

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Cornerstone at the Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE  103 West Martial Ave Lafayette, LA 70506	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46149</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's dignity by failing to provide a covering for a urinary catheter bag for 1 resident (#70) out of 41 sampled residents.</p> <p>Findings:</p> <p>On 07/10/2024, review of the facility's policy titled Quality of Life - Dignity with a last updated date of 06/26/2023 read in part: 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered .</p> <p>Review of Resident #70's EHR (Electronic Health Record ) revealed he was admitted to the facility on [DATE] with diagnoses including Acute Kidney failure, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms and Obstructive and Reflex Uropathy.</p> <p>Review of Resident #70's plan of care revealed the following problems :</p> <p>-Requires assist with ADLs (Activities of Daily Living ) related to dressing, grooming, bathing, and hygiene related to left femur fracture/muscle weakness</p> <p>-I have a suprapubic catheter r/t (related to ) BPH/obstructive and reflex uropathy</p> <p>On 07/08/2024 at 11:28 a.m., an observation was made of Resident #70 sitting in his wheelchair in the dining room. The resident's catheter drainage bag was observed with approximately 300 cc's of yellow urine, facing other residents in the dining room. There was no covering over the drainage bag.</p> <p>On 07/08/2024 at 11:38 a.m., S1DON (Director of Nursing ) observed Resident #70's catheter drainage bag with no covering or bag. She confirmed that the resident should have had a covering or bag over his catheter drainage bag.</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 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47965</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the cleanliness of wheelchairs for 2 (#30 and #35) out of 2 (#30 and #35) residents investigated for a safe, clean, comfortable and homelike environment, out of a total sample size of 41 residents.</p> <p>Findings:</p> <p>On 07/10/2024, a review of the facility's policy titled Wheelchair Cleaning with a last reviewed date of 01/07/2024 read in part, Policy: The purpose of this policy is to establish cleanliness of resident's wheelchairs .4.) Wheelchairs are to be cleaned weekly, when soilage, or upon request .</p> <p>Resident #30:</p> <p>Resident #30 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Muscle Weakness, Unspecified Lack of Coordination, and Occlusion and Stenosis of Right Posterior Cerebral Artery.</p> <p>A review of Resident #30's quarterly MDS dated [DATE], revealed in section C that she had a BIMS (Basic Interview for mental Status) of 14, indicating her cognition was intact. Further review revealed in section GG that she used a wheelchair.</p> <p>A review of the facility's wheelchair cleaning schedule revealed Resident #30's wheelchair was scheduled to be cleaned on Mondays and Thursdays but there was no documentation of when it was last cleaned.</p> <p>On 07/08/2024 at 8:44 a.m., an observation was made of Resident #30 in her wheelchair. The resident's wheelchair had a layer of dust on the metal parts of the chair that were visible.</p> <p>On 07/09/2024 at 07:41 a.m., a second observation was made of Resident #30 in her wheelchair. The resident's wheelchair was still dirty. The resident stated her wheelchair had never been cleaned.</p> <p>On 07/10/2024 at 10:40 a.m., an interview and observation of Resident #30's wheelchair was conducted with S14CNA (Certified Nursing Assistant) while the resident was outside on the patio. She confirmed the resident's wheelchair was dirty and stated it should not have been.</p> <p>Resident #35:</p> <p>Resident #35 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Major Depressive Disorder and Post-Traumatic Stress Disorder.</p> <p>A review of Resident #35's quarterly MDS revealed in section C that he had a BIMS of 12. Further review revealed in section GG that he used a wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's cleaning schedule revealed Resident #35's wheelchair was scheduled to be cleaned on Wednesday's and Saturdays, but there was no documentation of when it was last cleaned.</p> <p>On 07/10/2024 at 10:40 a.m., an interview and observation of Resident #35's wheelchair was conducted with S14CNA while the resident was outside on the patio. A thick layer of dust was observed on Resident #35's wheelchair. Resident #35 stated his wheelchair had never been cleaned. S14CNA confirmed Resident #35's wheelchair was dirty and stated that it should not have been.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17364</p> <p>Based on record review and interview, the facility failed to complete a baseline care plan that addressed pain for 1(#178) out of 41 sampled residents.</p> <p>Findings:</p> <p>Resident #178. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Hyperlipidemia, Diabetes, Hypertension, and Fracture Upper end of Right Humerus.</p> <p>Review of the resident's physician's orders revealed an order for Oxycodone 10 mg (milligrams) 1 po (by mouth) every 4 hours prn (as needed) pain.</p> <p>Review of the resident's baseline care plan dated 06/26/2024 revealed no evidence pain was addressed in the plan.