Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195593	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lagniappe Healthcare	1408 Summerlin Lane Bastrop, LA 71220

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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on observations, record review, and interviews, the facility failed to ensure residents were free from physical restraints imposed for the purpose of discipline or convenience for 1 (#276) of 1 (#276) resident reviewed for restraints. Findings: Review of the facility Use of Restraints policy revised December 2007 revealed the following, in part: Policy Statement: Restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls. Policy Interpretation and Implementation: 7. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions. 10. Restraints shall only be used upon the written order of a physician. The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 13. The following safety guidelines shall be implemented and documented while a resident is in restraints: b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of an emergency. (continued on next page)

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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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

c. A resident placed in a restraint will be observed at least every 30 minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident' medical record.

d. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each 2 hours in which restraints are employed.

e. Restrained residents must be repositioned at least every 2 hours on all shifts.

18. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms, but the underlying problems that may be causing the symptoms.

19. Care plans shall also include the measures taken to systematically reduce or eliminate the need for the restraint.

Review of resident #276's medical record revealed she was admitted to the facility on [DATE] with diagnoses of epilepsy, mild vascular dementia with mood disturbance, tracheostomy after aortic aneurysm repair, type 2 diabetes, chronic kidney disease, and obesity.

Review of resident #276's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 99, which indicated the interview was not successful. Further review revealed she required total assistance for most activities of daily living.

Review of resident #276's medical record revealed her care plan was revised on 12/03/2024 with a lap tray applied to her high-back wheelchair. Further review revealed there were no specific interventions regarding the lap tray, such as monitoring and releasing the lap tray.

Further review of the medical record regarding resident #276's lap tray revealed there was no documented evidence of the following: physician order, pre-restraint assessment, and release and monitoring of the lap tray every 2 hours per the facility restraint policy.

On 12/09/2024 at 10:45 a.m., an observation revealed resident #276 was observed in the secured unit in a specialized wheelchair with a lap tray that was tilted down. The resident was constantly moving her hands and was able to pick the lap tray up and move it around. Further observation revealed the lap tray was not positioned properly, it was loose and did not fit securely to the resident's wheelchair. The Velcro straps had been tied to the handles of the wheelchair.

On 12/09/2024 at 1:47 p.m., an observation revealed resident #276 was observed in the secured in a specialized wheelchair with a lap tray and the Velcro straps were fastened to the armrests of the wheelchair. The lap tray was tilted down and did not fit securely to the wheelchair due to her constantly moving her arms and the lap tray. S6Certified Nursing Assistant (CNA) and S12CNA were sitting near the resident but did not attempt to adjust the lap tray or report this finding to S4Licensed Practical Nurse (LPN).

On 12/10/2024 at 8:36 a.m., an observation revealed resident #276 was in secured unit in the day room in a specialized wheelchair with a lap tray that was not applied correctly. The Velcro straps were tied in a knot to the wheelchair handles. Further observation revealed the lap tray was loose and the resident was able to lift the lap tray with her hands.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/2024 at 11:50 a.m., an observation revealed resident #276 was in her room in the secured unit in a specialized wheelchair with the lap tray tilted down. The lap tray continued to be loose and the Velcro straps were fastened to the armrests on her wheelchair. Resident #276 was fidgeting and was able to move the lap tray up and down. S4LPN was present at this time and she revealed she tightens the strap but the resident was still able to loosen the Velcro straps. S4LPN confirmed the lap tray was not working out for the resident. On 12/10/2024 at 1:20 p.m., the surveyor and S2Director of Nursing observed resident #276's wheelchair and lap tray. S2DON confirmed the lap tray should be secured to the wheelchair armrests with the Velcro straps and should not be tied to the wheelchair handles. On 12/11/2024 at 03:08 p.m., an interview with S3RN/MDS Nurse Coordinator confirmed the following: there was no physician order for the lap tray when it was initially applied to the resident's wheelchair; no pre-restraint assessment completed prior to the lap tray being placed on her wheelchair; no specific interventions in the care plan regarding the lap tray; and no documented evidence nurses were monitoring and releasing the resident's lap tray every 2 hours.

