

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Acadia St Landry Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50950</p> <p>Based on record reviews and interviews, the facility failed to ensure the residents received mail on Saturdays. The deficient practice had the potential to affect 121 residents residing in the facility.</p> <p>Findings:</p> <p>A review of Resident #55's Quarterly MDS (Minimum Data Set) dated 11/27/2024 revealed she had a BIMS (Brief Interview for Mental Status) of 12, indicating she had moderately impaired cognition.</p> <p>A review of Resident #63's Quarterly MDS dated [DATE] revealed she had a BIMS of 13, indicating her cognition was intact.</p> <p>A review of Resident #99's Quarterly MDS dated [DATE] revealed she had a BIMS of 15, indicating her cognition was intact.</p> <p>On 02/10/2025 at 02:46 PM, during the resident council meeting, Resident #55, Resident #63, and Resident #99 stated they did not receive or were unsure if they received mail on Saturdays.</p> <p>On 02/11/2025 at 12:50 PM, an interview was conducted with S10T/SSA (Transportation/Social Services Assistant). S10T/SSA confirmed she is responsible for delivering mail to residents Monday through Friday. S10T/SSA confirmed she does not work on Saturday and Saturday's mail is held and delivered on Monday.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on record review, observation, and interviews, the facility failed to ensure a resident's change in condition was immediately reported for 2 (#43, #82) of 2 (#43, #82) residents as evidenced by:</p> <ol style="list-style-type: none"> Staff failing to report bilateral lower extremity edema for Resident #43 and; S10T (Transportation) failing to notify the physician of failed attempts to complete a consult for Resident #82's left shoulder pain. <p>Findings:</p> <p>Review of the facility's policy titled Change in Resident's Condition or Status, with a last reviewed date of 05/2017, read in part . Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the resident's Attending Physician, or physician on call when there has been a(n): d. significant change in the resident's physical, emotional, mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self- limiting); 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. There is a significant change in the resident's physical, mental, or psychosocial status.</p> <ol style="list-style-type: none"> Resident #43 <p>Review of Resident #43's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, atherosclerotic heart disease, and coronary artery without angina pectoris.</p> <p>Review of Resident #43's most recent Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating moderate cognitive impairment.</p> <p>Review of Resident #43's physician orders dated 02/2025 did not reveal interventions or medications related to edema.</p> <p>Review of Resident #43's care plan dated 12/03/2024 did not reveal any interventions for edema.</p> <p>Review of the facility's progress notes dated 12/16/2024 per S9LPN (Licensed Practical Nurse) read in part . resident had a 2+ pitting edema to her bilateral lower legs. Further review of S9LPN's progress note dated 02/06/2025 read in part .resident had a 2+ pitting edema to her bilateral lower legs.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of S11MD's (Medical Doctor) progress note dated 12/17/2024 read in part .Extremities: edema was absent. Further review of S11MD progress noted dated 02/06/2025 read in part .Extremities: edema was absent.</p> <p>On 02/11/2025 at 12:12 PM, an interview was conducted with S9LPN who stated she had observed Resident #43's bilateral lower extremities with 2+ pitting edema and confirmed she had not made the physician aware of the new onset of edema.</p> <p>On 02/12/2025 at 3:20 PM, an interview was conducted with S11MD who confirmed that staff had not made him aware of Resident #43's bilateral lower extremity edema and he should have been notified.</p> <p>2. Resident #82</p> <p>Review of Resident #82's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses that included in part, peripheral vascular disease, neuropathy, and left shoulder pain secondary to a fall.</p> <p>Review of Resident #82's most recent OBRA (Omnibus Budget Reconciliation Act) Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating moderate cognitive impairment.</p> <p>Review of Resident #82's physician order dated 02/05/2025 read in part .consult (local orthopedic physician) for left shoulder pain.</p> <p>On 02/11/2025 at 12:00 PM, an interview was conducted with Resident #82 who stated he had xray's completed on his left shoulder and he was told it was arthritis. The resident went on to state that his shoulder hurts with movement and his movement was limited to his left arm. He stated no one had told him what the doctors were going to do about his left shoulder pain.</p> <p>On 02/11/2025 at 3:00 PM, an interview was conducted with S13WC (Ward Clerk) who stated she had received the consult orders from the physician for Resident #82, and then sent the consult to S10T/SSA (Transportation/Social Services Assistant), so that they could make the appointment.