

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2024
NAME OF PROVIDER OR SUPPLIER  Cherry Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 5980 Cherry Ridge Rd Bastrop, LA 71220	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32231</p> <p>Based on observation, record review, and interviews, the facility failed to ensure the resident was treated with dignity and respect for 1 (#2) of 1 (#2) sampled residents who complained of a long call light response. The facility failed to ensure resident #2's call light was answered in a timely manner, after the resident had requested assistance from staff on 08/11/2024.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #2 was admitted to the facility on [DATE] with diagnoses including a colostomy. Further review revealed that resident #2 had a documented brief interview for mental status score of 14. A score of 13-15 indicated that resident #2 was cognitively intact with daily decision making skills.</p> <p>On 08/12/2024 at 10:23 a.m., an interview with resident #2 revealed he had used his call light three times on 08/11/2024 and requested staff assistance with the emptying of his colostomy bag.</p> <p>Review of the [NAME]-Care Report (a reporting system by which the facility obtained all nurse call activity) revealed a maximum response time of 32:34 (thirty two minutes and 34 seconds) on 08/11/2024.</p> <p>On 08/14/2024 at 11:56 a.m., S1Administrator was notified of resident #2's complaint of a long call light response on 08/11/2024. After reviewing the [NAME]-Care Report with S1Administrator, she confirmed a maximum wait time of 32:34 was too long of a response time.</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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(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and to prevent infection for 1(#3) of 2 (#1 and #3) sampled residents reviewed for pressure ulcers. The facility failed as evidence by resident #3 not having a dressing covering her sacral wound, in accordance with the physician's orders.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #3 was admitted to the facility on [DATE]. Resident #3's documented diagnoses included obesity, cerebral infarction, and an unstageable pressure ulcer of the sacrum.</p> <p>Review of the medical record revealed a physician's order dated 07/11/2024. Review of the order revealed that staff were to cleanse resident #3's sacral wound with wound cleanser, pat the wound dry, and apply Calcium Alginate to the wound bed. Further review of the order revealed to cover the wound with a silicone dressing, to change the dressing every other day and as needed.</p> <p>Upon entering resident #3's room on 08/12/2024 at 11:00 a.m., S4Certified Nursing Assistant (CNA) was observed repositioning the resident in bed. During the observation, a visual inspection of resident #3's skin with S4CNA revealed resident #3 had an open wound to her sacrum. Observation revealed there was no dressing covering the wound, therefore leaving it opened and exposed with feces inside of the wound bed. S4CNA revealed that she had bathed resident #3 at 9:30 a.m. and observed that resident #3 did not have a dressing in place at that time. She revealed that she had notified the nurse (referring to S5Licensed Practical Nurse) (LPN) of resident #3 not having a dressing on her sacrum.</p> <p>On 08/12/2024 at 11:28 a.m., S3Wound Care Nurse (WCN) was notified of the finding and the interview with S4CNA. S3WCN revealed that she was not aware of resident #3's sacral dressing being off. She confirmed that resident #3 should have had a dressing in place to cover the sacral pressure ulcer.</p> <p>On 08/12/2024 at 11:30 a.m., S1Administrator and S2Assistant Administrator were notified of the above findings.</p> <p>On 08/12/2024 at 11:35 a.m., S5LPN was notified of the interview with S4CNA. S5LPN revealed that she did not recall anyone notifying her of resident #3's sacral dressing being off.</p>		