

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Camelot Rehabilitation at Magnolia Park		STREET ADDRESS, CITY, STATE, ZIP CODE  1511 Dulles Drive 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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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> 39319</p> <p>Based on record review, observations and interviews the facility failed to provide a safe, clean, comfortable, and homelike environment. This was evidenced by:</p> <ol style="list-style-type: none"> <li>1. Observations made on 02/05/2025 on Hall U of multiple rooms walls with damaged sheetrock, unfinished sheetrock repair, and a call light unit detached from wall;</li> <li>2. Housekeeping staff failing to clean and sanitize room [ROOM NUMBER] on Hall U after a resident was discharged to the hospital;</li> <li>3. Observation made on 02/02/2025 at 2:50 PM of a light fixture that was not working properly in room [ROOM NUMBER] on Hall Y;</li> <li>4. Observation made on 02/02/2025 at 1:07 PM of a call light box that was detached from the wall in room [ROOM NUMBER] on Hall Y; and</li> <li>5. Observation made on 02/02/2025 at 2:01 PM of an electrical outlet cover plate that was bent away from wall making electrical wiring visible in room [ROOM NUMBER] on Hall Y.</li> </ol> <p>Findings:</p> <p>Review of the facility's policy, Maintenance Service with a revised date 10/30/24 revealed the following in part, Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: .b. Maintaining the building in good repair and free from hazards .d. Maintaining the heat/cooling system, plumbing fixtures., wiring, etc., in good working order . i. Providing routinely scheduled maintenance service to all areas .7. The Maintenance Director is responsible for maintaining the following records/reports. Inspection of building, work order request .</p> <p>On 02/04/2025 at 11:00 AM, an observation was made on Hall U. The following concerns were identified:</p> <p>Rm 1 -sheetrock damage to outer room wall</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Rm 2 -unpainted sheetrock repair on outer bathroom wall</p> <p>Rm 3 -Bed 1--sheetrock damage to right wall next to bed</p> <p>Bed 2-- sheetrock damage to outer room wall--hole to lower part of wall next to the air conditioner</p> <p>Rm 4 -room still not cleaned</p> <p>Rm 5-call bell detached from wall</p> <p>Rm 6 -sheetrock damage to outer wall next to bed</p> <p>Rm 7 -Bed 1 -unpainted sheetrock repair to outer bathroom wall next to bed</p> <p>Rm 8 -Bed 2 -sheetrock damage to wall at the head of the bed</p> <p>On 02/04/2025 at 11:20 AM, an observation of room [ROOM NUMBER] was conducted with S10Housekeeping Supervisor. The resident's bed cover was noted on the bed. Items were noted on the adjacent bed and trash was noted in the trash can. S10Housekeeping Supervisor confirmed that the room had not been cleaned and sanitized after the resident was discharged from the facility on 01/28/2025</p> <p>On 02/04/2025 at 11:30AM, an interview was conducted with S3Maintenance Supervisor. He confirmed that the above findings with the rooms were all issues and should have been taken care of.</p> <p>50950</p> <p>On 02/02/2025 at 2:50 PM, an observation was made of room [ROOM NUMBER]. The light above the bed did not turn on when the cord attached to the light fixture was pulled.</p> <p>On 02/03/2025 at 12:05 PM, a concurrent observation and interview was conducted with S3 Maintenance Supervisor. S3 Maintenance Supervisor observed that the light would not turn on. S3 Maintenance Supervisor confirmed the light should not be in this condition and should be working properly.</p> <p>On 02/02/2025 at 1:07 PM an observation was made of room [ROOM NUMBER]. The call light box was detached from the wall and was hanging by a red wire. A hole was observed in the wall where call light should have been attached.</p> <p>On 02/03/2025 at 11:29 AM, a concurrent observation and interview was conducted with S3 Maintenance Supervisor. S3 Maintenance Supervisor observed the call light box detached and hanging off of the wall. S3 Maintenance Supervisor confirmed the call light box should not have been detached and hanging from wall.