</p> <p>On 07/10/2024 at 2:06 p.m., an interview was conducted with S3MDS (Minimum Data Set Coordinator). S3MDS stated that she could not provide documentation that a pain assessment was initiated on the resident. S3MDS reviewed the resident's baseline care plan and confirmed that pain was not addressed in the plan.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17364</p> <p>Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered plan of care for each resident as evidenced by:</p> <ol style="list-style-type: none"> <li>1. failing to address Resident #38's Major Depression with Severe Psychotic Symptoms,</li> <li>2. failing to ensure Resident #58's catheter tubing was cleaned as ordered,</li> <li>3. failing to ensure Resident #70's diabetic sensor was implemented as ordered for blood sugar checks and,</li> <li>4. failing to address Resident #50's communication,</li> <li>5. failing to address Resident #62's need for feeding assistance for 5 (#38, #50, #62, #70, #58) out 41 sampled residents.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Resident #38. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included Major Depressive Disorder, Recurrent with Severe Psychotic Symptoms.</li> </ol> <p>Review of the resident's physician's orders revealed an order for Celexa (antidepressant medication) 20 mg (milligrams) one by mouth every day.</p> <p>Review of the resident's quarterly MDS (Minimum Data Set) dated 05/08/2024 revealed the resident was coded for being on an antidepressant medication.</p> <p>Review of the resident's care plan revealed no evidence Major Depression with Severe Psychotic Symptoms was addressed in the care plan.</p> <p>On 07/10/2024 at 9:10 a.m., an interview was conducted with S2MDS (Minimum Data Set Coordinator) and S3MDS. They both reviewed the resident's electronic clinical record and confirmed the resident's diagnosis included Major Depression Disorder, Recurrent with Severe Psychotic Symptoms. They both reviewed the resident's care plan and confirmed that it did not address the resident's diagnosis and agreed that it should have been in the care plan.</p> <p>44269</p> <ol style="list-style-type: none"> <li>2. Resident #58. Review of Resident #58's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnosis including but not limited to Sepsis, Neuromuscular Dysfunction of Bladder, Urinary Tract Infection, Acute Cystitis with Hematuria, and Quadriplegia.</li> </ol> <p>(continued on next page)</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>Review of the Resident's AM5 (5 day scheduled admission) MDS assessment dated [DATE] revealed the resident was coded as having a urinary appliance of indwelling catheter.</p> <p>Review of the Resident's care plan revealed the resident had a Potential for injury (Problem onset date 06/21/2024) r/t (related to) presence of suprapubic cath (catheter) r/t neuromuscular dysfunction of bladder with an interventions to clean cath with soap and water Q (every) shift.</p> <p>Review of the Resident's July 2024 eMAR (electronic Medication Administration Record) revealed nursing staff were to clean the resident's suprapubic catheter with soap and water Q shift and was documented as completed on 07/08/2024 day shift and 07/09/2024 day shift per S15LPN.</p> <p>On 07/08/2024 at 10:20 a.m., an observation was made of Resident #58 resting in bed and his suprapubic foley catheter tubing was observed hanging on the left side of his bedrail attached to a urinary collection bag. The catheter tubing closest to the urinary drainage bag was observed to have dried, brown colored sediment noted on the outside of the tubing.</p> <p>On 07/09/2024 at 12:24 p.m., a follow up observation was conducted of Resident #58 resting in bed and his foley catheter tubing was observed hanging on the left side of his bedrail attached to a urinary collection bag. The catheter tubing remained with dried, brown colored sediment noted on the outside of the tubing.</p> <p>On 07/09/2024 at 5:06 p.m., an observation and interview was conducted with S15LPN. S15LPN confirmed the resident's foley catheter tubing closest to the urinary drainage bag was not clean and had dried, brown colored sediment present.</p> <p>3. Resident #70. Review of Resident #70's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus.</p> <p>Review of the resident's July 2024 physician's orders revealed an order dated 06/14/2024- Change sensor (diabetic) q14days (every 14 days) on the 14th and 28th.</p> <p>Review of the resident's July 2024 eMAR revealed Monitor Sensor for Glucose that was documented as completed on 07/01/2024 thru 07/10/2024 at 6:00 a.m., 11:00 a.m., 4:00 p.m. and 9:00 pm. On 07/08/2024 and 07/09/2024 S15LPN documented she monitored the resident's sensor at 11:00 a.m. and 4:00 p.m. S13LPN documented that she monitored the resident's sensor at 11:00 a.m.</p> <p>On 07/09/2024 at 12:11 p.m., an interview was conducted with Resident #70. He stated he had not had his sensor present since he had been admitted to the facility. He further stated the nursing staff were sticking his finger to check his blood sugars and he was not aware that he could bring his glucose sensor while at the nursing facility.</p> <p>On 07/09/2024 at 1:25 p.m., an interview was conducted with S15LPN who confirmed Resident #70 did not have a glucose sensor and she had performed a finger stick to obtain his blood sugars.