STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195564	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acadia St Landry Nursing & Rehabilitation Center	830 S. Broadway Church Point, LA 70525

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record review and interviews the facility failed to ensure physician orders/plan of care were implemented as ordered for monitoring a bed alarm for proper functioning Q (every) shift for 1 (#2) of 4 (#1-#4)sampled residents. Findings: Review of Facility Policy titled, Policy for Fall Alarm, received and reviewed on 05/29/2024 read in part: 3. Alarms will be monitored every shift for proper functioning. Review of Resident #2's health record revealed an admitted [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, Depression, Schizoaffective Disorder, and Insomnia. Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 indicating the resident's cognition was severely impaired. Review of Resident #2's physician's orders revealed an order dated 01/16/2023 that read: Bed alarm while in bed monitor for proper functioning Q shift. Review of Resident #2's comprehensive plan of care revealed a problem of: Resident at Risk for Falls/Injury with an intervention that included, Bed alarm ordered while in bed. Monitor for proper functioning q shift. Review of Resident #2's March, April and May 2024 eTARs (Electronic Treatment Administration Records) revealed a treatment order for: Bed alarm while in bed, monitor for proper functioning Q shift. Further review of Resident #2's March, April and May 2024 eTARs revealed the treatment order to monitor the resident's bed alarm for proper functioning remained blank for the following dates: Day shift on March 9, 15, 24; April 6, 7, 20, 21, 28; May 4 and 19 Evening shift on March 4, 6, 7, 8, 11, 12, 13, 14, 18, 19, 20, 25, 26, 28 and April 1, 2, 4, 7, 8, 9, 25, 26, 30 and May 6, 9, 14, 16, 21, 23, 24, 26, 27 (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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night shift on March 6, 7, 8, 9, 10, 25, 29 and April 27 and May 3, 16, 17, 19, 26. On 05/28/202 at 1:45 p.m., an interview was conducted with S5CNA (Certified Nursing Assistant) in Resident #2's room. S5CNA stated that the only way to know if the resident's bed alarm was working was to test it by turning the resident and when the resident's weight was not detected, the bed alarm would signal a noise. S5CNA turned Resident #2, who was observed lying in bed, and when the resident's weight was taken off of the bed alarm pad, the bed alarm did not sound. S5CNA confirmed that the alarm was not working. On 05/28/202 at 1:50 p.m., an interview and observation of Resident #2 was conducted with S3LPN (Licensed Practical Nurse). S3LPN stated that she was the nurse assigned to Resident #2. She verified Resident #2 had a bed alarm that was checked once a week by the restorative aides. She verified that the bed alarm was not functioning appropriately. On 05/28/2024 at 2:00 p.m., an interview and record review was conducted with S1DON (Director of Nursing). She reported that the treatment nurses and the restorative aids were responsible for monitoring the working conditions of resident's alarms. Record review revealed multiple blanks on the eTARs for March, April, and May of 2024. S1DON verified that these blanks should have contained nursing signatures indicating staff were monitoring the resident's bed alarm.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49784 Based on observations, interview, and menu review, the facility's kitchen staff failed to follow the menu to ensure residents were served the appropriate portion/serving size of food during meals in order to meet the nutritional needs of the residents as evidenced by kitchen staff failing to use the correct serving utensils for pureed, mechanically soft, and non-mechanically altered foods. This deficient practice had the potential to contribute to an unpleasant dining experience, decreased intake, altered nutritional needs and weight loss for the 111 residents who consumed meals from the facility's kitchen. Findings: On 05/29/2024, a review of the facility's policy, Policy on Dietary Serving Sizes, revealed: Policy Purpose: To serve the appropriate portion/size of foods for meals. Procedure: 1. Use dietary menus provided by food supply company to provide the portion spread as recommended for each diet/texture using portion control information which is provided in dietary. Review of the lunch menu for 05/28/2024 revealed the following recommended serving portions: Carrot Souffle- 1/2 cup for Regular, Puree and Mechanical soft diets Mashed Potatoes- 1/2 cup for Puree diets Mechanical Soft Fried chicken- 4 oz (ounces) Pureed Fried Chicken- 1/2 cup Bite Size (Finger Food) - 4 oz On 05/28/2024 at 11:06 a.m., an observation was made of the kitchen staff serving meal trays. S2DM (Dietary Manager) provided menus of each food item served at lunch. Individual menus were reviewed, which indicated specific portion sizes to be served as listed above. Kitchen staff were observed serving incorrect portions as follows: Carrot souffle- #12 scoop (green) used (1/3 cup) Mashed potatoes-#12 scoop (green) used (1/3 cup) Chopped chicken - Red serving spoon used (2oz) Pureed fried chicken-Red serving spoon (1/4 cup) Bite sized Chicken- not measured, used tongs (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the lunch menu for 05/29/2024 revealed the following recommended serving portions for: Pureed Potato Salad- 1/2 cup for Regular, and Mechanical soft diets Steamed rice- 1/2 cup for Regular diets On 05/29/2024 at 11:00 a.m., an observation was made of the kitchen staff serving meal trays. S2DM provided menus of each food item served at this mealtime. Individual menus were reviewed, which indicated specific portion sizes to be served as listed above. Kitchen staff were observed serving incorrect portions as follows: Pureed potato salad- #12 scoop (green) used (1/3 cup) Steamed Rice- #12 scoop (green) used (1/3 cup) On 05/29/2024 at 11:45 a.m. an interview was conducted with S4COOK. She stated she was responsible for the lunch served today and for determining which serving utensils would be used for all meals served. She stated she knew which serving utensils to use from memory. She was unable to state how many ounces of food each serving utensils served. A review of the lunch menu with S4COOK conducted. She verified that she did not know how to utilize the menu to ensure the appropriate serving size was served for each menu item. S4COOK was unable to verify the serving size of each utensil. On 05/29/2024 at 11:50 a.m. an interview was conducted with S2DM. S2DM stated that the cooks were responsible for determining which serving utensils to use when serving portions of food. She referenced a chart on the wall in the kitchen which she said staff should use to determine which serving utensil to use for each portion size. She verified that incorrect serving utensils were used for both meals observed on 05/28/2024 and 05/29/2024 per the menus. She verified that bite sized meats should be measured per the menu for a mechanically soft diet and not served using tongs.