STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on observation and interview, the facility failed to provide a homelike environment for 1 (#50) out of 3 (#44, #48, and #50) residents investigated for environment out of a total sample of 55 residents. Findings: Resident #50 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Hypertension, Heart Failure, and Hyperlipidemia. Review of Resident #50's Quarterly MDS (Minimum Data Set) dated 02/21/2024 revealed the Brief Interview for Mental Status (BIMS) of 15, suggesting his cognition was intact. Under Section GG: Functional Abilities and Goals revealed the resident utilized a wheelchair as his mobility device. On 05/20/2024 at 8:47 a.m., an observation was made of Resident #50's bathroom. There were multiple areas of paint scraped off of the wall on the left side of the toilet. Further observation revealed there were multiple areas of paint scraped off the wall near the shower. On 05/22/2024 at 8:43 a.m., a second observation was made of the resident's bathroom. The multiple areas of paint scraped off the wall on the left side of the toilet and shower were still present. Further observation of Resident #50's room revealed a sharp piece of metal trim sticking out approximately halfway off of the doorway trim. On 05/22/2024 at 8:55 a.m., an interview and observation of the resident's bathroom was conducted with S4MS (Maintenance Supervisor). He confirmed the findings of the multiple areas of paint scraped off of the wall on the left side of the toilet and near the shower wall. He also confirmed the sharp piece of metal sticking out of the doorway trim. S4MS stated it was unacceptable and should not be like that and the sharp piece of metal sticking out of the doorway trim had the potential to harm a resident. On 05/22/2024 at 9:05 a.m., an interview and observation of the resident's bathroom was conducted with S2DON (Director of Nursing). S2DON confirmed the findings of the multiple areas of paint scraped off the wall on the left side of the toilet and shower. She also confirmed the sharp piece of metal sticking out of the doorway trim. She confirmed it was unacceptable and had the potential to hurt Resident #50 who wheels himself in his room.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777 Based on observation, record review, and interviews, the facility failed to complete a comprehensive assessment, including resident's dental status, within 14 days of admission for 1 (#131) of 1 (#131) resident reviewed for pain management from a sample of 55 residents. Findings: Record review of Resident #131's electronic record confirmed she was admitted on [DATE] with diagnoses of Vitamin Deficiency, Depression, Acute Embolism and thrombosis of deep veins, Long Term Use of Anticoagulants, Gastro Esophageal Reflux Disease, and Hypertension. On 05/20/2024 at 2:20 p.m., an observation of Resident #131's oral cavity revealed the residents' upper gums had missing and broken teeth at the gum level. Her bottom gums had approximately 6 teeth in the front that were broken and decayed. She stated she has pain continuously especially when she eats. Record review of Resident #131 Electronic MDS (Minimum Data Set) , with an Assessment Reference Date (ARD) of 5/7/2024 , Section L titled Oral/Dental Status under Dental read, No natural teeth or tooth Fragments, Cavity or broken natural teeth, Pain, Discomfort, Difficulty chewing. These three areas were blank. On 05/22/2024 at 10:14 a.m., an electronic record review was conducted with S11MDS of Resident #131's MDS with an ARD of 5/7/2024, Section L, Oral/Dental Status. She confirmed that she had not completed Resident #131's oral assessment. She stated Resident #131 was admitted to the facility on [DATE] and she was to finish the resident's oral assessment 14 days after the resident's admitted . She confirmed the resident's assessment should have been completed on 05/14/2024.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354 Based on record review and interview, the facility failed to ensure resident assessments were opened, completed, and electronically transmitted in a timely manner for 1 (#74) out of 3 (#51, #66 and #74) residents investigated for Resident Assessment out of a finalized sample of 55 residents. This deficient practice had the potential to affect 77 residents that resided in the facility. Findings: A review of resident #74's EMR (Electronic Medical Record) revealed an admitted [DATE] with diagnoses that included Edema and Hypothyroidism. Further review of the EMR revealed a discharge date of [DATE]. Continued review of the resident's EMR revealed no documented evidence that a discharge assessment was opened, completed and/or transmitted in the last 120 days. On 05/22/2024 at 2:02 p.m., a concurrent record review and interview was conducted with S10LPN (Licensed Practical Nurse). S10LPN confirmed the residents discharge date of [DATE]. She then viewed Resident #74's EMR and confirmed a discharge assessment had not been opened, completed, or transmitted. S10LPN also confirmed the