</p> <p>On 02/11/2025 at 3:04 PM, an interview was conducted with S10T/SSA who stated she received the consult and the information to arrange an appointment for the resident with the local orthopedic physician. She added the local orthopedic physician's nurse stated the resident could not be seen while he was in rehab. S10T/SSA was asked if she notified the nurse that the consult could not be completed and she stated she tried to call the nurse on 02/07/2025, but the nurse didn't respond. When asked if she tried again to notify the nurse that the consult could not be completed, she stated no.</p> <p>On 02/11/2025 at 3:12 PM, an interview was conducted with S11MD (Medical Doctor) who stated he was not aware that the consult was not completed and staff should have informed him of that so that he could have made different arrangements.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50950</p> <p>Based on interview and record review, the facility failed to provide form CMS (Centers for Medicare and Medicaid Services) 10123- Notice of Medicare Non Coverage (NOMNC) as required for 1 Resident (#97) out of 3 (#13, #97 and #107) residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Notification. The facility had a census of 121 residents.</p> <p>A review of Resident #97's SNF Beneficiary Notification Review form revealed that the facility initiated the resident's discharge from Medicare Part A services when benefit days were not exhausted. Resident #97 was discharged from Medicare Part A services on 1/31/2025. Further review of Resident #97's EHR failed to reveal that a Notice of Medicare Non Coverage (NOMNC) form was provided to the resident.</p> <p>On 02/12/2025 at 3:19 PM, an interview was conducted with S19MDS/LPN (Minimum Data Set/Licensed Practical Nurse). S19MDS/LPN stated Resident #97's discharge was facility initiated, and the resident also had skilled benefit days remaining at the time of the discharge. S19MDS/LPN confirmed she did not provide Resident #97 a NOMNC form, and Resident #97 did not sign a NOMNC form.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</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** 47965</p> <p>Based on interviews and record reviews, the facility failed to protect the resident's right to be free from neglect for 1 (#105) of 39 sampled residents. S8CNA failed to obtain the appropriate number of persons required to utilize a mechanical lift to transfer Resident #105.</p> <p>This deficient practice resulted in actual harm for Resident #105 on 09/13/2024 at approximately 6:35 AM when S8CNA (Certified Nursing Assistant) moved the resident from a lying position to sitting position in preparation to transfer him into a chair without the assistance of a second person or a mechanical lifter as required by his plan of care. When S8CNA turned away from the resident to get his chair, he fell on the floor and hit his head resulting in a laceration to his right eyebrow and right cheek that required stitches.</p> <p>Findings:</p> <p>Review of Resident #105's clinical records revealed an admitted [DATE] with diagnoses which included but were not limited to unspecified dementia, psychotic disturbance and anxiety, and repeated falls.</p> <p>Review of Resident #105's State Optional MDS dated [DATE] revealed the following: Section G: Section G0110 A - Bed mobility Two + persons physical assist. B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet) Two + persons Physical assist.</p> <p>Review of Resident #105's quarterly MDS (Minimum Data Set) dated 01/01/2025 revealed in Section C, his BIMS (Basic Interview of Mental Status) interview was unable to be completed and his cognitive skills for daily decision making were severely impaired. Further review revealed in Section GG that the resident was dependent in chair/bed transfer, and the ability to move from lying on the back to sitting on the side of the bed with no back support was not attempted due to medical condition and safety concerns.</p> <p>Review of Resident #105's care plan revealed a focus problem of ADL self-care performance related to limited mobility and limited range of motion initiated 07/01/2024 and revised on 07/22/2024. Interventions included the resident has contractures of the right and left knee and right and left hand .requires mechanical lift with 2 staff assistance for transfers.</p> <p>Review of the facility's investigative report revealed in part that on 09/13/2024 at 6:35 AM, S24LPN (Licensed Practical Nurse) was called into Resident #105's room by S8CNA and observed the resident lying on his right side on the floor with hematoma under Resident #105's right eye and laceration on right forehead. Bleeding noted. Further review revealed a witness statement written by S8CNA on 09/13/2024 which read in part, I S8CNA sat Resident #105 on side of bed and then turned around to put chair closer to transfer him into chair. When I turned back to him, he had leaned on his side and rolled onto the floor .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the hospital records dated 9/13/2024 at 7:30 AM, revealed the resident arrived at the ED (Emergency Department) on 09/13/2024 at 6:57 AM with chief complaint of laceration to right eyebrow and right cheek. Treatment: Suture repair, tissue adhesive closure - 5 sutures. Head CT (cat scan), normal, no abnormalities noted. discharged in stable condition.