</p> <p>On 07/10/2024 at 2:46 p.m., an interview was conducted with S13LPN. She confirmed the resident's blood sugars were being obtained by sticking his finger because he doesn't use his glucose sensor. S13LPN further confirmed the resident did not have his glucose sensor present.</p> <p>(continued on next page)</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>On 07/10/2024 at 3:06 p.m., an interview was conducted with S2MDS who stated she was responsible for completing Resident #70's care plan. S2MDS stated she was not aware the resident didn't have his glucose sensor and confirmed his current care plan and current orders reflected a sensor being used to measure his blood sugars. S2MDS confirmed the resident's EHR did not include finger sticks as the method for measuring the resident's blood sugars.</p> <p>On 07/10/2024 at 3:45 p.m., an interview was conducted with S1DON. S1DON stated she was just made aware by S2MDS that Resident #70 did not have a glucose sensor as ordered. S1DON confirmed finger sticks were not ordered for the Resident and his current care plan and orders were not being followed.</p> <p>49784</p> <p>4. Resident #50. Review of Resident #50's record revealed an admitted [DATE] with diagnoses that included Dysarthria, and Anarthria and Other Sequelae of Cerebral Infarction.</p> <p>Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired.</p> <p>On 07/08/24 at 10:09 a.m., an interview and observation was made with Resident #50. Resident #50's speech was very slurred and difficult to understand. Resident communicated with surveyor through writing after being offered a pen and paper.</p> <p>A record review of Resident #50's electronic medical record revealed a the following progress notes:</p> <p>Per S19SS (Social Services) on 02/21/2024 at 1:03 p.m. read in part .has trouble speaking well and hard to understand at times.</p> <p>Per S21LPN (Licensed Practical Nurse) on 07/09/2024 at 11:59 a.m. revealed in part .his level of communication is minimal but is not verbally expressive but nods to yes or no questions when asked.</p> <p>On 07/10/2024 11:37 a.m., an interview was conducted with S5LPN (Licensed Practical Nurse). She stated that Resident #50 was difficult to understand at times and that he had slurred speech and mumbled. She stated, at times, she had to use guessing or yes or no questions to communicate with the resident.</p> <p>On 07/10/2024 at 12:02 p.m., an interview and record review with S18ST (Speech Therapist) was conducted. S18ST stated that Resident #50 had severe dysarthria, and had very slurred speech. A review of S18ST's Discharge Recommendations revealed recommended strategies: instruction in use of direct, rather than open ended questions, to facilitate receptive skills and training in use of auditory rehearsal to facilitate successful communication exchange.</p> <p>On 07/10/2024 at 12:12 p.m., an interview and record review was conducted with S3MDS (Minimum Data Set). S3MDS stated that because Resident #50 had unclear speech, communication should have been addressed in the Plan of Care. She verified that speech and communication was not addressed in the Plan of Care.</p> <p>(continued on next page)</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>On 07/10/2024 at 01:33 p.m., an interview was conducted with S20CNA (Certified Nursing Assistant). She stated that she was familiar with Resident #50, and had cared for him. She further stated that he had very slurred speech that made him difficult to understand at times, therefore he would make his needs known by pointing and writing.</p> <p>5. Resident #62. Review of Resident #62's record revealed an admitted [DATE] with diagnoses that included Dementia with Behavior Disturbance, Muscle Weakness, Cognitive Communication Deficit, Vitamin Deficiency, and Major Depressive Disorder.</p> <p>Review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 3, which indicated the resident's cognition was severely cognitively impaired.</p> <p>Review of Resident #62's OSA (Optional State Assessment) dated 04/10/2024 revealed the resident required one person physical assistance when eating.</p> <p>Review of Resident #62's July 2024 physician orders revealed a diet order dated 02/29/2024 for nectar thick liquids/soft foods.</p> <p>Review of Resident #62's electronic health record revealed the following Registered Dietician (S22RD) notes:</p> <ul style="list-style-type: none"> <li>- Dated 04/10/2024 at 8:31 p.m., included in part .2. Continue to assist for all meals.</li> <li>- Dated 05/02/2024 at 2:40 p.m., included in part .2. Continue to assist for all meals.</li> </ul> <p>On 07/08/2024 at 11:45 a.m., an interview was conducted with Resident #62's two daughters. The daughters stated that the Resident #62 will eat with direction. They stated Resident #62 required assistance with eating.</p> <p>On 07/09/2024 at 12:16 p.m., an observation was made of Resident #62 being fed by a CNA in her room.</p> <p>On 07/09/2024 at 04:28 p.m., a record review and interview was conducted with S2MDS and S3MDS. S3MDS stated she had seen her being fed but does not know if she needs to be fed. The OSA MDS for 04/10/2024 was reviewed. S3MDS verified that the MDS was coded for Resident #62 receiving extensive assistance with eating. S2MDS confirmed that assistance with meals should have been addressed on the plan of care for Resident #62 and was not.