

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Regency House of Alexandria		STREET ADDRESS, CITY, STATE, ZIP CODE  5131 Masonic Drive Alexandria, LA 71301	
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844</b></p> <p>Based on interview and record review the facility failed to ensure that each Resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, by failing to honor a resident's right to request an incontinent wipe.</p> <p>Findings:</p> <p>1. Review of a Facility Policy titled Federal Rights of Residents with an effective date of 04/08/2024 read in part .</p> <p>Purpose:</p> <p>All residents in long term care facilities have rights guaranteed to them under Federal and State law.</p> <p>Standard:</p> <p>(E) The resident has a right to be treated with respect and dignity, including.</p> <p>(e)(2) The right to retain and use personal possessions.</p> <p>(f)(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Review of Resident #13's medical record revealed an admitted [DATE], with diagnoses which included in part . Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Right Dominant Side, Major Depressive Disorder, Anxiety Disorder, and Irritable Bowel Syndrome with Diarrhea.</p> <p>Review of Resident #13's Quarterly MDS with an ARD of 11/20/2024, revealed a BIMS score of 14, indicating intact or mildly impaired cognition. Resident #13 was dependent for toileting hygiene, and required partial/moderate assistance with personal hygiene.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #13's Care Plan with a Target date of 05/21/2025, revealed in part .Resident #13 had an ADL self-care performance deficit related to limited mobility: CVA with Right Hemiparesis, and bilateral hands and legs contractures, with approaches that included: Extensive assist of one person with bathing, dressing, oral care, hair care, and nail care. Resident #13 had bladder and bowel incontinence, and a diagnosis of Irritable Bowel Syndrome, with approaches that included check every two hours and provide peri-care as needed.</p> <p>Interview on 02/11/2025 at 9:30 a.m. with S1 Administrator, revealed on 01/19/2025 she received a call from Resident #13's niece stating Resident #13 had called her upset because a CNA refused to give her an incontinent wipe. S1 Administrator revealed S7 CNA stated she had already cleaned Resident #13, and was not going to give her an incontinent wipe. S1 Administrator revealed she terminated S7 CNA because she refused to honor a request from Resident #13. S1 Administrator confirmed S7 CNA should have given Resident #13 the incontinent wipe when she asked for it.</p> <p>Telephone interview on 02/12/2025 at 12:46 p.m. with Resident #13's private sitter revealed she was sitting with Resident #13 on 01/19/2025 when S7 CNA told Resident #13 she was not going to give her an incontinent wipe. The private sitter revealed S7 CNA stated you can give her a wipe if you want to. The private sitter revealed Resident #13 often asked for an incontinent wipe because she didn't feel as if she was clean.</p> <p>Telephone interview on 02/12/2025 at 3:52 p.m. with S7 CNA revealed she provided care for Resident #13 on 01/19/2025 7:00 a.m. to 3:00 p.m. shift. S7 CNA revealed Resident #13 had a private sitter in the room. S7 CNA revealed she had cleaned Resident #13 when she asked for an incontinent wipe. S7 CNA revealed she did not give Resident #13 the incontinent wipe because she performed inappropriate behavior with it. S7 CNA confirmed she should have given Resident #13 the incontinent wipe.</p>		

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<p>F 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844</b></p> <p>Based on observation and interview the facility failed to ensure each resident was treated with respect and dignity for 1 (Resident # 205) out 19 sampled residents. The facility failed to ensure Resident #205 had adequate clothing.</p> <p>Findings:</p> <p>Review of Resident #205's medical record revealed an admitted [DATE], with diagnoses that included in part .Major Depressive Disorder, Type 2 Diabetes Mellitus, Acute Respiratory Failure, and Unspecified Protein Calorie Malnutrition.</p> <p>Review of Resident # 205's Admission MDS with an ARD of 01/18/2025, revealed a BIMS score of 15, which indicated intact cognition. The MDS revealed Resident #205 required supervision or touching assistance with upper body dressing, and partial/moderate assistance with lower body dressing.</p> <p>Review of Resident #205's Care Plan with no review date, revealed in part .</p> <ol style="list-style-type: none"> <li>1. Resident had an ADL self-care performance deficit related to impaired balance, with approaches that included staff to supervise/assist resident with ADL's as needed.</li> <li>2. Resident had a potential for cognitive decline due to Neurocognitive Disorder with Lewy Bodies, with approaches that included I will be provided with a homelike environment.</li> </ol> <p>Observation and interview on 02/10/2025 at 9:49 a.m., revealed Resident #205 had on a white t-shirt, a coat and a pair of blue jeans. Resident #205 revealed he had a pair of stretch pants (joggers) that he had sent to the laundry a week ago, and they had not been returned to him. Resident #205 revealed he told two different employees (couldn't remember their names), about the missing joggers, but had not heard anything back.</p> <p>Observation of Resident #205 on 02/11/2025 at 2:15 p.m. revealed he had on a white t-shirt, a coat and a pair of blue jeans.</p> <p>Observation and interview of Resident #205 on 02/12/2025 at 10:24 a.m., revealed he had on a white t-shirt, a coat and a pair of blue jeans. Resident #205 revealed he came to the facility from the hospital, and never got the chance to return home to retrieve any of his clothes or other belongings.