

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2024
NAME OF PROVIDER OR SUPPLIER  Consolata Rehab and Wellness Center on the Teche		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 East Main Street New Iberia, LA 70560	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</b></p> <p>Based on observation, interviews and record review, the facility failed to ensure 1 (#1) of 3 (#1, #2, and #3) sampled residents was safe to perform self-administration of medication. The right to self-administer medications is the responsibility of the interdisciplinary team to assess and determine if this practice is clinically appropriate and safe.</p> <p>Findings:</p> <p>On 11/13/2024 a review of the facility's undated policy titled Self-Administration of Medications, read in part, Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.</p> <p>Review of Resident #1's electronic health record revealed an admitted [DATE] with Diagnoses which included, but were not limited to Urinary Tract Infection, Chronic Kidney Disease, Schizophrenia, and Bipolar Disorder.</p> <p>Review of Resident #1's 5 day MDS (Minimum Data Set) assessment with ARD (Assessment Reference Date) of 10/28/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating Resident #1's cognition was intact.</p> <p>Review of Resident #1 Physician Orders revealed an order written on 10/29/2024 for Magic Mouthwash 1 part Diphenhydramine 12.5mg (milligrams)/5ml (milliliter), 1 part Maalox, 1 part 2% Viscous Lidocaine. Swish, gargle, and spit 10 ml every 4 hours PRN (as needed) for 14 days. Further review of Resident #1's Physician's Orders failed to reveal an order to self-administer medications.</p> <p>Review of Resident's #1 medical records failed to reveal an assessment for the determination that it was clinically appropriate for the resident to self-administer medications.</p> <p>Review of Resident #1's plan of care failed to reveal goals or interventions for self-administration of medications.</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/2024 at 7:58 a.m., an observation was made of two clear medicine cups on Resident #1's night stand with 1/3 each of white creamy pink tint liquid. The resident stated it was the medicine for her sore mouth which the nurse left there.</p> <p>On 11/13/2024 at 2:18 p.m., an interview was conducted with S3LPN (Licensed Practical Nurse). She confirmed that there were two clear medicine cups with creamy white pink tint liquid at Resident #1's bedside this morning.</p> <p>S3LPN confirmed that the resident was on swish and swallow magic mouthwash with Lidocaine. She denied leaving the cups there and stated she was not sure who did. She confirmed that medications should not have been left at the resident's bedside.</p> <p>On 11/13/2024 at 2:43 p.m., an interview was conducted with S2DON (Director of Nursing). She confirmed the resident had no order to self-administer medications. She re-confirmed that medications should not have been left at the resident's bedside.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41419</p> <p>Based on record review, and interview, the facility failed to promote and facilitate resident self-determination through support of resident choice about aspects of his or her life in the facility that were significant to the resident for 1 (#2) of 3 sampled residents. The facility failed to accommodate Resident #2's choice to refuse care.</p> <p>Findings:</p> <p>Review of the facility's policy titled Residents' Rights with a review date of 01/22/2024 read in part .Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>B. be treated with respect, kindness, and dignity</p> <p>H. be supported by the facility in exercising his or her rights.</p> <p>Review of Resident #2's clinical record revealed an admitted [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, Heart Failure, Peripheral Vascular Disease, Cerebrovascular Accident, and Depression.</p> <p>Review of Resident #2's Quarterly (Minimum Data Set) MDS of 11/13/2024 revealed a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognition impairment.</p> <p>Review of Resident #2's Care Plan dated 05/09/2024 revealed resident required assistance for Activities of Daily Living (ADL) related to decrease mobility, COPD, Depression, and Anxiety.</p> <p>On 11/12/2024 at 2:58 p.m., an interview was conducted with Resident #2 who stated that she was not allowed to refuse a bed bath. She stated she received a bed bath daily, but sometimes she did not want to be bothered. She stated that on some days she does not feel well and does not want to be touched. She stated S9CNA (Certified Nursing Assistant) would not allow her to refuse a bath or honor her request for a bath at a later time during the day.</p> <p>On 11/12/2024 at 3:40 p.m., an interview was conducted with S9CNA who stated that the female residents who do not go to whirlpool received a bed bath daily. When S9CNA was asked if the resident does not want to bathe on any given day, what her response is, she stated they get a bath every day. She stated everyone wants to feel clean. When asked again if a hospice resident does not want to bathe, what does she do, and she responded that the resident would get a bath.