

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Ponchatoula Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1560 Highway 51 Ponchatoula, LA 70454	

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 0600</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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173</p> <p>Based on observation, record reviews, and interviews, the facility failed to ensure each resident had the right to be free from physical abuse by another resident for 2 (#61 and #99) of 27 residents reviewed for abuse in the final sample. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #99 was free from physical abuse by Resident #61. 2. Resident #61 was free from physical abuse by Resident #99. <p>Findings:</p> <p>Review of the facility's Abuse Components Plan Elder Justice Act and Affordable Care Act policy dated 10/24/2022 revealed the following, in part:</p> <p>1.5 Policy:</p> <p>Residents have the right to be free from abuse .</p> <p>2.0 Definitions</p> <p>Abuse is defined as the willful infliction of injury Instances of abuse .cause physical harm, pain or mental anguish.</p> <p>Willful means the individual must have acted deliberately.</p> <ol style="list-style-type: none"> 1. <p>Resident #99</p> <p>Review of the Clinical Record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder and Anxiety.</p> <p>Review of the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 06/04/2024 revealed Resident #99 had a BIMS (Brief Interview of Mental Status) score of 14, which indicated he was cognitively intact.</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 0600</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 #99's Incident Report revealed the following:</p> <p>Date: 08/07/2024 at 11:06 a.m.</p> <p>Resident Incident Description: Resident #99 reported the aggressor (Resident #61) purposefully rolled into him while he was getting coffee. At the time Resident #99 attempted to defend himself resulting in the altercation.</p> <p>On 08/12/2024 at 10:30 a.m., an interview was conducted with Resident #99. He stated there was an incident where Resident #61 purposefully ran into him with his electric wheelchair. He stated he felt threatened so he defended himself.</p> <p>2.</p> <p>Resident #61</p> <p>Review of the Clinical Record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses, which included Depression.</p> <p>Review of the Quarterly MDS with an ARD of 06/03/2024 revealed Resident #61 had a BIMS of 12, which indicated he was cognitively moderately intact.</p> <p>Review of Resident #61's Incident Report revealed the following:</p> <p>Date: 08/07/2024 at 11:06 a.m.</p> <p>Resident Incident Description: Resident #61 reported he ran into Resident #99 due to feeling the other resident told on him and got him in trouble with the Administrative staff.</p> <p>On 08/14/2024 at 3:50 p.m., an interview was conducted S10LPN. She stated she was working the day of the altercation between Resident #99 and Resident #61. She stated she was in another resident's room when she heard screaming. She stated when she walked out into the dining area she saw Resident #61 in his wheelchair with blood on his forehead and skin tear to his arm. She stated Resident #61 was alert, oriented and was aware of the situation.</p> <p>On 08/14/2024 at 4:04 p.m., an interview was conducted with S7WC. She stated she witnessed the incident that occurred between Resident #99 and Resident #61. She stated Resident #99 was sitting in his wheelchair when Resident #61 purposefully rammed his electric wheelchair into him. She stated after being hit, Resident #99 was half out of his wheelchair with one knee to the ground. She stated Resident #61 started to punch Resident #99 and Resident #99 began to defend himself and hit back. She stated Resident #61 was noted to have cuts on his face and forearm.</p> <p>On 08/15/2024 at 8:50 a.m., an interview was conducted with S3DON. She stated on 08/07/2024 Resident #99 and Resident #61 were involved in an altercation. She stated Resident #61 purposefully rammed his electric wheelchair into Resident #99. She stated out of self-defense Resident #99 began punching Resident #61. She stated both resident's actions were purposeful.</p> <p>(continued on next page)</p>		