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to provide respiratory care consistent with professional standards of practice for 2 (#36, and #66) out of 2 residents (#36 and #66) investigated for respiratory care, by failing to:</p> <ol style="list-style-type: none"> <li>1. label and properly store Resident #36's oxygen tubing; and</li> <li>2. label and properly store Resident #66's oxygen tubing, and obtaining an order for administering oxygen.</li> </ol> <p>Findings:</p> <p>On 07/10/2024, a review of the facility's policy titled Oxygen Administration with last reviewed date of 01/07/2024 read in part, Policy: Oxygen shall only be administered by physician order, except in an emergency .Prefilled humidifier bottles and nasal cannulas/masks will be changed every week and prn. All tubing and bottles are to be labeled each week when changed. When the tubing is not being used, it should be stored properly .</p> <p>Resident #36:</p> <p>Resident #36 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to End Stage Renal Failure, Unspecified Diastolic Heart Failure, and Obstructive Sleep Apnea.</p> <p>A review of Resident #36's annual MDS (Minimum Data Set) dated 05/23/2024, revealed the resident had a BIMS (Basic Interview for Mental Status) of 15, indicating his cognition was intact.</p> <p>A review of Resident #36's Physician orders revealed an order for O2 (oxygen) at 2L (Liters)/NC (nasal Cannula) PRN (as needed) SOB (shortness of breath) .</p> <p>On 07/08/2024 at 9:31 a.m., an observation was made of Resident #36 in his room. An unlabeled O2 tubing was observed open to air, exposed and wrapped around the O2 concentrator. Further observation revealed the humidifier bottle was also unlabeled.</p> <p>On 07/08/2024 at 9:35 a.m., an observation of Resident #36's room and an interview was conducted with S8LPN (Licensed Practical Nurse) She confirmed the resident's O2 tubing and humidifier bottle were unlabeled, and his O2 tubing was not stored in a bag, and stated they should have been.</p> <p>49784</p> <p>Resident #66:</p> <p>Resident #66 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Heart Failure, Chronic Kidney Disease, Stage 3, Generalized Edema, and Morbid Obesity.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #66's Quarterly MDS (Minimum Data Set) dated 04/17/2023, revealed the resident had a BIMS (Basic Interview for Mental Status) of 03, indicating his cognition was severely impaired.</p> <p>Review of Resident #66's physician orders failed to reveal an order for O2 (oxygen) use.</p> <p>On 07/08/2024 at 11:11 a.m., an observation and interview was conducted with S5LPN (Licensed Practical Nurse) of Resident #66's O2 nasal cannula and humidifier bottle. An unlabeled O2 tubing with nasal cannula was observed exposed and hanging from the O2 concentrator. Further observation revealed the humidifier bottle was also unlabeled. S5LPN confirmed Resident #66's nasal cannula should have been stored in a bag and dated. She also confirmed Resident #66's humidifier bottle should have been dated.</p> <p>On 07/09/24 at 8:13 a.m., an interview and observation with S11ADON (Assistant Director of Nursing) was made of Resident #66's room. Three O2 tanks were observed standing freely on the left side of Resident #66's bed. S11ADON confirmed the three free standing oxygen tanks should not be present in Resident #66's room, and should have been stored properly in the oxygen storage room.</p> <p>On 07/10/2024 at 1:28 p.m., an observation was made of Resident #66 with oxygen on through his nasal cannula.</p> <p>On 07/10/2024 at 1:31 p.m., a record review and interview was conducted with S5LPN and S1DON (Director of Nursing). Both S5LPN and S1DON both confirmed there was no physician order for O2 for Resident #66, and that there should have been a physician order to administer O2.</p>		

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NAME OF PROVIDER OR SUPPLIER  Cornerstone at the Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE  103 West Martial Ave Lafayette, LA 70506	
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17364</p> <p>Based on record review and interview, the facility failed to ensure that pain management was provided to residents complaining of pain for 1 (#178) out of 41 sampled residents.</p> <p>Findings:</p> <p>Resident #178. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Hyperlipidemia, Diabetes, Hypertension, and Fracture Upper end of Right Humerus.</p> <p>On 07/10/2024 at 10:30 a.m., an interview was conducted with the resident. The resident stated that his right arm was broken and that he was having a lot of pain. The resident stated that it was painful to move his right arm and shoulder. The resident stated he was requesting pain medication for 2 days and had not received anything. The resident stated he was told that the facility ran out of his pain medication and were waiting for an order for more.</p> <p>Review of the resident's physician's orders revealed an order for Oxycodone 10 mg (milligrams) 1 po (by mouth) every 4 hours prn (as needed) pain.