</p> <p>On 11/13/2024 at 2:05 p.m., a follow up interview was conducted with Resident #2 who repeated that S9CNA stated she allowed her to refuse a bath one time, and one time is all she could refuse. The resident stated S9CNA will not allow her to refuse bed baths.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>41419</p> <p>Based on observations and interviews, the facility failed to maintain privacy and confidentiality of residents' medical records for 1 (#R1) out of 4 sampled residents. The facility had a total census of 61 residents.</p> <p>Findings:</p> <p>Review of the facility's document titled, Resident Rights with a review date of 01/22/2024, and read in part . Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>T. privacy and confidentiality.</p> <p>Review of the facility's document titled Security of Medication Cart with a review date of 01/15/2024, read in part the nurse must initiate the computer privacy screen when the computer is out of the nurse's view.</p> <p>On 11/13/2024 at 8:00 a.m., an observation of the dining room area was conducted. Further observation revealed that Medication Cart B was parked outside the dining room area. The medication cart was observed unattended and unlocked with #R1's personal information being visible for visitors/residents in the facility.</p> <p>On 11/13/2024 at 8:01 a.m., an interview was conducted with S5LPN who confirmed that she should have initiated the privacy screen prior to leaving her cart unattended.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47965</p> <p>Based on interview and record review, the facility failed to ensure a resident's person centered care plan was reviewed and revised by the interdisciplinary team after each assessment for 1(#1) of 3 (#1, #2, and #3) sampled residents as evidenced by Resident #1's care plan not reflecting the resident's wish to transfer to another facility.</p> <p>Findings:</p> <p>Review of Resident #1's Electronic Health Record revealed she was admitted to the facility on [DATE] with Diagnoses which included, but were not limited to Urinary Tract Infection, Chronic Kidney Disease, Schizophrenia, and Bipolar Disorder.</p> <p>Review of Resident #1's 5 day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/28/2024 revealed in Section Q, Participation in Assessment and Goal Setting, that her goal was to remain in the facility.</p> <p>Review of Resident #1's current care plan revealed an entry with onset date of 02/27/2024, I wish to remain in facility/No plans to D/C (discharge) at this time.</p> <p>Review of a grievance dated 10/01/2024 revealed the resident complained SSD (Social Service Department) is refusing to submit referral packet for transfer to another facility.</p> <p>Review of S11SSD's (Social Service Director) discharge referrals for Resident #1 revealed faxed communication with referral facilities on 04/16/2024, 07/29/2024 and 07/30/2024 and emails on 10/03/2024 and 10/08/2024.</p> <p>During an observation and interview with Resident #1 on 11/12/2024 at 3:46 p.m., she stated that she had been trying to transfer to another facility.</p> <p>On 11/13/2024 at 10:51 a.m., an interview was conducted with S11SSD who stated that the resident requested to be transferred multiple times and she tried to place her but her requests have been denied.</p> <p>On 11/13/2024 at 11:08 a.m., an interview was conducted with S8MDS (Minimum Data Set) who stated she was responsible for revising the resident's care plan. S8MDS confirmed that she was aware that the resident wished to be transferred elsewhere. She also confirmed that the resident's care plan did not reflect her wish to be transferred and should have.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41419</p> <p>Based on observation, record review, and interview, the facility failed to ensure that nurse aides are able to demonstrate competency in skills necessary to care for residents' needs, as identified through observation of pleasure feedings for 1 (#3) of 4 (#1, #2, #3, R1) sampled residents.</p> <p>Findings:</p> <p>Review of Resident #3's clinical record revealed an admitted [DATE], with diagnoses which included Malnutrition, Vitamin D Deficiency, Type 2 Diabetes, Chronic Kidney Disease. Resident#3 received continuous PEG (Percutaneous endoscopic Gastrostomy) tube feedings with pleasure feedings.</p> <p>A further review of Resident #3's clinical record revealed a Speech Therapy Discharge Summary dated 08/21/2024 that read in part . Requires cueing to utilize strategy. The summary included interventions provided: swallow treatment facilitation of liquid delivery using small controlled sips/intake, facilitation of small bites/sips (1/2 to 1/3 tsp), facilitation of body positioning to increase safety with intake, training in use of double swallow to facilitate pharyngeal clearance and analysis of type/amount of cueing to complete a task. Swallow treatment: facilitate of chin tuck to chest to increase airway protection during intake and training in use of upright posture during meals. Care giver training to facilitate pleasure feedings using compensatory strategy to decrease risk of aspiration and penetration.