STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195566	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ollie Steele Burden Manor	4250 Essen Lane Baton Rouge, LA 70809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50093 Based on record reviews and an interview, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) prior to the discontinuation of Medicare Part A services for 3 (#25, #228, and #229) of 3 (#25, #228, and #229) residents reviewed for Beneficiary Notification. Findings: On 10/30/2024, a review of the facility's policy titled Advance Beneficiary Notice with a Copyright date of 2024, revealed the following: Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. c. A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility ore remaining in the facility. i. This notice is used when all covered services end for coverage reasons. Resident #25 Review of Resident #25's Beneficiary Notification Review form revealed his Medicare Part A skilled services last covered day was 08/11/2024. Further review revealed a NOMNC, Form CMS-10123 was not provided to Resident #25 prior to the discontinuation of skilled nursing services. Resident #228 Review of Resident #228's Beneficiary Notification Review form revealed his Medicare Part A skilled services last covered day was 09/18/2024. Further review revealed a NOMNC, Form CMS-10123 was not provided to Resident #228 prior to the discontinuation of skilled nursing services. Resident #229 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #229's Beneficiary Notification Review form revealed her Medicare Part A skilled services last covered day was 10/09/2024. Further review revealed a NOMNC, Form CMS-10123 was not provided to Resident #229 prior to the discontinuation of skilled nursing services. An interview was conducted on 10/30/2024 at 11:47 a.m. with S4MDS. She confirmed she had not provided a NOMNC, Form CMS-10123 to Residents #25, #228, and #229 prior to their discharge from Medicare Part A skilled nursing services. She stated she was not aware the NOMNC, Form CMS-10123 should have been provided to the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 44965 Based on interviews and record reviews, the facility failed to ensure each resident was assessed using the quarterly review instrument not less frequently than once every three months for 3 (#1, #19, and #20) of 11 (#1, #5, #6, #7, #8, #12, #14, #15, #19, #20, and #22) residents reviewed for Resident Assessment. Review of the facility's policy titled, MDS Completion and Submission Timeframes with a revision date of July 2017 revealed the following, in part: Policy Statement: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation: 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Resident #1 On 10/30/2024, a review of Resident #1's MDS assessments revealed a quarterly MDS with an ARD of 06/20/2024. Further review revealed no other MDS assessment had been opened or completed after 06/20/2024. Resident #19 On 10/30/2024, a review of Resident #19's MDS assessments on 10/30/2024 revealed a quarterly MDS with an ARD of 05/28/2024. Further review revealed an MDS was opened with an ARD of 08/27/2024, and the assessment had not been completed. Resident #20 On 10/30/2024, a review of Resident #20's MDS assessments revealed a quarterly MDS with an ARD of 06/25/2024. Further review revealed an MDS was opened with an ARD of 09/24/2024, and the assessment had not been completed. An interview was conducted with S4MDS on 10/30/2024 at 9:23 a.m. She stated she was one of the facility's MDS nurses. She stated quarterly MDS assessments should have been completed every three months. She reviewed Residents #1, #19, and #20's quarterly MDS assessments and stated they had not been completed quarterly and should have been. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with S3DON on 10/30/2024 at 11:58 a.m. She stated quarterly MDS assessments should have been completed every three months. She reviewed Resident #1, #19, and #20's MDS assessments. She confirmed Residents #1, #19, and #20's last quarterly MDS assessments had not been completed quarterly and should have been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on interviews and record reviews, the facility failed to ensure: 1. Each residents' discharge was encoded in an MDS assessment for 3 (#7, #12, and #22) of 11 (#1, #5, #6, #7, #8, #12, #14, #15, #19, #20, and #22) residents reviewed for Resident Assessment; and 2. A resident's discharge assessment was completed and transmitted for 1 (#6) of 11 (#1, #5, #6, #7, #8, #12, #14, #15, #19, #20, and #22) residents reviewed for Resident Assessment. Review of the facility's policy titled, MDS Completion and Submission Timeframes with a revision date of July 2017 revealed the following, in part: Policy Statement: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation: 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Review of the facility's policy titled, Electronic Transmission of the MDS with a revision date of November 2019 revealed the following, in part: Policy Statement: All MDS assessments and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS system in accordance with current regulations. 