discharge assessment should have been completed after the resident discharged from the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251 Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental disorder to the appropriate state-designated authority for Level II PASRR (Preadmission Screening and Resident Review) evaluation and determination for 1 (#20) out of 2 (#3,#20) sampled residents investigated for PASRR. This had a potential to effect a census of 77. Findings: On 05/22/2024 a review of the facility's policy titled PASRR Level II Request for Resident Review Guidelines to Follow if a Resident Review/Level II is Needed (review date 08/02/2023) was conducted. The policy read in part, If any of the below exist, a Resident Review may be required - The resident has a new mental health diagnosis, which will not normally resolve itself once the condition stabilizes. Review of Resident #20's electronic medical record revealed she was admitted to the facility on [DATE] with a diagnosis that included in part, Bipolar Disorder, Unspecified (05/31/2022). Review of Resident #20's current physician orders May 2024 revealed the resident had been prescribed the antipsychotic medication Seroquel 50 mg (milligrams) related to the diagnosis of Bipolar Disorder, Unspecified. Further review of Resident #20's records revealed no evidence that a Level II PASRR had been submitted to the appropriate state-designated authority for the new diagnosis. On 05/22/2024 at 11:48 a.m., an interview was conducted with S7SSD (Social Service Director). S7SSD confirmed that Resident #20 had a new diagnosis of Bipolar Disorder on 05/31/2022 and that a Level II PASRR had not been submitted for the new diagnosis and should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on staff interviews, observations and record review, the facility failed to follow the physician's orders for 1 (#8) resident as evidence by failing to check for residual before the nurse administered PEG (percutaneous endoscopic gastrostomy) tube water flush and bolus feeding as scheduled. The final sample size was 55. Findings: On 05/22/2024, a review of the facility's policy titled Restraints and Safety Devices with a last reviewed date of 08/02/2023 read in part, Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .Steps in the Procedure . 20. Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. 21. When correct tube placement and acceptable GRV has been verified, flush tubing . Review of Resident #8's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Gastro-Esophageal Reflux Disease, Gastrostomy Status, and Gastritis. Review of Resident #8's Quarterly MDS (Minimum Data Set) dated 04/09/2024 revealed the Brief Interview for Mental Status (BIMS) of 0, indicating his cognition was severely impaired. Under Section K: Swallowing/Nutritional revealed the resident required nutrients via feeding tube. Review of Resident #8's physician's orders revealed an order entry with a start date of 03/25/2024 read in part, Bolus one box of Jevity 1.5 twice daily at 10 a.m. and 4 p.m. Ensure to monitor for placement and perform residual checks . and a start date of 08/31/2022 read in part, Give 250 mL's (milliliters) H20 (water) flush four times daily. Ensure to monitor for placement and perform residual checks . During a random tube feeding observation at 11:07 a.m. on 05/21/2024, S5LPN (Licensed Practical Nurse) was observed administering Resident #8's PEG tube water flush and then administered a bolus feeding without checking the resident's stomach residual. On 05/21/2024 at 11:31 a.m., an interview was conducted with S5LPN who confirmed she did not checked the resident's stomach residual before she administered the PEG tube water flush and bolus feeding and should have checked the resident's stomach residual per physician's orders. On 05/22/2024 at 12:22 p.m., an interview was conducted with S2DON (Director of Nursing) who confirmed that before administering Resident #8's water flushes and bolus feeding via his PEG tube, S5LPN should have checked for stomach residual first.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777 Based on observation, record review, and interviews, the facility failed to effectively manage pain for 1 (#131) of 1 (#131) resident reviewed for pain management out of sample of 55 residents. Findings: On [DATE] at 2:00 p.m., review of the facility's policy dated [DATE] titled, Pain Assessment and Management, read in part, Purpose .to help the staff identify pain in the resident .that are consistent with the resident's goals and needs and that address the underlying causes of pain .Steps to . Recognizing pain .f. rubbing or favoring a particular part of the body. g. difficulty eating .Assess pain using a consistent approach and standardized pain assessment .Re-assess the residents pain and consequences of pain at least each shift for acute pain. Monitor the resident by performing a basic assessment (.pain scales .) .If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Record review of Resident #131's electronic record