

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195583	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  The Broadway Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 7534 Highway 1 Lockport, LA 70374	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>46361</p> <p>Based on observations, interviews, and record review, it was determined the facility failed to ensure a resident's adaptive call light was within reach for 1 (Resident #5) of 2 sampled residents with the ability to use a call light in a total sample of 8 investigated for Activities of Daily Living (ADLs).</p> <p>Findings included:</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/01/2024 revealed, in part, Resident #5 had a diagnosis of hemiplegia (a condition that causes weakness) affecting both left and right side of the body and was dependent on staff for ADLs.</p> <p>Review of Resident #5's Care Plan revealed, in part, Resident #5 required staff assistance with ADL's due right sided weakness and impaired mobility. Further review revealed staff was to ensure Resident #5's adaptive call light was within reach.</p> <p>Observation on 12/16/2024 at 11:45 AM revealed Resident #5 was lying in bed and Resident #5's adaptive call light was noted out of reach on the bed above her left shoulder.</p> <p>Observation on 12/17/2024 at 8:30 AM revealed Resident #5's adaptive call light was out of reach on Resident #5's bed above her left shoulder.</p> <p>In an interview on 12/17/2024 at 8:30 AM, Resident #5 indicated she had a bowel movement and needed to be changed. Resident #5 indicated she knew how to use the adaptive call light, but did not know where the adaptive call light was.</p> <p>In an interview on 12/17/2024 at 9:34 AM, S19Certified Nursing Assistant (CNA) indicated Resident #5 was dependent on staff for all ADLs. S19CNA further indicated Resident #5 was able to use her adaptive call light.</p> <p>Observation on 12/18/2024 at 10:40 AM revealed Resident #5 was lying in bed and Resident 5's Adaptive call light was out of reach on the bed above her left shoulder.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/18/2024 at 10:40 AM, Resident #5 indicated she did not know where the adaptive call light was. Resident #5 further indicated she could not reach above her left shoulder to use the adaptive call light to get staff assistance. Resident further indicated it bothered her that she was unable to reach her call light/pad to get staff assistance.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>46361</p> <p>Based on interviews, policy review, and record reviews it was determined the provider failed to ensure staff provided planned restorative services to assist with active range of motion, passive range of motion, walking, transfer, and eating for 12 (Resident #2, Resident #5, Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, Resident #16, Resident #17, and Resident #18) of 12 sampled residents reviewed for restorative services.</p> <p>Findings included:</p> <p>Review of the facility's policy titled Restorative Program Policy and Procedure undated, in part, residents will be assessed to identify possible need or benefit of a restorative program. After potential benefit is identified, specific program will be implemented as deemed medically. Restorative activities including repetition (reps), physical or verbal cueing, and task segmentation will be provided by any trained staff member under the supervision of a licensed nurse.</p> <p>Review of Resident #2's task schedule with a start date of 11/18/2024 revealed Resident #2 was to receive active range of motion to bilateral lower extremities x 1 limited assistance up to 3 sets of 10 reps each. Further review of task schedule with a start date of 11/18/2024 revealed Resident #2 was to receive walking with rolling walker x 1 person limited assistance up to 300 feet.</p> <p>Review of Resident #5's review of restorative program list Resident #5 was to receive passive range of motion and eating swallowing service. Review of Resident #5's therapy referral to restorative nursing with a date of 08/29/2024 revealed resident is to consume no more than 3 ounces of pleasure feeding of puree bolus with use of feeding strategies (small 1/2 tsp bolus, dry swallow after 2 boluses) with trained staff without signs and symptoms of aspirating (cough, wet voice, throat clearing) to maintain current swallow function.