

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Northeast LA War Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 Highway 165 North Monroe, LA 71211	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for 1 (#3) of 3 (#3, #4, and #56) residents reviews for activities of daily living.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #3 was admitted to the facility on [DATE] with diagnoses including in part, acute metabolic encephalopathy, cerebral infarction, and psychosis and delusion.</p> <p>Review of the admission Minimum Data Set, dated dated [DATE] revealed resident #3 had a brief mental Score of 08 which indicated that resident #3 had moderate cognitive impairment with his daily decision making skills.</p> <p>Review of resident #1's record revealed care planning for bathing/hygiene deficit dated 01/03/2025. The approaches included in part, total care for resident #3. Shower/clean and check fingernails.</p> <p>On 03/03/25 09:50 a.m., an observation revealed resident #3 lying in bed. Further observation revealed a buildup of dirt and grime observed underneath the nail beds of both his hands.</p> <p>On 03/03/2025 at 11:30 a.m., an observation revealed resident #3 sitting up in bed eating his lunch meal. Further observation revealed a buildup of dirt and grime under the nail beds of both of his hands.</p> <p>03/03/2025 at 11:45 a.m., S2Director of Nursing was notified of the observations the buildup of dirt and grime underneath resident #3's nail beds. S2Director of Nursing observed the resident eating his lunch with the dirty fingernails. She confirmed that resident #3's fingernail beds needed cleaning.</p> <p>On 03/06/2025 at 11:30 a.m., S1Administrator was notified of the above findings.</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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to 1) ensure residents had a physician's order for bed rails, 2) obtain consent from the resident or resident's representative for bed rail use, and 3) assess residents for the risk of entrapment from bed rails prior to the installation of bed rails for 3 (#3, #4, and #56) of 3 (#3, #4, and #56) residents reviewed for bed rails.</p> <p>Findings:</p> <p>Resident #3</p> <p>Review of the medical record revealed resident #3 was admitted to the facility on [DATE] with diagnoses including, acute metabolic encephalopathy, cerebral infarction, psychosis and delusion.</p> <p>Review of the admission minimum data set (MDS) dated [DATE] revealed resident #3 had a brief interview of mental status (BIMS) score of 08 which indicated that resident #3 had moderate cognitive impairment with his daily decision making skills. Further review revealed that resident #3 was independent with rolling left and right, sit-to-lying, lying to sitting on the side of bed, supervision or touching with sit to stand, and chair/chair transfer.</p> <p>On 03/03/2025 at 11:18 a.m. and on 03/05/2025 at 9:50 a.m., observations revealed resident #3 was lying in bed with a 1/4 bed rail raised on the left side of the resident's bed. The observations also revealed a second 1/4 bed rail that was lowered on the right side. The lowered bed rail on the right side remained attached to the bed.</p> <p>Review of resident #3's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent by the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #3's bed.</p> <p>On 03/05/2025 at 1:25 p.m., S2Director of Nursing was notified of the above findings. She confirmed resident #3's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #3's bed.</p> <p>On 03/06/2025 at approximately 11:30 a.m., S1Administrator was notified of the findings related to the use of bed rails for resident #3.</p> <p>Resident #4</p> <p>Review of the medical record revealed resident #4 was admitted to the facility on [DATE] with diagnoses that included psychosis and delusion.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the admission Minimum Data Set, dated dated [DATE] revealed resident #4 had a BIMS score of 04 which indicated that resident #4 had severe cognitive impairment with her daily decision making skills. Further review revealed that resident #4 required assistance with activities of daily living.</p> <p>On 03/03/2025 at 9:35 a.m. and 03/05/2025 at 8:45 a.m., observations revealed resident #4 was in bed with 1/4 bed rails raised on both sides of the resident's bed. Further observation revealed the left bed was loose and wobbly.</p> <p>Review of resident #4's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #4's bed.</p> <p>On 03/05/2025 at 1:25 p.m., S2Director of Nursing was notified of the above findings. She confirmed resident #4's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #4's bed.</p> <p>On 03/06/2025 at approximately 11:30 a.m., S1Administrator was notified of the findings regarding resident #4.</p> <p>19121</p> <p>Resident #56</p> <p>Review of the medical record revealed resident #56 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus, depression, restless leg syndrome, insomnia, hypertension, heart failure, chronic kidney disease, history of falls, edema and Non Hodgkin's lymphoma.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed it had not been completed at this time, due to the resident being admitted on [DATE].</p> <p>On 03/05/2025 at 1:25 p.m., an observation revealed resident #56 lying in bed with a 1/4 bed rail raised on the left side of the resident's bed.</p> <p>Review of resident #56's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #56's bed.</p> <p>On 03/05/2025 at 1:15 p.m., S2DON was notified of the above findings. She confirmed resident #56's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, or an assessment for the risk of entrapment prior to installation of bed rails on resident #56's bed.</p> <p>On 03/06/2025 at approximately 11:30 a.m., S1Administrator was notified of the findings regarding resident #56.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of communicable diseases and infection by, 1) having dirty and expired items inside of the medication cart, 2) having nail clippers and employee personal belongings inside of the wound care cart, and 3) having non-medication items inside of the medication storage room.</p> <p>Findings:</p> <p>On [DATE] at 9:40 a.m., observation of the medication cart with S5Licensed Practical Nurse (LPN) revealed one large medication cup holding tray that had multiple areas of an old, dried, unknown crusty substance and particles scattered throughout the tray and one box that contained multiple individualized packages of Povidone-Iodine that expired on ,d+[DATE]. S5LPN confirmed the medication cup holding tray was dirty and needed to be cleaned and the expired packages of Povidone-Iodine should not have been stored inside of the medication cart and available for resident use.</p> <p>On [DATE] at 10:00 a.m., observation of the wound care cart with S3LPN revealed a box that contained one tube of Silver Sulfadiazine cream 1%, two tubes of Mupirocin ointment, one non-woven dressing, one piece of Dr. Scholl's Corn Cushion, and one large pair of nail clippers. The nail clippers were in direct contact with the items inside of the box. Further observation revealed a small Ziploc bag that contained multiple pieces of Halls cough drops and Jolly Ranchers hard candy. S3LPN confirmed the bag of cough drops and hard candy belonged to her (S3LPN).</p> <p>On [DATE] at 10:51 a.m., S2Director of Nursing (DON) was notified of the above findings regarding the observations of the medication and wound care carts. S2DON confirmed that expired items should not be stored inside of the medication cart and available for resident use. S2DON further confirmed the pair of nail clippers should not have been stored in direct contact with the wound care supplies and S3LPN should not have stored her personal belongings inside of the wound care cart due to cross contamination.</p> <p>On [DATE] at 9:45 a.m., an observation of the medication storage room with S4Licensed Practical Nurse (LPN) revealed there was one large tote bag that contained two boxes of insulin syringes, one large black swivel/rolling chair, one large Christmas Tree box, one medium sized box of artificial flowers, seven Christmas stockings, one 8.4 ounce of Scope mouth wash, one 5.7 ounce of Crest tooth paste, one large book titled Mutts Comic Art of [NAME], one door hanger, one large item grabber, one New Testament Bible, and two medium sized blue therapy type floor mats. S4LPN confirmed the items should not have stored inside of the medication storage room.</p> <p>On [DATE] at 10:20 a.m., S2Director of Nursing was notified of the above findings from the observation in the medication storage room. She confirmed the items should not have been stored inside of the medication storage room due to cross contamination.</p>		