</p> <p>Review of the resident's MAR (Medication Administration Record) for July 2024 revealed the last dose of Oxycodone was administered on 07/05/2024 at 8:22 a.m. Further review of the resident's MAR revealed that on 07/09/2024 the resident complained of pain of 7 on a pain scale of 0-10 with 10 being the worst pain. On 07/10/2024, the resident complained of pain of 8. There was no documentation the resident received anything for pain on 07/09/2024 and on 07/10/2024.</p> <p>On 07/10/2024 at 11:13 a.m., an interview was conducted with S5LPN (Licensed Practical Nurse). S5LPN stated the resident had been complaining of pain and the facility was out of Oxycodone. S5LPN stated the physician needed to write a new prescription for the pharmacy to refill the Oxycodone. S5LPN stated the resident had been out of Oxycodone and needed a new prescription since 07/05/2024. S5LPN stated she informed S11ADON (Assistant Director of Nursing) that the physician needed to write a new prescription for Oxycodone. S5LPN stated she did not receive a response from the ADON or physician concerning refilling the Oxycodone. S5LPN stated the resident had not received anything for pain since 07/05/2024.</p> <p>On 07/10/2024 at 11:37 a.m., an interview was conducted with S11ADON. S11ADON confirmed she was the person responsible for contacting the physician to get new prescriptions for narcotics. S11ADON stated she was not informed by anyone that the resident needed a new prescription for Oxycodone. S11ADON confirmed the resident's physician was not notified that a new prescription was needed for Oxycodone.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44269</p> <p>Based on observation and interviews, the facility failed to ensure staff provided services to meet the needs of residents, as evidenced by facility nursing staff failing to respond to call lights in a timely manner for 2 (#58 and #61) out of 8 (#15, #30, #35, #36, #58, #61, #62, and #178) residents investigated for sufficient staffing out of a total sample of 41 residents.</p> <p>Findings:</p> <p>Resident #58</p> <p>Review of Resident #58's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Sepsis, Neuromuscular Dysfunction of Bladder, Urinary Tract Infection, Acute Cystitis with Hematuria and Quadriplegia.</p> <p>Review of the Resident's AM5 (5 day scheduled admission) Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15 indicating his cognition was intact.</p> <p>On 07/09/2024 at 4:53 p.m., an observation was made of Resident #58's suprapubic catheter tubing closest to the urinary drainage bag with dried, brown colored sediment noted on the outside of the tubing. The surveyor pressed the resident's call button. Upon pressing the resident's call button, the call system in his room immediately flashed a red light and beeped. The Surveyor waited ten minutes, but no staff answered the call button nor came to the resident's room. The Surveyor looked outside the Resident's room, into the hall and observed zero staff on the hall.</p> <p>On 07/09/2024 at 5:03 p.m., the surveyor walked to the nursing station to notify the nurse of the call bell being pressed, but no response was received. Upon walking to the nursing station, S15LPN was observed sitting at the desk with her head down and she was looking down on her personal cell phone. Surveyor knocked on the window to get S15LPN's attention. S15LPN immediately looked up and the surveyor asked if the call system was going off. S15LPN looked over at the notification screen of the call system and confirmed Resident #58's call bell was activated. S15LPN confirmed she did not answer the call bell and she should have answered the call bell promptly.</p> <p>47965</p> <p>Resident #61</p> <p>Resident #61 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Benign Prostatic Hyperplasia, Depression, and Squamous Cell Carcinoma.</p> <p>A review of Resident # 61's MDS (Minimum Data Set) assessment revealed he had a BIMS (Basic Brief Interview for Mental Status) score of 3 indicating his cognition was severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2024 at 9:47 a.m., an interview was conducted with Resident #61's RP (responsible party). She stated it takes 30 to 45 minutes for staff to respond to the call light. She further stated it happens all the time and was especially worse on the weekends. The resident's RP stated that sometimes she went out in the hall to find staff for assistance and majority of the time she was unable to locate staff.</p> <p>On 07/10/2204 at 9:16 a.m., surveyor pressed the call light from Resident #61's room and no one came to answer the call light. At 9:24 a.m., surveyor walked out to the hall and observed the digital alert by the back door flashing the resident's room number. Two CNAs (Certified nursing Assistants) were observed walking down the hall and had not responded to the call light. The facility's overhead announcement system was heard announcing Resident #61's room number and need for assistance. At 9:27 a.m. another CNA walked down the opposite side of the hall and went into a room, then walked back down hallway in the opposite direction of Resident #61's room.</p> <p>On 07/10/24 at 9:31 a.m., an interview was conducted with the CNA who walked down the hall at 9:27 a.m. She identified herself as S16CNA. She stated that she is was made aware of resident's calls light by the digital alert and the announcements. S16CNA confirmed she did not check the digital alert when she came down the hall. S16CNA also stated she heard the announcement but did not respond because she was on another hall.