</p> <p>Review of Resident #9's task schedule with a start date of 11/18/2024 revealed Resident #9 was to receive active range of motion to bilateral lower extremities x 1 person with standby assistance for cueing and supervision up to 3 sets of 10 reps each. Further review of task schedule with a start date of 11/19/2024 revealed Resident #9 was to receive assistance with sit to stand transfers using grab bars and or wheelchair up to 3 reps.</p> <p>Review of Resident #10's task schedule with a start date of 11/22/2024 revealed Resident #10 was to receive active range of motion to bilateral lower extremities x 1 person standby assistance for cueing and supervision up to 3 sets of 10 reps each. Further review of task schedule with a start date of 11/22/2024 revealed Resident #10 was to receive walking with rolling walker up to 200 feet with staff assistance and with staff reminding resident of safety and proper body mechanics when ambulating.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #11's task schedule with a start date of 11/25/2024 revealed Resident #11 was to receive active range of motion to bilateral lower extremities up to 3 sets of 10 reps each. Further review of task schedule with a start date of 11/25/2024 revealed Resident #11 was to receive walking with rolling walker up to 200 feet or more with staff assistance and with staff reminding resident of safety and proper body mechanics when ambulating.</p> <p>Review of Resident #12's task schedule with a start date of 11/26/2024 revealed Resident #12 was to receive active range of motion to bilateral upper and lower extremities at 3 sets of 10. Further review of task schedule with a start date of 11/26/2024 revealed Resident #12 was to receive walking using a rolling walker with standby assistance for 15 feet or more.</p> <p>Review of Resident #13's task schedule with a start date of 12/11/2024 revealed Resident #13 was to receive active range of motion exercises to bilateral lower extremities up to 3 sets of 10 reps each. Further review of task schedule with a start date of 12/11/2024 revealed Resident #13 was to receive walking with rolling walker and staff assistance up to 200 feet or more.</p> <p>Review of Resident #14's task schedule with a start date of 12/11/2024 revealed Resident #14 was to receive active range of motion exercises to bilateral lower extremities up to 3 sets of 10 reps each. Further review of task schedule with a start date of 12/11/2024 revealed Resident #14 was to receive walking with rolling walker and staff assistance up to 20 feet or more.</p> <p>Review of Resident #15's task schedule with a start date of 12/11/2024 revealed Resident #15 was to receive active range of motion exercises to bilateral lower extremities x1 person standby assistance for cuing and supervision up to 3 sets of 10 reps each. Further review of task schedule with a start date of 12/11/2024 revealed Resident #15 was to receive walking with rolling walker x 1 person standby limited to extensive assistance up to 100 feet or more and to remind resident of safety and proper body mechanics when ambulating.</p> <p>Review of Resident #16's task schedule with a start date of 12/11/2024 revealed Resident #16 was to receive active range of motion to right upper extremity x 1 person standby assistance with cuing and supervision up to 3 sets of 10 reps each. Further review of task schedule with a start date of 12/11/2024 revealed Resident #16 was to receive passive range of motion exercises to left upper extremity up to 3 sets of 10 reps each.</p> <p>Review of Resident #17's task schedule with a start date of 10/25/2024 revealed Resident #17 was to receive active range of motion to bilateral lower extremities joints at 3 sets of 10. Further review of task schedule with a start date of 10/25/2024 revealed Resident #17 was to receive walking using a rolling walker and standby assist of one person to ambulate 250 feet or more.</p> <p>Review of Resident #18's task schedule with a start date of 10/30/2024 revealed Resident #18 was to receive active range of motion to bilateral lower extremities up to 3 sets of 10 reps each. Further review of task schedule with a start date of 10/30/2024 revealed Resident #18 was to receive dressing/grooming tasks to upper body with staff set up assistance.</p> <p>In an interview on 12/16/2024 at 1:02 PM, S18Certified Nursing Assistant (CNA), indicated she was pulled from restorative services to work the hall.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/17/2024 at 12:57 PM, S18CNA indicated both restorative aides were pulled to the floor and no restorative services were completed on 12/16/2024.