</p> <p>Observation on 02/12/2025 at 10:33 a.m. of Resident #205's closet, revealed a pack of white t-shirts, socks, underwear and a coat. No other clothes were in Resident #205's closet. Resident #205 revealed he only had one pair of jeans that he had been wearing every day for a week. Resident #205 revealed the joggers were given to him by the facility, but laundry had not returned them. Resident #205 stated It made me feel really bad not to have clothes.</p> <p>Interview on 02/12/2025 at 10:51 with S13 LPN, revealed she provided care for Resident #205. S13 LPN revealed she was not aware of Resident #205 wearing the same pants every day for a week.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/12/2025 at 10:58 a.m. with S24 Admissions/Marketing/Acting SSD, revealed she was not aware of Resident #205 not having clothes (outwear).</p> <p>Interview on 02/12/2025 at 11:00 a.m. with S1 Administrator, revealed the facility did not currently have a Social Service Director, and S24 was the Acting SSD. S1 Administrator revealed she had purchased Resident #205 t-shirts, socks, and underwear. S1 Administrator revealed she had not purchased any other clothing items for Resident #205. S1 Administrator confirmed the facility should have assisted Resident #205 with obtaining clothes for outwear.</p>		

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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>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51503</p> <p>Based on interview and record review, the facility failed to promptly notify the physician and responsible party after a change in resident's condition for 1 (Resident #49) of 3 (Resident #49, Resident #13, and Resident #158) residents investigated for accidents. The facility failed to notify the physician and responsible party in a timely manner after an unwitnessed fall.</p> <p>Findings:</p> <p>Review of Resident #49's medical record revealed an admitted [DATE] with diagnoses that included in part . Vascular Dementia, Moderate, With Other Behavioral Disturbance, Non-St Elevation (Nstemi) Myocardial Infarction, Lack Of Coordination, Difficulty In Walking, and Need For Assistance With Personal Care .</p> <p>Review of Resident #49's Admission MDS with an ARD of 12/27/2024 revealed a BIMS score of 10, which indicated moderate cognitive impairment and no history of falls. Resident #49 was independent with rolling left to right, sit to lying, and lying to sitting. Resident #49 required set-up clean-up assist with chair/bed to chair transfer, with no wheelchair usage indicated.</p> <p>Review of Resident #49's nursing progress notes revealed in part .On 02/08/2025 at 3:11 p.m. S10 Medical Records LPN wrote .It was reported to me that resident fell . No injury noted at this time. Move all extremities. Resident sitting at nurses station .</p> <p>In an interview on 02/11/2025 at 9:11a.m., Resident #49's Son/RP, revealed that his father started falling after he was admitted to the facility. He did not have any falls at home. He stated S11 LPN called him on 02/09/2025 to inform him that his father had fallen on 02/08/2025 and the facility performed x-rays of his ribs.</p> <p>In an interview on 02/11/2025 at 10:50 a.m., S8 CNA stated she was scheduled 7:00 a.m. - 3:00 p.m. on 02/08/2025. S8 CNA was assigned to Resident #49 and was aware of Resident #49's fall on 02/08/2025. S8 CNA stated that on 02/08/2025 at about 3:00 p.m., she and S18 CNA were notified by the activity director that Resident #49 had fallen. S8 CNA stated when she and S18 CNA entered Resident #49's room he was sitting upright on the floor with his back/side against his wheelchair and feet out in front of him. S8 CNA stated she notified S10 Medical Records LPN of the fall and S10 Medical Records LPN came in to assess the resident. S8 CNA stated she and S18 CNA transferred him back into his wheelchair.</p> <p>(continued on next page)</p>		

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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>In an interview on 02/11/2025 at 11:45 a.m., S10 Medical Records LPN stated she worked 2:00 p.m.-10:00 p. m. on 02/08/2025 and was assigned to Resident #49. S10 Medical Records LPN stated she was alerted by S8 CNA that Resident #49 had fallen in his room at 3:00 p.m. on 02/08/2025. S10 Medical Records LPN stated she observed Resident #49 sitting upright with his back/side against the wheelchair in his room. S10 Medical Records LPN stated she completed a head-to-toe assessment, obtained his vital signs, and assessed for any injuries. S10 Medical Records LPN stated she did write a progress note regarding Resident #49's fall but failed to notify the physician/nurse practitioner and responsible party. S10 Medical Records LPN stated she knew she was supposed to notify the MD/NP and RP immediately of the resident's fall when it happened; she just did not because she had too much going on at that time. She confirmed that she should have taken the time to notify them to obtain new orders.</p> <p>In an interview on 02/11/2025 at 12:18 p.m., S2 DON revealed that the floor nurses have a certain processes to follow when a resident falls. S2 DON confirmed part of the fall/incident procedure does involve the floor nurse to notify the MD/NP and RP of the fall/incident on her shift. She would then document and obtain/carry-out any new orders. S2 DON stated all nurses know that if there is a fall/incident they should notify the MD/NP and RP on their shift. S2 DON confirmed that S10 Medical Records LPN should have notified the MD/NP and RP of resident #49's fall on her shift (2:00 p.m.