</p> <p>During a phone interview with S8CNA on 02/11/2025 at 2:45 PM, she confirmed that she was caring for Resident #105 when he fell on [DATE]. S8CNA stated that she was trying to transfer the resident from his bed to his chair. She stated she sat him at the side of the bed then turned away to grab the chair. She explained that the resident was on the floor when she turned back around. S8CNA was asked how she knew how to transfer the resident and she stated it is on a dot that indicated his transfer needs over Resident #105's bed but she didn't check it because it is usually the same. S8CNA stated that she did not bring the lifter to Resident #105's room to transfer him nor did she have another CNA in the room to help her. She stated that she had asked S22CNA to help her, but she was helping another resident. S8CNA stated she wanted to get her work done and decided to transfer Resident #105 by herself when he fell .</p> <p>During an interview and review of Resident #105's MDS with S2DON and S3IP on 02/12/2025 at 10:22 AM, S2DON and S1IP both agreed that because Resident #105 was coded in the MDS as not attempted transfer from lying to sitting at bedside due to safety concerns. Both confirmed that S8CNA should not have transferred the resident by herself.</p> <p>During a follow-up interview on 02/12/2025 at 4:41 PM, with S2DON, and S3IP. S2DON stated that S8CNA had been working at the facility since 1996 and should have known better. She stated S8CNA should not have gotten the resident from his bed to sit at the side of the bed without assistance of another person. S2DON and S3IP both stated that S8CNA should have waited for assistance before getting the resident out of bed.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269</p> <p>Based on record review and interview, the facility failed to refer residents with newly diagnosed mental disorders or had a significant change in their mental condition to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) for evaluation and determination for 2 (#22, #74) of 3 (#22, #74 and #89) residents investigated for PASARR in a final sample of 39 residents.</p> <p>Findings:</p> <p>Resident #22</p> <p>Review of Resident #22's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with the following pertinent diagnoses: Insomnia and Anxiety Disorder.</p> <p>Review of Resident #22's EHR revealed a Level I PASARR screening was completed on 02/07/2023 by the hospital case manager that the resident was admitted from.</p> <p>Further review of Resident #22's EHR revealed the resident was later diagnosed with Unspecified Psychosis on 12/08/2023.</p> <p>Review of Resident #22's February 2025 physician's orders revealed an order dated 02/15/2024 for an antipsychotic medication of Olanzapine tab (tablet) 5 MG (milligrams)- Give 1 tablet by mouth at bedtime related to Unspecified Psychosis.</p> <p>Review of Resident #22's EHR failed to reveal evidence that the facility referred the resident to the appropriate state-designated authority for Level II PASARR after being diagnosed with psychosis.</p> <p>On 02/12/2025 at 3:20 PM, an interview was conducted with S15LPN (Licensed Practical Nurse). She stated that she was responsible for the Resident Review and confirmed she only completed the Resident Review Form if the resident was readmitted to the facility from a Mental Health Hospital. S15LPN further stated she was not aware that a new Level II resident review diagnosed with serious mental disorder, intellectual disability, or a related condition. S15LPN confirmed no Level II review was completed after the new diagnosis of psychosis for Resident #22.</p> <p>51596</p> <p>Resident #74</p> <p>Review of Resident #74's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with the following pertinent diagnosis: Psychosis.</p> <p>Review of Resident #74's EHR revealed a PASARR Level I was completed on 08/02/2024 and indicated Resident #74 had not been diagnosed as having a mental illness.</p> <p>(continued on next page)</p>		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Review of Resident #74's Order Summary Report dated 02/12/2025 revealed an order for Quetiapine Fumarate 50mg give 1 tablet by mouth at bedtime for Unspecified Mood Disorder with an order date of 08/27/2024.</p> <p>Review of Resident #74's EHR failed to reveal evidence that the facility referred the resident to the appropriate state-designated authority for Level II PASARR after being diagnosed with psychosis.</p> <p>On 02/12/2025 at 3:09 PM, an interview was conducted with S14AADM. She confirmed Resident #74 did not have a PASARR Level II review.</p> <p>On 02/12/2025 at 3:17 PM, an interview was conducted with S15LPN. S15LPN confirmed no Level II review was completed after the new diagnosis of psychosis for Resident #74.</p> <p>On 02/12/2025 at 5:10 PM, S5LPN/Adm confirmed the facility did not have a PASARR policy.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540</p> <p>Based on record review and interviews, the facility failed to ensure a resident's plan of care was implemented for 1 (#107) out of 1 (#107) resident out of 39 sampled residents. The facility failed to ensure Resident #107's weekly weights were completed as ordered.