

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE 5976 US-65 North Lake Providence, LA 71254	

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 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>19256</p> <p>Based on observation and interviews, the facility failed: 1.) to post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the facility and 2.) to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>Findings:</p> <p>During the Resident Council Meeting on 05/06/2024 at 1:40 p.m., resident #6, resident #9, resident #31, resident #32, resident #34, and resident #53 were unaware of where the state inspection results were located.</p> <p>Observation with S1Administrator on 05/06/2024 at 2:54 p.m. revealed the state inspection results were not labeled and were held in a clear plastic bin on the wall out of the reach of the residents in wheelchairs. S1Administrator confirmed at this time that the state inspection results were not labeled and were not within reach of the residents in wheelchairs.</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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19098</p> <p>Based on record reviews and interviews, the facility failed to ensure the residents' code status was obtained and available for staff to review for 2 (#188, #186) of 2 (#188, #186) residents who did not have a code status available for staff review.</p> <p>Findings:</p> <p>Review of the facility Resident Rights Advance Directives Policy and Procedure dated March 2023 revealed in part:</p> <p>Purpose: To support the resident's right to have an Advance Directive.</p> <p>Guidelines: Upon admission, if the resident has not formulated an advance directive, the facility will determine if the resident wishes to formulate an advance directive. Information about whether or not the resident has an advance directive in place is featured in the medical record.</p> <p>Resident #188:</p> <p>On 05/07/2024 at 10:43 a.m. review of the record for resident #188 revealed an admitted [DATE]. Further review of the record revealed no documentation of an advance directive indicating the resident's code status.</p> <p>On 05/08/2024 at 1:51 p.m. a request to review the resident's advance directive was made.</p> <p>On 05/08/2024 at 2:56 p.m. an interview with S19Social Service Director (SSD) revealed the advance directive was in the social folder in her office and was not available to staff. S19SSD said she is new and just started and is in the process of going through each resident's record and social folder.</p> <p>22575</p> <p>Resident #186:</p> <p>On 05/07/2024 at 10:53 a.m. review of the record for resident #186 revealed an admitted [DATE]. Further review of the record revealed no documentation of an advance directive indicating the resident's code status.</p> <p>On 05/08/2024 at 9:57 a.m. S2DON (Director of Nursing) was informed there was no documented evidence of resident #186's advance directive. S2DON revealed that social services usually obtains the residents' advance directive upon admit.</p> <p>On 05/08/2024 at 2:56 p.m. an interview with S19SSD revealed resident #186's advance directive was in the social folder in her office and was not available to staff. S19SSD said she is new and just started and is in the process of going through each resident's record and social folder.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/2024 at 6:00 p.m. interview with S2DON and S18Regional Director of Clinical confirmed resident # 186's advanced directive should have been obtained upon admit and entered into the resident's electronic record available for staff to review.</p>

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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>19256</p> <p>Based on record reviews and interview, the facility failed to inform each resident as soon as possible of changes in Medicare covered services as evidenced by the facility's failure to provide: 1.) the Form Centers for Medicare and Medicaid Services (CMS) 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Form CMS 10123 Notice of Medicare Non-Coverage as required for 1 resident (#84) and 2.) the Form CMS 10123 Notice of Medicare Non-Coverage as required for 1 resident (#236) of 3 (#57, #84, and #236) residents reviewed for Beneficiary Notification who required the notification.</p> <p>Findings:</p> <p>Resident #84</p> <p>Review of the list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months completed by the facility revealed resident #84 was discharged from Medicare Part A Services on 04/04/2024 with benefit days remaining. Further review of the records revealed Form CMS-10055 and Form CMS-10123 had not been provided to resident #84.</p> <p>Resident #236</p> <p>Review of the list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months completed by the facility revealed resident #236 was discharged from Medicare Part A Services on 03/28/2024 with benefit days remaining. An interview with S10Minimum Data Set (MDS) nurse on 05/07/2024 at 2:00 p.m. revealed the resident had benefit days remaining and he had a planned discharge on 03/28/2024. Further review of the records revealed Form CMS-10123 had not been provided to resident #236.</p> <p>An interview with S1Administrator on 05/07/2024 at 3:25 p.m. revealed the Director of Social Services was responsible for completing the Form CMS 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Form CMS 10123 Notice of Medicare Non-Coverage for residents and she started her employment with facility last week. S1Administrator confirmed there was no documentation that resident #84 was provided Form CMS 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage and Form CMS 10123 Notice of Medicare Non-Coverage and there was no documentation that resident #236 was provided Form CMS 10123 Notice of Medicare Non-Coverage.</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>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>19098</p> <p>Based on observation and interview the facility failed to maintain a safe, clean, comfortable and homelike environment for 4 (#64, #74, #44, #83) of 4 (#64, #74, #44, #83) residents' rooms observed with environmental concerns.</p> <p>Findings:</p> <p>Review of the facility's policy for Physical Environment dated March 2023 revealed in part:</p> <p>Purpose: To provide a safe, functional, sanitary and comfortable environment for resident.</p> <p>Resident #44</p> <p>Observations of resident #44's room on 05/06/2024 at 2:25 p.m. and on 05/07/2024 at 11:13 a.m. revealed a metal fluorescent light fixture, approximately 3.5 feet long by 5 inches wide by 5 inches deep, was only secured to the wall on the very left side of the light fixture and the light fixture was leaning down to the right.</p> <p>On 05/08/2024 at 4:35 p.m. an observation of resident #44's room with S1Administrator and S20Maintenance Supervisor revealed the metal fluorescent light fixture was only secured to the wall on the left side and was leaning down to the right. Interview with S1Administrator and S20Maintenance Supervisor confirmed the light fixture in resident #44's room needed to be properly secured to the wall.</p> <p>41829</p> <p>Resident #83</p> <p>Observations of resident #83's room on 05/06/2024 at 11:50 a.m. and on 05/07/2024 at 11:30 a.m. revealed the following: 2 vertical holes (approximately 15 inches x 2.5 inches and approximately 24 inches x 2.5 inches) in the gypsum board wall behind the head of the bed, 2 areas (approximately 15 inches x 3 inches and 4 inches x 3 inches) where the paint was missing and gypsum board was gouged on the wall next to the bed, the door of closet was not secure to the closet and was leaning against the wall next to the closet. Observations of resident # 83's bathroom revealed the plastic dual roll toilet paper holder was lying on the floor next to the toilet, there was small holes in the wall of the bathroom where the toilet paper holder was previously attached.