-10:00 p.m.) to obtain any new orders and she failed to do so.</p> <p>In an interview on 02/12/2025 at 2:08 p.m., S2 DON confirmed that the Fall Incident Report that was completed by S10 Medical Records was back-dated to 02/08/2025. S2 DON stated the time of notification of the MD/NP and RP was completed on 02/09/2025 at 11:50 a.m. and the notification was performed by S11 LPN and not S10 Medical Records LPN.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>51096</p> <p>Based on observation, interview and record review, the facility failed to provide care and services that met professional standards of quality by failing to ensure medications were administered and accurately documented on the MAR for 1 (#44) of 4 sampled residents (#44,#155,#157,#159) observed during medication administration. The facility had a total census of 54 residents according to the Resident List Report provided by the facility.</p> <p>Findings:</p> <p>Review on 02/12/2025 of the facility's policy and procedure dated 09/01/2024, and titled Medication Administration read in part .</p> <p>Policy: Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice .</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>10. Ensure that the six rights of medication administration are followed:</p> <p>f. Right documentation</p> <p>11. Review MAR to identify medication to be administered.</p> <p>12. Compare medication source (bubble pack, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.</p> <p>23. Correct any discrepancies and report to nurse manager.</p> <p>Observation of Medication Administration on 02/11/2025 at 9:30 a.m. revealed S13 LPN punched out 1 tablet of Aspirin 81mg, 1 tablet of Vitamin D 50 mcg, 1 tablet of Iron 324mg, 1 tablet of Tamsulosin 0.4mg, 1 tablet of Furosemide 40mg, 1 tablet of Hydralazine 50mg, 1 tablet of Calcitriol 0.25mcg, 1 tablet of Carvedilol 6.25mg, 1 tablet of Clopidogrel 75mg, 1 tablet of Clonidine 0.2mg, 1 tablet of Finasteride 5mg, 1 tablet of Nifedipine 60mg, and 2 tablets of Sertraline 100mg and placed them in a medication cup. S13 LPN confirmed with this surveyor a total of 14 pills were administered to Resident #44.</p> <p>Review of Resident #44's February 2025 MAR revealed that on 02/11/2025 for 8:00 a.m. medication administration he received these PO medications as follows: Aspirin 81mg,Calcitriol 0.25mcg, Cholecalciferol 50mcg, Clopidogrel 75mg, Cyanocobalamin 1000mcg, Finasteride 5mg, Furosemide 40mg, Sertraline 200mg, Tamsulosin 0.4mg, Carvedilol 6.25mg, Clonidine 0.2mg, Ferrous Gluconate 324mg, Nifedipine 60mg, Sacubitril-Valsartan 49-51mg, Sodium Bicarbonate 650mg, and Hydralazine 50mg. Resident #44's MAR revealed Bactrim DS 800/160mg with a start date of 02/10/2025 was also to be administered with the 8:00 a.m. medications, but there was a (9) coded for see other/progress notes. This was a total of 18 pills to be administered.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Telephone interview on 02/12/2025 at 4:10 p.m. with S13 LPN confirmed that only 14 pills were administered to Resident #44 during the morning medication administration. S13 LPN revealed that she did not administer any other PO medications to Resident #44 scheduled for 02/11/2025 morning medication administration before or after this Surveyor observed Resident #44's morning medication administration. S13 LPN revealed that she did not administer the Bactrim DS 800/160mg, Sacubitril-Valsartan 49-51mg or Sodium Bicarbonate 650mg tablets due to them not being available. S13 LPN revealed that she did not administer the Cyanocobalamin because she forgot to pull it from the cart. S13 LPN confirmed that she did document the medications as administered but meant to go back and strike them out but there was a lot going on.</p> <p>Review of Resident #44's progress notes revealed a note dated 02/11/2025 at 9:35 a.m. that read in part . Bactrim DS Oral Tablet 800-160 mg; give 1 tablet by mouth two times a day for Abscess to buttocks for 7 days; Medication Unavailable. Authored by: S13 LPN.</p> <p>Observation of the Team 2 medication cart on 02/12/2025 at 4:26 p.m. with S12 LPN revealed Sodium Bicarbonate 650mg was on the cart in the over the counter medication area with an open date of 12/30/2024, Resident #44's Bactrim DS Oral Tablet 800-160 mg tablet blister card was on the cart with two pills removed. S12 LPN confirmed that he administered one Bactrim tablet on 02/10/2025 during Resident #44's night medication administration and one on 02/11/2025 during Resident #44's night medication administration. Resident #44's Sacubitril-Valsartan was not on the cart at all.</p> <p>Review of Resident #44's MAR and Bactrim DS Oral Tablet 800-160mg tablet blister medication card with a start date of 02/10/2025(8:00p.m.) on 02/12/2025 revealed three documented administrations 02/10/2025 at 8:00 p.m., 02/11/2025 at 8:00 p.m. and 02/12/2025 at 8:00 a.m. with only two pills removed from the blister pack.</p> <p>Interview on 02/12/2025 at 4:31 p.m. with S2 DON confirmed that Resident #44's Bactrim DS 800-160mg tablet, Sodium Bicarbonate 650mg, and Cyanocobalamin 1000mcg were on the medication cart and should have been administered according to the Resident #44's physician's orders but had not.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51096</p> <p>Based on observation, interview and record review, the facility failed to ensure that services provided or arranged in accordance with the resident's plan of care are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required. The facility failed to ensure that S6 CNA did not apply Zinc Oxide cream to Resident #206's stage 3 Sacral pressure sore.