</p> <p>Findings:</p> <p>A review of Resident #107's Admission Record, revealed she was admitted to the facility on [DATE] with diagnoses that included in part, gastrostomy status and acute kidney failure.</p> <p>A review of Resident #107's most recent quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 8, which indicated the resident's cognition was moderately impaired.</p> <p>A review of Resident #107's Order Summary Report revealed a physician's order, dated 09/20/2024 that read, weekly weight Q (every) Friday every evening shift every Friday.</p> <p>A review of Resident #107's weights in the EHR (Electronic Health Record) failed to reveal weekly weights on 10/04/2024, 10/11/2024, 10/18/2024, 11/01/2024, 11/08/2024, 11/15/2024, 11/22/2024, 12/06/2024, 12/13/2024, 12/20/2024, 01/03/2025, 01/10/2025, 01/17/2025, 01/24/2025, and 02/07/2025</p> <p>On 02/12/2025 at 9:20 AM, an interview was conducted with S7ResCNA Restorative Certified Nursing Assistant. She stated residents' weights are documented in a book, then put into the kiosk, and then the nurse puts them into the EHR. A record review of Resident #107's weights conducted at this time with S7ResCNA and weekly weights from October 2024 to February 2025 were not completed. She stated she was never notified about the resident being on weekly weights.</p> <p>On 02/12/2025 at 10:46 AM, an interview and record review were conducted with S2DON (Director of Nursing) She stated Resident #107's weights were ordered weekly by the physician. After reviewing the resident's medical records she confirmed Resident #107's weights were not completed weekly from October 2024 to February 2025 and should have been.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540</p> <p>Based on observations, interviews, and record review, the facility failed to provide the necessary care and services to provide a communication aid for 1 (#88) out of 3 (#65, #88, and #115) residents reviewed for communication.</p> <p>Findings:</p> <p>A review of Resident #88's admission record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, heart failure, hypertension, and atrial fibrillation.</p> <p>A review of Resident #88's most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, which indicated the resident was cognitively intact.</p> <p>A review of Resident #88's care plan initiated on 06/03/2024, revealed the resident had the potential for communication difficulties or declines due to speaks Spanish. Interventions included that read in part, use communication board or chart when needed/ordered for resident with difficulty in communication (initiated on 06/03/2024).</p> <p>On 02/10/2025 at 10:03 AM, an observation was conducted of Resident #88. Resident #88 pointed to different items in the room and on himself. Resident #88 was observed not speaking English. At this time, there was no communication aid/board to assist in communication with the resident in his room.</p> <p>On 02/10/2025 at 10:10 AM, an observation and interview was conducted with Resident #88 and S5LPN/Adm (Licensed Practical Nurse/Admissions). S5LPN/Adm stated the resident was Spanish speaking only and did not speak any English. She stated she was Spanish-speaking and could translate for the staff when she worked on Monday - Friday, 8:00 a.m. - 4:00 p.m. She confirmed there was no communication aid/board to assist in communication with the resident when she was not working. She translated to Resident #88 in Spanish how he communicates his needs to staff when she is not here, and the resident stated to her that he tries to point to stuff, but they do not understand him.</p> <p>On 02/12/2025 at 9:03 AM, an interview was conducted with S6CNA (Certified Nursing Assistant). She stated Resident #88 is Spanish-speaking only and is only able to say yes and hello in English. She stated the staff communicates with him through S5LPN/Adm who is Spanish-speaking. She stated when S5LPN/Adm is not here she will make hand gestures to the resident. She confirmed there was no communication aid at the bedside to assist in communication with the resident.</p> <p>On 02/12/2025 at 9:05 AM, an observation of Resident #88's room revealed that no communication aid was present to assist in communication with the resident.</p> <p>On 02/12/2025 at 9:09 AM, an interview was conducted with S4LPN (Licensed Practical Nurse). She stated Resident #88 speaks Spanish 90% of the time and they communicate to him with S5LPN/Adm. She stated when S5LPN/Adm was not working they communicate to him with body language. She confirmed there was no communication aid at the bedside to assist in communication with the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Acadia St Landry Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 830 S. Broadway Church Point, LA 70525	
