

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Oak Woods Home for the Elderly		STREET ADDRESS, CITY, STATE, ZIP CODE  1400 Davenport Avenue Mer Rouge, LA 71261	

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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40238</b></p> <p>Based on record reviews and interview, the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS (Centers for Medicare and Medicaid Services) not less frequently than once every 3 months for 2 (#36, #46) of 2 (#36, #46) residents reviewed for resident assessment out of a total of 18 sampled residents.</p> <p>Findings:</p> <p>Resident #46</p> <p>Record review revealed resident #46 was admitted to the facility on [DATE] and remained as an active resident at the facility. The most recent quarterly Minimum Data Set (MDS) assessment was completed on 08/26/2024.</p> <p>Resident #36</p> <p>Record review revealed resident #36 was admitted to the facility on [DATE] and remained as an active resident at the facility. The most recent quarterly MDS assessment was completed on 08/14/2024.</p> <p>02/03/2025 at 3:44 p.m., an interview with S2Director of Nursing (DON) confirmed the MDS quarterly assessments had not been completed every 120 days for residents #36 and #46.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51983</p> <p>Based on record review, interview, and observation, the facility failed to ensure that residents received adequate supervision and assistive devices to prevent accidents by failing to implement a new intervention following a fall for 1 (#51) of 2 (# 24, #51) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of resident #51's record revealed an admitted [DATE] with diagnoses of encephalopathy, unspecified; anxiety disorder, unspecified; unspecified dementia, severe, with other behavioral disturbance; unspecified injury of urethra, initial encounter, fracture of one rib, right side, initial encounter for closed fracture, wedge compression fracture of fourth lumbar vertebra, and initial encounter for closed fracture.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that the resident was severely impaired for cognition. Further review of the MDS revealed resident #51 required two person assistance with bed mobility and transfers. He also required one person physical assist for toilet use.</p> <p>Review of the fall risk assessment dated [DATE] revealed resident #51 was assessed to be at high risk for falls.</p> <p>Review of the Incident &amp; Accident (I &amp; A) Reports revealed on 01/16/2025 resident #51 had an unwitnessed fall in the room with a head injury and on 01/31/2025 he attempted to stand in the lobby and fell on to a chair.</p> <p>Review of resident #51's actual fall care plan revealed he had falls on 01/16/2025 and 01/31/2025. Further review revealed the following interventions for falls:</p> <ul style="list-style-type: none"> <li>-01/16/2025: Send resident to the emergency room for evaluation and treatment, and</li> <li>-01/31/2025: Place resident in a geri-chair for increased comfort.</li> </ul> <p>Review of resident #51's current care plan for crawling out of bed revealed following interventions:</p> <ul style="list-style-type: none"> <li>-Leave door open for ease of monitoring,</li> <li>-Set mattress at bedside to increase safety, and</li> <li>-When significant behaviors exacerbated, have aide sit in room with resident to prevent fall/injury.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/03/2025 at 8:32 a.m. revealed resident #51 was laying on the floor mattress next to the bed. S4Certified Nursing Assistant (S4CNA) instructed resident to get back in bed. Resident #51 then crawled back in bed unassisted from floor mattress. S4CNA then closed the door to his room when exiting.</p> <p>Observation on 02/04/2025 at 8:45 a.m. revealed the door was closed to resident # 51's room with the resident inside alone.</p> <p>An interview with S2Director of Nursing (DON) on 02/04/2025 at 9:00 a.m. confirmed resident #51's intervention for falls on 01/15/2025 was to leave his door open.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>13974</p> <p>Based on record review and interview the facility failed to ensure appropriate treatment and services were provided to prevent potential complications from enteral feeding by failing to record feedings and water flush amounts for 1 (#7) of 2 (#7 and #22) residents reviewed for tube feedings.</p> <p>Findings:</p> <p>Resident #7</p> <p>Review of the medical record revealed resident #7 received enteral feedings by way of a percutaneous endoscopic gastrostomy (PEG) tube for the diagnosis of adult failure to thrive.