confirmed she was admitted on [DATE], with diagnoses of Vitamin Deficiency, Depression, Dry eye syndrome, Acute Embolism and Thrombosis of deep veins, Magnesium Deficiency, Long Term Use of Anticoagulants, Gastro Esophageal Reflux Disease, and Hypertension. Record review of Resident #131's MDS (Minimum Data Set) dated [DATE] read in part, her BIMS score was 12 meaning she had moderate cognitive impairment. Her Oral Assessment read Obvious or likely cavity or broken natural teeth, Inflamed or bleeding gums or loose natural teeth. Record review of Resident #131's Care Plan dated [DATE] read in part, under Problem: Oral Status: Has natural teeth in poor condition with some missing, Several broken, likely inflammation .Approaches: Observe for signs and symptoms of difficulty chewing, decreased appetite or pain while chewing. Perform oral assessment .as needed . Under Problem: Risk for Pain, read in part, Administer medications as ordered by related to pain-Monitor effectiveness .Monitor for pain every shift. Record review of Resident #131's TAR (Treatment Administration Record) for [DATE] read in part, Monitor for pain every shift at 6:00 a.m., and 6:00 p.m. start date [DATE]. From [DATE] to [DATE] the LPNs (Licensed Practical Nurse) put checks on this document daily indicating they had assessed Resident #131 for pain daily on their shift at 6:00 a.m., and 6:00 p.m. On [DATE] at 2:20 p.m., an observation of Resident #131's oral cavity confirmed the residents' upper gums had most of her teeth missing and broken at the gum line. Her bottom gums had approximately 6 teeth in the front that were broken and decayed. She stated she has pain continuously and especially when she eats. She stated she has told the nurse her gums hurt when she eats. She stated she has had pain in her gums since her admission of [DATE]. She stated her pain at this time was a ,d+[DATE] and that she rubs her gums to relieve the pain. On [DATE] at 4:59 p.m., Resident #131 was observed eating her dinner. She stated states her pain was , d+[DATE]. She stated her gums and teeth became more painful when she started eating her dinner. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:00 a.m., an interview with Resident #131 revealed her pain was an ,d+[DATE] at this time. She stated the nurse will give her Tylenol and it helps the pain a little but does not get to a tolerable level. She stated she has had intolerable pain since we meet on Monday [DATE]. She stated she has a bad taste in my mouth that she feels is infection and does not like to talk to anyone because if her mouth smells as bad as it tastes then it has to smell bad. At this time, an observation revealed a slight odor coming from the resident's mouth. On [DATE] 11:45 a.m., an interview with Resident #131 revealed her pain level was ,d+[DATE] this morning. She stated the nurse rubbed some gel on her gums and brought the pain down to ,d+[DATE] at this time. She stated they gave her Tylenol this morning and this helped her pain. The resident stated it was hard to eat because her gums are sore. She stated she would like her pain tolerance to be ,d+[DATE] or lower. She stated her ideal pain would be ,d+[DATE]. Record review of Resident #131's EMAR (Electronic Medication Administration Record) dated ,d+[DATE] revealed a Physicians order to administered Tylenol 325 milligrams (mg) 2 tablets (650 mg) every 6 hours as needed for pain. The LPN administered the resident Tylenol on [DATE] 11:45 a.m. for Pain level of , d+[DATE] and on [DATE] at 9:30 a.m., for Pain level of ,d+[DATE]. Record review of the EMARS Administrative notes read in part, On [DATE] at 11:45 a.m., administered Resident #131 Tylenol 325 mg tablet for pain ,d+[DATE] for pain in her head/face. Follow up was completed on [DATE] at 6:21 p.m. medication was effective. On [DATE] at 9:30 a.m., administered Resident #131 Tylenol 325 mg tablet for pain ,d+[DATE]. Follow up was completed [DATE] at 7:23 p.m., medication was effective. Record review of Nurses Notes revealed the following, On [DATE] at 3:46 a.m., administered Tylenol 325 mg 2 Tablets orally for pain Right Shoulder pain as ordered. At 4:30 p.m., Resident states that the Tylenol effectively deceased the pain in her right shoulder. On [DATE] at 12:00 p.m., Resident complained of her Right Great Toes and Right foot pain. Resident was administered Tylenol 325 mg 2 Tablets for pain. Reassessed Resident in 30 minutes. At 12:30 p.m., Resident stated she had some relief from Tylenol. On [DATE] at 8:35 a.m., an observation of Resident #131's oral cavity with S3ADON (Assistant Director of Nursing) confirmed resident had missing, broken teeth and irritated gums. At this time, Resident #131 stated her pain level was ,d+[DATE]. The resident stated her mouth tasted bad and tht she felt she had an odor coming from her mouth. S3ADON stated the nurses should be trying to manage the resident's oral pain and if the Tylenol was not managing the pain then they should contact the physician. At this time, S3ADON looked at Resident #131's electronic record and reviewed Resident #131's ETAR, EMAR, and Nurses Notes. She stated Resident #131 had received Tylenol on [DATE], [DATE] and [DATE] for pain. She stated the nurses did not reassess the resident in a timely manner on [DATE] and [DATE]. She stated the nurses should assess the resident's pain 30 minutes to an hour after administering the medication.