PRINTED: 09/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING ______ B. WING ______	C **02/12/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey #LA00050757. No deficiencies cited as a result of this complaint. Complaint Survey #LA00050848. No deficiencies cited as a result of this complaint.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE:

(X6) DATE: 04/04/2019

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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WEST JEFFERSON HEALTH CARE CENTER	1020 MANHATTAN BLVD HARVEY, LA 70058

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F 000	INITIAL COMMENTS Complaint #LA00051276 and #LA00051553. Tag #656, 684 and 770 cited as a result of Complaint #LA00051553.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		5/24/19

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TITLE:
(X6) DATE: 05/03/2019

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F 656	Continued From page 1 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to perform weekly body audits as per the plan of care for 2 (Resident #5 and Resident #7) of 7 residents reviewed. This deficient practice had the potential to affect any of the 93 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form CMS-672. Findings: Resident #5: Review of the record revealed Resident # 5 was admitted to the facility on 03/20/19, with a diagnoses which, included, in part, Schizophrenia, Dementia, Thyroid Mass with Right Tracheal Deviation, Polyneuropathy. Review of the MDS/ARD (Minimum Data Set/Assessment Reference Date) with a date of 03/27/19 revealed Resident # 5 was assessed for Schizophrenia, Dementia, Thyroid Mass with Right Tracheal Deviation, Polyneuropathy. Under Section C revealed Resident had a BIMS score 5 meaning resident was cognitively impaired. Section M Skin Conditions revealed no risk for pressure ulcer, no skin ulcers, injury, or treatments.	F 656	Corrective actions were accomplished for the residents found to be affected by the alleged deficient practice by: Body Audit was completed on Resident #5 on 04/18/2019 Resident #7 was discharged to the hospital on 04/09/2019 a body audit will be conducted when he returns to the facility. All current residents have the potential to be affected by the alleged deficient practice. Corrective action was accomplished for them by completing body audits on all residents and any issues noted addressed. The measure put in place to ensure the deficient practice does not recur was education of the of the DON, ADON, and Wound Care Nurse on completing body audits on admit/readmit and then weekly. The facility will monitor its performance to ensure solutions are sustained by: The DON/Designee will conduct random audits of the admission/readmission and weekly body assessments. Audits will be	

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F 656	Continued From page 2 Record Review revealed no documentation of a skin audit being done. A Braden Skin Score dated 03/20/19 with a score of 22 was the last documentation of a skin evaluation being done. In an interview on 04/17/19 at 11:00am, S3LPN revealed the body audit practice at the facility for residents with a Braden Skin Score of 22 was that if a resident has no skin issues and their score is 21 or greater a daily skin assessments with ADL's (Activities of Daily Living) is performed and abnormal findings are reported to the nurse. In an interview 04/16/19 at 11:35am, S4DON stated Resident # 5 did not have a weekly skin assessment at this time. In an interview 04/17/19 on 11:15am, S1 RN Clinical Compliance Consultant stated body audits should be done every week by the LPN. Resident #7: Resident #7 was admitted to the facility on 01/21/16 with diagnoses of, in part, Wernicke's Encephalopathy, Alcohol Use and Vitamin Deficiency. Review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/19 revealed a Brief Interview of Mental Status (BIMS) score of 11. A score of 11 indicated moderate cognitive impairment. Review of Resident #7's Assessment of Pressure Sore Potential dated 01/15/19 revealed, in part, a score of 2. A score of 2 revealed the resident was at low risk. Review of Resident #7's Care Plan revealed, in	F 656	conducted 3 times weekly for 4 weeks and then weekly for 4 weeks. Then as deemed necessary by QAPI team. Results of audits will be reported weekly in QA meeting ad any issues discovered will be addressed with re-education and progressive discipline.	

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F 656	Continued From page 3 part, examine skin during bathing for signs and symptoms of irritation or breakdown. Review of Resident #7's Skin Inspection Report revealed assessments were completed on 02/22/19, 02/28/19, 03/05/19 and 03/14/19. In an interview on 04/16/19 at 11:00am, S4DON stated there were no skin assessments completed on Resident #7 since 03/14/19. S4DON stated all residents, regardless of risk score, should have a weekly skin assessment. S4DON further stated the facility staff had not been able to keep up with the weekly assessments recently.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a resident with a skin condition received treatment in accordance with professional standards of practice by failing to initiate an antibiotic timely, failing to document wound care and failing to obtain labs as ordered for 1 (Resident #7) of 7 residents reviewed. This deficient practice had the potential to affect any of the 93 residents who resided in the facility as	F 684	The resident found to be affected by the alleged deficient practice was discharged from the facility on 04/09/2019. All residents have the potential to be affected by the alleged deficient practice. Corrective action will be accomplished for them by conducting an audit of current residents charts for initiation of antibiotics,	5/24/19

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F 684

Continued From page 4

documented on the facility's Resident Census and Conditions of Residents Form CMS-672.
Findings:

Resident #7 was admitted to the facility on 01/21/16 with diagnoses of, in part, Wernicke's Encephalopathy, Alcohol Use and Vitamin Deficiency.