</p> <p>On 07/10/24 at 9:34 a.m., S14CNA was observed going into Resident #61's room. An interview was conducted as she exited the resident's room. S14CNA stated she was taking care of the resident today but she was on her break. She stated that when she took her break, the other CNA on the hall was responsible for covering her residents. S14CNA was asked if she had informed the other CNA that she was going on her break, and she stated that she had not and should have.</p> <p>On 07/10/2024 at 3:29 p.m., an interview was conducted with S17CORP (Regional Corporate Nurse). S17CORP confirmed the facility had staffing issues.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47965</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure the nursing staff provided the care to meet the residents' needs safely to attain or maintain the highest practicable physical well-being for 1 (#36) of 41 sampled residents. This was evidenced by S7LPN (Licensed Practical Nurse) not administering ordered PRN (as needed) medications to treat Resident #36's itching.</p> <p>Findings:</p> <p>Resident #36 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to End Stage Renal Failure, Unspecified Diastolic Heart Failure and Obstructive Sleep Apnea.</p> <p>A review of Resident #36's annual MDS (Minimum Data Set) dated 05/23/2024, revealed the resident had a BIMS (Basic Interview for Mental Status) of 15, indicating his cognition was intact.</p> <p>A review of Resident #36's Physician orders revealed an order written on 05/16/2024 for Hydrocortisone 1% (percent) cream apply to affected areas PRN itching. Further review revealed an order written on 05/16/2024 for Benadryl Allergy 25 mg (milligram) one PO (by mouth) Q4 (every 4) hours for itching.</p> <p>A review of Resident #36's June and July 2024 MAR (Medication Administration Record) revealed the resident had not received any of his Benadryl or Hydrocortisone for itching.</p> <p>On 07/08/24 at 9:31 a.m., an observation was made of Resident #36 in his room. A red rash was observed on the resident's bilateral thighs, lower legs and abdomen. The resident stated he had to get his nails cut because he was scratching it until it bled. He also stated day before yesterday (07/07/2024) he told the nurse about it.</p> <p>07/08/2024 at 9:35 a.m., an observation of Resident #36's rash was made with S7LPN. She confirmed the resident's rash and itching.</p> <p>On 07/09/24 at 11:16 a.m., an observation was made of Resident #36 in his room. The resident confirmed he was still itchy and stated that he had not received anything for his rash and itching.</p> <p>On 07/09/24 at 11:30 a.m., an interview was conducted with S7LPN. She stated that she left hospice a message to report the resident itching after observing his rash and itching yesterday. S7LPN confirmed that she had not offered or administered any of Resident #36's PRN medications for his itching and stated she should have.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>17364</p> <p>Based on observation and interview, the facility failed to ensure expired medications were not stored in medication room A.</p> <p>Findings:</p> <p>On 07/10/2024 at 3:40 pm, an inspection was conducted in medication room A. A bottle of Vitamin B Complex with Vitamin C was observed on the shelf and was observed with an expiration date of 05/24. A bottle of Ferrous Gluconate 240 mg (Milligrams) with an expiration date of 05/24 was observed on the shelf in the medication room. S13LPN (Licensed Practical Nurse) was present during this observation and she confirmed that the 2 bottles of medication were expired.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</b></p> <p>Based on observation and interview, the facility failed to honor and accommodate food preferences for 1 (Resident #15) out of 41 sampled residents. This deficient practice had the potential to affect all residents who consumed meals from the kitchen.</p> <p>Findings:</p> <p>On 07/10/2024 a review of the facility's policy titled, Resident Food Preferences with a revised date of 01/07/2024 read in part, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes</p> <p>Review of Resident #15's record revealed an admitted [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Hyperlipidemia, and Vitamin Deficiency.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact.</p> <p>On 07/09/24 12:07 p.m., an interview, observation, and review of Resident #15's Dietary Meal Ticket, and tray conducted with S10DM (Dietary Manager) revealed mashed potatoes was listed under the category of Dislikes. Mashed potatoes were observed on the Resident #15's meal tray. S10DM confirmed that mashed potatoes should not have been present on Resident #15's meal tray. S10DM then requested another meal tray from the dietary department. On observation of Resident #15's second meal tray, rice was observed on the tray. Further observation of Resident #15's Dietary Meal ticket revealed rice was present under the category of Dislikes. S10DM confirmed that rice was also listed as a dislike on Resident #15's Dietary Meal Ticket and should not be present on Resident #15's meal tray.