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<p>F 0600</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 08/15/24 09:03 a.m., an interview was conducted with S1ADM. S1ADM stated he was informed there had been an altercation between Resident #61 and Resident #99. He stated after speaking to the residents, Resident #61 told him he was upset with Resident #99, so he rammed into him using his electric wheelchair.</p> <p>On 08/15/2024 at 10:00 a.m., an observation and interview was conducted with S1ADM. The video surveillance of the 08/07/2024 incident occurring between Residents #61 and #99 was reviewed. Resident #61 was observed entering into the dining area where Resident #99 was sitting in his wheelchair. Resident #61 was observed running his electric wheelchair into Resident #99. Resident #61 continued to push Resident #99 in his wheelchair. Resident #99 stood up from his wheelchair and hit Resident #61. At that time both residents began hitting each other. S1ADM confirmed the above observation of Resident #61 and Resident #99 was purposeful and considered abuse.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on record review and interview, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1(#83) of 27 sampled residents by failing to ensure Resident #83 was coded correctly for active diagnoses.</p> <p>Findings:</p> <p>Review of Resident #83's clinical record revealed admitted [DATE]. Further review revealed Resident #83 had a diagnosis of Cataracts with onset date of 06/06/2024.</p> <p>Review of Resident #83's Quarterly MDS with ARD of 07/08/2024 revealed Cataracts was not coded as an active diagnosis in Section I.</p> <p>Review of Resident #83's optometrist progress note dated 06/06/2024 revealed, in part: diagnosis of Cataracts of left eye.</p> <p>Review of Resident #83's physician's progress notes dated 07/05/2024 revealed diagnoses which included Cataracts. History of Present Illness section revealed, in part: Resident #83 reported visual loss in the left eye for the last 3 weeks and was seen by the optometrist on 06/06/2024 who diagnosed him with cataracts which will require surgery.</p> <p>On 08/14/2024 at 9:40 a.m., an interview was conducted with S9MDS. She stated the process was for MDS department to review progress notes and add diagnosis to resident's diagnoses. After reviewing, Resident #83's progress note from optometrist appointment dated 06/06/2024, S9MDS confirmed the diagnosis for cataracts should have been added to the quarterly MDS with ARD of 07/08/2024 as an active diagnosis and was not.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981</p> <p>Based on interviews and record review, the facility failed to ensure services were provided by failing to follow physician orders for 1 (#18) of 26 residents investigated in the final sample.</p> <p>Findings:</p> <p>Review of the facility's policy titled Administering Oral Medications, dated 10/2010 revealed in part, the following:</p> <p>Steps in the procedure:</p> <p>6. Check the label on the medication and confirm the medication name and dose with the MAR.</p> <p>8. Check the medication dose. Re-check to confirm the proper dose.</p> <p>Review of Resident #18's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Acute on Chronic Diastolic Congestive Heart Failure and Chronic Respiratory Failure.</p> <p>Review of Resident #18's Physician's Orders revealed the following:</p> <p>Lorazepam Oral Concentrate 2 mg/mL. Give 0.25 mL by mouth every 4 hours as needed for agitation or shortness of breath, start date 08/06/2024.</p> <p>Review of Resident #18's MAR for August 2024 revealed the following:</p> <p>Lorazepam Oral Concentrate 2 mg/mL. 0.25 mL administered on 08/11/2024 at 2:06 p.m. by S4LPN.</p> <p>Review of the narcotic log for Resident #18 for August 2024 revealed the following:</p> <p>Medication: Lorazepam</p> <p>Name of Individual Administering: S4LPN</p> <p>Date: 08/11/2024</p> <p>Time: 2:06 p.m.</p> <p>Amount on Hand: 21 mL</p> <p>Amount Administered: 0.5 mL</p> <p>Amount Remaining: 20.5 mL</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was conducted on 08/13/2024 at 3:15 p.m. with S4LPN. She stated Resident #18 was having some shortness of breath on 08/11/2024 around 2:00 p.m. She stated she checked the narcotic log for the last administered time of Lorazepam for Resident #18. She stated Resident #18 had Lorazepam 0.5 mL ordered every 4 hours as needed. She stated she documented on the narcotic log and the MAR after she drew up the 0.5 mL of Lorazepam and administered it to Resident #18.</p> <p>An interview was conducted on 08/13/2024 at 4:00 p.m. with S3DON. She reviewed the narcotic log and MAR for Resident #18. She confirmed S4LPN did document a dose of 0.5 mL of Lorazepam given on 08/11/2024.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>46981</p> <p>Based on observation, interviews, and record review, the facility failed to ensure nurse staffing data requirements were documented on daily postings. This deficient practice had the potential to affect any of the 129 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's policy dated 01/2023 and titled Posting Direct Care Daily Staffing Numbers revealed in part, the following:</p> <p>Policy Interpretation and Implementation:</p> <p>2. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following:</p> <p>a. The name of the facility.</p> <p>An observation was made on 08/12/2024 at 8:05 a.m. of the staffing data sheet dated 08/12/2024. Further review revealed no documentation of the facility name.</p> <p>An interview was conducted on 08/12/2024 at 8:45 a.m. with S2AA. She reviewed the staffing data sheet dated 08/12/2024. She stated she was not aware the staffing data sheet required the facility name. She confirmed the staffing data sheet did not have the facility name.</p> <p>An interview was conducted on 08/12/2024 at 9:00 a.m. with S1ADM. He reviewed the staffing data sheet dated 08/12/2024. He confirmed the staffing data sheet did not have the facility name.</p>		