Review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/19 revealed a Brief Interview of Mental Status (BIMS) score of 11. A score of 11 indicated moderate cognitive impairment.

Review of Resident #7's Nurses Notes dated 04/05/19 at 1:00pm and signed by S5Licensed Practical Nurse (LPN) revealed, in part, area noted at hairline with dried blood tinged drainage and excoriated area across neckline area. Doctor called. Order given for Bactroban (a topical antibiotic) and dressing. Doctor will review on Thursday.

Review of Resident #7's Physician Telephone Order dated 04/05/19 revealed, in part, Bactroban to neck hair line rash

In an interview on 04/17/19 at 10:30am, S5Licensed Practical Nurse (LPN) stated Resident #7 had a history of non-compliance with care especially showers and personal care. S5LPN stated Resident #7 had a full face beard and long hair that covered his neck. S5LPN stated on 04/05/19 she assessed an excoriated area to Resident #7's hair line. S5LPN stated she notified Resident #7's physician and was given a verbal order for Bactroban. S5LPN stated she did not transcribe the Bactroban order

F 684

obtaining labs as ordered and documentation of completed wound care. Any identified issues will be corrected

The measures that were put in place to ensure that the alleged deficient practice will no recur are an in-service with nurses on initiation of antibiotics, use of the emergency drug kit, documentation of completed wound care and obtaining labs as ordered.

The facility plans to monitor its performance to make sure that the solutions are sustained by the DON/Designee conducting random monitoring of new antibiotic orders for timely initiation, documentation of wound care provided, and lab orders for completion. Monitoring will occur 3 times weekly for 4 weeks, then weekly for 4 weeks, and then as deemed necessary by the QAPI team. Results of monitoring will be reviewed in QA meeting and any discovered issues will be addressed with re-education and progressive discipline.

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F 684	Continued From page 5 to Resident #7's Treatment Administration Record (TAR). S5LPN further stated prior to when her shift ended she observed Resident #5's Nurse Practitioner (NP) was in the facility and S5LPN asked the NP to assess the area to Resident #7's hair line. Review of Resident #7's record revealed the NP wrote an order dated 04/05/19 and the order revealed, in part, consult wound care for posterior neck wound. Cleanse daily with wound cleanser and apply Bactroban. Check Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), FREE T4, Thyroid Stimulating Hormone (TSH) and Lipid Panel. Cipro 500milligrams (mg) twice per day (BID) (an oral antibiotic) for 10 days by mouth (PO). Review of Resident #7's clinical record revealed no documented evidence the CBC, CMP, Free T4, TSH and Lipid Panel were obtained. In an interview on 04/16/19 at 12:22pm, S4RN DON confirmed the labs were not obtained as ordered. S4RN DON stated the lab order was received on Friday 04/05/19 and should have been obtained on Monday 04/08/19. S4 RNDON confirmed the most recent labs obtained for Resident #7 were on 02/01/19. Review of Resident #7's April 2019 Medication Administration Record (MAR) revealed Cipro 500mg was started on 04/06/19 at 8:00pm. In an interview on 04/16/19 at 12:25pm, S1Registered Nurse (RN) Corporate Clinical Consultant stated Cipro 250mg was available in the emergency drug kit maintained in the facility and stated the Cipro should have been taken	F 684		

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F 684	Continued From page 6	F 684		

from the emergency drug kit until the prescription arrived from the pharmacy.

In an interview on 04/17/19 at 1:29pm, S6LPN stated she worked with Resident #7 on 04/06/19 and 04/07/19. S6LPN stated Cipro 500mg was on Resident #7's MAR; however, the medication was not available for the 04/06/19 8:00am administration. S6LPN stated the Cipro was not in the facility; therefore, she called pharmacy and requested the Cipro. S6LPN stated Resident #7's Cipro was delivered on 04/06/19 and she administered the first dosage of Cipro on 04/06/19 at 8:00pm. The surveyor asked S6LPN if she knew Cipro 250mg was available in the emergency drug kit maintained in the facility and S6LPN stated she did not know it was available. The surveyor asked S6LPN if she knew there was an emergency drug kit in the facility and S6LPN stated she knew they had a kit but did not know where the emergency drug kit was located. S6LPN further stated she saw in Resident #7's chart there was an order for wound care to the hairline and stated the treatment was not on a TAR for Resident #7. S6LPN confirmed there was no documented evidence wound care was provided for Resident #7 on 04/06/19 and 04/07/19.