</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 05/08/2024 at 4:39 p.m. an observation of resident #83's room with S1Administrator and S2Maintenance Supervisor revealed the following: 2 vertical holes (approximately 15 inches x 2.5 inches and approximately 24 inches x 2.5 inches) in the gypsum board wall behind the head of the bed, 2 areas (approximately 15 inches x 3 inches and 4 inches x 3 inches) where the paint was missing and gypsum board was gouged on the wall next to the bed, the door of closet was not secure to the closet and was leaning against the wall next to the closet. Observations of resident # 83's bathroom revealed the plastic dual roll toilet paper holder was lying on the floor next to the toilet, there was small holes in the wall of the bathroom where the toilet paper holder was previously attached. Interview with S1Administrator and S2Maintenance Supervisor confirmed that the closet door needed to be properly secured to the closet, the holes in the gypsum wall behind the bed and the gouges in the gypsum wall beside his bed needed to be repaired, and the toilet paper roll dispenser needed to be properly secured to the restroom wall.</p> <p>Resident #64:</p> <p>On 05/06/2024 at 2:03 p.m. an observation of resident #64's room revealed there was a large hole in the wall next to resident #64's bed exposing the water pipes to the bathroom. The hole was approximately 1.5 foot (ft) wide and 2.5 feet long with another open piece to the right side of the large hole that was approximately 2 feet wide and unknown how long due to resident #62 items in front of a portion of the hole.</p> <p>Further observation of resident #64's bathroom revealed there was a blanket that was folded and placed on floor behind the toilet next to the wall.</p> <p>On 05/08/2024 at 1:15 p.m. an observation of resident #64's room revealed the hole remained in the wall adjoining to the bathroom exposing the water pipes to the room.</p> <p>On 05/08/2024 at 4:44 p.m. an observation of resident # 64's room with S2Maintenance Director and S1Administrator confirmed there was a hole in the wall with exposed water pipes next to resident #64's bed.</p> <p>On 05/08/2024 at 4:44 p.m. further observation of resident #64's bathroom with S2Maintenance Director and S1Administrator confirmed the folded blanket remained on the floor between the toilet and the wall. Interview at that time with S2MaintenanceDirector and S1Administrator agreed the blanket that was folded on the floor between the toilet and the wall should not have been placed there</p> <p>22575</p> <p>Resident #74:</p> <p>On 05/08/2024 at 5:14 p.m. an observation of resident #74's bathroom revealed there was a large hole with exposed water pipes in the wall to the left of the toilet. The hole was a square opening approximately 3 ft x 3 ft.</p> <p>On 05/08/2024 at 4:40 p.m. an observation of resident # 64's bathroom with S2Maintenance Director and S1Administrator confirmed there was a hole in the wall with exposed water pipes next to resident #74's toilet.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on observation, record review and interviews the facility failed to protect a residents' right to be free from physical and psychosocial abuse by a Certified Nursing Assistant (CNA) for 1 (#16) of 4 (#10, #16, #63, and #73) residents reviewed for abuse.</p> <p>The deficient practice resulted in an actual harm for resident #16 (who was cognitively impaired) on 04/28/2024 during the day shift between 6:00 a.m. - 2:00 p.m. when S4CNA was observed by S5CNA and S6CNA punching resident #16 in the face, chest and side several times with a closed fist.</p> <p>Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the physical abuse, since a reasonable person would not expect to be treated in this manner in her own home or health care facility.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure for Freedom from Abuse, Neglect and Exploitation dated 03/2023 revealed:</p> <p>Purpose:</p> <p>To keep residents free from abuse, neglect, and corporal punishment of any kind by any person.</p> <p>Review of the medical record for resident #16 revealed diagnoses of major depressive disorder, intracranial injury without loss of consciousness, cervical root disorder, insomnia, anoxic brain damage, delusional disorder, psychotic disorder with delusions due to known physiological condition, dementia with behavioral disturbance, impulse disorder, and anxiety.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #16 had severe cognitive impairment for daily decision making and required extensive assistance with activities of daily living.</p> <p>Review of the physician orders dated 11/01/2023 revealed an order for resident #16 to have one on one care at all times. This physician order continued each month up to the present date of the survey.</p> <p>Review of the current plan of care revealed resident #16 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Resident #16 has a self-care performance deficit and required assistance with activities of daily living. Resident #16 required 1:1 care 24 hours a day.</p> <p>Review of the facility's Investigation Report dated 04/28/2024 at approximately 2:30 p.m. revealed S7CNA was the oncoming CNA assigned to resident #16's hall. Another aide, S8CNA asked for assistance in getting resident #16 to her room. S9CNA, S8CNA and S7CNA noticed a bruise on resident #16's face. The incident was immediately reported to S3Licensed Practical Nurse (LPN).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurses' notes dated 04/28/2024 at 4:40 p.m. revealed the staff reported that resident #16 had bruising and scratches on her body. The CNA brought the resident to the nurse to assess. The resident was sitting upright in a wheelchair, awake and alert. Upon assessment, the resident was noted to have bruising to the right eye, scratches to the left breast and one scratch to left posterior shoulder.</p> <p>Review of the Incident Report dated 04/28/2024 at 3:31 p.m. revealed resident #16 was noted to have bruising of the right eye, a scratch to the left breast and one scratch to the posterior shoulder. The resident was unable to give any description of incident. Further review of the Incident Report revealed everyone involved in the care of the resident was immediately suspended pending further investigation.</p> <p>On 05/06/2024 at 11:00 a.m., observation of resident #16 revealed she was in the hall sitting in a wheelchair with the 1:1 staff member next to her. Resident #16 was noted to have a bruise under her right eye.</p> <p>On 05/07/2024 at 4:30 p.m., an interview with S9CNA revealed she worked on 04/28/2024 from 2:00 p.m. - 10:00 p.m. and she noticed a bruise to resident #16's right eye and she informed S13ADON (Assistant Director of Nursing).</p> <p>On 05/06/2024 at 3:30 p.m., an interview with S13ADON revealed she was working on 04/28/2024 when the CNAs for the 2:00 p.m. - 10:00 p.m. shift came into work, they noticed that resident #16 had a bruise to her right eye. S13ADON further revealed that she assessed resident #16 and saw a bruise to her right eye and a scratch to her left chest and left shoulder.</p> <p>On 05/07/2024 at 10:30 a.m., an interview with S13ADON revealed on 04/28/2024 S4CNA had already completed her shift and had left the nursing home. S4CNA was called to come back to the nursing home to provide a statement of events when she worked with resident #16 on 04/28/2024. S4CNA returned to the nursing home, provided a statement and denied any issues regarding resident #16 during her shift on 04/28/2024. Further interview with S13ADON revealed she attempted to contact S5CNA and S6CNA on 04/28/2024 without success. S5CNA and S6CNA were the other two aides that assisted in the care of resident #16 on 04/28/2024.</p> <p>S13ADON revealed S5CNA and S6CNA came to the nursing home on 04/29/2024 and provided a statement. S5CNA and S6CNA revealed they saw S4CNA hit resident #16 in the face, chest and side multiple times on 04/28/2024. The facility notified the local Sheriff's department and the Sherriff's department started an investigation on 04/29/2024.</p> <p>Review of the statement provided by S5CNA revealed on 04/28/2024, S4CNA asked if S5CNA could help change resident #16. Resident #16 grabbed S4CNA's necklace and S4CNA got mad and began punching resident #16 repeatedly everywhere.</p> <p>Review of the statement provided by S6CNA revealed on 04/28/2024, S4CNA asked if S6CNA could help change resident #16. During the care resident #16 began to grab S4CNA and once she grabbed her S4CNA punched her in the face several times. Resident #16 broke S4CNA's necklace and S4CNA got mad and punched resident #16 in the face, chest and side multiple times.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Sheriff's Department Investigation Report revealed on 04/29/2024 at approximately 4:48 p.m. S4CNA confirmed she did hit resident #16 with a closed fist on the shoulder and back. S4CNA was arrested on 04/29/2024.