</p> <p>Review of a facility document Restorative Nursing Program Recommendations dated 08/21/2024 read in part .resident currently tolerates pleasure feedings of puree consistency foods and honey thickened liquids:</p> <ol style="list-style-type: none"> <li>1. Sit resident at 90 degree angle to consume oral diet</li> <li>2. Small bites/sips (teaspoon size amounts)</li> <li>3. Cue resident to chin tuck with swallow; double swallow</li> </ol> <p>On 11/13/2024 at 8:35 a.m., an observation was made of Resident #3 as she received a pleasure feeding from S6CNA (Certified Nursing Assistant). S6CNA gave Resident #3 puree eggs, oatmeal, and a brown substance that S6CNA was unable to identify. Further observation revealed the resident was also given honey thickened water through a straw and orange juice. S6CNA did not cue the resident to tuck his chin with swallowing or to double swallow. S6CNA then gave the resident a tablespoon full of puree eggs. She then gave the resident the remainder of the honey thickened water through a straw. S6CNA gave another tablespoon full of puree eggs. She followed that with giving the resident honey thick orange juice through a straw. The resident completed the orange juice, and S6CNA gave the resident the remaining puree eggs. At 8:37 a.m., S6CNA had completed feeding Resident #3 and began to remove the food tray from the resident's room. Resident #3 was observed lowering the head of his bed on his own immediately after eating. S6CNA did not cue the resident to remain elevated for at least thirty minutes.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/13/2024 at 8:45 a.m., an interview was conducted with S7ST who stated Resident #3's restorative plan was given to S2DON (Director of Nursing). She stated S12RCNA (Restorative Certified Nursing Assistant) was trained on the proper way to administer pleasure feedings for Resident #3 and assumed S12RCNA would be the one to feed the resident. S7ST further stated, Resident #3 was not to use a straw to drink his fluids and was to remain in an elevated position for at least thirty minutes after eating. S7ST was not aware that untrained floor staff had administered the pleasure feedings.</p> <p>On 11/13/2024 at 9:05 a.m., an interview was conducted with S6CNA who confirmed that she was not aware the Resident #3 was to be cued to chin tuck with swallowing and double swallow. S6CNA also confirmed she was not aware the resident was to have teaspoon bite sizes and not allowed to drink through a straw. She was not aware the resident was to remain sitting up thirty minutes after his pleasure feedings. S12RCNA confirmed she was not trained on how to administer Resident #3's pleasure feedings.</p> <p>On 11/13/2024 at 11:17 a.m., an interview was conducted with S2DON who confirmed she received Resident #3's restorative plan from S7ST further stated that the facility had one restorative aid who was S12RCNA. She stated she assumed S7ST only wanted S12RCNA to administer the resident's feedings. S2DON confirmed she did not clarify with S7ST who could administer the feedings since S12RCNA could not feed the resident all three meals, and she did not have any other staff trained when S12RCNA was not available. S2DON confirmed that she did not train any other staff on how to administer pleasure feedings to the resident.</p> <p>On 11/13/2024 at 11:18 a.m., an interview was conducted with S1ADM (Administrator) who stated restorative is a specific program and it would not be feasible to have other CNA's trained on restorative tasks.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>41419</p> <p>Based on observation and interview the facility failed to ensure medication Carts were locked when unattended for 2 (Cart A, Cart B) of 3 (Cart A, Cart B, Cart C) medication carts observed.</p> <p>Findings:</p> <p>Review of the facility's document titled Security of Medication Cart with a review date of 01/15/2024, read in part when the medication cart is not being used, it must be locked and parked at the nurses station or inside the medication room.</p> <p>On 11/12/2024 at 3:00 p.m., an observation of on Hall A was conducted. Further observation revealed Medication Cart A was unlocked and unattended. S4LPN (Licensed Practical Nurse) was observed sitting in the nurses station talking on her cell phone.</p> <p>On 11/12/2024 at 3:01 p.m., an interview was conducted with S4LPN. S4LPN confirmed that she should have locked her medication cart prior to leaving the cart unattended.</p> <p>On 11/12/2024 at 3:40 p.m., an observation of Hall B was conducted. Further observation revealed Medication Cart B was against the wall near the nurse's station, unattended and unlocked. A visitor was observed in the hallway near the nurse's station.</p> <p>On 11/12/2024 at 3:41 p.m., an interview conducted with S10ADON (Assistant Director of Nursing) confirmed the medication cart B was unlocked and unattended. S10ADON verified the cart should have been locked prior to the nurse leaving the cart unattended.</p> <p>On 11/12/2024 at 3:45 p.m., an interview was conducted with S3LPN. S3LPN confirmed that she left her medication cart unlocked, and she should have locked it prior to leaving it unattended.</p> <p>On 11/13/2024 at 8:00 a.m., an observation revealed Medication Cart B was parked outside the dining room area, unattended and unlocked.</p> <p>On 11/13/2024 at 8:01 a.m., an interview was conducted with S5LPN. S5LPN confirmed she should have locked the medication cart prior to leaving it unattended.</p>