</p> <p>Further review of the February 2025 physician orders revealed an order for Two-Cal high nutrition (HN) tube feeding at 45 milliliters per hour from 6:00 p.m. to 6:00 a.m. There was also an order for the PEG tube to be flushed with 150 milliliters of water every four hours while the feeding was not infusing from 6:00 a.m., to 6:00 p.m.</p> <p>Review of the February medication administration record revealed there was no documentation of the PEG tube flushes or tube feedings.</p> <p>On 02/03/2025 at 4:00 p.m., an interview with S2Director of Nursing (DON) confirmed there should have been documentation of the nighttime feeding and daytime water flushes in the medical record.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575</b></p> <p>Based on observations, interviews and record reviews the facility failed to provide respiratory care consistent with professional standards for 4 (#2, #18, #35, #22) of 4 (#2, #18, #35, #22) sampled residents reviewed for respiratory care.</p> <p>The facility failed to ensure respiratory equipment was:</p> <ol style="list-style-type: none"> <li>1) stored properly for resident #2, #18, #35, and #22,</li> <li>2) changed in a timely manner for resident #2 and #35 and,</li> <li>3) dated for resident #2 and #18.</li> </ol> <p>Findings:</p> <p>Resident #2:</p> <p>Review of the medical record for sampled resident #2 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic bronchitis, and history of cerebral infarction.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident #2 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact for daily decision making.</p> <p>Review of the physician's orders dated 03/26/2024 revealed administer oxygen (O2) at 2 liters for comfort/shortness of breath every shift as needed (prn).</p> <p>Review of the current care plan for resident #2 revealed may use oxygen at 2 liters per nasal cannula prn.</p> <p>On 02/02/2025 at 1:50 p.m., an observation revealed resident #2's nasal cannula tubing was dated 01/12/2025 and the oxygen tubing was draped over the top of the oxygen concentrator and part of the tubing was touching the floor. Further observation revealed the oxygen tubing was not stored in a bag while not in use. Also, resident #2's nebulizer and nebulizer tubing was on the bedside table and was not dated or stored in a bag. An interview with resident #2 revealed the nebulizer tubing was changed the same time as the other oxygen tubing, which was 01/12/2025.</p> <p>On 02/04/2025 at 2:30 p.m. S2Director of Nursing (DON) confirmed resident # 2's above oxygen equipment was not changed timely and was not stored properly. She further confirmed the nebulizer equipment was not dated or stored properly.</p> <p>Resident #18:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record for sampled resident #18 revealed an admitted [DATE] with diagnoses including essential hypertension, paroxysmal atrial fibrillation, unspecified dementia, and anxiety disorder.</p> <p>Review of the annual MDS assessment dated [DATE] revealed resident #18 had a BIMS score of 99 which indicated they were unable to complete the test. Further review revealed she was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the physician's orders dated 12/01/2024 revealed administer oxygen at 2 liters per nasal cannula, titration increased 1 liter until oxygen saturations are 95% or above every 4 hours as needed for hypoxemia.</p> <p>On 02/02/2025 at 9:00 a.m., 02/03/2025 at 8:49 a.m., and on 02/03/2025 1:00 p.m. observations revealed resident #18's nasal cannula tubing was draped over the top of the oxygen concentrator and part of the tubing was touching the floor. Further observation revealed there was no date noted on the tubing and it was not stored in a bag.</p> <p>On 02/04/2025 at 2:10 p.m., and interview with S2DON confirmed the facility failed to ensure resident #18's oxygen tubing was dated, and stored properly in a bag when not in use.</p> <p>Resident #35:</p> <p>Review of the medical record for sampled resident #35 revealed an admitted [DATE] with diagnoses including hypertension, and history of myocardial infarction.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #35 had a BIMS score of 11 which indicated he was moderately cognitively impaired. Further review revealed he required moderate to maximum assistance for most ADLs.</p> <p>On 02/02/2025 at 10:18 a.m. and 02/02/2025 at 2:00 p.m., observations revealed resident #35's nasal cannula tubing was dated 01/12/2025. The oxygen tubing was draped over the oxygen concentrator and was not stored in a bag.</p> <p>On 02/04/2025 at 2:30 p.m. S2DON was informed that resident #35's oxygen nasal cannula tubing was dated 01/12/2025, was not changed timely, and was not stored in a bag. She confirmed the tubing should be changed weekly and stored in a bag when not in use.