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17364</p> <p>Based on record review and interview, the facility failed to maintain medical records on each resident that were complete for 1 (#43) out of 41 sampled residents.</p> <p>Findings:</p> <p>Reviewed the facility's policy and procedure titled Charting and Documentation that was reviewed by facility on 01/07/2024 read in part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1. Documentation in the medical record may be electronic, manual or combination. 2. The following information is to be documented in the resident medical record: a. Objective observation; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the residents; f. Progress toward or changes in the care plan goals and objectives; and g. vital signs .</p> <p>Review of Resident #43's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Anemia, Idiopathic Peripheral Autonomic Neuropathy, and Rheumatoid Arthritis.</p> <p>Review of the resident's progress notes revealed no evidence that a nursing note was documented between 04/12/2024 and 05/14/2024. Review of the resident's nursing progress note dated 05/14/2024 at 10:33 a.m. revealed, N.O. (new order) per NP (Nurse Practitioner) Cephalexin (antibiotic) 500 mg (milligrams) Q (every) 8 hours x 7 days (for 7 days). There was no documentation of signs and symptoms the resident was exhibiting prior to order for Cephalexin.</p> <p>Review of the resident's nursing progress notes dated 05/24/2024 at 11:36 a.m. revealed, N.O. per Dr. ___ send out to (hospital) to r/o (rule out) DVT (Deep Vein Thrombosis) to RLE (right lower extremity). There was no documentation of an ongoing assessment of the resident's right lower extremity from 05/14/2024 to 05/24/2024.</p> <p>On 07/09/2024 at 10:25 a.m., an interview was conducted with S9LPN (Licensed Practical Nurse). S9LPN stated the resident was having redness and swelling to right lower leg for about 4 days. The LPN confirmed there was no documentation in resident #43's nurse's notes regarding her right lower leg. S9LPN stated that antibiotics was ordered to treat the resident's right lower leg. The LPN stated the resident completed the 7 day course of antibiotics. The LPN stated that a week later the resident's family was visiting and brought to their attention that the resident's right lower leg was swollen. S9LPN stated that an order was given to send the resident out to the hospital to rule out DVT. The LPN confirmed that she did not document any signs and symptoms the resident exhibited and confirmed there was no documentation of an ongoing assessment of the resident's right lower extremity from 05/14/2024 to 05/24/2024.</p> <p>(continued on next page)</p>		

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F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 07/09/2024 at 10:44 a.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated the nurses should document signs and symptoms the residents were exhibiting and should document ongoing assessments for effectiveness of the antibiotic treatment.		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46149</p> <p>Based on interviews and record reviews, the facility failed to ensure the updated hospice plan of care was on file and available at the facility for 1 (#52) out of 2 (#31, #52) residents investigated for hospice services.</p> <p>Findings:</p> <p>On 7/10/2024, a review of the facility's policy titled Hospice Program with a last reviewed date of 07/16/2023, read in part: 12. Our facility has designated ____ (Name)____ (Title) to coordinate care provided to the resident by our facility staff and the hospice staff He or she is responsible for the following: d. Obtaining the following information from the hospice : 1. The most recent hospice plan of care specific to each resident.</p> <p>Review of Resident #52's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses including: Type 2 Diabetes, Unspecified Sequelae of Cerebral Infarction, Aphasia, and Gastrostomy Status.</p> <p>Review of Resident #52's July 2024 physician's orders revealed an order date 01/04/2024 that read in part: Admit to ____hospice dx (diagnosis): senile degeneration of the brain.</p> <p>Review of Resident #52's plan of care revealed the following: I am a Full Code.</p> <p>Review of Resident #52's hospice binder revealed the resident's hospice careplan with a date of 01/09/2024. Review of the hospice careplan revealed the following: Advanced directive- patient chooses resuscitation if his/her lungs stop working.</p> <p>On 07/09/2024 11:47 p.m., a phone interview was conducted with Resident #52's hospice nurse who confirmed that the resident's code status was DNR (Do Not Resuscitate), and it was signed by the physician on 03/26/2024.</p> <p>Review of Resident #52's hard chart reveal a Lapost (Louisiana Physician's Orders for Scope Of Treatment) dated 03/26/2024 that read DNR.</p> <p>07/09/2024 at 11:50 p.m. an interview and record review was conducted with S1DON (Director of Nursing). The resident's hospice binder was reviewed with SS1DON. She stated the careplan that was on file in the binder was the most updated hospice careplan. The careplan was dated 01/09/2024. The resident's hospice careplan was reviewed with S1DON, revealing: Advance Directive - Patient chooses resuscitation if his/her heart or lung stopped. S1DON stated she was unaware that an updated hospice careplan with the resident's new code status was not obtained or on file at the facility.