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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 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 13974

Based on observations, interviews, and record reviews, the facility failed to ensure the assessments accurately reflected the residents' status by failing:

1) to ensure assessments were completed in a timely manner for 1 (#35) of 5 (#13, #16, #35, #48, #276) reviewed for unnecessary medications,

2) to accurately assess the resident's skin during weekly skin/body assessments for 1 (#33) of 3 (#33, #11, #40) residents reviewed for pressure ulcers,

3) to accurately assess a resident's dental status for 1 (#9) of 1 (#9) resident reviewed for dental issues, and

4) to ensure accurate daily nursing assessments were completed for 1 (#53) of 2 (#53, #303) residents reviewed for urinary catheter or urinary tract infections (UTI).

Findings:

Resident #35

On 12/09/2024 at 8:58 a.m., an observation revealed resident #35 had an albuterol inhaler on her bedside table. The resident reported she kept the inhaler at her bedside.

Review of resident #35's medical record revealed she had diagnoses which included chronic obstructive pulmonary disease and anxiety. Review of the Self Administration of Medications assessment dated [DATE] revealed resident #35 had been approved to self administer medications.

On 12/10/2024 at 10:50 a.m., interview with S3Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator confirmed an assessment had not been completed since 07/14/2023 to determine if the resident was capable of self administering the medications.