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354 Based on in record review and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis facility by failing to ensure dialysis communication forms were filled out completely for 1 (#66) resident sampled for dialysis. The deficient practice had the potential to affect 1 dialysis resident that resided in the facility. Findings: On 05/22/2024 at 2:27 p.m., a request was made for a facility policy for dialysis communication. No policy was provided by the time of survey completion and exit. A review of Resident #66's EMR (Electronic Medical Record) revealed an admitted [DATE] with diagnoses that included End Stage Renal Disease, Essential Hypertension, and Type 2 Diabetes Mellitus. A review of Resident #66's Physician's Orders from May 2024 revealed an order with a start date of 01/26/2024 that read; Hemodialysis at dialysis center on Tuesday, Thursday, Saturday. Send communication form on all visits. A review of Resident #66's dialysis communication forms revealed a total of 39 sheets with date ranges from 02/01/2024 through 05/18/2024 that contained incomplete documentation. Missing information included: blood pressure, pulse, respirations, temperature, date, time, medications administered, time of last meal, diet, fluid restriction, fluid restriction amount, significant alerts, and facility nurse name and signature. On 05/22/2024 at 11:49 a.m., a concurrent record review and interview was conducted with S6LPN (Licensed Practical Nurse). She confirmed that the nurses are to fill out the dialysis communication form completely prior to the resident leaving for dialysis treatment. S6LPN viewed Resident #66's dialysis communication forms and confirmed 39 communication forms were incomplete. On 05/22/2024 at 2:22 p.m., a concurrent record review and interview was conducted with S3ADON (Assistant Director of Nurses). S3ADON confirmed the nurses are to fill out the dialysis communication form completely prior to the resident leaving for dialysis treatment. S3ADON viewed resident #66's dialysis communication forms and confirmed that 39 forms were incomplete.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44269 Based on observations, record reviews, and interviews, the facility failed to ensure recipes for pureed, chopped, and bite sized meals were used during meal preparation. This failure had the potential to contribute to an unpleasant dining experience, decreased intake, altered nutritional needs, and weight loss for 1 (#26) resident who received pureed meals, 6 residents (#16, #19, #29, #32, #49 and #65) who received mechanical chopped meals, and 13 residents (#2, #4, #5, #7, #23, #28, #30, #42, #46, #58, #68, #69, and #71) who received bite sized meals. Findings: On 05/20/2024, a review of the facility's policy and procedure titled, Therapeutic Diets, with a reviewed date of 08/02/2023 revealed in part: .7. Residents on therapeutic diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the Attending Physician in conjunction with the Clinical Dietitian . Review of the facility's dinner menu for pureed, mechanical chopped and bite sized meals on 05/20/2024 revealed hamburger steak with gravy. Review of the facility's week 3 day 2 recipe for Hamburger Steak with Onion Gravy 3 oz (ounce) revealed: 15 servings of Ground Beef Patty (4 oz) = 15 each Salt= 1 teaspoon Spice pepper black= 1 teaspoon Season patties. Place patties on pan Yellow onions, sliced= 2 3/4 cup Brown gravy (mix)= 2 oz Chop onions. Place in pan. Smother meat in gravy and onions. Cover pan. Bake. Notes: 1. For ground or chopped menu items, grind or chop food to appropriate consistency. 2. Soft and Bite Sized: All food pieces must be less than or equal to 15 MM (Millimeters) x 15 MM in size. Note: 4 oz portion should yield 3 oz actual meat/protein. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pureed recipe for Hamburger steak with onion gravy revealed: 1. Prepare according to regular recipe Stock beef/soup base conversion= 1/4 cup and 2 tablespoon Food thickener bulk= 2 and 1/4 teaspoon 2. Prepare slurry. 