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46149</p> <p>Based on observations and interviews, the facility failed to ensure call systems were functioning for 3 residents (#5, #31, #66) out of a final sample of 41 residents.</p> <p>Findings:</p> <p>On 07/10/2024, a review of the facility's policy titled Answering the Call Light with a last reviewed date of 07/29/2023 read in part: 7. Report all defective call lights to the nurse supervisor promptly.</p> <p>Resident #31</p> <p>Review of Resident #31 EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease and Atrial Fibrillation.</p> <p>Review of Resident #31's significant change MDS (Minimum Data Set ) assessment dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12 , indicating his cognition was intact.</p> <p>On 07/10/2024 at 8:39 a.m. Resident # 31's call bell that was hooked to his shirt was pressed. An observation was made of the screen on C hall that displayed when a resident's call bell was activated. The resident's room number was not on the screen. At 8:49 a.m., an observation and interview was conducted with S6CNA (Certified Nursing Assistant). She stated that when a call bell is pressed, the screen on the hall beeps and the resident's room number is displayed on the screen. The surveyor then asked the S6CNA to press Resident #31's call bell. She stated the resident had two call balls that he used and proceeded to press both call bells. There was no beep heard after pressing either call bell. The screen on the hall was then observed with S6CNA. She confirmed that there was no beep, and the resident's room number was not displayed on the screen.</p> <p>On 07/10/2024 at 8:57 a.m., an interview was conducted with S4Maintenance. He stated they did not routinely check to see if the call bells are functioning or if the batteries need to be changed.</p> <p>49784</p> <p>Resident #5</p> <p>Review of Resident #5's record revealed an admitted [DATE] with diagnoses that included Schizoaffective Disorder, Cognitive Communication Deficit, and Repeated Falls.</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident's cognition was severely impaired.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Cornerstone at the Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE  103 West Martial Ave Lafayette, LA 70506	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/08/2024 at 9:46 a.m., an interview and observation was conducted with Resident #5. Resident #5 stated that he was able to use his call light, and then demonstrated by pressing his call light at 9:47 a.m. Surveyor waited inside of Resident #5's room from 09:47 a.m. to 10:01 a.m. No staff was observed to have addressed Resident #5's call light.</p> <p>On 07/08/2024 at 10:30 a.m., an interview and observation was conducted with S12MP(Maintenance Personnel). S12MP confirmed Resident #5's call light needed new batteries and was not in working condition.</p> <p>Resident #66</p> <p>Review of Resident #66's record revealed an admitted [DATE] with diagnoses that included Chronic Kidney Disease and Morbid Obesity.</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident's cognition was severely impaired.</p> <p>On 07/08/2024 at 9:21 a.m., an interview and observation was conducted with Resident #66. Resident #66 demonstrated by pressing his call light at 9:21 a.m. Surveyor remained in the room. At 9:37 a.m. no staff had addressed Resident #66's call light.</p> <p>On 07/08/2024 at 10:25 a.m., an interview and observation was conducted with S12MP. S12MP confirmed Resident #66's call light needed new batteries and was not in working condition. S12MP confirmed that staff were unaware of Resident #66's call light due to the call light not functioning properly.</p>

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NAME OF PROVIDER OR SUPPLIER  Cornerstone at the Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE  103 West Martial Ave Lafayette, LA 70506	
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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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49784</p> <p>Based on observations and interviews, the facility failed to provide a safe, sanitary, and comfortable environment as evidenced by failing to ensure that an exterior window was in good repair for 1 (Resident #66) out of 41 residents sampled.</p> <p>Findings:</p> <p>On 07/08/2024 a review of the facility's policy titled, Quality of Life- Homelike Environment with an updated date of 03/12/2024 read in part, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include in part, a. Clean, sanitary and orderly environment .</p> <p>On 07/08/2024 at 9:20 a.m., an observation was made of two large cracks, both roughly three feet in length on left pane of Resident #66's exterior window. Seven, thick, black pieces of tape were observed over the two large cracks.</p> <p>On 07/09/2024 at 8:04 a.m. and interview and observation of Resident #66's exterior window was conducted with S7AIT. S7AIT confirmed that the left pane of Resident #66's exterior window was in disrepair and should not have been in that condition.</p>		