</p> <p>40238</p> <p>Resident #22</p> <p>Record review revealed resident #22 was admitted to the facility on [DATE] with diagnoses that included pneumonia.</p> <p>Further review of the medical record revealed an active order written for resident #22 for Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) milligrams (mg)/3 milliliter (ml) (Ipratropium-Albuterol) -1 vial inhale orally four times a day via nebulizer related to pneumonia.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/02/2025 at 8:50 a.m., observation revealed resident #22 had a nebulizer mask uncovered resting on top of the nebulizer machine. The mask and tubing was open to air and not stored in any type of storage container.</p> <p>On 02/02/2025 at 3:00 p.m., observation revealed resident #22 had a nebulizer mask uncovered resting on top of the nebulizer machine.</p> <p>On 02/03/2025 at 1:10 p.m., observation revealed resident # 22 had a nebulizer mask uncovered resting on top of the bedside table. The mask and tubing was not stored in the storage bag which was on top of the table next to the nebulizing machine.</p> <p>On 02/04/2025 at 8:20 a.m., an interview with S2DON, confirmed the nebulizer mask should be kept in a storage bag when not in use.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails prior to the installation for 3 (#18, #24 and #27) of 3 residents reviewed for accident hazards.</p> <p>Findings:</p> <p>Resident 24</p> <p>Review of the medical record revealed for resident #24 revealed an admitted [DATE] with diagnoses of heart disease, hypertension, anxiety, coronary artery dissection, osteoarthritis, and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #24's Brief Interview for Mental Status (BIMS) score was 13 which indicated no cognitive impairment for daily decision making. Further review of the MDS revealed was independent with bed mobility, and required setup help with transfers.</p> <p>On 02/02/2025 at 10:12 a.m., and 02/03/2025 at 9:00 a.m. observations of resident #24 revealed she was sitting in her room in a wheelchair. Further observations revealed the bed had one quarter rail up on the right side of the bed and the bed rail on the left side was in the down position.</p> <p>Review of the February 2025 physician orders revealed an order dated 01/31/2025 that resident #24 may use bilateral quarter rails to aide in bed mobility.</p> <p>Review of the current care plan revealed resident #24 was at high risk for falls. Interventions included that resident #24 may use bilateral quarter rails to aide in mobility.</p> <p>Review of the medical record revealed no documented evidence that resident #24 was assessed for the entrapment of bed rails prior to installation.</p> <p>On 02/04/2025 at 2:10 p.m. interview with S2Director of Nursing (DON) revealed the facility did not assess for the entrapment risk for the bed rails prior to installation.</p> <p>Resident 27</p> <p>Review of the medical record for sampled resident #27 revealed admitted [DATE] with diagnoses of muscle weakness, abnormality of gait and mobility, lack of coordination, major depression, pain, psychosis, and Alzheimer's disease.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the facility was unable to determine the resident's BIMS score, and required extensive assistance with bed mobility and was totally dependent on staff for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/02/2025 at 9:10 a.m., 02/02/2025 at 2:35 p.m., and on 02/04/2025 at 9:45 a.m. observations of resident #27 revealed she was in the bed with one quarter bed rail up on the left side of the bed.</p> <p>Review of the February 2025 physician orders revealed an order dated 01/31/2025- may use bilateral quarter rails to aide in bed mobility every shift related to muscle weakness.</p> <p>Review of the current care plan revealed resident #27 needed quarter bed rails to assist with bed mobility. The interventions included to monitor for effectiveness of use of bed rails, monitor quarter rails to ensure no abnormalities are present that could impair skin integrity.</p> <p>Review of the medical record revealed no documented evidence that resident #27 was assessed for the entrapment of bed rails prior to installation.</p> <p>On 02/04/2025 at 2:10 p.m., an interview with S2DON revealed the facility did not assess for the entrapment risk for the bed rails prior to installation.</p> <p>22575</p> <p>Resident #18</p> <p>Review of the medical record for resident #18 revealed an admitted [DATE]with diagnoses of essential hypertension, paroxysmal atrial fibrillation, generalized osteoarthritis, and unspecified dementia with behavioral disturbance.</p> <p>Review of the annual MDS assessment dated [DATE] revealed resident #18's BIMS score was 99, which indicated they were unable to complete the test. Further review of the MDS revealed she was dependent on staff for all activities of daily living.