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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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/12/2025 at 10:20 AM, an observation of Resident #88's room revealed that no communication aid was present to assist in communication with the resident.</p> <p>On 02/12/2025 at 11:04 AM, an interview was conducted with S2DON (Director of Nursing). S2DON stated that Resident #88 was only Spanish-speaking, and he barely speaks any English. She stated that they communicate with the resident with S5LPN/Adm, who was Spanish-speaking. She confirmed that there was no communication aid at the bedside to assist in communication with the resident.</p> <p>On 02/15/2025 at 1:01 PM, S2DON stated there was not a policy and procedure related to communication/translation services.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540</p> <p>Based on record reviews and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis facility through use of dialysis communication forms for 1 (#8) out of 2 (#8 and #223) residents sampled for dialysis services.</p> <p>Findings:</p> <p>On 02/12/2025, a review of the facility's agreement with the Contracted Dialysis Agency with an effective date of 01/01/2011 read in part, Collaboration of Care - Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD (End-Stage Renal Disease) Dialysis Unit.</p> <p>A review of Resident #8's admission record revealed an admitted [DATE] with diagnoses that included, but were not limited to, dependence on renal dialysis and chronic kidney disease.</p> <p>A review of Resident #8's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating his cognition was moderately impaired. Section O - Special Treatments, Procedures, and Programs revealed the resident was receiving dialysis.</p> <p>A review of Resident #8's care plan initiated on 08/15/2024 revealed the resident was at risk for complications of renal failure/ESRD requiring dialysis. Interventions read in part, dialysis on Tuesdays, Thursdays, & Saturdays at a contracted dialysis agency.</p> <p>A review of Resident #8's dialysis communication record form located in the resident's paper medical record from January 2025 to the present was reviewed. The paper medical record revealed no documented evidence of a dialysis communication record form on 01/09/2025, 01/11/2025, 01/28/2025, 01/30/2025, and 02/04/2025.</p> <p>On 02/12/2025 at 9:10 AM, an interview was conducted with S4LPN (Licensed Practical Nurse). S4LPN stated there was a dialysis communication record form that was sent back and forth between the facility and the contracted dialysis agency on all dialysis days. She stated the dialysis communication record form was how the nurses and the dialysis nurses communicated with one another about the resident's needs and care. The dialysis communication record form include the resident's vital signs before and after dialysis treatment, how much fluid was removed from the resident, and any labs or medication(s) changes. S4LPN further stated upon the resident's return from dialysis, the dialysis communication record form was reviewed and then placed in the resident's paper medical record.</p> <p>On 02/12/2025 at 10:53 AM, a record review and interview was conducted with S2DON (Director of Nursing). She stated that a dialysis communication form is completed before and after every dialysis visit. S2DON then walked to the nurse's station to see if communication forms were in Resident #8's s paper medical record. She confirmed there were no dialysis communication forms on 01/09/2025, 01/11/2025, 01/28/2025, 01/30/2025, and 02/04/2025 and should have been.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/12/2025 at 2:39 PM, an interview was conducted with S20ADON (Assistant Director of Nursing). S20ADON provided two envelopes with dialysis communication forms from 01/28/2025 and 01/30/2025 and stated they were in Resident #8's backpack. She confirmed they were not in the resident's electronic or paper medical record for staff to review.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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>51596</p> <p>Based on observations and interviews, the facility failed to ensure drugs were stored in accordance with currently accepted professional principles by:</p> <ol style="list-style-type: none"> 1. having loose pills in 2 (Cart A and Cart B) of 2 medication carts checked for safe and secure storage; 2. failing to ensure expired medications were not available for administration to residents in 2 (Cart A and Cart B) of 2 medication carts checked for safe and secure storage; and 3. failing to ensure medications were stored at the proper temperatures to preserve their integrity. <p>This deficient practice had the potential to affect 121 residents residing in the facility.</p> <p>Findings:</p> <p>On 02/12/2025, a review of the facility's undated policy entitled, Storage of Medications, revealed, in part, drugs are stored at the proper temperature. Drugs are stored in the packaging, containers or other dispensing systems in which they are received. Nursing staff is responsible for maintaining medication storage areas in a safe manner. Outdated drugs are returned to the pharmacy or destroyed. Medications requiring refrigeration are stored in the refrigerator.