</p> <p>Findings:</p> <p>Review of Resident #206's clinical record revealed an admitted [DATE], with diagnoses that included Acquired Absence of Left Leg Below Knee; and Encounter for Change or Removal of Surgical Wound Dressing</p> <p>Review of Resident #206's Admission MDS with an ARD of 02/12/2025, revealed a BIMS of 15, which indicated Resident #206 was cognitively intact. Resident #206 used a wheelchair as a mobility device, and required supervision or touching assistance with eating, oral hygiene, and personal hygiene; substantial/maximal assistance with toileting, lower body dressing, putting on/taking off footwear; showering/bathing; and partial/moderate assistance with upper body dressing.</p> <p>Review of Resident #206's Care Plan revealed in part I have a Stage 3 pressure ulcer to my sacrum. Interventions to include . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Monitor/document/report PRN any changes in my skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage.</p> <p>Review of Resident #206's February 2025 Physician's Orders revealed in part . Cleanse stage 3 to sacrum with wound cleanser, pat dry, apply zinc oxide BID and PRN until healed.</p> <p>Observation on 02/10/2025 at 9:39 a.m. revealed Resident #206 in bed waiting for his diaper to be changed. Two plastic clear medicine cups, one with a yellow cream substance, and the other with a white cream substance with Resident #206's room number written on them, were observed on the nightstand in Resident #206's room.</p> <p>Observation and Interview with S13 LPN on 02/10/2025 at 10:55 a.m., confirmed that the creams in the two medication cups should not be in Resident #206's room. Resident #206 stated that the creams were applied to his bottom during his diaper change.</p> <p>Interview with S6 CNA on 02/10/2025 at 11:07 a.m., confirmed that she applied the two creams to Resident #206's bottom area during toileting care.</p> <p>Interview with S16 ADMIN RN on 02/11/2025 at 10:46 a.m., revealed that the yellow cream in the medicine cup was moisture barrier, and the white cream was Zinc. S16 ADMIN RN revealed Resident #206's wound was not covered with a dressing due to the physician not wanting the area to retain moisture.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082</b></p> <p>Based on observation, interview and record review the facility failed to provide respiratory care consistent with professional standards for 1 (Resident #156) of 2 (Resident #13 and Resident #156) sampled residents reviewed for respiratory care. The facility failed to ensure equipment was properly labeled and stored. Total sample size was 18.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Oxygen Concentrator, dated 12/31/2024 read in part .</p> <p>C. Nurse responsibilities: 1. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.</p> <p>Review of Resident #156's medical record revealed an admitted [DATE] with a re-entry date of 02/05/2025 with diagnoses that included in part .Acute and Chronic Respiratory Failure, Unspecified whether with Hypoxia or Hypercapnia; Chronic Systolic (Congestive) Heart Failure; Depression. Anxiety Disorder; Dependence on other Enabling Machines and Devices; Respiratory Disorders in Diseases.</p> <p>Review of Resident #156's 02/2025 Physician orders revealed the following orders in part .Change O2 (Oxygen) mask/nasal cannula and tubing every night shift every Wednesday and as needed.</p> <p>Review of Resident #156's Admission MDS with an ARD of 04/27/2025 revealed a BIMS summary score of 14 indicating intact cognition. Resident #156 required oxygen therapy.</p> <p>Observation on 02/10/2025 at 11:15 a.m. revealed Resident #156 lying in bed awake and alert with nasal cannula present in nares. Resident #156 stated she required continuous oxygen administration at 3 liters/minute. Oxygen tubing observed with a date of 01/29/2025.</p> <p>Observation on 02/11/2025 at 8:30 a.m. revealed Resident #156 lying in bed asleep wearing a nasal cannula with oxygen flowing at 3 liters/minute. Oxygen tubing observed with a date of 01/29/2025.</p> <p>Interview on 02/11/2025 at 8:32 a.m. with S9 LPN revealed Resident #156 wore oxygen continuously and all nurses were responsible for changing oxygen tubing. Observation with S9 LPN confirmed Resident #156's oxygen tubing had a date of 01/29/2025 and should be changed but had not been.</p>		

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NAME OF PROVIDER OR SUPPLIER  Regency House of Alexandria		STREET ADDRESS, CITY, STATE, ZIP CODE  5131 Masonic Drive Alexandria, LA 71301	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51096</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services to ensure procedures that assure acquiring, receiving, dispensing and administration of a non-controlled medication (Sacubitril-Valsartan) to meet the needs of the resident for 1 (Resident #44) of 4 sampled residents (#44, #155,#157 and #159) observed during medication administration. The facility had a total census of 54 residents according to the Resident List Report provided by the facility.</p> <p>Findings:</p> <p>Review on 02/12/2025 of the facility's policy titled Medication Ordering and Receiving from Pharmacy Provider, Section 3.2: Ordering and Receiving Non-Controlled Medications dated 01/2023 read in part .</p> <p>Policy: Medications and related products are received from the provider pharmacy on a timely basis.</p> <p>Procedures: Ordering medications from provider pharmacy:</p> <p>Timely delivery of new orders is required so that medication administration is not delayed.</p> <p>2. Receiving medications from the pharmacy:</p> <p>a. A licensed nurse or appropriate personnel as required by law</p> <p>Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/ supervisor.</p> <p>Retains a copy of the delivery receipt for an appropriate time to reconcile any ordering issues.