3. Process until smooth adding 1 oz slurry per portion. On 05/20/2024 at 1:36 p.m., S9KS (Kitchen Staff) was observed preparing pureed hamburger steak with onion gravy for one resident who received pureed meals. She added two whole cooked hamburger patties in the food processor and added an unmeasured amount of beef broth and stated usually just eyeball it when asked how much liquid was required. S9KS then blended the mixture, added an unmeasured amount of beef broth, blended the mixture, then added thickener straight from the container by sprinkling an unmeasured amount to the mixture, blended it, and then sprinkled more thickener to the mixture and blended it again. S8DM (Dietary Manager) was present during the preparation and had observed the finished texture. S8DM approved the texture. There was no recipe used. On 05/20/2024 at 1:48 p.m., S9KS was observed preparing the chopped hamburger steak by adding nine cooked hamburger patties with cooked onions in the food processor. S9KS then poured an unmeasured amount of beef broth into the food processor and blended the mixture to a chopped consistency. S9KS then added then blended mixture to a metal dish. S8DM was then observed adding an unmeasured amount of beef broth to the blended mixture and stirred the mixture. On 05/20/2024 at 1:51 p.m., S9KS was observed placing five cooked hamburger patties with cooked onions in the food processor. S9KS then blended the mixture, added an unmeasured amount of beef broth, blended the mixture again, and then added the mixture to a metal dish. On 05/20/2024 at 1:53 p.m., S9KS was observed placing 4 four cooked hamburger patties in the food processor, added unmeasured amount of beef broth, blended and added to a metal dish and stored for dinner meal. On 05/20/2024 at 1:55 p.m., an observation was conducted of S9KS was preparing the bite sized meats. Fourteen cooked hamburger patties were used by cutting each patty into eight pieces. She stated she knew one large baking sheet fitted 15-17 patties which was enough for the residents who received bite sized and mechanical chopped meats. S9KS denied use of following recipes, she stated the kitchen did have the recipes but the S8DM had instructed her to not follow the recipes because we put our own spin on it and eyeball how much to use. On 05/20/2024 at 2:05 p.m., S8DM showed the surveyor the kitchen's binder of recipes for pureed, mechanical chopped and bite sized diets. S8DM confirmed the kitchen staff did not use the recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44269 Based on observations, interview and policy and procedure review, the facility failed to store food in accordance with professional standards for food service and ensure sanitary conditions were maintained in the kitchen by failing to ensure opened containers in dry storage and foods stored in the facility's freezer were labeled and dated. Findings: On 05/20/2024, a review of the facility's policy and procedure titled, Food Receiving and Storage, with a last reviewed date of 08/02/2023 revealed in part: Foods shall be received and stored in a manner that complies with safe food handling practices . 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). On 05/20/2024 at 9:00 a.m., an initial tour of the facility's kitchen was conducted with S8DM (Dietary Manager). The facility's dry storage area revealed a one gallon bottle of vanilla extract that was opened and had been used. On a separate shelf of the dry storage area, there was one 16 ounce plastic container of grated parmesan that was opened and had been used. S8DM confirmed these two items had been opened and used; and should have been labeled and dated with the open date. On 05/20/2024 at 9:18 a.m., an observation of the facility's walk in freezer was conducted with S8DM. An observation was made of a one gallon storage bag of frozen chicken breast as well as one large opened bag of breaded chicken tenders that were not labeled and dated. S8DM confirmed the chicken breast and chicken tenders should have been labeled and dated. S8DM further confirmed the bag of chicken tenders was opened and should have been sealed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record review and interview, the facility failed to implement its antibiotic stewardship policy to timely evaluate culture and sensitivity results in order to determine appropriate antibiotic usage by failing to: 1. Obtain culture report and sensitivity data in a timely manner in order to initiate possible treatment for Residents #43 and #77 and; 2. Notify the physician of culture report and sensitivity data in order to ensure Resident #380 was prescribed the appropriate antibiotic, out of 6 (Residents #34, #43, #54, #65, #70, #77, and #380) residents reviewed for infection control tracking and trending during the Infection Control facility task. The facility's census was 77. This deficient practice resulted in actual harm when Resident #43's final urine culture and sensitivity final report dated 04/26/24 showed that the bacteria, Klebsiella pneumoniae, was present in the resident's urine. The facility failed to have the final culture and sensitivity report resulted on 4/26/2024 in the resident's record from a urinalysis specimen collected on 04/23/2024. The facility was not aware of the results and therefore not able to report the results to the resident's physician for possible treatment with antibiotics. On 04/30/2024, Resident #43 complained of weakness and dizziness and her blood pressure was 80/40 (low). The resident was subsequently sent to the emergency room the same day (04/30/2024) where a urine culture was ordered and showed Klebsiella pneumonia as previously identified in the culture that the facility collected on 4/23/2024. The resident was discharged from the emergency roiagnom on [DATE] with a prescription for antibiotic therapy. A review of the facility's policy titled, Antibiotic Stewardship read in part: 11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. 