her morning medications. She stated she had already taken a couple of the pills and S5LPN left the remaining pills for her to finish taking. On 04/13/2026 at 9:01 a.m., an interview was conducted with S5LPN. She verified there were two plastic medication cups containing 8 pills and 2 tablets on Resident #41's bedside table. She confirmed she did not observe Resident #41 consume all of her morning medications and should have.On 04/14/2026 at 2:53 p.m., an interview was conducted with S2DON. S2DON stated medications should not be left at any resident's bedside. S2DON confirmed the nurse should have observed Resident #41 consume all of her medications prior to exiting room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out ADLs received the necessary services to maintain good grooming and personal hygiene for 1 (#19) of 4 residents reviewed for ADL's. The facility failed to trim and clean Resident #19's fingernails. Findings: Review of Resident #19's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Spastic Hemiplegia affecting Left Non-dominant Side and Cerebral Infarction. Review of Resident #19's current Physician Orders revealed the following:Assess/Trim finger nails and toe nails monthly every day shift on Sunday. Order date: 01/01/2026. Review of Resident #19's current Care Plan revealed the following:Problem: Resident requires staff assistance for ADL care related to Cerebrovascular Accident (CVA) with hemiplegia. Interventions: Assist the resident with hygiene and grooming tasks as needed. On 04/12/2026 at 9:25 a.m., an observation was made of Resident #19 with fingernails noted to be long and dirty. Fingernails observed to extend approximately 1 centimeter past the nailbeds of all 10 fingers. Fingernails noted to have a brown colored substance under each nail. On 04/13/2026 at 1:30 p.m., an observation was made of Resident #19 with fingernails noted to be long and dirty. Fingernails observed to extend approximately 1 centimeter past the nailbeds of all 10 fingers. Fingernails noted to have a brown colored substance under each nail. An interview was conducted with Resident #19 at this time. He stated he would like for his fingernails to be cleaned and trimmed. On 04/13/2026 at 1:35 p.m., an observation was made with S7CNA of Resident #19's fingernails. S7CNA observed Resident #19's fingernails to be long and dirty. She stated CNAs were responsible for cleaning non-diabetic resident's fingernails and this task should be performed with their baths. She stated Resident #19 had received his bath that morning. S7CNA confirmed the resident's fingernails needed to be cleaned and trimmed and should have been completed with his bath. On 04/14/2026 at 2:53 p.m., an interview was conducted with S2DON. S2DON confirmed she expected staff to keep resident's fingernails clean and trimmed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident was offered a therapeutic diet when the health care provider ordered a nutritional supplement for 1 (#42) of 3 residents reviewed for nutritional status. Findings: Review of Resident #42's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Chronic Kidney Disease, Stage 4 Severe, Dependence On Renal Dialysis, and Chronic Systolic Congestive Heart Failure. Review of Resident #42's admission MDS with an ARD of 01/27/2026, revealed she had a BIMS of 15, which indicated she was cognitively intact. Further review revealed Resident #42 was on dialysis and received a therapeutic diet. Review of Resident #42's current Physician Orders revealed the following, in part:Start date 04/03/2026 Nepro three times a day. On 04/12/2026 10:13 a.m., an interview was conducted with Resident #42. She stated she was on dialysis and supposed to receive a protein shake with all meals, but did not always get it. She stated her kidney doctor wanted to her to drink the protein shakes three times a day to increase her protein levels. On 04/14/2026 at 12:13 p.m., an observation and concurrent interview was conducted with S7CNA. S7CNA delivered a lunch meal tray to Resident #42's room. An observation of Resident #42's meal ticket was made with S7CNA who confirmed the following: No Added Salt, Renal, Regular Diet, and Nepro supplement lunch. There was no Nepro supplement observed on the meal tray. S7CNA exited Resident #42's room and continued passing meal trays.On 04/14/2026 at 12:20 p.m., an observation and concurrent interview was conducted with S7CNA. She stated when she passed resident meal trays, if a supplement was missing, she went to the kitchen and requested it. She stated she did not observe anything missing from Resident #42's lunch tray. S7CNA observed Resident #42's meal ticket and confirmed a Nepro supplement was not on the meal tray and should have been.On 04/14/2026 at 12:33 p.m., an interview was conducted with S6LPN. She stated Resident #42 was on dialysis, had some weight loss and was ordered Nepro shakes three times a day with meals. She stated the kitchen staff were responsible for ensuring supplements were on the meal trays. She stated the CNAs knew by the meal ticket, Resident #42 should have a Nepro shake with meals. She stated if Resident #42's Nepro shake was not on the meal tray, the CNAs should go to the kitchen and get it or notify her and she would go get it. S6LPN confirmed the CNA who passed Resident #42's lunch tray should have realized the Nepro shake was not there and should have went to the kitchen and gotten one. On 04/14/2026 at 12:51 p.m., an interview was conducted with S9DM. She stated after a supplement was ordered, she updated the resident's meal tickets. She stated the kitchen staff should ensure the supplements were on the meal trays. She stated if the supplement was not placed on the tray, the CNA or nurse on the hall should get the supplement from the kitchen and provide it to the resident. She stated Resident #42 was ordered a Nepro shake with every meal. She stated a Nepro shake should have been provided to Resident #42 for each meal.On 04/14/2026 at 3:00 p.m., an interview was conducted S2DON. She stated the kitchen staff were responsible for ensuring supplements were on the resident's meal trays. She stated if the supplement was not placed on the meal tray, the CNA or nurse on the hall should go get the supplement from the kitchen and provide it to the resident. S2DON verified Resident #42 was ordered Nepro shakes with all meals and should have had one on her lunch tray.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 staff practiced appropriate infection control practices and proper glove use for 1 (#66) of 1 resident observed for peri-care.Findings: Review of Resident #66's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction. On 04/14/2026 at 10:30 a.m., an observation was made of incontinent care performed by S8CNA. S8CNA donned clean gloves and pulled back Resident #66's bed linens. S8CNA unfastened Resident #66's brief and noted the resident had a bowel movement. She began to clean stool and urine from the resident's perineal area with a wash cloth and perineal cleansing spray. S8CNA did not remove her soiled gloves or perform hand hygiene and then proceeded to turn Resident #66, place a clean brief and clean incontinence pad beneath her, and straighten her gown. On 04/14/2026 at 10:45 a.m., an interview was conducted with S8CNA. She confirmed she should have changed gloves and performed hand hygiene after performing perineal care and prior to applying a clean brief and incontinence pad and did not. On 04/14/2026 at 2:53 p.m., an interview was conducted with S2DON. S2DON confirmed she would expect staff to remove soiled gloves and put on clean gloves before going from dirty to clean when providing peri care.