

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER St Clare Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 Bishop Ott Drive Baton Rouge, LA 70806	

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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure menus were followed to meet the nutritional needs of residents by failing to ensure the correct portion sizes ordered were provided for 1 (#2) of 3 (#2,#5,#R1) residents reviewed for dining. This had the potential to affect 126 residents who received meals from the facility's kitchen.</p> <p>Findings:</p> <p>Review of the facility's policy, titled Tray Identification, dated 04/2007, revealed, in part:</p> <p>3. Nursing staff shall check each food tray for the correct diet before serving the residents.</p> <p>Review of Resident #2's clinical record revealed an admitted [DATE], with diagnoses which included, Mild Protein-Calorie Malnutrition and Hypokalemia.</p> <p>Review of Resident #2's physician's orders dated 12/11/2024 to 02/17/2025 revealed:</p> <p>1. Double Portions Diet-Regular texture, thin consistency, no rice, no grits.</p> <p>On 02/17/2025 at 11:36 a.m., an observation was made of Resident #2's lunch tray, revealed:</p> <p>1 serving of mashed potatoes with gravy</p> <p>1 serving of creole tomatoes</p> <p>1 serving of red beans no rice</p> <p>1 square of cornbread</p> <p>1 frosted cake</p> <p>1 cup of red juice</p> <p>1 cup of water</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER St Clare Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 Bishop Ott Drive Baton Rouge, LA 70806	

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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/17/2025 at 11:37 a.m., an observation was made of Resident #2's tray ticket. The tray ticket revealed: Diet- Regular; Texture -Regular; Diet Intervention-Double Portions.</p> <p>On 02/17/2025 at 11:38 a.m., an interview was conducted with S7LPN. S7LPN observed the contents of Resident #2's lunch tray and confirmed the lunch tray served did not have double portions.</p> <p>On 02/17/2025 at 11:41 a.m., an interview was conducted with S6DTM. S6DTM observed the contents of Resident #2's lunch tray. S6DTM confirmed the lunch tray served did not have double portions.</p> <p>On 02/17/2025 at 11:44 a.m., an interview was conducted with S1ADM. S1ADM confirmed Resident #2 should have double portions every meal and the lunch tray served on 02/17/2025 did not have double portions.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER St Clare Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 Bishop Ott Drive Baton Rouge, LA 70806	

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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965</p> <p>Based on observation, interviews, and record review, the facility failed to ensure a resident received meals to accommodate intolerances for 1 (#5) of 3 (#2, #5, and #R1) residents reviewed for dietary services.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Tray Identification revealed the following, in part:</p> <p>Policy Interpretation and Implementation:</p> <p>2. The food service manager or supervisor will check trays for corrects diets before the food carts are transported to their designated areas.</p> <p>3. Nursing staff shall check each food tray for the correct diet before serving the residents.</p> <p>Review of Resident #5's Clinical Record revealed she was admitted to the facility on [DATE].</p> <p>Review of Resident #5's Alert tab in her physical chart revealed the following:</p> <p>Allergies: Lactose Intolerance</p> <p>Review of Resident #5's current Care Plan revealed the following, in part:</p> <p>Focus: I am lactose intolerant</p> <p>Interventions: avoid allergen</p> <p>Review of Resident #5's Breakfast Meal Ticket dated 02/20/2025 revealed the following, in part:</p> <p>Beverage: 8 fluid ounces lactose free milk</p> <p>An observation was made of S9CNA feeding Resident #5 breakfast on 02/20/2025 at 10:03 a.m. Resident #5's meal ticket read lactose free milk. Resident #5 had an 8 ounce pre-packaged container of whole milk on her breakfast tray. S9CNA confirmed Resident #5 was served whole milk and should have been served lactose free milk.</p> <p>An interview was conducted with S4ADON on 02/20/2025 at 10:08 a.m. She reviewed Resident #5's breakfast meal ticket dated 02/20/2025 and confirmed it read lactose free milk.</p> <p>An interview was conducted with S3ADM on 02/20/2025 at 4:00 p.m. She confirmed a resident who was lactose intolerant and whose meal ticket read lactose free milk should not have been served whole milk.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER St Clare Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 Bishop Ott Drive Baton Rouge, LA 70806	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681</p> <p>Based on observation, record reviews, and interviews, the facility failed to ensure a resident's Medication Administration Record (MAR) was accurately documented for 1 (#2) of 5 (#2, #3, #4, #5, and #R2) residents sampled for pharmaceutical services. This had the potential to affect 126 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's policy, titled Documentation of Medication Administration, dated 11/2022, revealed, in part:</p> <ol style="list-style-type: none"> 1. A nurse or certified medication aide documents all medications administered to each resident on the resident's MAR. 2. Administration of medication is documented immediately after it is given. <p>Review of Resident #2's clinical record revealed an admitted [DATE], with diagnoses which included, Pain in Left Shoulder, Lymphedema, and Malignant Neoplasm of Breast.</p> <p>Review of Resident #2's physician's orders dated 12/11/2024 to 02/17/2025 revealed, in part:</p> <ol style="list-style-type: none"> 1. Fentanyl Transdermal Patch 12 micrograms/hour (mcg/hr). Apply 1 patch transdermal in the morning every 3 days related to pain. <p>On 02/19/2025 at 8:47 a.m., an observation was made of a Fentanyl patch to Resident #2's right chest wall. The patch revealed 2/16 KN. There were no other patches observed on Resident#2.</p> <p>On 02/19/2025 at 8:48 a.m., an interview was conducted with S10LPN, who confirmed the aforementioned observation. S10LPN stated the Fentanyl patch was applied on 02/16/2025. S10LPN confirmed the Fentanyl patch is ordered to be changed every 3 days, and a new patch should have been applied on 02/19/2025 at 6:00 a.m.</p> <p>Review of Resident #2's February MAR revealed the following:</p> <ol style="list-style-type: none"> 1. 02/19/2025 at 5:59 a.m. Fentanyl patch removed, with a check mark, electronically signed by S8LPN. 2. 02/19/2025 at 6:00 a.m. Fentanyl patch applied, with a check mark, electronically signed by S8LPN. <p>Upon further review, according to MAR Chart Codes, a check mark indicated the medication had been administered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER St Clare Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7435 Bishop Ott Drive Baton Rouge, LA 70806	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/19/2025 at 9:31 a.m., an interview was conducted with S8LPN, who stated she was the night nurse for Resident#2 on 02/18/2025. S8LPN stated, during medication administration for Resident #2 on 02/19/2025, at 6:00 a.m., she documented the Fentanyl patch was given, then was distracted by another situation and forgot to return to Resident #2 to apply the new Fentanyl patch. S8LPN stated the process is to give the medication first, then document medication as given on the MAR. S8LPN confirmed documenting medication as administered on the MAR when medication has not been administered is inaccurate documentation.</p> <p>On 02/19/2025 at 9:33 a.m., an interview was conducted with S2DON. S2DON confirmed all medications should be given according to physician orders, and all documentation of medication administration should be accurate. S2DON confirmed the documentation of Resident #2's Fentanyl patch was not accurate and should have been.</p>		