1. Resident #43: A review of resident #43's medical record revealed a urine specimen was collected for urinalysis on 04/23/2024. No final microbiology report was present in resident #43's medical record on 05/20/2024. Review of the final microbiology report that was obtained for this resident during the survey on 05/20/2024 indicated that on 04/26/2024, Klebsiella pneumoniae was present in the urine collected on 04/23/2024. No documentation was found that the physician had been notified of the final microbiology results or that Resident #43's infection had an antibiotic ordered for treatment. Review of S11LPN's nurse's notes dated 04/30/2024 at 8:00 a.m. revealed that Resident #43 had complaints of weakness and dizziness with a low blood pressure of 80/40. She was transferred to the emergency room . (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	Review of S11LPN's nurse's notes dated 04/30/2024 at 12:45 p.m. revealed that the resident returned from the emergency with a diagnosis of Urinary Tract Infection and a new order for the antibiotic, Cipro. Review of Resident #43's emergency room visit notes on 04/30/2024 revealed that the resident had a diagnosis of UTI (Urinary Tract Infection) and discharged with an order for Ciprofloxacin (antibiotic). Resident #77: A review of resident #77's medical record revealed a Urine Culture and Sensitivity was collected on 04/30/2024. The final microbiology report issued on 05/03/2024 revealed that Enteroccocus faecalis was present in the resident's urine. Review of S12LPN's nurse's dated 05/05/2024 at 5:15 p.m. revealed that the physician was notified with no new orders at that time related to the resident being in the hospital. On 05/21/2024 at 01:10 p.m., an interview was conducted with S3ADON (Infection Preventionist.) S3ADON stated that the floor nurses were responsible for obtaining the culture results. She stated that the QA (Quality Assurance) Nurse or herself also attempts to call the lab for the results, but it may not be the day the results were issued. This would depend on which days her or the QA nurse worked. She stated that the facility has had difficulty with the laboratory sending final culture reports. She stated that someone at the facility usually has to call the lab and request the results. She confirmed that Resident #43's final urine (C&S) results from the urine sample collected on 04/23/2024, was not present in Resident #43's medical record. She also confirmed that there was no documentation the physician had been notified of the results and that no treatment was initiated for the urinary tract infection. She stated that final microbiology results should have been obtained by the facility, the physician should have been notified, and that an appropriate treatment should have been initiated for Resident #43's infection. She also confirmed that Resident #77's C & S final report on 05/03/2024 for the urine collected on 04/30/2024, was not reported to the physician until 05/05/2024 which was 2 days after the results were available. 2. Review of Resident #380's physician orders revealed an order date 04/10/2024 for Macrobid (brand name for Nitrofurantoin) 100mg capsule, give one capsule by mouth twice daily for seven days. A review of resident #380's medical record revealed a Urine Culture and Sensitivity was collected on 04/10/2024. The final microbiology report issued on 04/12/2024 revealed that Klebsiella pneumoniae ESBL (Extended Spectrum Beta-Lactamase) was present in the urine and that the organism was resistant to Nitrofurantoin (Macrobid). There was no documentation in the resident's record that the culture and sensitivity report was reported to the physician or that a change in treatment was initiated due to the bacteria being resistant to the antibiotic the resident had been prescribed for the treatment of the urinary tract infection. On 04/18/2024, Resident #380 was discharged to her home. (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	On 05/21/2024 at 01:10 p.m., a continued interview with S3ADON (Infection Preventionist) confirmed that Resident #380's culture and sensitivity report of the urine, collected on 04/10/2024, was resulted on 04/12/2024. She confirmed the organism identified on the report was resistant to the antibiotic (Macrobid) ordered on 04/10/2024 for the resident's Urinary Tract Infection. She verified that that no documentation was present regarding the physician being notified of these results or that the treatment for the resident's urinary tract infection was changed. She verified that the physician should have been notified in a timelier manner of Resident #380's final microbiology results and that the treatment should have been changed to an appropriate antibiotic based on those results