

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Colonial Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4312 Ithaca Street Metairie, LA 70006	

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 0660</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>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>41876</p> <p>The facility failed to ensure the discharge process was followed by failing to:</p> <ol style="list-style-type: none"> 1. Ensure a resident's discharge location was accurate (Resident #1); 2. Ensure a resident and/or resident's responsible party (RP) was provided information in order to select a home health agency (Resident #1); and, 3. Ensure the resident and/or RP received the discharge summary and instructions prior to discharge (Resident #1). <p>This deficient practice was identified for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for discharge planning.</p> <p>Findings:</p> <p>Review of Discharge-Transfer of a Resident Policy and Procedure effective 08/21/2017 revealed, in part, the purpose of the policy and procedure was to ensure a safe departure from the facility and provide sufficient information for after care of the resident. Further review revealed when a resident was discharged, the facility must complete the Discharge Summary/Instructions assessment and review the assessment with the resident and/or RP prior to discharge. Review revealed the resident and/or RP must sign a copy of the assessment form to indicate they have received and understood the instructions, and a copy of the assessment form should be given to the resident and/or RP. The signed copy of the assessment form should be placed in the resident's record.</p> <p>Review of Resident #1's Admission Minimum Data Set with an Assessment Reference Date of 03/31/2024 revealed, in part, Resident #1 was admitted to the facility from the hospital on 03/06/2024 with a goal to be discharged back into the community.</p> <p>Review of Resident #1's care plan with a start date of 03/25/2024 revealed, in part, Resident #1 was care planned to return to her home with interventions for staff to assist Resident #1 with obtaining community resources for discharge, accommodate for Resident #1's discharge goals of care and treatment, and arrange and/or notify Resident #1 of the home health agency of Resident #1's choosing.</p> <p>Review of Resident #1's Face Sheet revealed Resident #1's address and Resident #1's Responsible Party's address were the same location.</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 0660</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 note written by S4Social Services Director (SSD) on 03/08/2024 at 8:32 a.m. revealed, in part, prior to admission, Resident #1 resided in a senior living community. Further review revealed Resident #1 planned to be discharged to the community after she completed therapy.</p> <p>Review of the facility's Detail Admission/Discharge Report from 04/03/2024 through 06/03/2024 revealed, in part, Resident #1 was discharged home from the facility on 05/02/2024 with home health care.</p> <p>Review of Resident #1's Discharge Summary/Instructions revealed, in part, on 05/02/2024, Resident #1 was discharged home with home health services. Further review revealed Resident #1's RP's address was listed as Resident #1's discharge address. Review of the discharge instructions revealed no signature present to confirm the above mentioned information was provided.</p> <p>There was no documented evidence, and the facility was unable to provide any documented evidence Resident #1 and/or Resident #1's RP was provided discharge instructions or signed the Discharge Summary/Instructions assessment form to acknowledge receipt of the discharge instructions.</p> <p>There was no documented evidence, and the facility was unable to provide any documented evidence Resident #1 and/or Resident #1's RP was provided a list of compiled home health agencies to pick from.</p> <p>In an interview on 05/31/2024 at 3:20 p.m., Resident #1's granddaughter indicated there were issues with Resident #1's discharge because the facility had set up Resident #1 to be discharged to Resident #1's RP's address instead of Resident #1's home address. Resident #1's granddaughter further indicated at discharge, Resident #1 nor Resident #1's RP were provided information regarding the location Resident #1 was being discharged to. Resident #1's granddaughter also indicated Resident #1 and Resident #1's RP were not provided a list of home health agencies to choose from.</p> <p>In an interview on 06/04/2024 at 12:39 p.m., S2Licensed Practical Nurse (LPN) confirmed when she discharged a resident, a copy of the discharge instructions were provided to the resident and/or the resident's family. S2LPN further indicated she would obtain the resident and/or the resident's family's signature on the discharge instructions and then would place the copy in the resident's chart. S2LPN further indicated she would have the resident and/or resident's family sign the instructions to acknowledge the discharge instructions were provided to them prior to the discharge.</p> <p>In an interview on 06/05/2024 at 11:33 a.m., S3LPN confirmed she was the nurse who discharged Resident #1. S3LPN further confirmed she did not get the discharge summary form signed by Resident #1 or Resident #1's RP. S3LPN indicated she did not go over Resident #1's discharge arrangements with Resident #1 or Resident #1's RP at the time of the discharge.</p> <p>In an interview on 06/05/2024 at 11:45 a.m., S2Director of Nursing (DON) indicated she was aware Resident #1 planned to return to her own address when discharged. S2DON confirmed Resident #1's Discharge Summary/Instructions revealed Resident #1 was discharged to Resident #1's RP's address, which was incorrect. S2DON stated Resident #1's Discharge Summary/Instructions form should have been reviewed and signed by Resident #1 and/or Resident #1's RP to ensure Resident #1 and/or Resident #1's RP were aware of all discharge arrangements prior to discharge. S2DON indicated reviewing the discharge arrangements prior to discharge could have caught the error of Resident #1's discharge location. S2DON confirmed S4SSD should have confirmed Resident #1's discharge address of the prior to initiating and setting up discharge.</p> <p>(continued on next page)</p>		

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<p>F 0660</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>In an interview on 06/05/2024 at 12:56 p.m., S4SSD indicated when in Resident #1's care plan meeting, Resident #1's family said Resident #1 would return home on discharge, and S4SSD assumed the address on Resident #1's face sheet was Resident #1's home address. S4SSD stated she could not recall if she ever specifically verified that Resident #1 was going back to the address on Resident #1's face sheet. S4SSD confirmed Resident #1's discharge address was incorrect, and S4SSD should have verified the discharge location during the discharge process. S4SSD confirmed she had not provided Resident #1 and/or Resident #1's RP a list of available home health agencies to choose an agency from.</p>