</p> <p>Review of the February 2025 physician orders revealed an order dated 01/31/2025 that resident #18 may use bilateral quarter rails to aide in bed mobility.</p> <p>Review of the current care plan revealed resident #18 required quarter bed rails. Interventions included that resident #18 may use bilateral quarter rails to assist with turning and repositioning.</p> <p>Review of the medical record revealed no documented evidence that resident #18 was assessed for the entrapment of bed rails prior to installation of the bed rails.</p> <p>On 02/04/2025 at 2:10 p.m., an interview with S2DON revealed the facility did not assess for the entrapment risk for the bed rails prior to installation.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>18118</p> <p>Based on record reviews and interview, the facility failed to ensure there was sufficient staff available at all times to provide nursing and related services to meet the resident's needs and safety in a manner that promotes each resident rights, physical, mental and psychosocial well-being. The facility failed to ensure there was sufficient staff on 07/21/2024, 07/28/2024 and on 08/31/2024 to provide care and services to the residents residing in the facility.</p> <p>Findings:</p> <p>Review of the Payroll Based Journal (PBJ) staffing data submission for fiscal year 2024, Quarter 4 (July 1 - September 30) revealed one star staffing rating, excessively low weekend staffing and failed to have nursing coverage 24 hours/day triggered.</p> <p>Review of the facility's staffing patterns provided to the survey team revealed Sunday, 07/21/2024, hours provided to the residents were 135 hours and the required hours were 129.25 with 55 residents.</p> <p>Review of the actual time sheets for the staff providing care and services to the residents on 07/21/2024 revealed the total hours were 106.91 hours.</p> <p>Review of the facility's staffing patterns provided to the survey team revealed Sunday, 07/28/2024, hours provided to the residents were 136 hours and the required hours were 131.6 with 56 residents.</p> <p>Review of the actual time sheets for the staff providing care and services to the residents on 07/28/2024 revealed the total hours were 76.07 hours.</p> <p>Review of the facility's staffing patterns provided to the survey team revealed Sunday, 08/31/2024, hours provided to the residents were 140 hours and the required hours were 136.3 with 58 residents.</p> <p>Review of the actual time sheets for the staff providing care and services to the residents on 08/31/2024 revealed the total hours were 124.02 hours.</p> <p>On 02/04/2025 at 2:30 p.m. interview with S1Administrator confirmed that the hours on the time sheets were less than the required hours on the staffing patterns.</p> <p>On 02/04/2025 at 3:10 p.m. interview with S1Administrator confirmed she did not have any more time sheets or hours to provide to the surveyor for the dates listed above.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>40238</p> <p>Based on observations and interview the facility failed to ensure the nurse staffing data was posted daily. The facility failed to ensure the nurse staffing data was readily accessible to residents and visitors.</p> <p>Findings:</p> <p>On 02/02/2025 at 7:45 a.m., observation revealed a daily nurse staffing sheet dated 01/8/2025 in a glass case at the front entrance of the facility. The nurse staffing sheet was filled out correctly but was not for the correct day.</p> <p>On 02/03/2025 at 7:50 a.m., observation revealed a daily staff posting dated 02/01/2025 in a glass case at the front entrance of the facility.</p> <p>On 02/04/2025 at 7:50 a.m., observation revealed a daily staff posting dated 02/01/2025 in a glass case at the front entrance of the facility.</p> <p>On 02/04/2025 at 10:01 a.m., an interview with S1Administrator confirmed the daily staffing sheets were not posted daily.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18118</p> <p>Based on record reviews and interviews, the pharmacist failed to identify and report irregularities to the attending physician, the facility's medical director and director of nursing (DON) for 2 (#8 and #19) of 6 (#2, #8, #19, #24, #46 and #154) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Resident 19</p> <p>Review of the medical record for resident #19 revealed an admitted [DATE] with diagnoses including atrial fibrillation, fatty liver, cardiac pacemaker, prosthetic heart valve, heart failure, anxiety, glaucoma, hyperlipidemia and major depression.