

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2025
NAME OF PROVIDER OR SUPPLIER  Pointe Coupee Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1820 False River Road New Roads, LA 70760	

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 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</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 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure services provided by the facility met professional standards of quality for 1 (#1) of 5 (#1, #2, #3, #R1, and #R2) residents reviewed for professional standards. The facility failed to ensure nursing staff:1.Accurately transcribed Resident #1's Lantus insulin order;2. Clarified blood glucose monitoring orders with the physician for Resident #1, a Diabetic resident receiving Insulin; and3. Obtained a blood glucose level when Resident #1 experienced a change in condition.This deficient practice resulted in an immediate jeopardy situation on 08/05/2025 when Resident #1's insulin order was inaccurately transcribed into his electronic medical record and MAR. Resident #1 admitted to the facility from a local hospital on [DATE] with an order for Lantus 100 unit/mL inject 5 units subcutaneously daily. S4LPN transcribed the order into Resident #1's electronic medical record and MAR as Lantus 100 unit/mL inject 30 units subcutaneously daily. S4LPN did not seek clarification from Resident #1's physician for blood glucose monitoring or implement standing orders for blood glucose monitoring. From 08/06/2025 through 08/11/2025, Resident #1 received 30 units of Lantus 100 unit/mL subcutaneously daily with no blood glucose monitoring. On 08/11/2025 at 1:30 p.m., Resident #1 experienced sleepiness and drooling. S7LPN did not obtain a blood glucose level on Resident #1. On 08/11/2025 at 3:34 p.m., S7LPN was alerted by Resident #1's family of a change in Resident #1's condition. S7LPN obtained an order to transfer Resident #1 to a local emergency department via ambulance. At 4:18 p.m., a paramedic obtained Resident #1's blood glucose level, which was 23 mg/dL. Resident #1 was administered 25 grams of intravenous Dextrose 50% and transferred to a local hospital where he was diagnosed with Hypoglycemia. The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the Lantus Pharmaceutical Insert with a revision date of 05/2019 revealed the following, in part:Warnings and Precautions:5.2 Hyperglycemia or Hypoglycemia with Changes in Insulin RegimenChanges in insulin strength, manufacturer, type, or method of administration may affect glycemic control and predispose to hypoglycemia or hyperglycemia. These changes should be made cautiously and only under close medical supervision, and the frequency of blood glucose monitoring should be increased.5.3 HypoglycemiaHypoglycemia is the most common adverse reaction associated with insulin, including Lantus. Severe Hypoglycemia can cause seizures, may be life-threatening or cause death. Review of the facility's Clinical Data Coordinator Job Description dated 2025 revealed the following, in part:Area of Supervision: Chart organization and physician order review.Job Summary: The Clinical Data Coordinator maintains record keeping according to the policies and procedures established for the nursing facility to comply with all regulations, bot state, federal, and other. This position also maintains information including accurate physician orders within the Electronic Medical Record and on the resident's physical medical record chart per regulations. Resident #1Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Review of Resident #1's admission MDS with an ARD of 08/11/2025 revealed a BIMS of 5, which indicated severe cognitive impairment. Review of Resident #1's Baseline Care Plan dated 08/06/2025 revealed, in part, services and treatment to include Diabetic monitoring. Review of Resident #1's Discharge Medication Reconciliation Order Report from a local hospital dated 08/05/2025 revealed, in part, to take Lantus 100 unit/mL 5 units subcutaneously daily and discontinue blood glucose test. Review of Resident #1's electronic Physician Orders revealed an order entry by S4LPN on 08/05/2025 to start on 08/06/2025 for Lantus 100 unit/mL inject 30 units subcutaneously daily. Further review revealed no order for blood glucose monitoring. Review of Resident #1's MAR dated August 2025 revealed 30 units of Lantus 100 unit/mL was administered daily from 08/06/2025 through 08/11/2025. Further review of the MAR revealed no documented blood glucose levels. Review of Resident #1's Nurses' Notes dated 08/11/2025 revealed the following, in part:At 1:30 p.m. by S7LPN: Certified Nursing Assistant reported to me that resident wasn't his normal self, not talkative as usual, went to the room and assessed the patient, vitals were Blood Pressure 136/71, Pulse 81, Temperature 97.6, Oxygen saturation 95% on room air, responding, no further concerns as of present, plan of care ongoing. Further review revealed no documentation a blood glucose level was obtained.At 3:34 p.m. by S7LPN: Resident #1's family came to the nurses' station asking for assistance