</p> <p>In an interview on 12/17/2024 at 2:28 PM, S7Certified Nursing Assistant (CNA) Supervisor, indicated restorative services were not provided on 12/16/2024.</p> <p>In an interview on 12/17/2024 at 2:35 PM, S3Assistant Director of Nursing (ADON), indicated restorative was to be done Monday through Saturday and due to restorative aides being pulled to the hall on 12/16/2024, restorative services were not provided on 12/16/2024 as required.</p> <p>In an interview on 12/18/2024 at 10:15 AM, S18CNA, indicated restorative schedule was Monday through Friday and every other Saturday and due to being pulled to the floor on 12/16/2024, restorative services were not provided.</p> <p>In an interview on 12/18/2024 at 10:15 AM, S7CNASupervisor, indicated the restorative aides were pulled to the floor on 12/16/2024 and restorative services were not provided as required.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34608</p> <p>Based on observations, interviews, record reviews, facility document review, and facility policy review it was determined the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. A resident who was cognitively impaired, had a high risk of falls, and a history of falls had appropriate interventions to decrease the risk of future falls (Resident #4); and,</li> <li>2. A resident who required a two-person assistance with transfers received adequate assistance with transfers (Resident #8).</li> </ol> <p>This deficient practice was identified for 2 (Resident #4 and Resident #8) of 8 sampled residents reviewed for accidents.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1.</li> </ol> <p>Review of Resident #4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/2024, revealed, in part, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated Resident #4 had severe cognitive impairment. Further review revealed Resident #4 required limited assistance of one person physical assist for bed mobility; and extensive assistance of one person physical assist for transfers.</p> <p>Review of Resident #4's annual MDS with an ARD date of 07/23/2024 revealed, in part, Resident #4 had a BIMS of 3, which indicated Resident #4 had severe cognitive impairment.</p> <p>Review of the facility's incident report dated 11/20/2024 revealed, in part, Resident #4 had an unwitnessed fall on 11/20/2024. Further review of the facility's incident report revealed Resident #4 had unwitnessed fall on 10/15/2024 and 10/29/2024.</p> <p>Review of Resident #4's care plan with an initiation date of 08/09/2024 and a revision date of 11/21/2024, revealed in part, Resident #4 was at risk for falls due to a diagnosis of Parkinson's disease. Further review of Resident #4's fall care plan revealed:</p> <p>Resident #4 had a fall on 02/03/2024 with an intervention of staff to offer coffee in AM upon arrival to dining, a fall on 05/23/2024 with an intervention to apply bright colored tape to brake extender and apply grip strips to the floor in front of the recliner, a fall on 06/04/2024 with an intervention to remove the lotion from room and staff to apply as needed, a fall on 10/15/2024 with an intervention for the fall mat to be removed from the room, a fall on 10/29/2024 with an intervention to offer a busy blanket when in the recliner, and a fall on 11/20/2024 with an intervention of grip strips to floor in front of commode. Other interventions for falls included place Resident #4's call bell in reach and encourage resident too call for assistance. Further review of Resident #4's care plan revealed, in part, Resident #4 had impaired cognitive function, impaired thought processes, and episodes of confusion due to Parkinson's disease.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/16/2024 of Resident #4's wheelchair revealed, in part the bright colored tape on the extender arms was peeling off of the left side and there was no bright colored tape on the right side extender. Further observation revealed a sign was posted on the wall as to remind Resident #4 to call for assistance.</p> <p>In an interview on 12/16/2024 at 11:50 AM, S11Certified Nursing Assistant (CNA) indicated Resident #4 was care planned for colored tape, but could not explain the purpose of the colored tape.</p> <p>Observation on 12/16/2024 of Resident #4's wheelchair revealed, in part, the bright colored tape was removed from the left arm extender and replaced with a rubber gray stopper to both extenders.</p> <p>In an interview on 12/18/2024 9:45 AM, Resident #4 indicated she could not see the sign posted on the wall and did not know what the sign posted was for, nor could Resident #4 verbalize why the bright color tape was on the extender of the wheelchair.