</p> <p>Review of the current care plan revealed resident #19 was at risk for fluid volume deficit related to the use of diuretics. Interventions included to assess daily for signs and symptoms of dehydration and over hydration, and to assess for edema every day. Further review of the care plan revealed resident #19 had the potential for abnormal bleeding due to anticoagulant therapy use. Interventions included to monitor for signs and symptoms of abnormal bleeding.</p> <p>Review of the February 2025 physician's orders revealed an order dated 09/13/2024 for Apixaban (anticoagulant) 5 milligrams (mg), give 1 pill two times a day, and an order dated 09/14/2024 for Lasix (diuretic) 20 mg to be given every day.</p> <p>Review of the medical record for resident #19 revealed no documented evidence that the nurses monitored for edema and bleeding as stated in the care plan.</p> <p>Review of the record for resident #19 revealed the pharmacist performed a monthly Drug Regimen Review (DRR) dated 01/08/2025, 12/02/2024 and 11/05/2024. Further review of the DRR revealed no documented evidence that the pharmacist addressed the bleeding and edema monitoring was not documented for the resident.</p> <p>On 02/04/2025 at 9:00 a.m. an interview with S2Director of Nursing (DON) confirmed there was documentation that edema and bleeding was monitored for resident #19. S2DON further confirmed the pharmacist failed to address that edema and bleeding was not monitored for resident #19 during the monthly DRR.</p> <p>13974</p> <p>Resident #8</p> <p>Review of the medical record for resident #8 revealed she received the blood thinner Clopidogrel 75 mg daily with a supporting diagnosis of cerebral infarction.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Oak Woods Home for the Elderly		STREET ADDRESS, CITY, STATE, ZIP CODE  1400 Davenport Avenue Mer Rouge, LA 71261	
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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>Review of resident #8's medication administration record revealed there was no documentation that the facility was monitoring the resident for bleeding.</p> <p>Review of the monthly drug regimen review revealed consultant pharmacist failed to identify that resident #8 was not being monitored for bleeding.</p> <p>On 02/03/2025 at 4:00 p.m., interview with S2DON confirmed there was no bleeding monitoring for resident #8 and the consultant pharmacist failed to report the irregularity to the facility.</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><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 each resident's medication regimen was free from unnecessary medications by failing to 1) monitor edema for a resident who received a diuretic for 2 (#2, and #19), and 2) monitor for bleeding for a resident who received an anticoagulant for 3 (#8, #19 and #46) of 6 (#2, #8, #19, #24, #46 and #154) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Resident 19</p> <p>Review of the medical record for resident #19 revealed an admitted [DATE] with diagnoses including atrial fibrillation, fatty liver, cardiac pacemaker, prosthetic heart valve, heart failure, anxiety, glaucoma, hyperlipidemia and major depression.</p> <p>Review of the current care plan revealed resident #19 was at risk for fluid volume deficit related to the use of diuretics. Interventions included to assess daily for signs and symptoms of dehydration and over hydration, and to assess for edema every day. Further review of the care plan revealed resident #19 had the potential for abnormal bleeding due to anticoagulant therapy use. Interventions included to monitor for signs and symptoms of abnormal bleeding.</p> <p>Review of the February 2025 physician's orders revealed an order dated 09/13/2024 for Apixaban (anticoagulant) 5 milligrams (mg), give 1 pill two times a day, and an order dated 09/14/2024 for Lasix (diuretic) 20 mg to be given every day.</p> <p>Review of the record for resident #19 revealed no documented evidence of monitoring for bleeding or edema checks as stated in the care plan.</p> <p>On 02/03/2025 at 4:00 p.m. interview with S2Director of Nursing (DON) confirmed resident #19 received Apixaban and Lasix and there was no documentation of monitoring for bleeding or edema documented for resident #19.</p> <p>13974</p> <p>Resident #8</p> <p>Review of the medical record revealed resident #8 received the blood thinner Clopidogrel 75mg daily with a supporting diagnosis of cerebral infarction.</p> <p>Review of resident #8's medication administration record revealed there was no documentation that the facility was monitoring the resident for bleeding.</p> <p>On 02/03/2025 at 4:00 p.m., interview with S2DON confirmed there was no recorded monitoring for bleeding related to resident #8.</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>22575</p> <p>Resident 2</p> <p>Review of the medical record for resident #2 revealed an admitted [DATE] with diagnoses including edema, and hypertension.