In an interview on 04/17/19 at 11:30am S1RN Corporate Clinical Nurse confirmed there was no documented evidence wound care was provided to Resident #7 as per the order received on 04/05/19.

Review of Resident #7's Nursing Lookback Assessment Note dated 04/09/19 revealed, in part, area noted at baseline of neck. Area excoriation with purulent drainage noted area

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F 684	Continued From page 7 reddened with yellowish and edematous from base of neck. Order received to send to emergency room for evaluation of wound. Review of Resident #7's Physician Telephone Order dated 04/09/19 revealed, in part, send to ER for evaluation and treatment of wound to posterior neckline.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to obtain laboratory services as ordered by the physician for 2 (Resident #6 and Resident #7) of 7 records reviewed. This deficient practice had the potential to affect any of the 93 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form CMS-672. Findings: Resident #6: Review of Resident #6's clinical record revealed Resident #6 was admitted to the facility on 03/22/19 with the diagnosis in part; Cerebrovascular Accident (Stroke) and Generalized Muscle Weakness.	F 770	Corrective action was obtained for Resident #6 by having ordered labs completed 04/17/2019. Resident #7 was discharged to the hospital 04/09/2019. All current residents have the potential to be affected by the alleged deficient practice. Corrective action was obtained by conducting a audit of current resident's chart to ensure that all ordered labs were obtained. Any discovered issues will be corrected by obtaining ordered labs. The measures that were put in place to ensure that the alleged deficient practice will not recur was an in-service educating	5/24/19

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F 770	Continued From page 8 Review of Resident #6's Physician Admission Orders dated 03/22/19 revealed documented orders in part; an order to obtain laboratory blood work for a Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) times two. Review of Resident #6's clinical laboratory record revealed no documented laboratory results for a CBC or a BMP times two. In an interview on 04/16/19 at 01:30pm, S3LPN stated she would have to call the laboratory for the results because she could not find the results in Resident #6's medical record. . In an interview on 04/17/19 at 09:49am, S1/RN Corporate Clinical Consultant and S3/LPN both stated Resident #6's labs were not done and they were not sure why the labs were not done. S1RN Corporate Clinical Consultant stated she called the laboratory and was told there was no results for Resident #6's CBC and BMP. Resident #7: Resident #7 was admitted to the facility on 01/21/16 with diagnoses of, in part, Wernicke's Encephalopathy, Alcohol Use and Vitamin Deficiency. Review of Resident #7's record revealed a telephone order dated 04/05/19 and the order revealed, in part, check Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), FREE T4, Thyroid Stimulating Hormone (TSH) and Lipid Panel. Review of Resident #7's clinical record revealed no documented evidence the CBC, CMP, Free	F 770	nurses on obtaining labs as ordered and on the process of lab requisitions. The facility plans to monitor its performance to make sure that solutions are sustained by the DON/Designee randomly auditing lab orders to ensure completion. Auditing will occur 3 times a week for 4 weeks, then weekly for 4 weeks, and then as deemed necessary by the QAPI team. Results of audit will be reviewed weekly in QA meeting and any discovered issues will addressed with re-education and progressive discipline.	

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F 770	Continued From page 9 T4, TSH and Lipid Panel were obtained. In an interview on 04/16/19 at 12:22pm, S4RN DON confirmed the labs were not obtained as ordered. S4RN DON stated the lab order was received on Friday 04/05/19 and should have been obtained on Monday 04/08/19. S4RN DON confirmed the most recent labs obtained for Resident #7 were on 02/01/19.	F 770		