</p> <p>On 02/02/2025 at 2:01 PM, an observation was made of room [ROOM NUMBER]. The electrical outlet cover plate covering the electrical outlet was observed next to the resident's bed. The cover plate was bent and protruding off of the wall. A hole in wall was observed with wiring exposed behind the cover plate.</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 - Some</p>	<p>On 02/03/2025 at 11:27 AM, a concurrent observation and interview was conducted with S3 Maintenance Supervisor. S3 Maintenance Supervisor observed the bent electrical outlet cover plate. S3 Maintenance Supervisor confirmed the electrical outlet cover plate should not have been bent and protruding from the wall.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47251</p> <p>Based on interview and record review the facility failed to ensure the MDS (Minimum Data Set) was coded accurately for use of Bipap (Bilevel Positive Airway Pressure) for 1 (#19) resident of 5 (#19, #41, #78, #95 and #112) residents investigated for respiratory care.</p> <p>Resident #19</p> <p>Review of Resident #19's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Type 2 Diabetes Mellitus with unspecified complications, Major Depressive Disorder and other, Sleep Apnea.</p> <p>Review of Resident #19's current physician's orders read, RCU (Respiratory Care Unit): Bipap (Bilevel Positive Airway Pressure) S/T (Spontaneous/Timed) 16/12 RR (Respiration Rate) = 12 @ 21% at HS (Hour of Sleep) six times a day.</p> <p>Review of Resident #19's care plan read in part, Focus: The resident has Bipap related to sleep apnea.</p> <p>Review of Resident #19's MAR/TAR (Medication Administration Record/Treatment Administration Record) for November 2024 revealed Resident #19 used a Bipap nightly as ordered.</p> <p>Review of Resident #19's MDS with an ARD (Assessment Reference Date) of 11/27/2024 revealed Resident #19 did not use a Bipap.</p> <p>On 02/03/2025 at 4:11 PM, an interview and record review was conducted with S6MDS (Minimum Data Set). She confirmed that Resident #19 had a current order for use of a BiPAP at night and she used it nightly for the entire month of November 2024 according to the MAR/TAR. S6MDS confirmed that Resident #19's Quarterly MDS with an ARD of 11/27/2024 was not coded for use of a Bipap and should have.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50950</p> <p>Based on record review and interview, the facility failed to ensure a residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent the development of new pressure ulcers for 2 (#95 and #108) out of 6 (#8, #10, #53, #95, #108 and #112) residents investigated for pressure ulcers by:</p> <ol style="list-style-type: none"> <li>1. Filing to perform weekly wound assessments for pressure ulcers for Resident # 95; and</li> <li>2. Failing to conduct accurate skin assessments for Resident # 108</li> </ol> <p>Resident #95</p> <p>Review of Resident #95's electronic health record revealed an admitted [DATE] with diagnoses which included, but were not limited to, Morbid Severe Obesity Due To Excess Calories, Chronic Diastolic Congestive Heart Failure, Cirrhosis Of Liver, and Diarrhea.</p> <p>Review of Resident #95's Nurses' Notes dated 01/15/2025 revealed in part: Resident admitted from LGMC . Wound care assessment done .Resident noted having stage 3 pressure ulcer to sacral cornu .measuring 1. 5cm (centimeter) x 1cm x 0.1cm .Stage 3 pressure ulcer to medial sacrum .measuring at 1 X 0.5 X 0.1 . Stage 3 pressure to right buttocks .measuring 1.5cm x 1cm x 0.1cm</p> <p>On 02/04/2025 a review of Resident #95's electronic health record review was conducted, it revealed the last wound assessment for Resident #95's three pressure ulcers was dated on 01/15/2025.</p> <p>On 02/04/2025 at 10:28 AM, an interview was conducted with S2DON (Director of Nursing). S2DON confirmed that the only evidence she could find of Resident #95's 3 pressure ulcer wound measurements were in a nurses' note dated 01/15/2025. S2DON stated wound measurements should be conducted weekly and documented in the electronic health record.</p> <p>39319</p> <p>Patient #108</p> <p>Review of Resident #108 clinical record revealed he was admitted to the facility on [DATE]. His diagnoses include in part, Cerebral Infarction; Type 2 Diabetes mellitus; Chronic respiratory failure; Unspecified Severe protein-calorie malnutrition; Dysphagia; Gastrostomy and tracheostomy status. Pressure ulcer of other site, Stage 3.