

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Prairie Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Edwin Elliott Drive Pine Prairie, LA 70576	

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 - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>20604</p> <p>Based on observation and interview the facility failed to ensure that residents requiring assistance with meals were treated with respect and dignity by failing to ensure residents were not labeled and their names displayed on a list according to their care needs on 1 (Hall #Z) of 3 (Hall #X, Hall #Y and Hall #Z) halls.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Policy 49 revealed the following: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity .1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .</p> <p>Observations on 08/26/2024 at 1:30 p.m. and 08/27/2024 at 3:05 p.m., revealed a sheet of paper posted at the Kiosk station on Hall #Z with 4 resident names labeled as feeders. This was visible to anyone passing on the hall.</p> <p>An interview on 08/27/2024 at 3:15 p.m. with S8 LPN revealed that the 4 resident names that was labeled as feeders were viewable from anyone passing on the hall, and stated that there are a lot of family members down this hall.</p> <p>An interview on 08/28/2024 at 8:11 a.m. with S2 DON, revealed that S8 LPN made her aware yesterday (08/27/2024) of the sheet of paper hanging at the kiosk on Hall #Z. S2 DON stated resident information including labeling resident's as feeders was inappropriate and should not have been hanging at the kiosk station.</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>44844</p> <p>Based on record review and interview the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) in a timely manner for 1 (Resident #55) reviewed for Beneficiary Notification.</p> <p>Findings:</p> <p>Review of Resident #55's Beneficiary Notification Review revealed in part .Resident #55's Medicare covered Part A services started on 07/05/2024 and her last Medicare Part A covered day was 07/18/2024.</p> <p>Review of Resident #55's NOMNC revealed in part .Resident #55's last covered day of Medicare Part A service was 07/18/2024. Resident #55's NOMNC revealed Resident #55's signed the NOMNC on 07/17/2024 to acknowledge she received and understood the notice.</p> <p>Review of the above mentioned NOMNC revealed the facility did not issue Resident #55's NOMNC at least two days prior to the end of Medicare Part A coverage to allow her the right to appeal the discharge.</p> <p>Interview on 08/28/2024 at 9:19 a.m. with S4 SSD revealed she was currently responsible for issuing NOMNC's to the resident/and or resident representative when the facility initiated a Medicare Part A discharge. S4 SSD confirmed she did not issue a NOMNC to Resident #55 at least two days prior to their Medicare Part A discharge as required.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46773</p> <p>Based on record review and interview, the facility failed to transmit a MDS (Minimum Data Set) Assessment within 14 days of completion for 1 (#81) of 1 sampled Resident with MDS record over 120 days old. Findings:</p> <p>Review of the clinical record for Resident #81 revealed the Resident was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, Type 2 Diabetes, Essential Hypertension, and Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side.</p> <p>Review of Resident #81's Discharge MDS Assessment with ARD (Assessment Reference Date) of 04/26/2024 revealed the assessment had been transmitted.</p> <p>Review of the facility's MDS transmission reports revealed Resident #81's Discharge Assessment with ARD of 04/26/2024 had been transmitted on 08/28/2024.</p> <p>Interview on 08/28/2024 at 10:41 a.m. with S5 LPN/MDS Nurse confirmed Resident #81's 04/26/2024 Discharge MDS was completed but never transmitted.</p> <p>Interview on 08/28/2024 with S2 DON revealed Resident #81's Discharge MDS with ARD date of 04/26/2024 was not transmitted in a timely manner, but should have been.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 44844</b></p> <p>Based on interview and record review the facility failed to develop/implement a person-centered care plan for 1 (Resident #53) of 2 (Resident #26 and Resident #53) sampled residents to include respiratory care for Resident #53. Total sample size was 27.</p> <p>Findings:</p> <p>Review of Resident #53's Clinical Record revealed an admitted [DATE] with diagnoses that included in part . Dysphagia Oropharyngeal Phase, Disturbance of Salivary Secretion, Gastrostomy status, and Cough Unspecified.</p> <p>Review of Resident #53's Annual MDS with an ARD of 06/18/2024 revealed Resident #53 had a BIMS score of 99 (which indicated a resident's interview was incomplete). The MDS revealed Resident #53 was coded as Dependent for oral hygiene, toileting hygiene, shower/bath, and personal hygiene</p> <p>Record review of Physician orders dated 08/2024 for Resident #53 read in part . change suction canister and tubing every 48 hours. If suction machine was used and as needed.</p> <p>Review of Resident #53's Care Plan revealed no documentation of suctioning or a suction machine maintenance.</p> <p>Interview on 08/28/2024 at 10:41 a.m. with S7 LPN MDS confirmed a care plan had not been developed for the use of Resident #53's suctioning or maintenance of respiratory equipment and it should 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**</b> 44315</p> <p>Based on observation, interview and record review the facility failed to provide respiratory care consistent with professional standards for 2 (Resident #10 and Resident #67) of 2 (Resident #10 and Resident #67) sampled residents reviewed for respiratory care. The facility failed to ensure respiratory equipment was properly stored and labeled.