</p> <p>Observation of Medication Administration on 02/11/2025 at 9:30 a.m. revealed S13 LPN punched out 1 tablet of Aspirin 81mg, 1 tablet of Vitamin D 50 mcg, 1 tablet of Iron 324mg, 1 tablet of Tamsulosin 0.4mg, 1 tablet of Furosemide 40mg, 1 tablet of Hydralazine 50mg, 1 tablet of Calcitriol 0.25mcg, 1 tablet of Carvedilol 6.25mg, 1 tablet of Clopidogrel 75mg, 1 tablet of Clonidine 0.2mg, 1 tablet of Finasteride 5mg, 1 tablet of Nifedipine 60mg, and 2 tablets of Sertraline 100mg and placed them in a medication cup. S13 LPN confirmed with this surveyor a total of 14 pills were administered to Resident #44.</p> <p>Review of Resident #44's February 2025 Physician Orders revealed an active order for Sacubitril-Valsartan Oral Table 49-51mg, Give 1 tablet by mouth two times a day for CHF (Congestive Heart Failure), with a start date of 09/26/2024.</p> <p>Review of Resident #44's February 2025 MAR revealed that on 02/11/2025 for 8:00 a.m. medication administration he was administered Sacubitril-Valsartan 49-51mg documented by S13 LPN.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Telephone interview on 02/12/2025 at 4:10 p.m. with S13 LPN confirmed that only 14 pills were administered to Resident #44 during the morning medication administration. S13 LPN revealed that she did not administer any other PO medications to Resident #44 scheduled for 02/11/2025 8:00 a.m. medication administration before or after this Surveyor observed Resident #44's morning medication administration. S13 LPN revealed that she did not administer the Sacubitril-Valsartan 49-51mg tablet because it was not available. S13 LPN confirmed that she did document the medication as administered but meant to go back and strike it out but did not.</p> <p>Observation of the Team 2 medication cart on 02/12/2025 at 4:26 p.m. with S12 LPN revealed Resident #44's Sacubitril-Valsartan blister card was not on the cart at all. S12 LPN was not able to recall when he last administered the medication to Resident #44.</p> <p>Interview on 02/12/2025 at 4:31 p.m. with S2 DON revealed nurses are to look in the resident's cubby in the medication storage room first, then check the Pixus for any medication that is ordered to be administered and is not on the medication cart. The nurse is then to report to Nursing Administration staff that the medication is out. S2 DON confirmed that Resident #44's Sacubitril-Valsartan 49-51mg blister pack was not on the medication cart.</p> <p>Observation of the Medication storage room on 02/12/2025 at 4:35 p.m. with S2 DON and S17 Corporate Nurse confirmed Resident #44's Sacubitril Valsartan 49-51mg blister pack was not in his cubby or in the Pixus.</p> <p>Review of the facility's Drug Record Book with a Supply Date Range: Orders from 01/01/2025-02/28/2025 revealed the facility last received a quantity of 28 tablets which is a 2 week supply of Sacubitril-Valsartan for Resident #44 on 01/20/2025.</p> <p>Interview on 02/12/2025 at 5:12 p.m. with S16 ADMIN RN and S17 Corporate Nurse revealed that there was an order created for the Sacubitril-Valsartan for Resident #44 on 01/30/2025 but was not released due to Insurance denial. S16 ADMIN RN confirmed that Resident #44 would have run out of this medication by 02/03/2025 even though it was still being documented as administered by nursing staff.</p> <p>Interview on 02/12/2025 at 5:42 p.m. with S16 ADMIN RN revealed that all nurses are responsible for ordering resident medications. S16 ADMIN RN stated medications are usually ordered by the night nurse when a medication runs low. The night nurse then reconciles all medications received from pharmacy via a pharmacy delivery manifest. S16 ADMIN RN confirmed that there was no further follow-up for Resident #44's missing Sacubitril-Valsartan and should have been.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>51096</p> <p>Based on observation, interview and record review the facility failed to ensure their medication error rate was not 5 percent or greater. The facility had 4 medication errors (11.76%) out of 34 opportunities for errors observed. The facility had a total census of 54 residents according to the Resident List Report provided by the facility.</p> <p>Findings</p> <p>Review on 02/12/2025 of the facility's policy and procedure dated 09/01/2024, and titled Medication Administration read in part .</p> <p>Policy: Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice .</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>10. Ensure that the six rights of medication administration are followed:</p> <p>f. Right documentation</p> <p>11. Review MAR to identify medication to be administered.</p> <p>12. Compare medication source (bubble pack, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.</p> <p>23. Correct any discrepancies and report to nurse manager.</p> <p>Observation of Medication Administration on 02/11/2025 at 9:30 a.m. revealed S13 LPN punched out 1 tablet of Aspirin 81mg, 1 tablet of Vitamin D 50 mcg, 1 tablet of Iron 324mg, 1 tablet of Tamsulosin 0.4mg, 1 tablet of Furosemide 40mg, 1 tablet of Hydralazine 50mg, 1 tablet of Calcitriol 0.25mcg, 1 tablet of Carvedilol 6.25mg, 1 tablet of Clopidogrel 75mg, 1 tablet of Clonidine 0.2mg, 1 tablet of Finasteride 5mg, 1 tablet of Nifedipine 60mg, and 2 tablets of Sertraline 100mg and placed them in a medication cup. S13 LPN confirmed with this surveyor a total of 14 pills were administered to Resident #44.