</p> <p>Review of Resident #108's annual MDS (Minimum Data Set) dated 06/20/2024 revealed in part, BIMS (Brief Interview of Mental Status) not conducted due to resident rarely/never understood. He was total dependence with two+ person physical assist with bed mobility. Further review revealed under letter M: Skin Conditions, the resident wasn't coded for having an unstageable pressure ulcer.</p> <p>Review of Resident #108's quarterly MDS (Minimum Data Set) dated 08/26/2024 revealed under letter M: Skin Conditions, the resident was coded for having an unstageable pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Wound Evaluation dated 08/09/24 read, Pressure-Unstageable (Slough and/or eschar). Body location: left elbow. New (7 days old). Acquired: in-house acquired.-Unstageable Dimensions: 6.25cm (centimeters) x 2.5cm x 2.5cm .wound bed-100% eschar .exudate: none .</p> <p>Review of Resident #108's skin assessment dated [DATE] revealed the resident's had no new wounds.</p> <p>On 02/04/2025 at 2:15PM, an interview was conducted with S2DON (Director of Nursing). She confirmed skin assessments should be conducted by the Treatment Nurse weekly. She also confirmed that the CNAs (Certified Nursing Assistant) are also responsible for assessing a resident's skin during bathing. She confirmed that Resident #108's left elbow pressure ulcer should have been identified before it had become an unstageable wound.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</b></p> <p>Based on record review, observations and interviews, the facility failed to provide appropriate and sufficient services, treatment, and care according to standards of professional practice for 1 (#3) of 4 (#3, #38, #62, and #78) residents that were reviewed for urinary catheter or UTI (urinary tract infection). The facility failed to ensure Resident #3's urinary catheter drainage tubing was properly secured off of the floor.</p> <p>Findings:</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Obstructive and Reflux Uropathy, Bladder Neck Obstruction.</p> <p>Review of Resident #3 Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed in Section GG Chair/bed-to-chair transfer that Resident #3 was coded as 3, indicating that the resident required partial/moderate assistance.</p> <p>On 02/02/2025 at 9:55 AM, an observation was conducted of Resident #3 in his room. The resident had a urinary catheter drainage bag laying on the floor roughly one foot away from the right side of his bed. The drainage bag was connected by tubing to Resident #3's suprapubic catheter.</p> <p>On 02/02/2025 at 12:54 PM, and observation and interview was conducted S11LPN (Licensed Practical Nurse). S11LPN stated that Resident #3 does not transfer himself and that staff assists him with transfers. She confirmed that the urinary catheter drainage bag was laying on the floor and should not have been.</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** 47251</b></p> <p>Based on observation, interview, and record review the facility failed to ensure the resident's respiratory equipment was stored properly for 2 (Resident #19 and Resident #41) out of 5 (Resident #19, #41, #78, #95 and #112) 36 sampled residents reviewed for respiratory care.</p> <p>On 02/04/2025 review of the facility's policy titled Departmental (Respiratory Therapy) - Prevention Infection with a review date of 10/30/2024 read in part, Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag marked with date and resident's name, between uses. On 02/04/2025 at 4:17 PM, S2DON (Director of Nursing) confirmed that this is the policy used for proper storage of all respiratory equipment.</p> <p>Resident #19</p> <p>Review of Resident #19's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Type 2 Diabetes Mellitus with Unspecified Complications, Major Depressive Disorder and Other, Sleep Apnea.</p> <p>Review of Resident #19's current physician's orders that read, RCU (Respiratory Care Unit): Bipap (Bilevel Positive Airway Pressure) S/T (Spontaneous/Timed) 16/12 RR (Respiration Rate) = 12 @ 21% at HS (Hour of Sleep) six times a day.</p> <p>Review of Resident #19's care plan read in part, Focus: The resident has Bipap related to sleep apnea.</p> <p>On 02/02/2025 at 11:31 AM, an observation was made of Resident #19's Bipap mask on her bedside table opened to air. Resident #19 stated that her Bipap mask should be in a bag, but she did not have one.