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F 000	INITIAL COMMENTS Compalint Survey #LA00051787	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed ensure a cleaning solution was not left unattended on a janitor's cart that was accessable to any resident. This deficient practice had the potential to affect any of the 97 residents who reside in the facility as documented on the Resident Census and Conditions of Residents Form (CMS- Form 672) who may be confused and wander around the facility. Findings: Review of the facility's "Hazardous Areas in the Facility" policy revealed in part, Policy Interpretation and Implementation: 4. The facility's Safe Committee shall recommend measures to ensure that residents cannot access hazardous areas in the facility. Review of Xcelente' Multipurpose cleaner label revealed in part, diluted at 1:43 (or greater in water). HMIS Hazard Rating Health =1, Flammability =0, Physical Hazards =0. First Aid:	F 689	1. Corrective action was obtained by removing the Xcelente' from top of cart and locking cart. 2. All current residents have the potential to be affected by the alleged deficient practice. Corrective action was obtained by removing Xcelente' from top of cart and locking cart. 3. The measures put in place to ensure the alleged deficient practice does not recur was an in-service conducted on 6/05/2019 with Housekeeping staff on "Storage of Chemicals" which addressed storage of chemical inside of cart and carts being locked. 4. The facility will monitor its performance to make sure solutions are sustained by: a. Administrator/Designee will conduct random checks of Housekeeping Carts to ensure carts and locked and chemicals	6/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195591	A. BUILDING ______ B. WING ______	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 In eyes: rinse cautiously with water for several minutes, remove contact lenses. In skin: wash with soap and water if irritation occurs, get medical help. If inhaled: remove victim to fresh air and call poison control. If swallowed: rinse mouth and DO NOT induce vomiting. Observation on 06/05/19 at 10:25am accompanied by S1Administrator and S3Housekeeping Supervisor revealed a janitor's cart sitting on Hall D unlocked and unattended. Further observation revealed a refillable spray bottle of Xcelente' Multipurpose cleaner sitting on top the cart and a spray bottle was half full of Xcelente' Multipurpose cleaner. In an interview on 06/05/19 at 10:25am S3Housekeeping Supervisor indicated the bottle of Xcelente' cleaner should not have been left on top of the janitor's cart unattended. S3Housekeeping Supervisor also indicated the janitor's cart should have been locked. S1Administrator confirmed the Xcelente' cleaner should not have been left on top of the janitor's cart unattended and the cart should have been locked.	F 689	are stored properly. b. Cart checks will be made 5 times weekly for 4 weeks the weekly for 4 weeks and then as deemed necessary by Interdisciplinary team. Results of checks will be reported weekly in QAPI Meetings for first 8 weeks then reviewed in Quarterly QAPI Meetings. c. Any identified problems will be handled with reeducation and progressive discipline.	

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	195591	A. BUILDING ______ B. WING ______	R-C **07/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD** **HARVEY, LA 70058**

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F 000	INITIAL COMMENTS An evidence review was conducted for all previous deficiencies cited on 06/05/19. All deficiencies from this survey have been corrected.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An evidence review was conducted for all previous deficiencies cited on 04/17/19. All deficiencies from this survey have been corrected.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	195591	A. BUILDING ______ B. WING ______	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	1020 MANHATTAN BLVD HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Recertification Survey and Complaint #LA00053436. No deficiencies were cited for Complaint # LA00053436.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		12/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/12/2019

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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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform the resident or his or her legal representative in writing that Medicare services may not be covered, and of the resident's/beneficiary's potential liability for payment for non-covered services as evidence by failing to ensure liability notices were completed as required. This deficient practice was identified for 2 (Resident #52, and Resident #244) of 3 residents reviewed for beneficiary protection notification. The facility had a total census of 97 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form CMS-672. Findings: Resident #52 Record review revealed Resident #52's last day	F 582	(1) Social Worker Met with Resident#52 (signed ABN letter on 5-30-19) and Resident #244 (signed ABN letter on 11-15-19) and provided Residents with an explanation as to why Medicare was no longer paying for their services. Form was completed in its entirety. (2) A chart audit was conducted on 11-21-19 utilizing a 6-month look-back period to identify any residents that had the potential to be affected by the deficient practice. None were identified. (3) Social Worker was In-Serviced on Advanced Beneficiary Notices on 11-22-19. Social Worker will complete ABN Letters and have Resident/RP sign within 72 hours prior to services ending.	

