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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195623 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/11/2024 |
| NAME OF PROVIDER OR SUPPLIER Northwest Louisiana Veterans Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 3130 Arthur Ray Teague Parkway Bossier City, LA 71112 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on record review and interview the facility failed to ensure a Physician/Nurse Practitioner (NP) or Resident Representative was notified after a resident had an in-house code and was transferred to the emergency room (ER) for 1 (Resident #1) of 3 (Resident #1, #2, and #3) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's LDVA (Louisiana Department of Veteran Affairs) Veteran and Resident Manual dated 10/07/2022 revealed in part:</p> <p>I. Notification of changes:</p> <p>i. facility management must immediately inform the veteran's/resident's legal representative or an interested family member when there is:</p> <p>b. a significant change in the veteran's/resident's physical, mental, or psychosocial status (e.g. (for example), a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>d. a decision to transfer or discharge the veteran/resident from the facility.</p> <p>Review of Resident #1's Medical Record revealed an admitted [DATE] with the following diagnoses, in part: acute respiratory failure with hypoxia, type 2 diabetes, major depressive disorder, anxiety disorder, pancreatic mass, and other pulmonary embolism.</p> <p>Review of Resident #1's Medical Record failed to reveal a Physician/NP or Resident Representative had been notified of Resident #1's in-house code and transfer toER on [DATE].</p> <p>During a telephone interview on 04/09/2024 at 2:00 p.m., Resident #1's Representative reported family was not notified Resident #1 coded and was sent toER on [DATE].</p> <p>During an interview on 04/09/2024 at 4:45 p.m., S3ADON (Assistant Director of Nursing), acknowledged the facility had not notified Resident #1's Representative of the code and transfer to ER and should have.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 04/11/2024 at 8:00 a.m., S2DON (Director of Nursing) verified documentation of notification of change could not be located in Resident #1's Medical Record. S2DON acknowledged Resident #1's Representative and Physician/NP should have been notified.</p> <p>During an interview on 04/11/2024 at 9:00 a.m., S1Administrator acknowledged Resident #1's Representative or Physician had not been notified of the change in condition and should have been notified.</p> <p>During an interview on 04/11/2024 at 2:15 p.m., S5NP could not confirm she had been notified of Resident #1 having been transferred to theER on [DATE].</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on record reviews and interviews, the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure Nursing staff accurately documented glucose checks for 1 (Resident #1) of 3 (Resident #1, #2, and #3) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's Blood Glucose Monitoring policy with a revision date of 05/11/2023 revealed in part:</p> <p>I. Purpose: to provide a policy for accurate and timely monitoring of blood glucose levels.</p> <p>F. Blood Sugar Testing:</p> <p>Document results on the Medication Administration Record (MAR) .</p> <p>Review of Resident #1's Medical Record revealed an admitted [DATE] with the following diagnoses, in part: acute respiratory failure with hypoxia, type 2 diabetes, major depressive disorder, anxiety disorder, pancreatic mass, and other pulmonary embolism.</p> <p>Review of Resident #1's Physician orders revealed an order dated 01/23/2024, which read in part: Humulin R to house sliding scale bid (two times a day) - blood glucose finger stick:</p> <p>200 - 250 = 2 units; 251 - 300 = 4 units; 301- 350 = 6 units; 351- 400 = 9 units .</p> <p>Review of Resident #1's MAR failed to reveal documentation of Resident #1's blood glucose levels ordered for 01/24/2024 at 4:00 p.m. and 01/25/2024 at 6:00 a.m.</p> <p>Review of Resident #1's Medical Record revealed a nurse's note by S3ADON (Assistant Director of Nursing) dated 01/25/2024 at 4:36 p.m., which read in part: S3ADON called to room for unresponsive resident (Resident #1). Respirations very shallow with agonal breathing and pulse very weak . Blood Sugar 404 .</p> <p>During an interview on 04/11/2024 at 2:15 p.m., S5NP (Nurse Practitioner) reported blood glucose levels should be documented on the resident's MAR each time the glucose is checked in order to track and trend a resident's blood sugar.</p> <p>During an interview on 04/11/2024 at 2:30 p.m., S2DON (Director of Nursing) confirmed she could not locate documentation of Resident #1's blood glucose levels ordered for 01/24/2024 at 4:00 p.m. and 01/25/2024 at 6:00 a.m. S2DON acknowledged blood sugar levels should be documented on the resident's MAR. S2DON confirmed if the blood sugar levels were not documented on the MAR there would be no way for the NP to evaluate Resident #1's blood sugars.</p> | | |