</p> <p>On 02/02/2025 at 11:35 AM, an observation and interview with S5LPN (Licensed Practical Nurse) was conducted. She confirmed that Resident #19's BiPAP mask was on her bedside table opened to air and not stored properly. She confirmed that the Bipap mask should have been in a bag labeled with the date and her name and there was no bag available.</p> <p>50950</p> <p>Resident #41</p> <p>Review of Resident #41's EHR (Electronic Health Record) revealed an admitted [DATE] with diagnoses which included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and obstructive sleep apnea.</p> <p>Review of Resident #41's most recent Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 15, indicating his cognition was intact. Section O: Special Treatments, Procedures and Programs checked for oxygen therapy and CPAP use.</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>On 02/02/2025 at 10:52 AM, an observation was made of Resident #41's CPAP (continuous positive airway pressure) machine at the bedside. The CPAP mask was in the machine's basket, open to air making contact with the basket. The CPAP mask was not stored in a storage bag. Further observation revealed a nasal cannula on the seat of Resident #41's motorized wheelchair, open to air with the nose piece of the tubing making contact with the seat of the wheelchair. The nasal cannula was not stored in storage bag. Resident #41 confirmed the staff assists him with applying and removing both his CPAP mask and oxygen tubing.</p> <p>On 02/02/2025 at 11:03 AM, a concurrent observation and interview was conducted with S8LPN (Licensed Practical Nurse) in Resident #41's room. S8LPN viewed CPAP mask and nasal cannula and confirmed the CPAP mask and nasal cannula were not stored properly and should be stored in a plastic bag when not in use. S8LPN also confirmed it is the nurses' responsibility to make sure nasal cannulas and CPAP masks are stored properly when not in use.</p> <p>On 02/04/25 at 08:50 AM, an interview was conducted with S2DON (Director of Nursing). S2DON confirmed oxygen tubing such as nasal cannulas and CPAP masks should be stored in a plastic storage bag when not in use and confirmed that the nursing staff is ultimately responsible for proper storage of respiratory equipment when not in use.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>50950</p> <p>Based on observations and interview, the facility failed to ensure staffing information posted daily was current and in a prominent place readily accessible to residents and visitors. The facility's census was 133.</p> <p>Findings:</p> <p>On 02/04/2025 at 2:00 PM, an observation was made of staffing data sheets filed in a closed binder. The binder was set in a window at the nurses' station directly across the hall from the administrative offices. The hall was not in a pathway frequently used by residents or visitors. The staffing sheets for 02/03/2025 and 02/04/2025 were not in the binder.</p> <p>On 02/04/2025 at 2:09 PM, an interview was conducted with S7ASADMIN (Assistant Administrator). She confirmed that staffing data sheets for 02/03/2025 and 02/04/2025 were not in the binder and staffing sheets that are in a closed binder are not readily accessible to residents or visitors.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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>51503</p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure expired medications were not available for administration to residents in 1 (Med Room C) of 4 (Med Room A, Med Room B, Med Room C, and Med Room D) medication rooms. This deficient practice had to potential to affect 133 residents residing in the facility.</p> <p>Findings:</p> <p>Review of a facility policy on 02/04/2025 at 12:38 PM titled Storage of Medications (unknown original date) with a revised date of 04/2019, revealed the following in part . the facility stores all drugs and biologicals in a safe, secure, and orderly manner . 3. The nursing staff is responsible for maintaining medication storage and preparation areas are in a safe manner . 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .</p> <p>Observation on 02/02/2025 at 2:50 PM, of Med Room C with S9LPN (Licensed Practical Nurse), revealed the following expired items:</p> <ol style="list-style-type: none"> <li>1. Forty-Nine (49) 0.9% Sodium Chloride 10ml pre-filled flushes (normal saline flush) with an expiration date of 08/2024.</li> <li>2. Forty-Nine (49) 0.9% Sodium Chloride 10ml pre-filled flushes (normal saline flush) with an expiration date of 09/2024.</li> <li>3. Ten (10) 0.9% Sodium Chloride 10ml pre-filled flushes (normal saline flushes) with an expiration date of 11/2024.</li> <li>4. Two (2) Heparin 500usp/5ML (100usp units/ml in 0.9% Sodium Chloride) 6ml prefilled syringes with an expiration date of 11/2023.</li> <li>5. Seven (7) Heparin 50usp units/5ml (10usp units/ml) in 0.9% Sodium Chloride (5ml pre-filled in 12ml syringe) with an expiration date of 07/2022.</li> <li>6. Twenty-Eight (28) Heparin 50usp units/5ml (10usp units/ml) in 0.9% Sodium Chloride (5ml pre-filled in 12ml syringe) with an expiration date of 01/2023.</li> <li>7. Ten (10) Heparin 50usp units/5ml (10usp units/ml) in 0.9% Sodium Chloride (5ml pre-filled in 12ml syringe) with an expiration date of 02/2024.</li> <li>8. Five (5) Heparin 50usp units/5ml (10usp units/ml) in 0.9% Sodium Chloride (5ml pre-filled in 12ml syringe) with an expiration date of 06/2024.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. One (1) Heparin 50usp units/5ml (10usp units/ml) in 0.9% Sodium Chloride (5ml pre-filled in 12ml syringe) with an expiration date of 07/2024.</p> <p>On 02/02/2025 at 2:58 PM, S9LPN confirmed in an interview that the above Normal Saline flushes and Heparin pre-filled syringes were expired. S9LPN stated that there should not have been any expired medications available. S9LPN stated the expired Normal Saline flushes and Heparin pre-filled syringes should have been discarded.</p> <p>Interview of S2DON (Director of Nursing) on 02/04/2025 at 11:30 AM, confirmed that Med Room C should not have had expired medications available for usage, and should have been disposed of properly and were not.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Camelot Rehabilitation at Magnolia Park		STREET ADDRESS, CITY, STATE, ZIP CODE  1511 Dulles Drive Lafayette, LA 70506	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176</b></p> <p>Based on observations, and interview, the facility failed to store food in accordance with professional standards for food service, and ensure sanitary conditions were maintained in the kitchen as evidenced by:</p> <ol style="list-style-type: none"> <li>1. opened food items in the walk in cooler not labeled with the date and time; and</li> <li>2. expired foods in the dry storage area.</li> </ol> <p>This deficient practice had the potential to affect the 116 residents who consumed food from the kitchen.</p> <p>Findings:</p> <p>On [DATE], a review of the facility's policy titled, Food Receiving and Storage, with a last revision date of [DATE], last reviewed date of [DATE], revealed in part . Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: .6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in-first out system. 7. All food stored in the refrigerator or freezer will be covered, labeled and dated (use by date) .</p> <p>On [DATE] at 8:30 AM, a tour of the facility's kitchen was conducted with S1DS (Dietary Supervisor), who stated that she was responsible for the day to day management of the kitchen.</p> <p>On [DATE] at 8:41 AM, an observation of the walk in cooler was conducted with S1DS and revealed the following items were opened and not labeled with the date and time they were opened nor the use by date:</p> <ol style="list-style-type: none"> <li>1. large container of Italian dressing</li> <li>2. large container of thousand island dressing</li> <li>3. large container of mayonnaise</li> <li>4. large container of mustard</li> <li>5. large container of pickles</li> <li>6. gallon of milk</li> <li>7. carton of almond milk</li> <li>8. carton of soy milk</li> </ol> <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 - Some</p>	<p>9. carton of pineapple juice</p> <p>10. carton of cranberry juice</p> <p>11. carton of apple juice</p> <p>12. container of au jus prep</p> <p>S1DS confirmed the food items listed above were opened, and not labeled with the date and time they were opened nor the use by date, and should have been.