</p> <p>Review of the February 2025 physician's orders revealed an order dated 01/22/2025 for Bumetanide (diuretic) 1 mg, give by mouth 1 time a day for fluid retention related to edema.</p> <p>Review of the current care plan revealed resident #2 was on diuretic therapy. Further review revealed an intervention to administer diuretic medications as ordered by physician and monitor for side effects and effectiveness every shift.</p> <p>Review of the record for resident #2 revealed no documented evidence of monitoring for edema checks.</p> <p>On 02/04/2025 at 2:30 p.m., an interview with S2DON confirmed there was documentation of monitoring resident #2 for edema.</p> <p>40238</p> <p>Resident #46</p> <p>On 02/02/2025 at 10:36 a.m., an interview with resident #46 revealed he took the blood thinner, Coumadin every night since being admitted to the facility in March of 2024.</p> <p>Record review revealed resident #46 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease, cerebral infarction, and myocardial infarction.</p> <p>Further record review revealed an active order for warfarin sodium (anticoagulant) oral tablet 2 mg to be given by mouth at bedtime related to cerebral infarction.</p> <p>Review of the January and February 2025 medication administration record revealed resident #46 had been taking warfarin sodium oral tablet 2 mg nightly as ordered. Further review of the medical record revealed no documented evidence of monitoring for bleeding while receiving an anticoagulant.</p> <p>On 02/03/2025 at 4:10 p.m., an interview with S2DON confirmed resident #46 had not been monitored for bleeding for the months of January and February 2025 while receiving anticoagulant treatment.</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>40238</p> <p>Based on observations the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The failed practice was made evident by uncleanliness of the kitchen which included the food storage areas, meal serving area, cooking areas and the three compartment sink.</p> <p>Findings:</p> <p>On 02/02/2025 at 8:15 a.m., an initial tour of kitchen revealed grease buildup behind and underneath the deep fryer. Splattered food was observed on the wall and glass in front of the serving counter where the resident meal trays were prepared. Rust and food particles were observed on the storage shelf beneath the serving counter. Dust/dirt build up was observed on the circulating fan inside the walk in refrigerator which had blown the dust/dirt onto the ceiling and wall opposite of the fan inside the walk in refrigerator.</p> <p>Observation of the three compartment sink revealed what appeared to be a lime scale buildup on the top of the three compartment sink.</p> <p>On 02/02/2025 at 12:17 p.m., a confirmation interview/observation was conducted with S6Dietary Manager (DM). S6DM was shown the grease buildup behind and underneath the deep fryer, the food splattered on the wall and glass in front of the serving line, and the rust on the storage shelf beneath the serving counter. S6DM was also shown the dust/dirt build up on the circulating fan inside the walk in refrigerator. S6DM was shown the uncleanliness of the three compartment sink. S6DM confirmed the areas were in need of cleaning.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>18118</p> <p>Based on record review and interview the facility failed to accurately submit mandatory direct care staffing information, based on payroll, to Centers for Medicare &amp; Medicaid Services (CMS) for Fiscal Year (FY) Quarter 4 2024 (July 1 - September 30).</p> <p>Findings:</p> <p>Review of the PBJ (Payroll Based Journal) Staffing Report for FY Quarter 4 2024 (July 1- September 30) revealed the facility triggered for Failed to Submit Data for the Quarter, One Star Staffing Rating, Excessively Low Weekend Staffing, No Registered Nurse (RN) hours, and failed to have Licensed Nursing Coverage 24 hours/day.</p> <p>On 02/02/2025 at 11:20 a.m. interview with S1Administrator confirmed the former Human Resources Director was not submitting the staffing information based on payroll to CMS.</p> <p>40238</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>18118</p> <p>Based on observations, record reviews and interviews the facility failed to maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of communicable diseases and infections by failing 1) to have signage on residents' doors that were COVID positive and/or Enhanced Barrier Precautions (EBP) that included specific personal protective equipment (PPE) required for staff use for 4 (#35, #43, #47, and #154), and 2) to ensure indwelling catheter tubing was not touching the floor for 2 (#35 and #154) of 5 (#14, #35, #43, #47, and #154) residents reviewed for infection control.