</p> <p>Review of Resident #44's February 2025 MAR revealed that on 02/11/2025 for 8:00 a.m. medication administration: Aspirin 81mg, Calcitriol 0.25mcg, Cholecalciferol 50mcg, Clopidogrel 75mg, Cyanocobalamin 1000mcg, Finasteride 5mg, Furosemide 40mg, Sertraline 200mg, Tamsulosin 0.4mg, Carvedilol 6.25mg, Clonidine 0.2mg, Ferrous Gluconate 324mg, Nifedipine 60mg, Sacubitril-Valsartan 49-51mg, Sodium Bicarbonate 650mg, and Hydralazine 50mg was documented as administered by mouth. Resident #44's MAR revealed Bactrim DS 800/160mg with a start date of 02/10/2025 was also to be administered with the 8:00 a.m. medications, with a (9) coded for see other/progress notes. This was a total of 18 pills to be administered.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Telephone interview on 02/12/2025 at 4:10 p.m. with S13 LPN confirmed that only 14 pills were administered to Resident #44 during the morning medication administration. S13 LPN revealed that she did not administer any other oral medications to Resident #44 scheduled for 02/11/2025 morning medication administration before or after this Surveyor observed Resident #44's morning medication administration. S13 LPN revealed that she did not administer the Bactrim DS 800/160mg, Sacubitril-Valsartan 49-51mg or Sodium Bicarbonate 650mg tablets due to the medications not being available. S13 LPN revealed that she did not administer the Cyanocobalamin because she forgot to pull it from the cart. S13 LPN confirmed that she did document the medications as administered but meant to go back and strike them out but did not.</p> <p>Review of Resident #44's progress notes revealed a note dated 02/11/2025 at 9:35 a.m. that read in part . Bactrim DS Oral Tablet 800-160 mg; give 1 tablet by mouth two times a day for Abscess to buttocks for 7 days; Medication Unavailable. Authored by: S13 LPN.</p> <p>Observation of the Team 2 medication cart on 02/12/2025 at 4:26 p.m. with S12 LPN revealed Sodium Bicarbonate 650mg was on the cart in the over the counter medication area with an open date of 12/30/2024. Resident #44's Bactrim DS Oral Tablet 800-160 mg tablet blister card was on the cart with two pills removed. S12 LPN confirmed that he administered one Bactrim tablet on 02/10/2025 during Resident #44's night medication administration and one on 02/11/2025 during Resident #44's night medication administration. Resident #44's Sacubitril-Valsartan blister pack was not on the cart at all.</p> <p>Review of Resident #44's MAR revealed Bactrim DS Oral tablet with a start date of 02/10/2025 at 8:00 p.m. and three documented administrations: 02/10/2025 at 8:00 p.m., 02/11/2025 at 8:00 p.m. and 02/12/2025 at 8:00 a.m.</p> <p>Review of Resident #44's Bactrim DS Oral Tablet 800-160mg tablet blister pack with a start date of 02/10/2025 revealed only two pills were removed from the blister pack.</p> <p>Interview on 02/12/2025 at 4:31 p.m. with S2 DON confirmed that Resident #44's Bactrim DS 800-160mg tablet, Sodium Bicarbonate 650mg, and Cyanocobalamin 1000 mcg were on the medication cart and should have been administered according to Resident #44's physician's orders. S2 DON confirmed Resident #44's Sacubitril-Valsartan tablets were not on the cart, in the medication storage room cubby or in the Pixus. S2 DON confirmed that if the medications had not been given by the nurse, the medications should not have been documented as administered but had been.</p> <p>Interview on 02/12/2025 at 5:12 p.m. with S16 ADMIN RN confirmed Resident #44 would have run out of the Sacubitril-Valsartan tablets by 02/03/2025 even though it was still being documented as administered by nursing staff and should not have been.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51503</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in a secure manner by failing to ensure medications were not left at the bedside for 1 (Resident #25) of 19 sampled residents.</p> <p>Findings:</p> <p>Review of a facility policy on 02/11/2025 at 1:39 p.m. titled, Medication Storage (unknown original date) with a revised date of 09/01/2024, revealed the following part .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .1. A. All drugs and biologicals will be stored in locked compartments (medication carts) .</p> <p>Review of Resident #25's medical record revealed an admitted [DATE], with diagnoses that included in part . Pressure Ulcer of Sacral Region, Stage 4, Peripheral Vascular Disease, Bipolar Disorder, Schizoaffective Disorder, Bipolar Type, and Need for Assistance with Personal Care .</p> <p>Review of Resident #25's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 02/06/2025 revealed a BIMS (Brief Interview for Mental Status) score of 11, which indicated moderate cognitive impairment. Resident #25 required dependence/total care for bed mobility (roll left/right), transfer (tub/shower), and toileting hygiene.</p> <p>Review of Resident #25's current clinical physician orders revealed no orders for Zinc Oxide ointment or Nystatin powder.</p> <p>Review of Resident #25's discontinued/completed clinical physician orders revealed the following:</p> <ol style="list-style-type: none"> <li>1. A discontinued order for Zinc Oxide External Paste 20 % (Zinc Oxide (Topical)) Apply to decubitus wound buttock topically two times a day for decubitus wound care apply after Mupirocin with a start date of 07/31/2023 and a discontinued date of 08/04/2023.</li> <li>2. A completed order for Nystatin Powder (Nystatin (Bulk)) Apply to bilateral groin and peri-area topically two times a day for fungal dermatitis for 7 Days with a start date of 12/22/2024 and a discontinued date of 12/29/2024.</li> </ol> <p>Observation on 02/10/2025 at 9:30 a.m. revealed 1 tube of Zinc Oxide ointment and 1 bottle of Nystatin powder on Resident #25's bedside dresser drawer. Both medications observed unsecure and unattended on the resident's bedside dresser drawer.