STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195611	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond Nursing Home	501 Old Covington Highway Hammond, LA 70403

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48912 Based on record review, observation, and interviews, the facility failed to provide pharmaceutical services, including procedures which assure administering of all drugs and biologicals, to meet the needs of each resident. The facility failed to ensure an insulin pen needle was primed prior to administration of insulin per manufactures guidelines for 1 of 1 (#46) resident observed for insulin administration. Findings: Review of the Insulin Lispro's manufacturer insert revealed the following, in part: Priming your Pen Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. Review of Resident #46's current Physician Orders revealed, in part: Accucheck four times a day Insulin Lispro 100 unit/mL, inject sliding scale four times a day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Hammond Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Old Covington Highway Hammond, LA 70403	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 11:35 a.m., an observation was made of S4RN performing an accucheck on Resident #46, which revealed a blood sugar of 378 requiring 10 units of insulin per sliding scale. On 11/06/2024 at 11:40 a.m., an observation was made of S4RN preparing and administering Resident #46's Insulin Lispro pen. S4RN prepared 10 units of insulin without priming the insulin pen needle prior to administering the insulin to Resident #46. On 11/06/2024 at 2:15 p.m., an interview was conducted with S4RN. S4RN stated she was not aware how to prime the insulin pens. S4RN confirmed she did not prime the insulin pen needle prior to administering Resident #46's insulin dose, and should have. On 11/06/2024 at 1:03 p.m., an interview was conducted with S2DON. S2DON stated an insulin pen should be primed prior to administration. S2DON confirmed she expected staff to follow manufacturer's recommendation of priming the insulin pens as directed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond Nursing Home	501 Old Covington Highway Hammond, LA 70403

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on record reviews and interviews, the facility failed to ensure adequate monitoring for side effects with the use of psychotropic medication was completed for 1 (#15) of 5 (#15, #51, #63, #66, and #67) residents reviewed for unnecessary medications. Findings: Review of Resident #15's clinical record revealed a readmitted [DATE] with diagnoses which included: Bipolar, Major Depressive Disorder, Impulse Disorder, and Dementia with Behavioral Disturbances. Review of Resident #15's active physician orders revealed, in part: 08/02/2024- Fluoxetine 40 mg 1 tablet by mouth every day; Namenda 10mg 1 tablet by mouth twice a day; and Zyprexa 2.5 mg 1 tablet by mouth at bedtime. 10/01/2024- Seroquel 50 mg 1 tablet by mouth twice a day. Review of Resident #15's current medication administration record revealed Resident #15 had received the above medications within the last week. Further review revealed there was no documentation of monitoring for psychotropic medication side effects for Resident #15, and the facility was unable to provide documentation. On 11/07/2024 at 10:26 a.m., an interview was conducted with S4RN. S4RN confirmed she had not been monitoring or documenting Resident #15's psychotropic medication side effects, and should have. On 11/07/2024 at 9:40 a.m., an interview was conducted with S2DON. S2DON reviewed Resident #15's clinical record and confirmed there was no documentation of monitoring for side effects of Resident #15's psychotropic medications, and should have been.