</p> <p>On 05/07/2024 at 11:00 a.m., an interview with S3LPN revealed on 04/28/2024 at 2:10 p.m., S7CNA came and informed her that resident #16 had a bruise on her left eye. S3LPN revealed S13ADON and she assessed the resident and she was observed to have a bruise to her right eye and a scratch to her left breast and left shoulder.</p> <p>On 05/08/2024 at 6:15 p.m., an interview with S1Administrator confirmed resident #16 was physically abused by S4CNA and it was everyone's responsibility at the nursing facility to ensure residents are free from abuse.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on record review and interview the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately to the facility administration for 1 (#16) of 4 (#10, #16, #63 and #73) residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure for Abuse with a revised date of 05/15/2023 revealed:</p> <p>Intent: To promote a safe environment for residents, visitors, and employees through prompt and appropriate response and follow up to abuse allegations and events.</p> <p>Review of the medical record for resident #16 revealed diagnoses of major depressive disorder, intracranial injury without loss of consciousness, cervical root disorder, insomnia, anoxic brain damage, delusional disorder, psychotic disorder with delusions due to known physiological condition, dementia with behavioral disturbance, impulse disorder, and anxiety.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #16 had severe cognitive impairment for daily decision making and required extensive assistance with activities of daily living.</p> <p>Review of the current plan of care revealed resident #16 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Resident #16 has a self-care performance deficit and required assistance with activities of daily living. Resident #16 required 1:1 care 24 hours a day.</p> <p>Review of the facility's Investigation Report dated 04/28/2024 at approximately 2:30 p.m. revealed S7CNA was the oncoming CNA assigned to resident #16's hall. Another aide, S8CNA asked for assistance in getting resident #16 to her room. S9CNA, S8CNA and S7CNA noticed a bruise on resident #16's face. The incident was immediately reported to S3Licensed Practical Nurse (LPN).</p> <p>Review of the nurses' notes dated 04/28/2024 at 4:40 p.m. revealed the staff reported that resident #16 had bruising and scratches on her body. The CNA brought the resident to the nurse to assess. The resident was sitting upright in a wheelchair, awake and alert. Upon assessment, the resident was noted to have bruising to the right eye, scratches to the left breast and one scratch to left posterior shoulder.</p> <p>Review of the Incident Report dated 04/28/2024 at 3:31 p.m. revealed resident #16 was noted to have bruising of the right eye, a scratch to the left breast and one scratch to the posterior shoulder. The resident was unable to give any description of incident. Further review of the Incident Report revealed everyone involved in the care of the resident was immediately suspended pending further investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/06/2024 at 3:30 p.m., an interview with S13Assistant Director of Nursing (ADON) revealed she was working on 04/28/2024 when the CNAs for the 2:00 p.m. - 10:00 p.m. shift came into work, they noticed that resident #16 had a bruise to her right eye. S13ADON further revealed that she assessed resident #16 and saw a bruise to her right eye and a scratch to her left chest and left shoulder.</p> <p>On 05/07/2024 at 10:30 a.m., S13ADON revealed on 04/28/24 S4CNA had already completed her shift and had left the nursing home. S4CNA was called to come back to the nursing home to provide a statement of events when she worked with resident #16 on 04/28/2024. S4CNA returned to the nursing home, provided a statement and denied any issues during her shift on 04/28/2024. Further interview with S13ADON revealed she attempted to contact S5CNA and S6CNA on 04/28/2024 without success.</p> <p>S13ADON revealed S5CNA and S6CNA came to the nursing home on 04/29/2024 and provided a statement. S5CNA and S6CNA revealed they saw S4CNA hit resident #16 in the face, chest and side multiple times. The facility notified the local Sheriff's department and the Sherriff's department started an investigation on 04/29/2024.</p> <p>Review of the statement provided by S5CNA revealed on 04/28/2024 S4CNA asked if S5CNA could help change resident #16. Resident #16 grabbed S4CNA's necklace and S4CNA got mad and began punching resident #16 repeatedly everywhere. Further review of S4CNA's statement revealed she really didn't know what to do and was scared to say something.</p> <p>Review of the statement provided by S6CNA revealed on 04/28/2024 S4CNA asked if S6CNA could help change resident #16. During care resident #16 began to grab S4CNA and once she grabbed her S4CNA punched her in the face several times. Resident #16 broke S4CNA's necklace and S4CNA got mad and punched resident #16 in the face, chest and side multiple times. Further review of S4CNA's statement revealed documentation that she was shaken up about the situation and afraid to tell. So we proceeded to go back to the hall and do our last rounds.</p> <p>On 05/07/2024 at 10:45 a.m., an interview with S1Administrator revealed staff should report any type of abuse immediately. Further interview with S1Administrator confirmed S5CNA and S6CNA did not report the abuse to resident #16 by S4CNA immediately.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE  5976 US-65 North Lake Providence, LA 71254	
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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22575</p> <p>Based on record review and interviews, the facility failed to conduct a comprehensive assessment which included the resident's safe smoking assessment for 1 (#18) of 1 (#18) residents reviewed for smoking.</p> <p>Findings:</p> <p>Review of the facility policy and procedures for Physical Environment: Smoking - Supervised Smokers dated March 2023 revealed in part: Guidelines: Smoking assessments will be completed on admission, quarterly, with significant change of condition and as needed for residents who wish to smoke. Smoking assessment will include a return demonstration of ability to safely manage smoking paraphernalia.</p> <p>Review of resident #18's medical record revealed she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, and chronic kidney disease.</p> <p>Review of resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status (BIMS) score of 13 which indicated no cognitive impairment. Review of resident #18's active care plan revealed she required extensive to total dependence for all activities of daily living.</p> <p>On 05/06/2024 at 4:02 p.m. an observation of resident #18 revealed she was outside in the designated smoking area smoking a cigarette.</p> <p>Review of resident #18's Nursing Smoking Screen dated 11/26/2023 revealed she was assessed as an unsafe smoker. Further review revealed there was no documented evidence that the facility had conducted a quarterly smoking assessment for resident #18 per the facility policy. The resident's quarterly smoking assessment should have been conducted in 02/2024.</p> <p>On 05/08/2024 at 6:00 p.m. an interview with S2Director of Nursing and S18Regional Director of Clinical confirmed resident #18's smoking assessment should have been conducted quarterly per the facility policy. S18Regional Director of Clinical confirmed that resident #18's quarterly smoking assessment was not conducted quarterly in 02/2024.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19098</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming, and personal hygiene for 5 (#26, #44, #60, #64 and #71) of 5 (#26, #44, #60, #64 and #71) residents sampled for Activities of Daily Living.</p> <p>Findings:</p> <p>Resident #26</p> <p>On 05/07/2024 at 4:02 p.m. record review for resident #26 revealed diagnoses in part of: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, aphasia, dysphagia, chronic obstructive pulmonary disease (COPD), type 2 diabetes, anxiety disorder, vascular dementia with behavioral disturbance, hypertension, end stage renal disease, and congestive heart failure.