</p> <p>Observation of Cart A on 02/11/2025 at 9:38 AM with oversight from S25LPN (Licensed Practical Nurse) revealed 3 unidentified and loose tablets in the bottom of the 2nd drawer of the cart. Observation revealed 1 bottle of Folic Acid 1000mg (milligram) tablets with an expiration date of 10/2024 and 1 bottle of Vitamin B6 100mg tablets with an expiration date of 11/2024. An interview was conducted with S25LPN at this time who confirmed the loose tablets and expired medications were in the medication cart and should not have been.</p> <p>Observation of Medication Storage Room A on 02/11/2025 at 10:15 AM with oversight from S25LPN revealed two unopened boxes Latanoprost solution 0.005% eye drops labeled refrigerate in an unrefrigerated drawer. S25LPN confirmed the two medications labeled refrigerate should have been stored in the refrigerator but were not.</p> <p>Observation of Cart B on 02/11/2025 at 11:30 AM with oversight from S26LPN revealed 4 unidentified and loose tablets in the bottom of the 2nd drawer of the cart. Observation revealed 1 bottle of Nasal Moisturizing Spray with an expiration date of 01/2025, 1 bottle of Lutein 15mg tablets with an expiration date of 12/2024, and one bottle of Vitamin E 450mg tablets with an expiration date of 10/2024. An interview was conducted with S26LPN at this time who confirmed the loose tablets and expired medications were in the medication cart but should not have been.</p> <p>(continued on next page)</p>

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 02/11/2025 at 2:55 PM was conducted with S2DON (Director of Nursing). She confirmed loose tablets and expired medications should not be in the medication carts. She confirmed medications labeled refrigerate should have been stored in the refrigerator.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49784</p> <p>Based on observations and interviews, the facility failed to maintain a clean and sanitary kitchen to prevent the likelihood of foodborne illnesses and store and serve meals in accordance with professional standards for food service safety. The deficient practice had the potential to effect the 118 residents who consumed meals prepared from the facility's kitchen.</p> <p>On 02/10/2025 at 8:35 AM, an initial tour of the kitchen was conducted with S17DM (Dietary Manager) and revealed the following:</p> <p>1. Food storage:</p> <p>A. Refrigerated items:</p> <ol style="list-style-type: none"> 1. One bottle of lemon juice with an expiration date of 12/14/2024 2. One bottle of barbecue sauce with an expiration date of 09/11/2024 3. One bottle of whipped topping with an expiration date of 06/27/2024 4. One container of sour cream with an expiration date of 01/27/2025 5. One container of sour cream with an expiration date of 01/27/2025 6. One bag of cabbage with an expiration date of 01/19/2025 7. A freezer burned box of pies 8. Opened and undated beef <p>B. Dry storage:</p> <ol style="list-style-type: none"> 1. Ten individually packed soft baked cookies with an expiration date of 09/25/2024 2. Three individually packed soft baked cookies with an expiration date of 10/19/2024 3. One individually packed soft baked cookie with an expiration date of 12/03/2024 4. One dead cockroach under a shelf 5. Crumbs and dirt on the floor under shelving units 6. Dried substances on the light switches and face plate over the light switches 7. Dried substances on a double light switch outside of the door <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>C. Food preparation station:</p> <ol style="list-style-type: none"> 1. Dried food debris on the facing of a drawer under the table 2. Dusty dishes and dish covers on the counter 3. Dried food debris on a wall over the station 4. Crumbs on the bottom shelf <p>2. Equipment:</p> <ol style="list-style-type: none"> A. Dirt and trash debris on a maintenance double shelved rolling cart B. Yellow particles in a watery liquid in the collection tray of the steamer C. [NAME] debris on the ice scoop D. [NAME] debris on the bottom of the ice scoop container E. Dirt and dried food debris on the bottom exterior edges of the large, rolling, warming cart F. Food debris and dirt on the bottom interior and orange shelving of the large, rolling, warming cart G. Dried food debris on the front facing of the large, rolling, warming cart H. Dried food debris on the front facing of the microwave oven I. Dried food debris and crumbs inside the microwave oven J. Dried food debris and crumbs on the waffle maker K. Crumbs on a blender L. Crumbs and dust on a food scale M. Dust on an electric can opener N. Dried food debris and grease on the fryer O. Dried food debris on the faces of the ovens P. Dried food debris on the front and side facing of the refrigerator Q. Dust and crumbs on the bottom ventilation cover of the refrigerator R. Orange, dried, food debris on the face plate of the mixer <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>S. Crumbs and dried food debris on the slicer</p> <p>T. Black substance on a return ventilation cover</p> <p>3. Unopened Items:</p> <p>A. Two bags of hamburger buns, opened and not dated</p> <p>B. Two bags sliced bread, opened and not dated</p> <p>C. Two bags of hot dog buns opened and not dated</p> <p>4. Storage Containers:</p> <p>A. Dust, dirt, and debris on the lid of the frosting mix storage container</p> <p>B. Dust, dirt, and debris on the lid of the white/yellow cake storage