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<p>F 0761</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>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46981</p> <p>Based on observations, interviews, and record review, the facility failed to ensure medications were properly stored in 2 (Med Cart 2 and Med Cart 3) of 3 (Med Cart 1, Med Cart 2, and Med Cart 3) medication carts observed for medication storage.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Storage of Medications, dated 11/2020 revealed in part, the following:</p> <p>The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature.</p> <p>7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location.</p> <p>Review of the Lorazepam medication insert, which was located within the Lorazepam box, revealed in part, the following:</p> <p>How should I store Lorazepam? Store Lorazepam at a cold temperature. Refrigerate at 36 degrees Fahrenheit to 46 degrees Fahrenheit.</p> <p>Review of research information given to surveyor by facility's Pharmacy Consultant revealed in part, the following:</p> <p>Lorazepam storage: Refrigerate between 36 degrees Fahrenheit to 46 degrees Fahrenheit.</p> <p>Review of additional document given to surveyor by facility's Pharmacy Consultant titled Oral and Enteral Medications revealed in part, the following:</p> <p>Lorazepam Solution: Store in refrigerator.</p> <p>An observation was made on 08/12/2024 at 9:40 a.m. of Med Cart 2 with S5LPN. Observed 1 opened bottle of Lorazepam 2mg/mL for Resident #18, which was warm to touch, located in the narcotic lock box drawer of the medication cart. The Lorazepam bottle and box revealed a label which read Refrigerate located on the box and bottle.</p> <p>(continued on next page)</p>

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<p>F 0761</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>An interview was conducted on 08/12/2024 at 9:40 a.m. with S5LPN. S5LPN confirmed the label on Resident #18's bottle and box of Lorazepam read Refrigerate and should have been placed back into the refrigerator after each dose. S5LPN confirmed the bottle of Lorazepam was room temperature and opened. S5LPN reviewed the narcotic log book for Resident #18's Lorazepam and stated the last dose administered was on 08/11/2024.</p> <p>An observation was made on 08/12/2024 at 10:10 a.m. of Med Cart 3 with S6LPN. Observed 1 opened bottle of Lorazepam 2mg/mL for Resident #97, which was warm to touch, located in the narcotic lock box drawer of the medication cart. The Lorazepam bottle and box revealed a label which read Refrigerate located on the box and bottle.</p> <p>An interview was conducted on 08/12/2024 at 10:10 a.m. with S6LPN. S6LPN confirmed the label on Resident #97's bottle and box of Lorazepam read Refrigerate and should have been placed back into the refrigerator after each dose. S6LPN confirmed the bottle of Lorazepam was room temperature and opened. S6LPN reviewed the narcotic log book for Resident #97's Lorazepam and stated the last dose administered was on 08/12/2024. S6LPN stated she gave the last dose on 08/12/2024 at 9:32 a.m., and the bottle of Lorazepam was already located in Med Cart 3 prior to administering it. S6LPN stated the bottle of Lorazepam was left in Med Cart 3 for at least a week.</p> <p>An interview was conducted on 08/13/2024 at 12:05 p.m. with a local pharmacist. She stated liquid Lorazepam required refrigeration and would lose its potency if left in room temperature for extended periods of time.</p> <p>An interview was conducted on 08/13/2024 at 12:11 p.m. with the facility's pharmacist. She stated liquid Lorazepam required refrigeration and would lose its potency if left at room temperature for extended periods of time.</p>