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #26 had a Brief Interview of Mental Status (BIMS) score of 14 indicating the resident was cognitively intact. Review of the functional assessments revealed resident required substantial/maximum assistance with toileting, bathing, dressing, and hygiene.</p> <p>On 05/06/2024 at 9:43 a.m. an observation of resident #26 revealed his fingernails were long with debris under nails, resident's beard was long, and in need of shaving.</p> <p>Interview with resident #26 on 05/06/2024 at 9:43 a.m. revealed he agreed he was in need of having his beard shaved and his fingernails needed to be trimmed and cleaned.</p> <p>On 05/07/2024 at 3:56 p.m., an observation of resident #26 while S2Director of Nursing (DON) was present revealed resident #26's fingernails continued to be long and dirty and the resident's beard remained unshaven. S2DON confirmed resident #26's fingernails were long and dirty, and his beard needed to be shaved.</p> <p>Resident #64</p> <p>On 05/08/2024 at 4:58 p.m. record review for resident #64 revealed diagnoses in part of COPD, muscle weakness, lack of coordination, respiratory failure, hypertension, gait and mobility problems, psychoactive substance abuse, cellulitis right and left lower limb, cardiomyopathy, idiopathic aseptic necrosis of left femur, cirrhosis of liver, osteonecrosis of the femur, and chronic viral hepatitis C.</p> <p>Review of the annual MDS dated [DATE] revealed resident #64 had a BIMS score of 15 indicating the resident was cognitively intact. Review of the functional assessments revealed resident required partial/moderate assistance with bathing, dressing, and hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/06/2024 at 1:56 p.m. an observation of resident #64 revealed a very strong urine odor and body odor, toenails were long with black material under the nails, fingernails were dirty with dark material under the nails, and multiple stains and odor noted to the resident's shirt.</p> <p>On 05/07/2024 at 3:59 p.m. observation of resident #64 while S2DON was present revealed resident #64 remained unkempt by wearing the same stained and odorous shirt as on 05/06/2024, fingernails were in need of cleaning and trimming, toenails were long and dirty with dark material under the nails.</p> <p>On 05/07/2024 at 3:59 p.m. an interview with S2DON confirmed resident #64 was in need of grooming, bathing, clean clothing, fingernails needed to be cleaned, and toenails needed to be cleaned and trimmed.</p> <p>22575</p> <p>Resident #60:</p> <p>Review of the medical record for resident #60 revealed diagnoses of cerebral infarction, hemiplegia affecting his right dominant side, and cognitive communication deficit.</p> <p>Review of resident #60's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 99 which indicated the facility was unable to conduct the test.</p> <p>Review of resident #60's active care plan revealed he required extensive to total assistance for all activities of daily living, which included personal hygiene.</p> <p>On 05/06/2024 at 9:15 a.m. observation of resident #60's fingernails and toenails revealed a brown substance was observed under his fingernails and toenails and all nails needed trimming.</p> <p>On 05/07/2024 at 03:45 p.m., an observation of resident #60's fingernails and toenails with S21Certified Nursing Assistant (CNA) present revealed S21CNA confirmed the resident's fingernails and toenails needed to be cleaned and trimmed.</p> <p>On 05/07/2024 at 03:50 p.m. an interview with S22Licensed Practical Nurse (LPN) confirmed that resident #60's fingernails and toenails needed to be cleaned and trimmed.</p> <p>On 05/08/2024 at 06:00 p.m. an interview with S2DON and S18Regional Director of Clinical confirmed resident # 60's fingernails and toenails should have been cleaned and trimmed.</p> <p>41829</p> <p>Resident #44</p> <p>Record review revealed resident #44 was admitted to the facility on [DATE] with diagnoses that included dementia, type 2 diabetes mellitus without complications, non-ST elevation myocardial infarction, heart failure, generalized weakness, lack of coordination, cognitive communication deficit, and hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 4 which indicated resident #44 had severe cognitive impairment. Further review revealed resident #44 required partial/moderate assistance with bathing, showering, and personal hygiene.</p> <p>Review of the active care plan revealed resident #44 had an Activities of Daily Living (ADL) self-care performance deficit. Personal hygiene/oral care: the resident is totally dependent on (1) staff for personal hygiene and oral care.</p> <p>On 05/06/2024 at 02:26 p.m. an observation of resident #44 revealed there was a brown, grime substance under fingernails on both hands.</p> <p>On 05/07/2024 at 11:11 a.m. an observation of resident #44 revealed there was a brown, grime substance under finger nails on both hands.</p> <p>On 05/07/2024 at 04:40 p.m. an interview with S2DON (Director of Nursing) confirmed resident #44's fingernails needed to be trimmed and cleaned.</p> <p>Resident #71</p> <p>Record review revealed resident #71 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease, essential hypertension, personal history of venous thrombosis and embolism, major depressive disorder, retention of urine, and fatigue.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed it was in progress. Review of the 5 day admission MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated resident #71 was cognitively intact. Further review revealed resident #71 was dependent on staff for toileting, transfers, hygiene, bathing/showering, and dressing.</p> <p>Review of active care plan revealed resident #71 had an ADL self-care performance deficit. Personal hygiene/oral care: the resident is totally dependent on (2) staff for personal hygiene and oral care.</p> <p>On 05/06/2024 at 11:15 a.m. an observation and interview with resident #71 revealed he was sitting in a manual wheel chair in the therapy department. Resident #71's fingernails on both hands were long and jagged with a brown, grime substance under fingernails on both hands. Resident #71 had a long full beard and mustache. Resident #71 reported he would like to have his fingernails cleaned and trimmed and his beard cut and mustache trimmed but no one has offered to assist him. Resident #71 reported he always had a mustache, but never had a beard before being admitted to the facility.</p> <p>On 05/07/2024 at 11:08 a.m. an observation of resident #71 revealed fingernails on both hands were long and jagged with a brown, grime substance under fingernails on both hands. Resident #71's beard and mustache was long.</p> <p>On 05/07/2024 at 03:45 p.m. an interview with S2DON was conducted in resident #71's room. S2DON confirmed resident #71's fingernails needed to be trimmed and cleaned. S2DON further confirmed resident #71's beard needed to be cut and his mustache need to be trimmed.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19098</p> <p>Based on observations, record reviews and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 (#60) of 2 (#10 &amp; #60) residents reviewed for positioning/mobility and 2 (#26 &amp; #39) of 3 (#26, #39, &amp; #83) residents reviewed for skin conditions. The facility failed to: 1) identify non-pressure related wounds to resident #26, 2) provide a right hand roll to resident #60 and 3) provide treatment to resident #83's scrotal wound.</p> <p>Findings:</p> <p>Resident #26</p> <p>Record review for resident #26 revealed the resident was admitted on [DATE] with diagnoses in part of: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, type 2 diabetes, vascular dementia with behavioral disturbance, hypertension, end stage renal disease, and calciphylaxis wounds (known as calcific uremic arteriopathy, it is characterized by painful skin lesions caused by cutaneous arteriolar calcification leading to restricted blood flow to tissue (ischemia) and injury or death of tissue or organs (infarction)).</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #26 had a Brief Interview of Mental Status (BIMS) of 14 which indicated the resident was cognitively intact.</p> <p>Review of the functional assessments revealed the resident required substantial/maximum assistance for toileting, bathing, dressing, and hygiene and partial/moderate assistance for turning.