19098

Resident #33

Review of the record for resident #33 revealed diagnoses in part of : unspecified sequelae of other non-traumatic intracranial hemorrhage, anxiety disorder, typhoid arthritis, history of other venous thrombosis and embolism, malignant neoplasm of parotid gland, flaccid hemiplegia affecting the left non-dominant side, atrial fibrillation, aphasia following other non-traumatic intracranial hemorrhage, dysphagia following other non-traumatic intracranial hemorrhage, and hypertension.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #33 had a Brief Interview for Mental Status (BIMS) of 99 indicating they were unable to complete the assessment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the functional abilities revealed resident #33 was dependent on staff for eating, oral hygiene, toileting, shower/bathing, dressing, hygiene and turning and mobility. Review of the pressure sore risk assessment dated [DATE] revealed resident #33 was scored as high risk for pressure ulcer development. Review of the current plan of care for pressure ulcers revealed staff were to perform weekly skin audits by licensed personnel. Review of the weekly skin/wound observations revealed on 09/04/2024, S2Director of Nurses (DON) performed a head to toe assessment that revealed skin breakdown on the right big toe and left lower medial leg. Further review revealed there were no other issues noted at this time. Review of the weekly skin/wound observation assessments dated 10/10/2024, 10/16/2024, 10/23/2024, 11/20/2024 and 12/04/2024 by S11Licensed Practical nurse (LPN) revealed she documented the resident's skin as intact and there was no mention of the resident's current pressure ulcer area. Further review of the record for resident #33 revealed he had a pressure ulcer which started on 09/04/2024 and there was current treatment being provided to the same pressure ulcer area. On 12/11/2024 at 1:34p.m., an interview with S2DON confirmed the skin/wound observations dated 10/10/2024, 10/16/2024, 10/23/2024, 11/20/2024 and 12/04/2024 by S11LPN were not accurate and did not show resident #33 already had a pressure ulcer that was being treated. Resident #9 Review of the record for resident #9 revealed an admitted [DATE] with diagnoses in part of displaced transverse fracture of shaft of right femur, subsequent encounter for closed fracture with routine healing, and hypertension. On 12/09/2024 at 12:27 p.m., an observation and interview with resident #9 revealed her dentures were extremely loose and moved in her mouth while talking. Resident #9 stated her dentures were very loose and it made it difficult to chew her food and her gums were sore. She said she can really only chew soft foods. On 12/10/2024 at 8:20 a.m. observation again of resident #9 revealed her dentures continued to be loose and move in her mouth when spoken too. An observation of the breakfast tray revealed resident #9 only ate about 25% of her breakfast. On 12/11/2024 review of the admit nursing evaluation dated 10/28/2024 revealed under dental: Dentures: upper full- fit good, lower full- fit good. Review of the admission note dated 10/28/2024 by S7LPN revealed she documented resident #9 had upper and lower full dentures with good fit. Review of the oral cavity observation dated 10/28/2024 by S7LPN revealed the following: Dental -None of the above were present (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If resident had dentures/other appliance, describe fit - Good Review of the admission MDS assessment dated [DATE] revealed resident #9 had a BIMS of 13 indicating she was cognitively intact. Further review of the MDS under the section Oral Dental Status: B. No natural teeth or tooth fragment(s) (edentulous). The MDS did not identify: Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). Review of the 5 day MDS assessment dated [DATE] under the oral and dental- did not identify the resident's dentures were loose fitting. Review of the initial nutritional assessment dated [DATE] by S10Registered Dietician (RD) revealed Dental - nothing was noted about the resident's loose dentures. On 12/11/2024 at 10:14 a.m., an interview with S7LPN revealed resident #9 may have only told her she had dentures and may not have had them in when she did her assessment. S7LPN confirmed the dietary assessment did not even address the resident wearing dentures. On 12/11/2024 at 10:20 a.m., an interview with S8Social Services Director confirmed she was not aware resident #9 had issues with her dentures. On 12/11/2024 at 10:28 a.m., an interview with resident #9 again revealed she wears her dentures all the time and had them in when she was admitted . She again confirmed her dentures were too loose, she had ulcers in her mouth, and she had to eat soft foods. On 12/11/2024 at 1:37 p.m., an interview with S2DON revealed she went and spoke with the dietary manager and found out that resident #9 did mention her dentures were not fitting correctly and her gums were sore. S2DON said there was a slip of paper on the dietary manager's desk regarding the mouth issues and it has been entered into the computer. 40238 Resident #53 Record review revealed resident #53 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection, sepsis, lack of coordination, muscle wasting, osteoarthritis, and hypothyroidism. Record review revealed a physician order on admission for resident #53 to receive Ceftriaxone (Rocephin - antibiotic) 2 grams intravenously (IV) once daily with a stop date of 11/01/2024. Review of the medication administration record revealed resident #53 received Ceftriaxone as ordered and the medication was discontinued on 11/01/2024 with no record of Ceftriaxone administered IV from 11/02/2024-11/15/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse`s notes revealed documentation on 11/04/2024, 11/05/2024, 11/06/2024, 11/08/2024, 11/10/2024, 11/12/2024 and 11/15/2025 by S4Licensed Practical Nurse (LPN) that resident #53 continued to receive Rocephin IV related to sepsis. Further review revealed S5LPN also documented on 11/05/2024 that resident #53 continued to receive Rocephin IV related to sepsis. On 12/10/2024 at 10:30a.m., an interview with S2DON confirmed staff should not have recorded in the nurse`s notes that Ceftriaxone was still in use after it was discontinued on 11/01/2024. S2DON confirmed the nurses' notes appeared to have been copied and pasted by S4LPN and S5LPN from previous notes when resident #53 was receiving IV Ceftriaxone.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 13974 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to monitor for bleeding risks for 1 (#16) of 5 (#13, #16, #35, #48, #276) residents reviewed for unnecessary medications. Findings: Review of the medical record for resident #16 revealed she had diagnoses which included atrial fibrillation and bradycardia. Review of resident #16's physician orders revealed she received the anticoagulant medication, Xarelto, 15 milligrams daily. Further review of resident #16's medical record revealed no documented evidence the facility was monitoring the resident for bleeding risks. On 12/11/2024 at 10:05 a.m., an interview with S3Registered Nurse/Minimum Data Set Coordinator confirmed nurses had not been monitoring resident #16 for bleeding risks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 19098 Based on observation, record review, and interview, the facility failed to ensure staff followed infection control prevention standards by failing to wear a gown for 1 (#33) of 2 (#33, #11) residents observed for Enhanced Barrier Precaution (EBP) isolation during wound care. Findings: Review of the Enhanced Barrier Precaution (EBP) policy and procedure dated August 2022 revealed in part: Policy Statement: EBP are utilized to prevent the spread of multi-drug resistant organisms. Policy Interpretation and Implementation 1. EBP are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBP employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: h. Wound care 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. On 12/11/2024 at 11:12 a.m., an observation of wound care revealed S9Wound Care Nurse did not donn a gown prior to performing wound care. After wound care was completed, an interview with S9Wound Care Nurse confirmed she did not wear a gown during the wound care and should have. S9Wound Care Nurse stated she forgot to put the gown on.