STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195612	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Living Center	605 Hilltop Avenue Franklinton, LA 70438

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on interviews and record review, the facility failed to employ staff with appropriate competencies and skills sets to carry out the functions of the food and nutrition service by failing to have a certified dietary manager on staff. Findings: Review of S7DM's food service management and safety certification revealed an expiration date of [DATE]. On [DATE] at 10:03 a.m., an interview was conducted with S7DM. S7DM stated her food service management and safety certification expired on [DATE]. She stated she or any other staff in the facility did not have a certificate or degree for food service or dietary management. On [DATE] at 10:50 a.m., an interview was conducted with S1ADM. He stated he realized today S7DM's food service management and safety certification had expired. He stated he or any other staff in the facility did not have a certificate or degree for food service or dietary management.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48872 Based on observations, interviews, and record review, the facility failed to ensure that the food items served from the menu met the resident's personal dietary choices for 1 (#15) of 16 sampled residents reviewed in the initial pool. Findings: Review of the Clinical Record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Anorexia, Irritable bowel syndrome with Constipation, Gastro-esophageal Reflux Disease without Esophagitis, Vitamin Deficiency, Nausea, and Dysphagia. Review of the Quarterly MDS with an ARD of 02/02/2024 revealed Resident #15 had a BIMS of 15, which indicated she was cognitively intact. On 04/07/2024 at 10:32 a.m., an interview was conducted with Resident #15. She stated the rice served at the facility was not good. She stated she would prefer mashed potatoes every day, but the facility did not accommodate her preference. She stated she told S7DM about her preferences a while ago, but she was still receiving rice, which was not her preference. On 04/08/2024 at 11:59 a.m., an observation was made of Resident #15's lunch tray. Her lunch tray consisted of a pork chop with rice and gravy, cornbread and okra. Resident #15 ate 0% of lunch. On 04/08/2024 at 12:01 p.m., an interview was conducted with Resident #15. She stated she did not touch her tray today because she did not like the rice. She stated she had previously told S7DM of her preferences not to be served rice, and she would prefer mashed potatoes. She stated she did not tell the CNA today because she had already informed staff and it never changed. At this time, an observation of Resident #15's meal ticket revealed dislikes, which included rice. Further review revealed special notes which included will eat potato salad and cheesy potatoes. On 04/09/2024 at 11:44 a.m., an observation of Resident #15's lunch tray revealed chicken and dumplings with rice. Resident #15 ate 10% of her lunch tray. On 04/09/24 at 11:51 a.m., an interview was conducted with S9CNA. She stated she picked up Resident #15's tray for lunch today, and Resident #15 requested a substitute. She stated she told Resident #15 the substitute was bell peppers, and Resident #15 stated she did not want the substitute. She stated she did not offer Resident #15 anything else as a substitute to accommodate her preferences. On 04/09/2024 2:22 p.m., an interview was conducted with S7DM. She was made aware of the observations of Resident #15's meal tickets for lunch on 04/08/2024 and 04/09/2024 and the food Resident #15 was served. She stated according to the meal tickets for Resident #15, rice should not have been served on her tray and another preferred substitute should have been provided. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2024 at 2:49 p.m., an interview was conducted with S1ADM. He stated he would expect staff to honor resident food preferences for their likes and dislikes. He stated if the likes and dislikes are on the meal ticket and the resident received a dislike on their tray it would not be acceptable.

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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** 48872 Based on observations, interviews and record review, 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. The facility failed to ensure: 1. S6CNA wore proper Personal Protective Equipment (PPE) while providing care for Resident #15 who was on Enhanced Barrier Precautions (EBPs); and 2. S4LPN used appropriate hand hygiene between administering medications to 5 (#1, #3, #5, #16 and #29) of 5 (#1, #3, #5, #16 and #29) resident's observed during medication pass. Findings: 1. Review of the facility's policy dated 08/2022, titled, Enhanced Barrier Precautions, revealed, in part: 1. Enhanced barrier precautions (EBPs) are used as an infection control intervention to reduce the spread of multi-drug resistant organisms to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: c. transferring d. providing hygiene f. changing briefs or assisting with toileting 5. EBPs are indicated .for residents with wounds . regardless of Multidrug Resistant Organism colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound . 9. Staff are trained prior to caring for residents on EBPs. Review of the Clinical Record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Pressure Ulcer of Left Heel Stage 3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/2024 at 9:40 a.m., an observation was made of Resident #15. S6CNA transferred the resident from the wheelchair to the toilet using a stand-up lift. S6CNA did not have a gown on during the transfer. On 04/11/2024 at 9:45 a.m., an interview was conducted with S6CNA. She stated Resident #15 was not on EBPs. She confirmed she did not use a gown during the transfer. On 04/11/2024 at 11:42 a.m., an interview was conducted with S3ADON. She stated Resident #15 was on EBPs because of her stage 3 heel wound. She stated the process for residents on EBP was to don gloves and gown for any kind of direct contact care for the residents. She confirmed transferring a resident to the toilet was considered direct contact care. On 04/11/2024 at 2:27 p.m., an interview was conducted with S2DON. She stated Resident #15 had an active stage 3 wound on her heel and was on EBPs for direct contact care of the resident. She stated nursing staff should wear gloves and a gown when transferring Resident #15 from the wheelchair to the toilet. 2. Review of the facility's policy revised on 08/2015 titled, Handwashing/Hand Hygiene, revealed, in part: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub .for the following situations: . b. Before and after direct contact with residents. c. Before preparing or handling medications . Review of the facility's policy revised on 04/2019 titled, Administering Medications, revealed, in part: 25. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves .) for the administration of medications . On 04/09/2024 at 8:20 a.m., an observation was made of S4LPN during medication administration. S4LPN did not use hand sanitizer or wash hands after administering medication to Resident #16 and before medication preparation for Resident #1. Further observation revealed S4LPN did not use hand sanitizer or wash hands in the hallway or the room before, during and after administering medication to Resident #1. On 04/09/2024 at 8:22 a.m., an observation was made of S4LPN preparing medication's for administration to Resident #5. S4LPN entered Resident #5's room, administered the medication's to the resident by handing a cup of pills to Resident #5 to take by mouth. S4LPN exited the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/2024 at 8:27 a.m., an observation was made of S4LPN preparing medication's for administration to Resident #3. S4LPN entered Resident #3's room, administered the medication's to the resident by handing a cup of pills to Resident #3 to take by mouth. S4LPN exited the room without performing hand hygiene. On 04/09/2024 at 8:30 a.m., an observation was made of S4LPN not using hand sanitizer or washing hands before preparation of medication for Resident #29. On 04/09/24 at 8:45 a.m., an interview was conducted with S4LPN. She confirmed she did not use hand sanitizer or wash her hands before or after medication administration in between Residents #1, #3, #5, and #16 and before medication administration for Resident #29. On 04/09/24 at 2:28 p.m., an interview was conducted with S2DON. She stated during medication administration she expected the nurses to sanitize or wash hands before the nurse entered residents' rooms and after they exited residents' rooms.