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NAME OF PROVIDER OR SUPPLIER: Hammond Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Old Covington Highway Hammond, LA 70403	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48912 Based on record review, observations, and interviews, the facility failed to ensure drugs were stored and labeled properly in accordance with current accepted professional principles. The facility failed to ensure: 1. Insulin pen and vial containing multiple doses of insulin were labeled with an open date in 1 (Med Room A) of 1 medication room reviewed; 2. Liquid medications were labeled with an open date in 1(Med Cart A) of 3 (Med Cart A, B, and C) medication carts reviewed; and 3. Medication Cart A and Cart C was locked when unattended. Findings: 1. On 11/04/2024 at 12:30 p.m., an observation was made of Med Room A with S5RN, which revealed the following: 1-Lantus insulin pen was opened and undated. 1-Lantus insulin vial was opened and undated. On 11/04/2024 at 12:33 p.m., an interview was conducted with S5RN. S5RN confirmed all insulin should be dated when opened, and was not. On 11/04/2024 at 12:38 p.m., an interview was conducted with S2DON. S2DON confirmed staff was expected to date insulin after opening. 2. On 11/04/2024 at 12:19 p.m., an observation was made of Med Cart A with S5RN, which revealed the following: 1-16 oz. bottle of Docusate Sodium Liquid 50 mg/ 5 mL was opened and undated. 1-16 oz. bottle of Lactulose Solution 10g/15 mL was opened and undated. On 11/04/2024 at 12:25 p.m., an interview was conducted with S5RN. She confirmed the above findings, and stated the medication bottles should have been dated when opened and were not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hammond Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Old Covington Highway Hammond, LA 70403	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/04/2024 at 12:38 p.m., an interview was conducted with S2DON. S2DON confirmed she expected staff to date liquid medications after opening. 3. On 11/06/2024 at 8:08 a.m., an observation was made of medication Cart A unlocked and unattended. On 11/06/2024 at 8:10 a.m., an observation was made Cart A unattended, unlocked, while a resident, staff, and visitor passed by. On 11/06/2024 at 8:14 a.m., an interview was conducted with S6LPN. S6LPN confirmed medication Cart A should have been locked when unattended. On 11/06/2024 at 11:20-11:24 a.m., an observation was made of medication Cart C unattended and unlocked. On 11/06/2024 at 12:09 p.m., an interview was conducted with S4RN. S4RN confirmed medication Cart C should have been locked when unattended. On 11/06/2024 at 2:00 p.m., an interview was conducted with S2DON. S2DON confirmed she expected staff to keep medication carts locked when unattended.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on observations and interview, the facility failed to store, prepare, and distribute foods under sanitary conditions. The facility failed to ensure: 1. Food was properly sealed and dated after opening; and 2. Presence of expired food intended for use. There were a total of 78 out of 85 facility residents who were provided meals and beverages from the facility's kitchen. Findings: Review of the facility's undated policy titled, Food Service to Prevent Risk of Cross Contamination revealed the following, in part; Purpose: To ensure that all residents meals are cooked, stored, transported, and served using methods that reduce risk of cross contamination and food borne illnesses. Process: 4. All food shall have a date of delivery and used by the manufacturer's recommendation. Opened product shall be dated as to the date opened and not kept on shelf beyond the manufacturer's recommendation. During the initial tour of the facility's kitchen on [DATE] at 8:37 a.m., with S3DM the following observations were made: Cooking area: ,d+[DATE]oz. bottle of seasoned salt was opened and undated. ,d+[DATE]oz. bottle of garlic and herb seasoning was opened and undated. Walk in Freezer: 1-,d+[DATE] bag of chicken nuggets-opened, unsealed, and undated. Walk in Refrigerator: 2-packages of 6 tortillas expired [DATE]. ,d+[DATE] count of hot dog buns were undated with delivery date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	,d+[DATE] count of hamburger buns were undated with delivery date 1-loaf of white bread was undated with a delivery date. Pantry: 24-individually wrapped cereal expired [DATE]. 3-boxes of corn starch expired [DATE]. On [DATE] at 9:00 a.m., an interview was conducted with S3DM. S3DM confirmed the aforementioned items during initial tour, and she confirmed the dates of expired items. S3DM confirmed expired items should have been discard prior to today. S3DM confirmed all items which were opened should have been sealed and dated with open dates. S3DM further confirmed the bread products should have been dated with delivery date and was not. On [DATE] at 1:28 p.m., an interview was conducted with S1ADM. S1ADM confirmed all expired foods should be discarded appropriately. S1ADM confirmed all opened items should be dated and labeled with an open 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on observations, record reviews, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection for 3 (#71, #82, and #84) of 5 (#39, #63, #71, #82, and #84) residents reviewed for Infection Control. The facility failed to: 1.) Identify Residents who required Enhanced Barrier Precautions (EBP) 2.) Ensure staff adhered to Enhanced Barrier Precautions while providing direct care to indwelling devices Findings: Resident #71 A review of Resident #71's Clinical Record revealed the resident was admitted to the facility on [DATE]. A review of Resident #71's Admission MDS with an ARD of 10/13/2024 revealed he had a BIMS of 13, which indicated he was cognitively intact. Further review revealed Resident #71 had a venous stasis ulcer. A review of the facility's Pressure Ulcer Weekly Log revealed Resident #71 had a stasis ulcer to the left leg, acquired on 09/30/2024. A review of Resident #71's Physician Orders revealed no orders for EBP. On 11/06/2024 at 9:05 a.m., an interview and observation was conducted with Resident #71. Resident #71 had a dressing to his left foot. Resident #71 stated he had wounds on his left ankle and left toe. On 11/06/2024 at 10:41 a.m., an observation was made of S4RN providing wound care for Resident #71. S4RN did not wear a gown while performing wound care to Resident #71's wounds. There was no EBP signage on the resident's door and no PPE noted outside the door or in the residents room. On 11/06/2024 at 2:05 p.m., an interview was conducted with S4RN. She stated she was unaware of what Enhanced Barrier Precautions were. She confirmed she did not wear a gown while performing wound care to Resident #71. Resident #82 A review of Resident #82's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Percutaneous Endoscopic Gastrostomy (PEG) tube. A review of Resident #82's Quarterly MDS with an ARD of 10/09/2024 revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section K- Swallowing/Nutritional Status K0520- Nutritional Approaches- B. Feeding Tube On 11/06/2024 at 8:29 a.m., an observation was made of Resident #82's room. There was no PPE observed outside of the resident's room and no EBP signage observed on the resident's door. On 11/06/2024 at 11:10 a.m., an observation was made of S7LPN administering a bolus tube feeding to Resident #82. S7LPN did not wear a gown while administering the tube feeding to Resident #82. On 11/06/2024 at 1:11 p.m., an interview was conducted with S7LPN. She confirmed she did not wear a gown when she administered Resident #82's tube feeding. She stated she was unaware she needed to utilize EBP prior to providing direct care to Resident #82. Resident #84 A review of Resident #84's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Percutaneous Endoscopic Gastrostomy (PEG) tube. A review of Resident #84's Quarterly MDS with an ARD of 09/24/2024 revealed the following: Section K- Swallowing/Nutritional Status K0520- Nutritional Approaches- B. Feeding Tube On 11/06/2024 at 11:50 a.m., an observation was made of S6LPN administering a bolus feeding and medications through the PEG for Resident #84. S6LPN did not wear a gown while administering the tube feeding and medications for Resident #84. On 11/06/2024 at 1:20 p.m., an interview was conducted with S6LPN. She confirmed she did not wear a gown while administering the bolus feeding and medications through Resident #84's PEG. She stated she was unaware she needed to utilize EBP prior to providing direct care to Resident #84. On 11/06/2024 at 3:55 p.m., an interview was conducted with S2DON. She stated there were no residents who currently resided in the facility who were on EBP at this time. She confirmed she was unaware it was required for staff to wear a gown when providing direct care for Residents #71, #82, and #84. 47191 47546