</p> <p>Review of current May 2024 physician orders for resident #26's wound care revealed:</p> <p>Coccyx - (calciphylaxis) clean site with wound cleanser, pat dry with gauze, paint with betadine, cover with foam dressing daily, and prn (as needed) soilage.</p> <p>Left Hip - (calciphylaxis) clean site with wound cleanser, pat dry with gauze, paint with betadine, apply foam dressing daily, prn soilage.</p> <p>Scrotum - (calciphylaxis) clean with wound cleanser , pat dry with gauze, paint with betadine and cover with dressing of choice daily and prn soiled or non-intact.</p> <p>On 05/07/2024 at 9:32 a.m., review of the current wound assessments revealed resident #26 had the identified wounds: Left trochanter (hip) - Ulcer/calciphylaxis- acquired in house 04/16/2024- measuring 3.79 centimeters (cm) x 2.94 cm with an area of 7.8 cm<sup>2</sup> when identified. Coccyx- calciphylaxis- acquired in house 04/29/2024 measuring 6.1 cm x 5.6 cm x 10.0 cm<sup>2</sup> when identified. Scrotum-Calciphylaxis- acquired in house 05/01/2024 measuring 2.5 cm x 0.7 cm with an area of 1.5 cm<sup>2</sup> when identified.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the weekly skin assessments dated 05/04/2024, 04/27/2024, and 04/20/2024 revealed no new wounds.</p> <p>Observation of wound treatment with S12Treatment Nurse and S13Assistant Director of Nursing (ADON) on 05/08/2024 at 10:19 a.m. revealed wound treatment was provided to the left trochanter, coccyx and scrotum as ordered. During the wound treatment for resident #26 with S12Treatment Nurse and S13ADON, the following new wounds were identified: Left gluteal fold, the right heel was black and hard, left heel had a black hard area, and a dark blister area to left inner knee.</p> <p>On 05/08/2024 at 3:30 p.m., review of the wound documentation for the unidentified wounds found on 05/08/2024 revealed the following: Left gluteal fold- Length 8.11 cm x 0.94 cm - total area 0.8 cm2, Front left knee- 1.59 cm x 1.36 cm - total area 1.47 cm2, Right heel- 4.28 cm x 2.3 cm - total area 7.49 cm2, and Left heel- 3.93 cm x 1.31 cm - total area 3.86 cm2.</p> <p>S13ADON confirmed during the wound treatment that the new areas had not previously been identified or reported to the treatment nurse. S13ADON further said the CNAs are supposed to report any areas to the nurse when providing care and the floor nurses are to complete the weekly skin assessment. S13ADON further said the areas looked to be calciphylaxis like the rest of the wounds and not pressure related, but the resident's physician will determine the classification of the wounds.</p> <p>41829</p> <p>Resident #39</p> <p>Record review revealed resident #39 was admitted to the facility on [DATE] with diagnoses that included stage 4 pressure ulcer of right hip, stage 3 pressure ulcer of sacral region, dementia, anemia, reduced mobility, peripheral vascular disease, hereditary idiopathic neuropathy, edema, mild protein-calorie malnutrition, major depressive disorder, gastrostomy status, and bilateral above the knee amputation.</p> <p>Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed BIMS (Brief Interview Mental Status) score of 15 which indicated resident #39 was cognitively intact. Resident #39 was dependent on staff assistance for all ADLs (Activities of Daily Living). Resident #39 required extensive one person assistance with eating, bed mobility, toileting, hygiene, and bathing. Resident #39 required extensive two person assistance with transfers. Resident #39 was incontinent of bowel and bladder. Resident #29 was at risk for pressure ulcers/skin injuries. Resident #39 had 2 stage 4 pressure ulcers.</p> <p>Review of active May 2024 physician orders revealed an order for moisture associated dermatitis to scrotum apply moisture barrier cream to scrotum area TID (three times daily and prn (as needed) after incontinent care (ordered 05/07/2024 at 17:45).</p> <p>Weekly skin checks - document results on weekly skin observation assessments.</p> <p>Review of progress note dated 05/03/2024 at 22:57 revealed the following in-part: Complaint of pain in perineal area. Treatment applied to area and pain medication administered by S17LPN.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/07/2024 09:05 a.m. an observation of resident #39 revealed he was sitting in geri chair with head elevated up 60 degrees, resting quietly, and watching TV in his room.</p> <p>On 05/07/2024 at 3:55 p.m. an interview with S9CNA (Certified Nursing Aide) revealed she works the 2 pm-10 pm shift. S9CNA reported she checks on resident #39 every 2 hours to make sure he is clean and dry and provides incontinent care and change his brief when need. S9CNA reported that she uses the wedge cushions to help position him. Surveyor observed S9CNA check resident #39 to see if he needed to be changed. Resident #39 was noted to have an incontinent episode and S9CNA provided incontinent care. Surveyor observed an irregular shaped ulceration approximately 4.5 cm (centimeter) x 1.5 cm to resident #39's right scrotum. There was no drainage or odor noted. There was no signs of infection noted.</p> <p>On 05/07/2024 at 4:10 p.m. an interview with S12Treatment Nurse revealed she was not aware of resident #39 having a wound on his scrotum.</p> <p>On 05/07/2024 at 4:30 p.m. the surveyor informed S2DON (Director of Nursing) of the wound observed on resident #39's right scrotum. The surveyor informed S2DON there was no documentation of the wound or an order for wound care noted.</p> <p>On 05/08/2024 at 08:30 a.m. an interview with S15CNA revealed one day last week, either Wednesday or Thursday, she noticed resident #39 had redness to his right scrotum and a small crack in the skin and she notified S16LPN (Licensed Practical Nurse). S15CNA reported she had been putting the pink cream on his scrotum every brief change. S15CNA reported that sore on his scrotum has gotten bigger since last week.</p> <p>On 05/08/2024 at 08:35 a.m. an interview with S3LPN revealed she was not notified of resident #39 having any issues with the skin on his scrotum until today.</p> <p>On 05/08/2024 at 08:39 a.m. an interview with S13ADON (Assistant Director of Nursing) revealed she was not aware of resident #39 having a wound on his scrotum until yesterday evening when S2DON asked her to assess resident #39's scrotum. S13ADON reported she and S12Treatment Nurse assessed resident #39's scrotum yesterday evening around 5:00 p.m. and identified a new moisture associated dermatitis to his right scrotum. S13ADON reported they obtained measurements and took a picture of the wound. S13ADON notified the physician and obtained an order for moisture barrier cream to scrotum area three times a day and prn after incontinent care.</p> <p>Review of wound assessment revealed the following: #4 MASD (Moisture Associated Skin Damage) - IAD (Incontinence Associated Dermatitis) Right scrotum. New wound identified 05/07/2024 acquired in house. Wound measurements: length 4.44 cm, width 1.59 cm, deepest point 0. No tunneling. No undermining. Wound bed 80% epithelial and 20% granulation. No evidence of infection. No exudate. Physician made aware. Order noted to apply moisture barrier cream TID and prn incontinent care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/2024 at 08:50 a.m. an interview with S16LPN revealed she was notified by S15CNA last week on 05/02/2024, that resident #39 had a red area on the right side of his scrotum. S16LPN reported she assessed resident #39's scrotum and found the skin to the right side of his scrotum to be red but did not see any breaks in the skin. S16LPN reported the CNA's were applying zinc and a pink cream to the area every brief change. S16LPN reported she did not make a nurses note to document her assessment of resident #39's scrotum. S16LPN reported she did not notify S12Treatment Nurse of the redness to resident #39's scrotum because she thought S12Treatment Nurse already knew about it.</p> <p>22575</p> <p>Resident #60</p> <p>Review of the medical record for resident #60 revealed diagnoses of cerebral infarction, hemiplegia affecting his right dominant side, and cognitive communication deficit.</p> <p>Review of resident #60's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he had a BIMS score of 99 which indicated the facility was unable to conduct the test. Review of resident #18's active care plan revealed he required extensive to total assistance for all activities of daily living.</p> <p>Review of resident #60's May 2024 physician orders revealed a 10/23/2023 order for a hand roll to be placed in his right hand to prevent contractures.</p> <p>On 05/07/2024 at 3:45 p.m. and 05/08/2024 at 8:40 a.m., observations revealed resident #60 was in his gerichair in his room. Further observation revealed the resident did not have a hand roll in his right hand.</p> <p>On 05/07/2024 at 3:23 p.m., an interview with S22LPN revealed she had worked with resident for approximately 2 months. S22LPN confirmed she had not observed a hand roll in resident #60's right hand this week. She also confirmed she had not observed a hand roll in resident #60's right hand for the past 2 months that she had worked with him.</p> <p>On 05/08/24 at 06:00 p.m., an interview with S2DON and S18Regional Director of Clinical confirmed staff failed to ensure that resident # 60's right hand roll was in place as ordered.</p>		