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<p>F 0867</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>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48184</p> <p>Based on interviews and record review, the facility failed to implement appropriate plans of action to correct identified quality deficiencies for 1(#83) of 27 sampled residents.</p> <p>Findings:</p> <p>Review of the facility's Quality Assurance and Performance Improvement (QAPI) Program, revealed, in part, the following:</p> <p>Program: Facility leadership, including the Administrator and Director of Nursing are responsible to ensure there is an on-going, sustainable QAPI program that addresses identified priorities while allowing for adequate resources, staff time, and training.</p> <p>Facilities must maintain the following documentation and evidence of its ongoing QAPI program:</p> <p>Documentation demonstrating development, implementation and evaluation of corrective actions or performance improvement activities.</p> <p>Implementation: The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include:</p> <ul style="list-style-type: none"> a. Tracking and measuring performance c. Identifying and prioritizing quality deficiencies. e. Developing and implementing corrective action or performance improvement activities. f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. <p>Review of facility's Plan of Action/Continuous Quality Improvement, dated 07/22/2024, revealed, in part, the following:</p> <p>Problem Area Identified: Resident's care plans, and diagnoses list are not accurately completed.</p> <p>Corrective Actions: S2DON or designee will review 8 resident care plans and diagnoses a week to check accuracy. An in-service with the MDS staff was completed to ensure that residents care plans and diagnosis are completed and accurate.</p> <p>Review of the facility's Audits for Care plan Checklist, revealed no audit was conducted on Resident #83.</p> <p>Review of Resident #83's clinical record revealed admitted [DATE]. Further review revealed Resident #83 had a diagnosis of Cataracts with onset date of 06/06/2024.</p> <p>(continued on next page)</p>

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<p>F 0867</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 #83's Quarterly MDS with ARD of 07/08/2024 revealed Cataracts was not coded as an active diagnosis in Section I.</p> <p>An interview was conducted on 08/14/2024 at 9:40 a.m. with S9MDS. She stated the process was for MDS department to review progress notes and add diagnosis to resident's diagnoses. After reviewing, Resident #83's progress note from optometrist appointment dated 06/06/2024, S9MDS confirmed the diagnosis for cataracts should have been added to the quarterly MDS with ARD of 07/08/2024 as an active diagnosis and was not.</p> <p>An interview was conducted on 08/15/2024 at 2:40 p.m. with S3DON. S3DON reviewed Resident #83's clinical chart and confirmed he had a Cataract diagnosis dated 06/06/2024. She confirmed Resident #83's Quarterly MDS with an ARD of 07/08/2024 did not accurately reflect his current diagnosis of Cataracts. She stated there was an open QAPI for resident's care plans, and diagnoses list not accurately completed. She confirmed they had not addressed the issues of diagnoses on the MDS for Resident #83.</p> <p>An interview was conducted with S1ADM on 08/15/2024 at 1:20 p.m. He confirmed there was an open QAPI addressing MDS and Care Plans not reflecting active diagnosis. He confirmed they had not addressed the issues of diagnoses' on the MDS for Resident #83.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48912</p> <p>Based on observation and interviews, the facility failed to maintain an infection control program to ensure staff performed proper hygiene administering medication for 1 (#12) of 4 (#12, #38, #41, and #386) residents observed for medication administration.</p> <p>Findings:</p> <p>On 08/13/2024 at 7:35 a.m., an observation was made of S8MAC preparing medication for Resident #12. S8MAC dropped a pill onto the floor, picked up the pill, discarded the pill, and then continued to prepare additional medications without performing hand hygiene.</p> <p>On 08/13/2024 at 7:39 a.m., an interview was conducted with S8MAC. She confirmed she did not perform hand hygiene after picking up the pill off the floor and administering medication to Resident #12 and should have.</p> <p>On 08/13/2024 at 4:30 p.m., an interview was conducted with S3DON. She stated she expected staff to perform proper hand hygiene during medication administration. S3DON confirmed S8MAC should have performed hand hygiene after picking up the pill off the floor before continuing medication administration.</p>