</p> <p>Observation on 12/18/2024 of Resident #4 revealed, in part, the colored tape was absent from both brake extenders.</p> <p>The facility staff was informed of the above mentioned interview with Resident #4 and was unable to offer any evidence, cognitively impaired Resident #4 understood the sign posted on the wall as a reminder to call for assistance, or understood the reason for the bright colored tape was applied to the wheelchair extenders.</p> <p>2.</p> <p>A review of the facility's Transfer of the Resident policy, undated, revealed, in part, the purpose of the policy is to provide and assist residents with transfers in a safe manner, and staff is to obtain help when necessary when assisting residents with transfers.</p> <p>Review of Resident #8's Quarterly/State Optional Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/2024 revealed, in part, Resident #8 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #8 had moderate cognitive impairment, and required extensive assistance of two or more persons for transfers.</p> <p>Review of Resident #8's electronic care plan with a revision date of 09/06/2024 revealed, in part, Resident #8 required assistance of two staff members for transfers.</p> <p>Review of the facility's incident report revealed, in part, S8Certified Nursing Assistant (CNA) attempted to transfer Resident #8 without assistance of a second staff member on 11/29/2024 and Resident #8 sustained a 6 centimeter x 3 centimeter bruise to the left forearm.</p> <p>Review of Resident #8's Nurses Progress Notes dated 11/29/2024 revealed, in part, S8CNA reported she attempted to transfer Resident #8, and Resident #8 was unsteady and S8CNA grabbed Resident #8 left arm to keep Resident #8 from falling.</p> <p>Review of S8CNA's witness statement dated 11/29/2024 revealed, in part, S8CNA attempted to transfer Resident #8 without assistance of a second staff member and Resident #8 started to fall and S8CNA grabbed Resident #8's arm to stop her from falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #8's witness statement dated 11/30/2024 revealed, in part, on 11/29/2024 S8CNA attempted to transfer Resident #8 without assistance of a second staff member. Further review of Resident #8's witness statement revealed Resident #8 told S8CNA she needed two people to transfer because Resident #8 could not stand.</p> <p>Review of the facility's investigation report revealed, in part, Resident #8's cognitively intact (BIMS 13) roommate witnessed the above mentioned incident on 11/29/2024, and verified S8CNA attempted to transfer Resident #8 without the assistance of a second staff member.</p> <p>In an interview on 12/16/2024 at 3:00 PM, S7CNA Supervisor indicated Resident #8 required the assistance of two staff members for assistance for assistance with transfers. S7CNA Supervisor further indicated on 11/29/2024, S8CNA attempted to transfer Resident #8 without the assistance of a second staff member.</p> <p>In an interview on 12/16/2024 at 3:07 PM, S9CNA indicated on 11/29/2024 she asked S8CNA for assistance in transferring Resident #8 from the chair to the bed because Resident #8 required two staff members for assistance with transfers. S9CNA further indicated S8CNA attempted to transfer Resident #8 without assistance of a second staff member.</p> <p>In an interview on 12/16/2024 at 4:12 PM, S10Licensed Practical Nurse (LPN) indicated on 11/29/2024 S8CNA reported while transferring Resident #8 she grabbed Resident #8's arm to keep her from falling, and Resident #8 sustained a bruise to her left arm. S10LPN further indicated Resident #8 required two staff members assist with transfers and S8CNA attempted to transfer Resident #8 without assistance of a second staff member.</p> <p>In an interview on 12/17/2024 at 1:00 PM, S2Director of Nursing (DON) verified Resident #8 required two or more persons for assistance with transfers. S2DON confirmed S8CNA attempted to transfer Resident #8 without assistance of a second staff member. S2DON indicated S8CNA should not have not attempted to transfer Resident #8 without assistance of a second staff member.</p> <p>In an interview on 12/17/2024 at 1:05 PM, S1Administrator indicated after the facility's investigation it was determined S8CNA failed to follow Resident #8's required transfer assistance of two staff members and she should have.