container</p> <p>C. Dust, dirt, and debris on the lid of the frosting mix storage container</p> <p>D. Dust, dirt, and debris on the lid of the cornbread mix storage container</p> <p>E. Dust, dirt, and debris on the lid of the blueberry muffin/brownie mix storage container</p> <p>F. Dust, dirt, and debris on the lid of the blueberry muffin/brownie mix storage container</p> <p>G. Dust, dirt, and debris on the lid of the grits storage container</p> <p>H. Dust on the lid of the cheese cake mix/chocolate cake mix storage container</p> <p>I. Dust on the lid of the pancake mix storage container</p> <p>J. Crumbs and dust on the lid of the sliced potatoes storage container</p> <p>K. Crumbs and dust on the lid of the diet cake mix storage container</p> <p>L. Crumbs and dust on the lid of the diet cheese cake/lemon cake/ gingerbread mix storage container</p> <p>M. Crumbs and dust on the lid of the cookies storage container</p> <p>N. Dried brown food residue on the side of the flour storage bin</p> <p>O. Dried brown food residue on the side of the sugar storage bin</p> <p>P. Crumbs on the lid of the rice storage bin</p> <p>5. Dishwashing station:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A. Dried, yellow food debris on the left adjacent wall to the three compartment sink</p> <p>B. Black substance resembling mold/dirt on the wall over the backsplash in the dish washing room</p> <p>C. [NAME] and brown debris on the floor underneath the automatic dishwasher</p> <p>D. A thick, black substance was on the floor and baseboards of the dishwashing room</p> <p>E. A box on the lower shelf of the three compartment sink contained pot holders with a plunger on top of the potholders.</p> <p>6. Other surfaces:</p> <p>A. Crumbs on stored, clean serving containers</p> <p>B. Crumbs on a shelf storing clean pots and pans</p> <p>C. Dirty floor underneath the pots and pans storage shelf</p> <p>D. Crumbs on a tray holding clean utensils</p> <p>7. Food temperatures served from mobile food cart on Hall A:</p> <p>A. Rice with sausage served at 129 degrees</p> <p>B. Black eyed peas served at 108 degrees</p> <p>C. Collard greens served at 109 degrees</p> <p>D. Milk served at 51 degrees</p> <p>S17DM confirmed findings during the tour.</p> <p>On 02/10/2025 at 12:10 PM, an interview was conducted with S17DM. She stated that there were no specific cleaning schedules documented for review. She stated that the cook and one dietary aid were responsible for cleaning the pots, pans, and serving dishes and the dietary aids were responsible for cleaning the food carts after meals. She stated that these were the only specific cleaning duties assigned. She was unaware of any policies related to cleanliness in the kitchen.</p> <p>On 02/10/25 at 12:27 PM, an interview and observation was conducted with S17DM on HallA. Food temperatures of the last tray served on Hall A were taken by S17DM which included: rice with sausage at 129 degrees; black eyed peas at 108 degrees; collard greens at 109 degrees; and milk at 51 degrees. S17DM confirmed that these were not appropriate temperatures to serve.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</p> <p>Based on observation, interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure the well-being of residents by failing to provide oversight of the kitchen's cleanliness, sanitation, and practices for safe food service. The deficient practice had the potential to effect the 118 residents who consumed meals prepared from the facility's kitchen.</p> <p>Findings:</p> <p>Cross Reference F812</p> <p>On [DATE] at 8:35 AM, an tour of the facility's kitchen revealed surfaces with an accumulation dust, dirt, food residue and other debris and expired food items. In addition, a meal was served at temperatures that were not within an appropriate range during distribution of hall trays.</p> <p>Review of the facility's State of Louisiana Department of Health, Office of Public Health, Retail Food Notice of Violations dated [DATE] at 12:30 PM, read in part: Non-Critical Items: Description of Violations: Non-food contact surfaces of equipment have an accumulation of dust, dirt, food residue and other debris. Food carts are not clean. Floors are not clean. (Corrected). Floors along the walls under the dishwashing machine and in the dishwashing room are not clean. (Repeated)</p> <p>Review of the facility's State of Louisiana Department of Health, Office of Public Health, Retail Food Notice of Violations dated [DATE] at 10:00 AM, read in part: Non-food contact surfaces of equipment have an accumulation of dust, dirt, food residue and other debris. Inside the microwave oven and seasoning cabinet are not clean. (Repeat). Floors are not clean. Floors are not clean along the walls under the shelves in the walk in cooler, walk in freezer and the dishwashing area (Repeat).</p> <p>On [DATE] at 4:30 PM, an interview was conducted with S1ADM (Administrator). S1ADM confirmed the presented findings in the kitchen.</p> <p>On [DATE] at 9:43 AM, an interview was conducted with S1ADM. He stated he was unaware of any inspection performed by OPH (Office of Public health) since 2023. S1ADM stated that S17DM had been notified of the results but had not relayed those results to him. He stated that S17DM (Dietary Manager) was responsible for all activities in the kitchen, including ensuring cleanliness, however, he had total oversight of the kitchen.