</p> <p>(continued on next page)</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>On 02/10/2025 at 9:35 a.m., in an interview and observation with S9 LPN, S9 LPN confirmed that Resident #25 had 1 tube of Zinc Oxide ointment and 1 bottle of Nystatin powder left at the bedside unattended. S9 LPN stated the Zinc Oxide ointment and Nystatin powder should not have been left at the resident's bedside unattended. S9 LPN confirmed that all medications (including ointments and powders) should be secured and locked on the medication cart when not in use.</p> <p>Further review of the record revealed there was no physician's order to allow Resident #25 to keep any medications in the room at the bedside and there was no assessment to determine if Resident #25 was safe to have the medications in the room at the bedside to self-administer.</p> <p>On 02/11/2025 at 10:05 a.m., S2 DON revealed in an interview that Resident #25 had previous orders for Nystatin Powder that were completed on 12/29/2024 and previous Zinc Oxide ointment orders that were discontinued on 08/04/2023. S2 DON confirmed that Resident #25 does not self-administer his medications and the tube of Zinc Oxide ointment and bottle of Nystatin powder should have been disposed of properly. S2 DON confirmed that Resident #25 should not have medications left at the bedside unattended and all medications should be stored and locked in the medication cart when not in use.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>44844</p> <p>Based on observation and interviews the facility failed to ensure garbage and refuse were disposed of properly.</p> <p>Findings:</p> <p>Review of a Facility Policy on 02/12/2025, titled Disposal of Garbage and Refuse with a review/revision date of 09/01/2024 read in part .</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding areas shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.</p> <p>Observation and interview on 02/11/2025 at 8:30 a.m., of the area outside of the facility's kitchen revealed one blue dumpster. Dirty gloves and debris (old cardboard boxes), littered the ground surrounding the dumpster. S22 Dietary Manager confirmed the findings at the time of observation.</p> <p>Interview on 02/11/2025 at 8:33 a.m. with S23 Maintenance Director, revealed the trash was left by the sanitation employees.</p> <p>Interview on 02/12/2025 at 12:20 p.m. with S1 Administrator revealed S23 Maintenance Director was responsible for ensuring debris was picked up around the dumpster.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51096</p> <p>Based on observation, record review, and interview the facility failed to follow infection control practices to prevent the development and transmission of infection. The facility failed to: (1) Implement Enhanced Barrier Precautions for Resident #206. (2) Ensure staff wore proper PPE while providing incontinent care to Resident #155. (3) Ensure that the facility's water management system was tested for Legionella.</p> <p>Findings:</p> <p>Review on 02/11/2025 of the facility's policy and procedure dated 09/01/2024, and titled Enhanced Barrier Precautions read in part .</p> <p>Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. Prompt recognition of need:</p> <p>a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.</p> <p>b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions.</p> <p>2. Initiation of Enhanced Barrier Precautions:</p> <p>b. An order for enhanced barrier precautions will be obtained for residents with any of the following:</p> <p>i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds .) and/ or indwelling medical devices (PICC lines) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>3. Implementation of Enhanced Barrier Precautions:</p> <p>a. Make gowns and gloves available near or outside of the resident's room.</p> <p>4. High-contact resident care activities include:</p> <p>d. Providing hygiene</p> <p>10. Enhanced Barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound .</p> <p>(continued on next page)</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>Table 1: Implementing Contact versus Enhanced Barrier Precautions</p> <p>Resident Status:</p> <p>Has a wound . and secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with an MDRO. - Use EBP: Yes, if they do not meet the criteria for contact precautions.</p> <p>Has a wound . without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with an MDRO. - Use EBP: Yes</p> <p>Examples of secretions or excretions include diarrhea . or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen.</p> <p>Resident #206</p> <p>Review of Resident #206's clinical record revealed an admitted [DATE], with diagnoses which included Elevated [NAME] Blood Cell Count, Type II Diabetes; Cerebral Infarction; Acquired Absence of Left Leg Below Knee; and Encounter for Change or Removal of Surgical Wound Dressing.</p> <p>Review of Resident #206's Admission MDS with an ARD of 02/12/2025 revealed a BIMS of 15, which indicated the resident was cognitively intact. Resident used a wheelchair as a mobility device. Resident required supervision or touching assistance with eating, oral hygiene, and personal hygiene; substantial/maximal assistance with toileting, lower body dressing, putting on/taking off footwear; showering/bathing; and partial/moderate assistance with upper body dressing.</p> <p>Review of Resident #206's Care Plan revealed in part I have a Stage 3 pressure ulcer to my sacrum. Interventions included . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Monitor/document/report PRN any changes in my skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage. I have a diabetic ulcer of my right heel. Interventions included . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.</p> <p>Review of Resident #206's 02/2025 Physician's Orders revealed no order for Enhanced Barrier Precautions.</p> <p>Interview with Resident #206 on 02/10/2025 at 9:39 a.m. revealed he recently had a leg amputation a week and a half ago.</p> <p>Observation of Resident #206 in bed on 02/10/2025 at 10:48 a.m. revealed Resident #206's wife in the room. Resident #206's wife stated that Resident #206 had a sore on his bottom and a pressure sore to his heel area. No enhanced barrier precaution signage or personal protective equipment (PPE) noted in Resident #206's room or outside door. Resident #206's wife stated that she had not been educated on any type of infection control precautions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Regency House of Alexandria		STREET ADDRESS, CITY, STATE, ZIP CODE  5131 Masonic Drive Alexandria, LA 71301	