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>46361</p> <p>Based on observation, record review, facility policy review, and interviews, it was determined the facility failed to administer a resident's enteral feeding (intake of food through a tube placed into the stomach) as ordered for 1 (Resident #5) of 1 sampled residents who received enteral feedings in a total sample of 8 investigated for dietary services.</p> <p>Findings included:</p> <p>Review of the facility's undated policy titled, Enteral Nutritional Therapy-Tube Feeding Policy and Procedure revealed, in part, for enteral feedings using a feeding pump the nurse was to enter the amount to be infused according to the physician's order and to verify pump settings each shift.</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/01/2024 revealed, in part, Resident #5 had dysphagia (difficulty swallowing) and required nutrition and hydration through a feeding tube.</p> <p>Review of Resident #5's December 2024 physician's orders revealed, in part, an order with a start date of 12/13/2024 for Glucerna 1.2 Cal (a tube feeding formula) 65 milliliters per hour (mL/hour ) nocturnal feedings (occurring at night). Start feeding at 6:00 PM and stop feeding at 6:00 AM.</p> <p>Observation on 12/16/2024 at 10:58 AM revealed Resident #5 had Glucerna 1.2 Cal infusing at 55 mL/hour via a tube feeding pump.</p> <p>In an interview on 12/17/2024 at 1:02 PM, S5Licensed Practical Nurse (LPN) indicated Resident #5's physician's order for the enteral feeding had recently changed and she was not aware. S5LPN confirmed Resident #5's enteral feeding should have been stopped at 6:00 AM, and should not have been infusing at 55 mL/hr.</p> <p>In an interview on 12/18/2024 at 9:15 AM, S3Assistant Director of Nursing (ADON) indicated S6LPN, the night nurse, should have stopped Resident #5's enteral feeding on 12/16/2024 at 6:00 AM.</p> <p>In an interview on 12/18/2024 at 12:36 PM, S6LPN indicated she was responsible to stop Resident #5's enteral feedings on 12/16/2024 at 6:00 AM. S6LPN further indicated she could not recall if she verified Resident #5's formula was infusing at the rate as order, and could not recall if she stopped Resident #5's enteral feeding at 6:00 AM as required.</p>		

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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 0805</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 prepared in a form designed to meet individual needs.</p> <p>34608</p> <p>Based on record reviews, observations, and interviews, the facility failed to provide a resident with the correct diet to meet their needs for 1 (Resident #2) of 8 sampled residents reviewed for dietary services.</p> <p>Findings included:</p> <p>Review of the facility's Diet Orders policy, undated, revealed in part, when there is a nutritional indication, the facility will provide a diet that is individualized to meet the clinical needs and desires of the resident.</p> <p>Review of Resident #2's active diagnosis listed revealed, in part, Resident #2 had a of dysphagia following a cerebral infarction.</p> <p>Review of Resident #2's Quarterly and State Optional Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024 revealed, in part, Resident #2 had a Brief Interview for Mental Status (BIMS) of a 5, which indicated severe cognitive impairment, had a diagnosis of dysphagia following a cerebral infarction, and received a mechanically altered diet.</p> <p>Review of Resident #2's care plan with an initiation date of 08/20/2024 and revision date of 12/11/2024 revealed, in part, Resident #2 required a mechanically altered diet due too risk of aspiration.</p> <p>Review of Resident #2's meal ticket on 12/16/2024 at 11:10 AM revealed Resident #2 was to receive a mechanical soft diet with chopped meats, add puree soup; special instructions no soup, no cereal &amp; milk, no gumbo, no straws, and puree rice only.</p> <p>Observation on 12/16/2024 at 11:10 AM revealed Resident #2 was served white beans and regular rice, chopped sausage, mustard greens, a slice of bread, and a piece of cake.</p> <p>In an interview on 12/16/2024 at 11:10 AM, S17Certified Nursing Assistant confirmed Resident #2's meal ticket indicated he was to have puree rice only and he was served and currently eating regular rice with white beans.</p> <p>In an interview on 12/18/2024 at 11:30 AM, S3ADON confirmed Resident #2 was served the wrong diet on Monday, 12/16/20024 when Resident #2 was served regular rice for the lunch meal service. S3ADON further indicated she was present and observed Resident #2's tray and confirmed Resident #2 was served regular rice and should have been served pureed rice.</p>