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections by failing to ensure contact precautions were followed for 1 (#74) of 4 (#21, #27, #74 and #273) residents on contact precautions.</p> <p>Findings:</p> <p>On 02/13/2025, a review of the facility's policy titled Application of Transmission-Based Precautions with a revised date of 11/05/2024, read in part .Contact Precautions: Intended to prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment. Staff caring for residents on Contact Precautions should wear gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.</p> <p>Resident # 74 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to urinary tract infection, and benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>A review of Resident #74's quarterly MDS dated [DATE] revealed he had an indwelling catheter.</p> <p>A review of Resident #74's care plan revealed a focus area dated 01/28/2025 for Contact Isolation precaution. Interventions included in part, signs placed outside of resident's room to alert staff visitors to check with nurse before entering room and proper PPE (Personal Protective Equipment) required before entering room.</p> <p>On 02/10/2025 at 10:20 AM, an observation was made of Resident #74's room. A large sign was observed on the door that read in part: Contact Precautions Everyone Must .Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit .</p> <p>During an interview with S7ResCNA (Restorative Certified Nursing Assistant) on 02/10/2025 at 10:20 AM, S7ResCNA stated that Resident #74 was at therapy. When asked if the resident still went to therapy while on contact precautions, she stated He has been going to therapy. S7ResCNA opened the resident's door and confirmed he was not in the room.</p> <p>On 02/10/2025 at 10:28 AM, an observation was made of the therapy room. S21PTTech (Physical Therapy Tech) was pushing the resident in his wheelchair and was not wearing gown or gloves. S21PTTech stated she was taking the resident back to his room. When asked stated she was unaware he was on Contact Precautions.</p> <p>On 02/10/2025 at 11:06 AM S22CNA (Certified Nursing Assistant) was observed in Resident #74's room without gown or gloves. She was pushing the resident in his wheelchair towards his door. S3IP (Infection Preventionist) confirmed S22CNA did not have a gown or gloves on while in the resident's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Acadia St Landry Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 02/10/2025 at 11:09 AM, Resident #74's was asked who took him to therapy in the morning, and he stated S7ResCNA took him to therapy.</p> <p>During an interview with on 02/10/2025 at 10:58 AM with S3IP, she confirmed Resident #74 was on Contact Precautions. She stated that he had ESBL (Extended spectrum beta-lactamase) in his urine and was on antibiotics. S3IP stated the resident should not have gone to therapy due to risk of contamination.</p> <p>During a follow-up interview with S7ResCNA on 02/11/2025 at 10:50 AM, stated that she was aware the resident was on Contact Precautions but confused it for enhanced barrier. S7ResCNA stated she should not have taken the resident out his room because he was on Contact Precautions.</p> <p>During an interview with S23OT (Occupational therapist) on 02/11/2025 at 2:10 PM, she stated Resident #74 received physical, occupational and speech therapy. She stated that therapy staff never goes to his room to get him, so they were unaware that he was on contact precautions and were not using gown or gloves. She further stated that the infection preventionist usually makes them aware, but she did not.</p>		

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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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observation and interview, the facility failed to ensure that residents who were capable of using call bells were able to reach the call bell for 1 (#60) of 39 sampled residents.</p> <p>Findings:</p> <p>Resident #60 was admitted to the facility on [DATE] with diagnoses which included, but were not limited, to major depressive disorder and repeated falls.</p> <p>A review of Resident #60's quarterly MDS (Minimum Data Set) dated 10/30/2024, revealed in Section GG that she had no upper extremity impairments.</p> <p>On 02/10/2025 at 9:46 AM, an observation was made of Resident #60 in her room. The resident was lying in her bed and her call bell was on the night stand at the foot of her bed. The call bell was outside of the resident's reach. When asked, Resident #60 stated that she did not know where her call bell was.</p> <p>During an observation and interview with S18LPN (Licensed Practical Nurse) on 02/10/2025 at 9:50 AM, she confirmed the resident's call bell was out of Resident #60's reach. S18LPN stated Resident #60 was capable of using her call bell, and it should have been pinned to the resident's bed where she can reach it and not placed on the night stand at the foot of bed where the resident was unable to reach it.</p>