</p> <p>On [DATE] at 8:55 AM, an observation of the dry storage room was conducted with S1DS and revealed the following: a plastic gallon bag with an opened bag of powdered lemonade dated [DATE], a plastic gallon bag with an opened bag of fudge mix dated [DATE], and a plastic gallon bag with an opened bag of powdered chocolate pudding dated [DATE]. S1DS confirmed the food items were expired and should have been removed from the dry storage area and discarded.</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>51503</p> <p>Based on record review and interview, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program was developed, implemented, and/or maintained in an effective and comprehensive manner. The facility failed to maintain documentation of evidence of its ongoing facility QAPI program. This deficient practice has the potential to affect 133 residents residing in the facility.</p> <p>Findings:</p> <p>Review of a facility policy on 02/04/2025 at 3:00 PM titled, QAPI Program (unknown original date documented) with a revised date of 12/2016, revealed the following in part .all employees will participate in ongoing QAPI efforts .the QAPI program has been developed to incorporate the continuous quality improvement and quality assurance processes consisting of ongoing analysis of clinical data and program results, identifying and prioritizing opportunities for improvement, implementing interventions, and evaluating the effectiveness of those intervention on the quality of care and services.</p> <p>On 02/04/2025 at 11:40 AM and 2:45 PM, the surveyor requested that S2DON (Director of Nursing) provide the facility's QAPI Program information.</p> <p>On 02/04/2025 at 3:12 PM, S2DON revealed in an interview that she could not locate the facility's QAPI binder, which had evidence of the facility's ongoing QAPI program.</p> <p>On 02/04/2025 at 3:45 PM, S2DON revealed in an interview that she did not know what happened to the QAPI binder and believed it was misplaced.</p> <p>On 02/04/2025 at 4:15 PM, S2DON stated in an interview that she could not provide evidence of the facility's QAPI program due to the QAPI binder being misplaced.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>51503</p> <p>Based on record review and interview, the facility failed to provide documentation of the Quality Assurance and Performance Improvement (QAPI) program that addresses the facility's performance improvement activities and projects. The facility failed to provide evidence of the number and frequency of improvement projects conducted, which addressed the scope and complexity of the facility's provided services. This deficient practice had the potential to affect 133 residents residing in the facility.</p> <p>Findings:</p> <p>Review of a facility policy on 02/04/2025 at 3:00 PM titled, QAPI Program (unknown original date) with a revised date of 12/2016 revealed the following in part .all employees will participate in ongoing QAPI efforts . the QAPI program has been developed to incorporate the continuous quality improvement and quality assurance processes consisting of ongoing analysis of clinical data and program results, identifying and prioritizing opportunities for improvement, implementing interventions, and evaluating the effectiveness of those intervention on the quality of care and services .</p> <p>The facility was unable to present any documented evidence of activities, projects, frequency of improvement projects addressing services for the Quality Assurance and Performance Improvement (QAPI) program during the survey.</p> <p>On 02/04/2025 at 3:12 PM, S2DON (Director of Nursing) revealed in an interview that she could not locate the facility's QAPI binder which had evidence of the facility's ongoing QAPI program in place.</p> <p>On 02/04/2025 at 4:15 PM, S2DON stated in an interview that she could not provide evidence of the facility's QAPI program due to the QAPI binder being misplaced.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>51503</p> <p>Based on record review and interview, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Provide evidence that Quality Assessment and Assurance (QAA) committee met at least quarterly and as needed; and</li> <li>2. Provide evidence that ensured the QAA committee was composed of at a minimum: the DON (Director of Nursing, Medical Director or his/her designee, the Infection Preventionist (IP), and at least three other staff, one of whom must be the facility's administrator, owner, board member, or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems.</li> </ol> <p>This deficient practice had to potential to affect 133 residents residing in the facility.</p> <p>Findings:</p> <p>Review of a facility policy on 02/04/2025 at 3:00 PM titled, QAPI Program (unknown original date) with a revised date of 12/2016, revealed the following in part .all employees will participate in ongoing QAPI efforts . the QAPI program has been developed to incorporate the continuous quality improvement and quality assurance processes consisting of ongoing analysis of clinical data and program results, identifying and prioritizing opportunities for improvement, implementing interventions, and evaluating the effectiveness of those intervention on the quality of care and services .</p> <p>The facility was unable to present any documented evidence of the facility QAA committee meetings. The facility was unable to present any documentation of who attended the facility QAA committee meetings.</p> <p>On 02/04/2025 at 3:12 PM, S2DON revealed in an interview that she could not locate the facility's QAPI binder which had evidence of the facility's ongoing QAPI program and evidence of QAA committee meeting information.</p> <p>On 02/04/2025 at 4:15 PM, S2DON stated in an interview that she could not provide evidence of the facility's QAPI program due to the QAPI binder being misplaced.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50950</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure proper PPE (Personal Protective Equipment) was worn while providing care for 3 (#53, #95, #118) out of 36 sampled residents.</p> <p>Findings:</p> <p>Resident #95</p> <p>On 02/04/2025, a review of the facility's policy titled, Enhanced Barrier Precautions Cheat Sheet with a last reviewed date of 10/30/2024 read in part, Examples of Enhanced-Based Precaution Residents: Wounds-includes .pressure ulcers .indwelling medical devices .feeding tubes .Enhanced-Based Precautions are indicated during: .changing briefs or assisting with toileting .Implementation: gowns and gloves are used during high-contact sessions .</p> <p>Review of Resident #95's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, congestive heart failure, cirrhosis of liver, and pressure ulcer of sacral region, stage 3.</p> <p>Review of Resident #95's physician's orders revealed an order dated 01/22/2025 that read, Nursing Intervention: Implement and maintain enhanced barrier precautions when performing high contact care activities.</p> <p>On 02/03/2025 08:08 AM An observation was made of a sign posted on Resident #95's room door indicating she was EBP and staff should wear a gown as a part of their PPE.</p> <p>On 02/03/2025 at 08:22 AM, a concurrent observation and interview was conducted with S11CNA (Certified Nursing Assistant). S11CNA was observed not wearing a gown while changing the Resident #95's incontinence brief. S11CNA confirmed that Resident #95 was on EBP and failed to wear a gown while providing resident care.</p> <p>On 02/03/2025 at 9:22 AM, an interview was conducted with S2DON (Director of Nursing). She confirmed a gown and gloves must be donned when providing high contact activities such as changing a resident's incontinence brief if a resident is indicated for EBP.</p> <p>Resident # 118</p> <p>Review of Resident #118's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, muscle wasting and atrophy, severe protein calorie malnutrition, and gastrostomy status.</p> <p>Review of Resident #118's physician's orders revealed an order dated 04/04/2025 that read, Nursing Intervention: Implement and maintain enhanced barrier precautions when performing high contact care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/03/2025 at 3:41 PM, a concurrent observation and interview was conducted with S12LPN (Licensed Practical Nurse). S12LPN arrived in Resident #118's room to change his incontinence brief. S12LPN left Resident #118's room and obtained an incontinence brief and gloves and returned to Resident #118's room to provide care. S12LPN was not wearing a gown when she changed Resident #118's incontinence brief. An observation was made of a sign posted on Resident #118's room door indicating he was EBP and staff should wear a gown as a part of their PPE. S12LPN confirmed she was aware the resident was on EBP and failed to wear a gown while providing resident care.