to resident's room. Nurse went to the resident's room. Resident was lethargic and drooling. Nurse Practitioner and Registered Nurse notified. Called a local ambulance company to send resident to the hospital. Further</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure a resident was free from a significant medication error by failing to transcribe the accurate insulin order in the electronic medical record for 1 (#1) of 3 (#1, #2, and #3) residents reviewed receiving insulin. This deficient practice resulted in an immediate jeopardy situation on the morning of 08/06/2025 when Resident #1, a Diabetic resident, began receiving the incorrect dose of Lantus 100 unit/mL insulin. Resident #1 admitted to the facility from a local hospital on [DATE] with an order for Lantus 100 unit/mL inject 5 units subcutaneously daily. S4LPN transcribed the order into Resident #1's electronic medical record as Lantus 100 unit/mL inject 30 units subcutaneously daily. From 08/06/2025 through 08/11/2025, Resident #1 received 30 units of Lantus 100 unit/mL subcutaneously daily. On the afternoon of 08/11/2025, Resident #1 experienced a hypoglycemic episode, with a blood glucose level of 23 mg/dL. Resident #1 was administered 25 grams intravenous dextrose 50% and transferred to a local hospital where he was diagnosed with Hypoglycemia. The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the Lantus Pharmaceutical Insert with a revision date of 05/2019 revealed the following, in part: Warnings and Precautions: 5.2 Hyperglycemia or Hypoglycemia with Changes in Insulin Regimen Changes in insulin strength, manufacturer, type, or method of administration may affect glycemic control and predispose to hypoglycemia or hyperglycemia. These changes should be made cautiously and only under close medical supervision, and the frequency of blood glucose monitoring should be increased. 5.3 Hypoglycemia Hypoglycemia is the most common adverse reaction associated with insulin, including Lantus. Severe Hypoglycemia can cause seizures, may be life-threatening or cause death. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Review of Resident #1's Discharge Medication Reconciliation Order Report from a local hospital dated 08/05/2025 revealed, in part, to take Lantus 100 unit/mL 5 units subcutaneously daily. Review of Resident #1's electronic Physician Orders revealed an order entry by S4LPN on 08/05/2025 to start on 08/06/2025 for Lantus 100 unit/mL inject 30 units subcutaneously daily. Review of Resident #1's MAR dated August 2025 revealed 30 units of Lantus 100 unit/mL was administered in the morning on the following dates by the following nurses: 08/06/2025 by S5LPN, 08/07/2025 by S6LPN, 08/08/2025 by S6LPN, 08/09/2025 by S5LPN, 08/10/2025 by S5LPN, and 08/11/2025 by S5LPN. Review of Resident #1's Nurses' Notes dated 08/11/2025 revealed the following, in part: At 3:34 p.m., Resident #1's family came to the nurses' station asking for assistance to resident's room. Nurse went to the resident's room. Resident was lethargic and drooling. S2NP and Registered Nurse notified. Called a local ambulance company to send resident to the hospital. At 4:46 p.m., resident was leaving the building via ambulance to a local hospital. Review of Resident #1's Ambulance Record dated 08/11/2025 revealed the following, in part: Vitals: At 4:18 p.m. - blood glucose level 23 Treatments/Medications: 4:33 p.m. - Medication: 25 grams intravenous dextrose 50% administered 4:41 p.m. - Treatment - Assessment: returned to baseline Glasgow Coma Scale after intravenous Dextrose given Narrative: Arrival: Contact was made in resident's room at a local nursing home. Resident was lying semi-Fowler in his bed and was ill-appearing with poor responsiveness. After obtaining a blood glucose reading of 23, I established intravenous access and administered intravenous Dextrose. Resident rapidly returned to baseline mental status before being moved onto stretcher to be secured for transport. Assessment: Glasgow Coma Scale 9 at contact, with resident requiring painful stimuli to evoke a response. Resident responded to pain with incoherent sounds and withdrawal from painful stimuli. Resident's blood glucose, assessed on EMS glucometer under standing order for altered mental status, reads 23. Resident's Glasgow Coma Scale improved rapidly from 9 to 15 shortly after administering intravenous Dextrose 50%. Review of Resident #1's Hospital Paperwork from a local hospital dated 08/11/2025 revealed the following, in part: Triage Complaint: Hypoglycemia History and Physical: This patient is a resident of a local nursing home and had an altered mental status earlier this afternoon. The Emergency Medical Services personnel checked his blood glucose level, and after giving him 50% Dextrose his Glasgow Coma Scale went up to 15. Diagnosis: Hypoglycemia due to Diabetes Mellitus Type 2 An interview was conducted with S4LPN on 09/03/2025 at 3:05 p.m. She confirmed she transcribed Resident #1's hospital discharge orders into the electronic medical record on 08/05/2025. She confirmed Resident #1's insulin order should have been</p>		