</p> <p>Findings:</p> <p>Resident 43</p> <p>Review of the medical record for resident #43 revealed the resident tested positive for COVID infection and was placed on isolation on 01/28/2025 through 02/07/2025.</p> <p>Review of the current care plan for resident #43 revealed the resident was COVID positive and isolation precautions were in place.</p> <p>Observation on 02/02/2025 at 8:05 a.m. of resident #43's door revealed there was no signage on the outside of the door to alert staff and/or visitors of the specific PPE required prior to entering the resident's room.</p> <p>On 02/02/2025 at 9: 15 a.m. interview with S2Director of Nursing (DON) confirmed resident #43's door should have signage regarding PPE requirements for the resident on isolation.</p> <p>Resident 154</p> <p>Review of the medical record for resident #154 revealed the resident had an indwelling catheter.</p> <p>Observation on 02/02/2025 at 2:39 p.m. of resident #154's door revealed there was no signage on the outside of the door to alert staff and/or visitors of the specific PPE required for a resident on EBP regarding his indwelling catheter.</p> <p>On 02/03/2025 at 8:45 a.m. interview with S5Registered Nurse (RN)/Infection Preventionist confirmed resident #154's door should have signage to indicate the specific PPE required for a resident on EBP.</p> <p>On 02/03/2025 at 9:08 a.m., and on 02/03/2025 at 9:00 a.m. observations of resident #154 revealed he was in his room and an indwelling catheter was observed hanging on his walker and the catheter tubing was directly touching the floor.</p> <p>On 02/03/2025 at 4:00 p.m., interview with S2DON confirmed resident #154's catheter tubing should not have been allowed to touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>22575</p> <p>Resident 35</p> <p>Review of resident #35's current physician's orders revealed an order dated 12/19/2024 for an indwelling Foley catheter.</p> <p>Observation on 02/02/2025 at 10:18 a.m. of resident #35's door revealed the sign on his door read Please see nurse before entering which failed to include which PPE was required for EBP regarding his indwelling catheter.</p> <p>On 02/04/2025 at 2:30 p.m. an interview with S2DON confirmed resident #35's door should have signage regarding specific PPE requirements for a resident on EBP.</p> <p>On 02/02/2025 at 10:18 a.m., 02/02/2025 at 2:00 p.m., and 02/03/2025 at 1:15 p.m. observations of resident #35 revealed he was in his room in bed and an indwelling catheter was observed hanging on the left side of his bed. Further observations revealed the catheter tubing and bag were touching the floor.</p> <p>On 02/04/2025 at 2:30 p.m., an interview with S2DON confirmed resident #35's catheter tubing and bag should not have been allowed to touch the floor.</p> <p>Resident 47</p> <p>Review of the medical record for resident #47 revealed the resident tested positive for COVID infection and was placed on isolation on 01/28/2025 through 02/07/2025.</p> <p>Review of the current care plan for resident #47 revealed the resident was COVID positive and isolation precautions were in place.</p> <p>Observation on 02/02/2025 at 8:38 a.m. of resident #47's door revealed the sign on her door read Please see nurse before entering which failed to include the specific PPE required before staff entered the resident's room.</p> <p>On 02/04/2025 at 2:30 p.m., an interview with S2DON confirmed the above sign on the resident's door should have included specific PPE requirements for staff.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>13974</p> <p>Based on observation and interview, the facility failed to ensure it was adequately equipped to allow residents to call for staff assistance from toileting facilities. The failed practice was evidenced by a public bathroom having a call light pull cord wrapped around a grab bar which prevented it from being available to activate if a resident needed to activate the call light from the floor.</p> <p>Findings:</p> <p>On 02/02/2025 at 8:30 a.m., observation during a tour of the facility revealed there was an unlocked bathroom located near the chapel. The bathroom was accessible to residents. Observation of the bathroom revealed the call light pull cord was wrapped several times around the grab bar. The call light could not be activated by pulling on the end of the cord.</p> <p>On 02/03/2025 at 8:10 a.m., observation/interview with S3Houskeeping Supervisor revealed the bathroom remained unlocked and the pull cord remained wrapped around the grab bar. S3Houskeeping Supervisor also confirmed the call light cord was wrapped around the garb bar and could not be activated by a resident on the floor if they needed to call for assistance.</p>