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Care of Respiratory Equipment read in part . Any resident receiving any type of respiratory treatment on a continuous or PRN basis is to have said treatment listed on his treatment sheet. All respiratory equipment is to be maintained by nursing. Oxygen nasal cannulas are to be changed at least every 72 hours, labeled and dated. Oxygen concentrator canisters are to be changed every 3 months, labeled and dated.</p> <p>Review of the facility's policy titled, Oxygen Concentrator read in part . Procedure:</p> <p>4. Nasal cannula is to be checked daily and changed every 3 days (minimum) when in use and to be kept clean and functional. When not in use, cannula is to be stored in Zip lock bag.</p> <p>Resident #67</p> <p>Review of Resident #67's medical record revealed an admitted [DATE] with diagnoses that included Alzheimer's disease with late onset, Chronic Diastolic Congestive Heart Failure, Atrial Fibrillation, Essential Primary Hypertension, Chronic Obstructive Pulmonary Disease (COPD) and other nonspecific abnormal findings of lung field.</p> <p>Review of Resident #67's Physician's Orders for 08/2024 revealed an order to administer oxygen at 3 liters for saturation 92% or less as needed.</p> <p>Review of Resident's Quarterly MDS with an ARD of 07/30/2024 revealed a BIMS score of 03, indicative of severe cognitive impairment. Review of MDS revealed Resident #67 received hospice services.</p> <p>Review of Resident #67's Care Plan with review date 10/30/2024 revealed in part . I have COPD, Pulmonary Nodules and Chronic Diastolic Congestive Heart Failure. Interventions included in part . to administer oxygen if ordered. Change my oxygen tubing (if oxygen is ordered) per protocol and as needed (such as if it falls on floor or I do not store tubing in appropriate place/ manner). Staff will educate/ encourage/ redirect me frequently and not to take my oxygen off without calling for staff assistance for and infection control.</p> <p>Observation on 08/26/2024 at 11:30 a.m. of Resident #67 awake lying in bed. Oxygen nasal cannula and tubing observed left open to air, not contained or labeled with date lying on oxygen concentrator at bedside. Humidifier water bottle and tubing observed to be attached to oxygen concentrator without a label with date.</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>Observation on 08/27/2024 at 9:17 a.m. revealed Resident #67 awake lying in bed. He stated he had used oxygen a couple of days ago. Observation of oxygen nasal cannula and tubing noted left open to air, not stored or dated and lying on top of the oxygen concentrator. Oxygen water humidifier bottle not dated attached to concentrator.</p> <p>Observation and interview in Resident #67's room on 08/27/2024 at 11:28 a.m. with S3 LPN revealed Resident #67's oxygen tubing and nasal cannula not contained or labeled with a date and left open to air lying on top of his oxygen concentrator at bedside. S3 LPN revealed that his hospice nurse may have changed out humidifier and placed Resident #67 on oxygen when she came yesterday morning around 09:30 a.m. S3 LPN revealed it was overlooked on her part and she should have dated and placed Resident #67's oxygen nasal cannula and tubing in a Zip Lock bag and did not.</p> <p>Interview on 08/27/2024 at 11:57 a.m. with S2 DON confirmed the above findings. S2 DON revealed that the oxygen equipment storage policy is to have tubing placed in a sealed bag, dated with tape on tubing and change out tubing every three days by the nurse on duty and was not done.</p> <p>44844</p> <p>Resident #10</p> <p>Review of Resident #10's Clinical Record revealed an admitted [DATE] with diagnoses that included in part . Alzheimer's Disease with Late Onset, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Pneumonia Unspecified, Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure.</p> <p>Review of Resident #10's Physician orders for August 2024 revealed in part .Budesonide Inhalation Suspension 0.5 MG/2ML (breathing treatment). 1 vial orally via nebulizer two times a day related to Chronic Obstructive Pulmonary Disease.</p> <p>Review of Resident #10's care plan with a Target date of 10/16/2024 revealed in part .I require oxygen therapy. I sometimes experience Shortness of Breath upon exertion or while lying flat, with interventions that included: Administer me oxygen if ordered. Change my oxygen tubing per protocol and as needed (such as if it falls or I do not store the tubing in the appropriate place/manner). I have Congestive Heart Failure administer my medication if ordered.</p> <p>Observation and interview on 08/26/2024 at 9:55 a.m. revealed Resident #10 was in bed. Nebulizer mask lying on top of a refrigerator uncovered. Resident #10 revealed she received breathing treatments every day.</p> <p>Observation on 08/28/2024 at 9:20 a.m. revealed Resident #10's nebulizer mask was lying uncovered on top of her refrigerator.</p> <p>Observation and interview on 08/28/2024 at 9:26 a.m. with S6 LPN revealed Resident #10 received nebulizer treatments every 6 hours. Observation of Resident #10's nebulizer mask with S6 LPN revealed it was lying uncovered on top her refrigerator. S6 LPN confirmed Resident #10's nebulizer mask was uncovered and it should not have been.</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>Interview on 08/28/2024 at 9:37 a.m. with S2 DON revealed the floor nurses were responsible for maintaining and changing respiratory equipment. S2 DON confirmed Resident #10's nebulizer mask should not have been lying uncovered on top of her refrigerator.</p>