</p> <p>On 02/04/2025 at 08:50 AM, an interview was conducted with S2DON (Director of Nursing). She confirmed a gown and gloves must be donned when providing high contact activities such as changing a resident's incontinence brief if a resident is indicated for EBP.</p> <p>51503</p> <p>Resident #53</p> <p>Findings:</p> <p>Review of Resident #53's medical record revealed diagnoses that included in part . Multiple Sclerosis, Encounter for Palliative Care, Polyneuropathy in Diseases Classified Elsewhere, and Depression.</p> <p>Review of Resident #53's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/29/2024, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #53 was cognitively intact.</p> <p>Review of resident #53's physician orders revealed an order to implement and maintain Enhanced Barrier Precautions when performing high contact care activities every shift, with a start date 01/14/2025.</p> <p>Observation on 02/02/2025 at 9:35 AM., revealed Enhanced Barrier Precautions (EBP) signage was posted on a wall next to Resident #53's door, and prior to entering the resident's room. Two (2) Certified Nursing Assistants (CNAs) were observed to enter Resident 53's room with a mechanical lift to transfer Resident #53. The 2 CNAs did not donned gowns prior to the transfer of Resident #53 with the mechanical lift, and proceeded with transferring the resident.</p> <p>Observation and interview of Resident #53 on 02/02/2025 at 11:03 AM, revealed Resident #53 sitting up in her geri-chair in her room. Resident #53 stated she had a pressure sore on her bottom, and that the 2 CNAs who transferred her from the bed to geri-chair wore gloves during the transfer.</p> <p>On 02/02/2025 at 12:22 PM, an interview with S4CNA confirmed that an EPB sign was posted on the wall next to Resident #53's door, and prior to entering the resident's room. S4CNA confirmed the EBP sign indicated she (S4CNA) should wear a gown and gloves when caring for Resident #53. Observation at that time with S4CNA revealed EBP signage was posted on the wall next to Resident #53's door. S4CNA confirmed that Resident #53 required gown and gloves during Activities of Daily Living (ADL) care, such as transferring. S4CNA confirmed that she did not wear a gown when she transferred Resident #53 on 02/02/2025 at 9:35 AM.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/04/2025 at 11:20 AM, S2DON revealed in an interview that staff are required to wear gown and gloves when caring for a resident who has EBP. S2DON confirmed that staff should have worn a gown and gloves when Resident #53 was transferred this morning with the mechanical lift.</p> <p>Unable to contact other CNA for interview.</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>51503</p> <p>Based on observation and interview the facility failed to ensure hallway hand rails were securely affixed to the walls on 1 (Hall W) of 6 (Hall U, Hall V, Hall W, Hall X, Hall Y, and Hall Z) hallways observed in the facility. This failed practice had the potential to affect all mobile residents that reside on Hall W.</p> <p>Findings:</p> <p>Review of a facility policy on 02/04/2025 at 12:38 PM titled, Maintenance Service with a revision date of 12/2009 revealed the following in part . 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of the maintenance personnel include .</p> <p>a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.</p> <p>b. Maintaining the building in good repair and free from hazards. 9. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned .</p> <p>Observations made on 02/02/2025 at 9:52 AM, 02/02/2025 at 11:20 AM, 02/02/2025 at 12:10 PM, and 02/02/2025 at 12:15 PM revealed a hand rail was broken outside of Room A on Hall W. The handrail was observed with one end detached from the wall and pointing outward into Hall W. A screw was exposed and pointing out of the end of the detached portion of the hand rail.</p> <p>On 02/02/2025 at 12:15 p.m., an interview with S3 Maintenance Supervisor confirmed the hand rail on Hall W was broken and detached from the wall. S3 Maintenance Supervisor stated the broken hand rail was unsafe and should have been fixed.</p>		