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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with S9 LPN on 02/11/2025 at 8:45 a.m. revealed that Enhanced Barrier Precaution was noted by a red dot next to a resident's name by the resident's door.</p> <p>Observation of Resident #206 in bed on 02/11/2025 at 12:39 p.m. revealed no red dot located next to Resident #206's name by his door and no other signage for Enhanced Barrier Precaution.</p> <p>Observation of Resident #206's toileting care on 02/11/2025 at 12:49 p.m. revealed Resident #206 had a bowel movement and S8 CNA did not wear a gown during toileting care.</p> <p>Interview with S2 DON on 02/11/2025 at 2:30 p.m. revealed that residents with any type of wound should be on Enhanced Barrier Precautions. S2 DON confirmed that Resident #206 had wounds, did not have a red dot located next to his name by his door and was not on Enhanced Barrier Precautions but should have been.</p> <p>51082</p> <p>Resident #155</p> <p>Review of Resident #155's medical record revealed an admitted [DATE], with diagnoses that included in part .Aftercare Following Joint Replacement Surgery; Infection following a procedure, Surgical Site; Other Mechanical Complication of other Internal Orthopedic Devices, Implants, and Grafts; Other Staphylococcus.</p> <p>On 02/12/2025 at 5:45 p.m. S16 Admin RN stated Resident #155's Admission MDS is still in progress and not yet submitted due to Resident #155 being a new admit.</p> <p>Review of Resident #155's Baseline Care Plan revealed in part .PICC line; Total x2 assist with ADL's. Maintain safety precautions due to generalized weakness; Provide supportive devices: Brace to left knee.</p> <p>Review of Resident #155's 02/2025 Physician's Orders revealed in part . Enhanced Barrier Precautions required for high contact resident care activities (PICC line) every shift.</p> <p>Observation on 02/10/2025 at 10:57 a.m. of Resident #155's name plate revealed a red dot next to Resident #155's name upon entrance into her room. Resident #155 stated she was admitted on Friday and had a PICC line for IV antibiotics. Observed PICC line to Resident #155's upper right arm. Resident #155 stated she is incontinent, wears an adult brief, and is dependent on staff to provide incontinent care.</p> <p>Observation on 02/11/2025 at 9:40 a.m. of Resident #155's name plate revealed a red dot next to Resident #155's name upon entrance into her room.</p> <p>Observation of Resident #155's incontinent care on 02/11/2025 at 10:00 a.m. revealed S5 CNA and S20 CNA wore gloves and provided incontinent care for Resident #155. Neither S5 CNA nor S20 CNA wore a gown while providing incontinent care for Resident #155.</p> <p>Interview on 02/11/2025 at 10:32 a.m. with S5 CNA revealed she saw Resident #155's PICC line and should have worn a gown while providing incontinent care but did not.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Regency House of Alexandria		STREET ADDRESS, CITY, STATE, ZIP CODE  5131 Masonic Drive Alexandria, LA 71301	
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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>Interview on 02/11/2025 at 10:41 a.m. with S14 CNA Supervisor revealed all CNA's received online training during orientation on EBP. S14 CNA Supervisor confirmed S5 CNA and S20 CNA should have worn appropriate PPE while providing incontinent care for Resident #155 but did not.</p> <p>Interview on 02/11/2025 at 10:50 a.m. with S2 DON revealed all staff were in-serviced on EBP and were aware to wear the correct PPE for resident's who require EBP.</p> <p>44844</p> <p>Based on interview 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 disease and infections, by failing to test the facility's water system for Legionella.</p> <p>Findings:</p> <p>Review of the Facility's Water Management Program with no review date read in part .</p> <p>Abstract:</p> <p>All facilities are required to demonstrate measures to minimize the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems and devices.</p> <p>Scope: The primary focus of the Water Management Team is to ensure that residents have the safest and sanitary environment based on best practice processes throughout their continuum of care.</p> <p>9. Establishment of a surveillance process to detect health-care associated Legionnaires Disease.</p> <p>Goals:</p> <p>1. Ensure chemical and physical control measures and limits are performing as desired per industry standards to reduce the risk of Legionella growth.</p> <p>Review of the Infection Prevention and Control Program revealed no documented evidence of testing for Legionella in the facility's water system.</p> <p>Interview on 02/12/2025 at 3:19 p.m. with S1 Administrator confirmed the facility had not been testing for Legionella in the water system. S1 Administrator revealed the last time the facility tested for Legionella in the water system was 09/16/2024.</p>		