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NAME OF PROVIDER OR SUPPLIER  Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE  5976 US-65 North Lake Providence, LA 71254	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on record review and interview the facility failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure nurses had documentation of medications administered for 1 (#16) of 5 (#16, #26, #53, #61, and #64) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Review of the facility's Pharmacy Services Medication Administration Policy dated 03/2023 revealed:</p> <p>Purpose: To provide residents with safe, accurate medication administration.</p> <p>2. Medications will be prepared and administered in accordance with:</p> <p>a. Prescriber's order;</p> <p>b. Manufacturer's specifications (not recommendations);</p> <p>c. Accepted professional standards and principles.</p> <p>Review of the medical record for resident #16 revealed diagnoses of major depressive disorder, intracranial injury without loss of consciousness, cervical root disorder, insomnia, anoxic brain damage, delusional disorder, psychotic disorder with delusions due to known physiological condition, dementia with behavioral disturbance, impulse disorder, and anxiety.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed resident #16 had severe cognitive impairment for daily decision making and required extensive assistance with activities of daily living.</p> <p>Review of the May 2024 physician orders revealed an order for the following with a start date of 11/01/2023:</p> <p>Clonazepam 1 mg (milligrams) to be given orally three times a day (tid),</p> <p>Divalproex Sodium delayed release 500 mg to be given orally tid,</p> <p>Gemfibrozil 600 mg to be given orally two times a day (bid),</p> <p>Benzotropine Mesylate 1 mg to be given orally bid,</p> <p>Melatonin 3 mg to be given orally every day (qd),</p> <p>Loratadine 10 mg to be given orally qd,</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nudexta 20 -10 mg to be given orally bid,</p> <p>Ziprasidone Hydrochloride 20 mg to be given orally bid,</p> <p>Mirtazapine 15 mg to be given orally at bedtime,</p> <p>Gabapentin 300 mg to be given orally bid, and</p> <p>Docusate Sodium 200 mg to be given orally qd.</p> <p>Review of the May 2024 Medication Administration Record (MAR) revealed there was no documented evidence of the above medications administered on 05/04/2024 and 05/06/2024 at 6:00 p.m.</p> <p>On 05/08/2024 at 11:45 a.m., an interview with S2Director of Nursing (DON) revealed she was not sure why the resident did not receive the medications.</p> <p>On 05/08/2024 at 4:40 p.m., an interview with S16Licesnsed Practical Nurse (LPN) revealed she worked with the resident on 05/04/2024 and 05/06/2024 and she forgot to sign out the medications when she administered them.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>18118</p> <p>Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) provided services of 8 consecutive hours a day on 12/23/2023, 12/25/2023, 12/26/2023 and 12/30/2023.</p> <p>Findings:</p> <p>Review of the facility's Payroll Based Journal (PBJ) Data time sheets for the dates of 12/23/2023, 12/25/2023, 12/26/2023 and 12/30/2023 revealed that there was no staffing hours for the RN. There was no evidence the RN worked 8 consecutive hours on those dates.</p> <p>Review of the time sheets revealed no documented evidence a RN worked for 8 hours on the dates listed above.</p> <p>On 05/08/2024 at 8:20 a.m., an interview with S1Administrator revealed she was unable to find the documentation or time sheet to prove a RN worked for 8 hours on the dates listed above.</p>

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>19256</p> <p>Based on record reviews and interview, the facility failed to ensure the State Adverse Actions Website checks were completed for Certified Nursing Assistants (CNA) monthly for 3 (S23CNA, S24CNA, and S25CNA) of 5 (S23CNA, S24CNA, S25CNA, S26CNA, and S27CNA) personnel files reviewed.</p> <p>Findings:</p> <p>Review of S23CNA's personnel file revealed a hire date of 12/08/2023. Further review of S23CNA's personnel file revealed there was a State Adverse Actions check on 05/03/2024. There was no documentation of monthly State Adverse Actions checks prior to 05/03/2024.</p> <p>Review of S24CNA's personnel file revealed a hire date of 08/28/2023. Further review of S24CNA's personnel file revealed there was a State Adverse Actions check on 05/03/2024. There was no documentation of monthly State Adverse Actions checks prior to 05/03/2024.</p> <p>Review of S25CNA's personnel file revealed a hire date of 02/05/2024. Further review of S25CNA's personnel file revealed there was a State Adverse Actions check on 05/03/2024. There was no documentation of monthly State Adverse Actions checks prior to 05/03/2024.</p> <p>An interview with S1Administrator on 05/07/2024 at 10:45 a.m. revealed the Human Resource Coordinator was responsible for the State Adverse Actions checks and she was not available this week. S1Administrator confirmed there was no documentation of State Adverse Action checks prior to 05/03/2024.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>19098</p> <p>Based on record reviews and interviews, the pharmacist failed to report any irregularities to the attending physician and the facility's medical director and director of nursing for 3 (#26, #53, and #62) of 5 (#16, #26, #53, #61, and #64) records reviewed for unnecessary medication review.</p> <p>Resident #26</p> <p>On 05/07/2024 at 4:02 p.m. review of the record for resident #26 revealed, in part, the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, aphasia, dysphagia, chronic obstructive pulmonary disease, type 2 diabetes, anxiety disorder, vascular dementia with behavioral disturbance, hypertension, end stage renal disease (ESRD), congestive heart failure (CHF), and left great toe amputation.</p> <p>Review of May 2024 physician orders revealed current orders for the following laboratory tests::</p> <p>Chemistry 14, Glycated Hemoglobin (A1C) every 3 months due in July, October, January and April. Further lab orders revealed to have liver function test (LFT) every 6 months in July and January and for complete blood count (CBC), prostatic-specific antigen (PSA), and lipids in July.</p> <p>On 05/08/24 at 5:03 p.m., an interview with S13Assistant Director of Nurisng (ADON) revealed she was only able to locate the laboratory results of a complete blood count and complete metabolic panel dated 04/19/2024. S13ADON said that dialysis draws labs every month on resident #26 and she has called to get those labs for January 2024 and April 2024.</p> <p>Review of the monthly Drug Regiment Review (DRR) for February 2024 and March 2024 and April 2024 revealed the pharmacist did not address the missing labs that were ordered for resident #26.</p> <p>On 05/08/2024 at 5:19 p.m., an interview with S13ADON confirmed she has been handling the DRR. She confirmed the pharmacist did not report the missing labs.</p> <p>Resident #64</p> <p>On 05/08/2024 at 4:58 p.m. record review for resident #64 revealed diagnoses in part of: chronic obstructive pulmonary disease (COPD), muscle weakness, lack of coordination, respiratory failure, hypertension, psychoactive substance abuse, cellulitis right and left lower limb, cardiomyopathy, idiopathic aseptic necrosis of left femur, cirrhosis of liver, osteonecrosis femur, and chronic viral hepatitis C.</p> <p>Review of the May 2024 Physician Orders in part revealed a current order for Furosemide (Lasix) 40 milligrams (mg) by mouth every day (QD) for edema.