1. Resident #7 Review of Resident #7's Clinical Record revealed he admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident #7's MDS Assessments revealed no discharge MDS was opened and/or completed. Resident #12 Review of Resident #12's Clinical Record revealed she admitted to the facility on [DATE] and discharged on [DATE]. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's MDS Assessments revealed no discharge MDS was opened and/or completed. Resident #22 Review of Resident #22's Clinical Record revealed he admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident #22's MDS Assessments revealed no discharge MDS was opened and/or completed. An interview was conducted with S4MDS on 10/30/2024 at 9:23 a.m. She stated she was one of the facility's MDS nurses. She confirmed Residents #7, #12, and #22 had discharged from the facility and discharge MDSs had not been opened, completed, nor transmitted and should have been. An interview was conducted with S3DON on 10/30/2024 at 11:58 p.m. She stated an MDS assessment should have been completed upon each resident's discharge from the facility. She confirmed Resident #7 discharged from the facility on 07/11/2024 and no discharge MDS was opened, completed, or transmitted and should have been. She confirmed Resident #12 passed away in the facility on 10/04/2024 and there was no discharge assessment opened, completed, or transmitted and there should have been. She confirmed Resident #22 discharged from the facility on 06/27/2024 and no discharge MDS was opened, completed, or transmitted and should have been. 2. Resident #6 Review of Resident #6's Clinical Record revealed she admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident #6's Discharge MDS Assessment with an ARD of 07/12/2024 revealed the assessment was incomplete and not transmitted. An interview was conducted with S4MDS on 10/30/2024 at 9:23 a.m. She stated she was one of the facility's MDS nurses. She confirmed Resident #6's discharge assessment was incomplete and had not been transmitted. An interview was conducted with S3DON on 10/30/2024 at 11:58 p.m. She stated discharge assessments should have been completed within 7 days of the discharge and transmitted within 14 days of completion. She confirmed Resident #6 discharged from the facility on 07/12/2024. She confirmed the discharge assessment for Resident #6 was opened and not completed or transmitted and should have been.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093 Based on record review and interviews, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was completed for 1 of 1 (#21) resident reviewed for PASARR. Findings: On 10/30/2024, a review of the facility's policy titled Resident Assessment - Coordination with PASARR Program with a Copyright date of 2024, revealed the following: Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Review of Resident #21's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Schizophrenia. Review of Resident #21's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/30/2024, revealed an active diagnosis of Schizophrenia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #21's Clinical Record revealed a Level I PASARR was completed on 01/17/2024. Review of the Level I PASARR form revealed Resident #21 had a diagnosis of Schizophrenia. Further review revealed a referral was not made to appropriate state designated authority for Level II PASARR evaluation and determination. An interview was conducted on 10/30/2024 at 12:30 p.m. with S3DON. S3DON stated when Resident #21's was admitted to the facility, a Level II PASSAR was not required because she was not expected to remain in the facility for greater than 30 days. S3DON confirmed a Level II PASARR should have been completed when Resident #21 remained in the facility longer than 30 days. She stated S5SW was responsible for submitting the Level II PASARR to the appropriate state designated authority. An interview was conducted on 10/30/2024 at 2:00 p.m. with S5SW. S5SW confirmed Resident #21 had a diagnosis of Schizophrenia, which meant the resident met the criteria to have a Level II PASARR submitted to the appropriate authority. S5SW also confirmed she was responsible for submitting the Level II PASARR for Resident #21, and the Level II PASARR had not been submitted to the appropriate authority and should have been.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50093 Based on observation and interview, the facility failed to post nurse staffing data on a daily basis which included the total resident census for 1 of 1 area reviewed for nurse staffing data. This deficient practice had the potential to affect any of the 20 residents residing in the facility. Findings: Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised on 08/2022, revealed the following: Policy Interpretation and Implementation 2. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: c. The resident census at the beginning of the shift for which the information is posted. An observation was made on 10/29/2024 at 11:15 a.m. of the daily staffing sheet, dated 10/29/2024, posted on the wall outside of the Director of Nursing's office. There was no resident census included on the sheet. An interview was conducted on 10/29/2024 at 11:25 a.m. with S3DON. S3DON stated she was responsible for posting the daily staffing sheet. She confirmed the resident census number was not included on the daily staffing sheet and it should have been.