</p> <p>Review of the April 2024 and May 2024 medication administration record (MAR) revealed no documentation of the nurse checking for edema prior to administering the Lasix.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the February 2024 and March 2024 and April 2024 DRR revealed the pharmacist did not address the monitoring for edema while resident #64 was receiving Lasix.</p> <p>On 05/08/2024 at 5:19 p.m., interview with S13ADON confirmed she has been handling the DRR. She confirmed the pharmacist did not report there was no monitoring for edema for resident #64.</p> <p>18118</p> <p>Resident #53</p> <p>Review of the medical record for resident #53 revealed diagnoses of myocardial infarction, obesity, muscle weakness, pulmonary embolism, leiomyoma of uterus, edema, psychotic disorder, depression, and anxiety.</p> <p>Review of the physician orders dated 10/18/2023 revealed an order for Furosemide 40 mg to be administered orally one time a day for edema, and Spironolactone 25 mg to be given one time a day orally for edema.</p> <p>Review of the medical record for April 2024 and May 2024 revealed no documented evidence of edema checks performed for resident #53.</p> <p>On 05/08/2024 at 1:30 p.m., an interview with S2DON revealed no documented evidence of edema checks noted for resident #53.</p> <p>Review of the Consultant Pharmacist's March 2024 and April 2024 monthly DRR revealed the pharmacist failed to address no documented evidence of edema checks performed.</p> <p>On 05/08/2024 at 5:30 p.m., an interview with S13ADON confirmed the pharmacist did not address the edema checks not being performed for resident #53.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>19098</p> <p>Based on record reviews and interviews, the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs for 3 (#26, #53 and #64) of 5 (#16, #26, #53, #61 and #64) sampled residents reviewed for unnecessary medications. The facility failed to 1) perform edema checks for residents #53 and #64 while taking a diuretic, and 2) obtain labs as ordered for resident #26.</p> <p>Findings:</p> <p>Resident #26</p> <p>On 05/07/2024 at 4:02 p.m. review of the record for resident #26 revealed in part the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, aphasia, dysphagia, chronic obstructive pulmonary disease, type 2 diabetes, anxiety disorder, vascular dementia with behavioral disturbance, hypertension, end stage renal disease (ESRD), congestive heart failure (CHF), and left great toe amputation.</p> <p>Review of May 2024 physician orders revealed current orders for the following laboratory tests::</p> <p>Chemistry 14, Glycated Hemoglobin (A1C) every 3 months due in July, October, January and April. Further lab orders revealed to have liver function test (LFT) every 6 months in July and January and for complete blood count (CBC), prostatic-specific antigen (PSA), and lipids in July.</p> <p>On 05/08/24 at 5:03 p.m. an interview with S13Assistant Director of Nursing (ADON) revealed she was not able to locate the laboratory results for the Glycated Hemoglobin (A1C) for January 2024 and April 2024, the LFT for January 2024, or the CBC, PSA and lipids for July 2023.</p> <p>On 05/08/2024 at 5:19 p.m., an interview with S13ADON confirmed they did not obtain the Glycated Hemoglobin (A1C) for January 2024 and April 2024, the LFT for January 2024, or the CBC, PSA and lipids for July 2023 for resident #26.</p> <p>Resident #64</p> <p>On 05/08/2024 at 04:58 p.m. record review for resident #64 revealed diagnoses in part of: chronic obstructive pulmonary disease (COPD), muscle weakness, lack of coordination, respiratory failure, hypertension, psychoactive substance abuse, cellulitis right and left lower limb, cardiomyopathy, idiopathic aseptic necrosis of left femur, cirrhosis of liver, osteonecrosis femur, and chronic viral hepatitis C.</p> <p>Review of the April 2024 and May 2024 Physician Orders revealed a current order for Furosemide (Lasix) 40 mg by mouth every day (QD) for edema.</p> <p>Review of the April 2024 and May 2024 Medication Administration Record (MAR) revealed no documentation of the nurse checking for edema prior to administering the Lasix.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/2024 at 5:19 p.m., an interview with S13ADON confirmed there was no monitoring of edema with the administration of the Lasix order for resident #64.</p> <p>18118</p> <p>Resident #53</p> <p>Review of the medical record for resident #53 revealed diagnoses of myocardial infarction, obesity, muscle weakness, pulmonary embolism, leiomyoma of uterus, edema, psychotic disorder, depression, and anxiety.</p> <p>Review of the physician orders dated 10/18/2023 revealed an order for Furosemide 40 milligrams (mg) to be administered orally one time a day for edema, and Spironolactone 25 mg to be given orally one time a day for edema.</p> <p>Review of the medical record revealed no documented evidence of edema checks performed for resident #53.</p> <p>On 05/08/2024 at 1:30 p.m., an interview with S2DON revealed no documented evidence of edema checks noted for resident #53.</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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>19098</p> <p>Based on observation, record review and interview the facility failed to store, prepare and distribute food in accordance with professional standards for food service safety. This failed practice had the potential to affect all residents who receive meals from the kitchen.</p> <p>Findings:</p> <p>On 05/06/2024 at 8:28 a.m. observation of the kitchen environment with S11DM (Dietary Manager) revealed the front of ice machine was open exposing inside of machine and electrical components.</p> <p>Observation of the stand-up refrigerator revealed the temperature reading was 48 degrees Fahrenheit. Observation of the temperature logs hanging on the 3 refrigerators and the 2 freezers in the kitchen revealed there were no temperature logs maintained. Interview at that time with S11DM confirmed the temperature logs had not been maintained.</p> <p>Observation of the walk-in refrigerator revealed a temperature reading of 61 degrees Fahrenheit. Further observation revealed there were vegetables and multiple food items stored in the refrigerator. S11DM said they would have to take everything out of the refrigerator. Observation again revealed there was no temperature log maintained for this refrigerator.</p> <p>Observation of the inside of the stand-up refrigerator in the kitchen revealed a pan of red beans, sausage and rice with no date and 1 bowl of unidentified food with unreadable date and S11DM said she was not sure what it was.</p> <p>A request for a chemical test strip for the 3 compartment sink revealed the S11DM attempted to check the sanitizer by running the test strip under the running stream and not filling the sink with the sanitizer and checking the levels. S11DM revealed no one showed her how to check the sanitizer in 3 compartment sink.</p> <p>While at the 3 compartment sink S14Dietary Worker picked up large pans out of 3 compartment sink from sanitizer bin. The compartment had no water in it. S14Dietary Worker said he washed the pans, and then just hoses them off with the sanitizer and leaves them in the sink to dry.</p> <p>Requested to review the log for the sanitizer checks on the 3 compartment sink and S11DM confirmed there was no log for the sanitizer checks for the dish machine or 3 compartment sink.</p> <p>Observation of the dishwashing area revealed the clean dishes were stacked facing in the up-right position.</p> <p>On 05/06/2024 at 11:00 a.m. observation of the steam table temperatures for the noon meal revealed an electric thermometer was used. S14Dietary Worker placed the thermometer in the food items without ever cleaning the thermometer prior to placing it in food items or between food items.</p> <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>Review of the food temperature log revealed no documentation of checking food temperatures on the steam table since 03/24/2024.</p> <p>On 05/06/2024 1:30 p.m., interview with S11DM revealed she had been employed at facility since 04/01/2024 and only has restaurant management experience. She further confirmed she did not receive training on the correct way to be the dietary manager of a kitchen in a nursing facility.</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on record reviews and interviews, the facility failed to ensure it operated and provided services in compliance with Federal, State, and local laws by 1) not providing a sufficient number of nursing service personnel to provide nursing care to all residents, and 2) not ensuring residents received nursing care in accordance with resident care plans 24 hours per day for 2 (#38 &amp; #39) of 2 (#38 &amp; #39) sampled residents.</p> <p>Findings:</p> <p>The current Long Term Care Minimum Licesning Standards, statute 9823, A. states the nursing facility shall provide 2.35 hours of care per patient per day.</p> <p>Review of the Nursing/Ancillary Personnel Staffing Pattern Reporting Form dated 03/01/2024 through 05/04/2024 revealed the facility did not meet the required hours according to the State statue noted above. The staffing form showed the facility was short on the hours provided to the resdient census on 11 out of 65 days.</p> <p>On 05/08/2024 at 2:50 p.m., an interview with S1Administrator confirmed the facility did not meet the required hours for 11 days listed on the Personnel Staffing Patterns that were provided.</p> <p>22575</p> <p>Resident #38</p> <p>Review of the medical record for resident #38 revealed diagnoses of paraplegia, congestive heart failure, and generalized osteoarthritis.</p> <p>Review of resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 which indicated he was moderately cognitively impaired. Review of resident #38's active care plan revealed he was totally dependent on staff for most of his activities of daily living.</p> <p>On 05/08/2024 at 8:50 a.m., an interview with resident #38 revealed the Certified Nursing Assistants (CNA) on his hall take a long time to answer his call light especially on the night shift.</p> <p>On 05/08/2024 at 2:43 p.m., an interview with S2Director of Nursing (DON) confirmed there was insufficient CNA staffing on the evening and night shifts for multiple days in the last 2 weeks.</p> <p>41829</p> <p>Resident #39</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE  5976 US-65 North Lake Providence, LA 71254	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/06/2024 at 10:10 a.m., an interview with resident # 39's family member revealed they are short staffed on the night shift on the resident's hall. Resident #39's family member further reported they usually only have one aide for this resident's hall and have to pull aides from other halls.</p> <p>On 05/08/2024 at 1:16 p.m., an interview with S2Director of Nursing (DON) revealed they staff 2 CNAs on each hall for the day shift (6 a.m. - 2 p.m.) and 2 CNAs on each hall for the evening shift (2 p.m. -10 p.m.). S2DON reported they staff 1 CNA for each hall with 1 floater on the night shift (10 p.m. - 6 a.m.). S2DON further reported on the day shift the following CNAs are not included in that number: CNA Supervisor, bath aide, restorative CNA, and the CNA who provides 1:1 sitting with resident #16. Surveyor requested a copy of the evening and night shift staffing assignment for last 2 weeks.</p> <p>During review of the evening and night shift CNA staffing assignment for last 2 weeks with S2DON on 05/08/2024 at 2:43 p.m., S2DON confirmed they were short 1 CNA on each of the following shifts: 04/24/2024 night shift (10 p.m. - 6 a.m.), 04/25/2024 night shift (10 p.m. - 6 a.m.), 04/27/2024 evening shift (2 p.m. -10 p.m.), and 04/28/2024 night shift (10 p.m. - 6 a.m.).</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>22575</p> <p>Based on observation and interview the facility failed to maintain all resident care equipment in safe operating condition for 2 (#26, #48) of 2 (#26, #48) residents observed with resident care equipment concerns. This failure had the potential to affect the 82 residents in the facility.</p> <p>Findings:</p> <p>Resident #48</p> <p>Review of the record for resident #48 revealed in part the following diagnoses: traumatic subarachnoid hemorrhage, primary generalized osteoarthritis, generalized muscle weakness, unsteadiness on feet, other abnormalities of gait and mobility, other lack of coordination, and unspecified dementia.</p> <p>Further review of the record revealed resident #48 had a Brief Interview for Mental Status (BIMS) of 3 indicating he was severely cognitively impaired and required the use of a wheelchair for locomotion.</p> <p>On 05/07/2024 at 03:40 p.m. observation of resident #48's wheelchair revealed the rubber protective cover on the resident's right wheelchair handle was missing.</p> <p>On 05/08/2024 at 3:30 p.m. S22Licensed Practical Nurse (LPN) confirmed resident # 48's right wheelchair handle's rubber cover was missing and was in need of repair. She revealed she was unsure how long the wheelchair handle had been missing.</p> <p>On 05/08/2024 at 6:00 p.m. S2Director of Nursing and S18Regional Director of Clinical was informed of resident #48's above concern with his wheelchair. They confirmed that resident #48's wheelchair should have been repaired in a timely manner.</p> <p>Resident #26</p> <p>On 05/07/2024 at 4:02 p.m. review of the record for resident #26 revealed in part the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, aphasia, dysphagia, chronic obstructive pulmonary disease, type 2 diabetes, anxiety disorder, vascular dementia with behavioral disturbance, hypertension, end stage renal disease (ESRD), congestive heart failure (CHF), and left great toe amputation.</p> <p>Further review of the record revealed resident #26 had a BIMS of 14 indicating cognition was intact and required the use of a wheelchair for locomotion.</p> <p>On 05/06/2024 at 9:49 a.m. observation of resident #26's wheelchair revealed the right armrest was torn all the way to wood portion of armrest.</p> <p>On 05/07/2024 8:51 a.m. observation of resident #26's wheelchair revealed the right armrest was torn all the way to wood portion of arm rest.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE  5976 US-65 North Lake Providence, LA 71254	

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/08/24 11:20 p.m. observation of resident #26 wheelchair revealed the right armrest was torn all the way to wood portion of arm rest.</p> <p>On 05/08/2024 at 01:17 p.m. interview with S15Certified Nursing Assistant CNA confirmed she transfers resident #26 into the wheelchair with the torn right arm rest. S16CNA further confirmed the area is torn all the way through the padding down to the wood part of arm and that she has never reported the torn area on the right armrest of the wheelchair.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>22575</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations and interviews and record review, the facility failed to maintain an effective pest control program to ensure residents had a pest free environment. The deficient practice affected 4 (#48, #60, #18, #38) of 4 (#48, #60, #18, #38) sampled residents and had the potential to affect all 82 residents that resided in the facility. Findings:</p> <p>Review of the facility's policy titled, Physical Environment Safe, Functional, Sanitary Environment dated March 2023 read in part .</p> <p>Purpose: To provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.</p> <p>Guidelines: The facility will maintain an effective pest control program to control pests and rodents.</p> <p>Observations on all days of the survey (05/06/2024 - 05/08/2024) revealed there were multiple flies flying around throughout the facility, including the dining room, all resident hallways, and in common areas of the facility.</p> <p>On 05/07/2024 at 3:40 p.m. an observation revealed resident #48 was in his room in bed and there was a fly noted on the resident's sheet near his head.</p> <p>On 05/07/2024 at 3:45 p.m. an observation revealed resident #60 was in his room in bed with his eyes closed. There were 3 flies noted near his bed.</p> <p>On 05/07/2024 at 3:55 p.m. an observation revealed resident #18 in was in her wheelchair in the hallway. The resident had a dressing on her right lower leg with a fly noted on top of the dressing.</p> <p>On 05/08/2024 at 8:50 a.m. an observation revealed resident #38 was in his room in bed. A fly was flying around his head and landed on his face. Resident #38 waved his hand to get the fly off his face.</p> <p>On 05/08/2024 at 6:00 p.m. S18Regional Director of Clinical confirmed the facility failed to ensure the residents' environment was free from pest.</p>		