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F 582	Continued From page 2 of covered Part A skilled services was 05/31/19, and Resident #52 remained in the facility. Further review of Resident #52's record revealed Resident #52's Advance Beneficiary Notice of Non-coverage Form CMS-R-131 (ABN) was signed and dated by Resident #52 on 05/30/19 but no option choice was selected. Resident #244 Record review revealed Resident #244's last day of covered Part A skilled services was 11/20/19, and Resident #244 remained in the facility. Further review of Resident #244's record revealed Resident #244's ABN was signed and dated by Resident #244 on 11/15/19 but no option choice was selected. In interview on 11/20/19 at 12:25pm, S8/Social Worker (SW) stated she was responsible for obtaining Liability notices. (ABNs) for the facility. S8/SW reviewed Resident #52's and Resident #244's liability notices with surveyor and S8/SW acknowledged no option choice was selected. In interview on 11/20/19 at 2:55pm, S4/Regional Director of Quality confirmed no options was elected on liability notices for Resident #52 and Resident #244.	F 582	ABN Letters will be discussed M-F in the morning meeting. All completed ABN letters will be logged onto a monitoring tool. (4) Completed ABN Letters will be monitored in the morning meeting 5 times per week for 6 weeks by the administrator and logged on to a monitoring tool. ABN letters will continue to be monitored in the morning meeting thereafter and check PRN by Administrator. Any concern identified will be corrected and handled accordingly at the time it’s identified by the Administrator designee	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		1/4/20

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F 689	Continued From page 3 accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure each resident had monitoring of wanderguard device to prevent accidents. For 1(Resident #18) of 7 residents who wore a wanderguard device out of total sample of 40 Residents in the investigation stage. This deficient practice had the potential to affect all 97 residents residing in the facility as documented on the facility's Resident Census and Conditions (CMS 672 Form). Findings: Record review revealed Resident #18 was admitted to the facility on 05/12/16. Further review of Resident #18's record revealed resident #18 had a diagnosis of Neurocognitive Disorder. Record review of Resident #18's Minimum Data Set revealed in part, a Brief Interview for Mental Status (BIMS) revealed score of 6 (score of 0-7 is severe impairment). Further review of Resident #18 record revealed he had a wander/elopement risk with an ankle alarm. Record review of Resident #18's Physician orders dated 11/11/19 revealed an order for a wanderguard bracelet related to a potential for elopement. Further review of the same order reveal documentation to check the device for proper functioning on every shift and check placement daily on every shift. Review of Resident #18's Risk of Elopement and/or Wandering Review dated 05/30/19 revealed documentation Resident #18 was at high risk for wandering or Elopement, which	F 689	(1) Residents at risk for elopement were checked for placement and proper functioning during survey Results were recorded. (2) Other Residents with the potential to be affected were identified via char audits. None were found to have had elopement episodes. (3) Nursing staff was In-Serviced on the following: (A) Wander guards are to be checked on residents every shift daily for proper placement and expiration date. (B) Visual observations of residents should be made every 2 hours due to potential risk for elopement. (C) Wander-Guard testing policy . (D) Documentation of wander-guard monitoring should be placed on MAR after every shift. (4) Wander guard checks will be monitored 5 times per week for 6 weeks by the DON/Designee. Checks will be documented on a QA monitoring tool. Any concerns identified will be corrected and handled accordingly at the time it's identified by the DON/Designee.	

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F 689	Continued From page 4 required frequent monitoring. Further review revealed Resident #18 was cognitively impaired with poor decision-making skills, and Resident #18 was able to independently ambulate. Review of Resident #18's medication administration record (MAR) and behavior record dated November 2019 revealed no documentation Resident #18's device was checked for proper functioning on every shift and the device placement was not checked daily on every shift. In an interview on 11/21/19 at 11:24am, S1Certified Nursing Assistant (CNA) stated there was no form for her to document Resident #18's wanderguard bracelet. In an interview on 11/21/19 at 12:30pm, S13Licenced Practical Nurse (LPN) stated the maintenance staff was responsible for monitoring Resident #18's wanderguard bracelet. S13LPN confirmed that she was not monitoring Resident #18's wanderguard bracelet. In an interview on 11/21/19 at 1:56pm, S5Corporate Registered Nurse (RN) confirmed Resident #18's wanderguard bracelet was not being monitored. S5CorporateRN confirmed there was no documentation on Resident #18's November 2019 MAR to reflect the monitoring of Resident #18's wanderguard bracelet, which was ordered by the physician.	F 689		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a	F 800		1/3/20

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F 800	Continued From page 5 nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure the steam tables were holding food temperatures at a safe temperature. This deficient practice was identified for 1 of 1 steam table observed. This deficient practice had the potential to affect any of the residents in the facility who received food from the steam table. The facility census was 97 residents as documented on the facility's Census and Conditions of Residents Form (CMS-672). Findings: Observation of food temperatures on the steam tables with S7Cook on 11/21/19 at 11:00 AM revealed the following temperatures: white cooked rice 122 degrees F, puree: pork chops 109 degrees F, rice 112 degrees F, and zucchini 103 degrees F. In an interview on 11/21/19 at 11:00 AM, S7Cook stated the steam table is turned up to maximum heat. Food is placed on steam table at least no greater than 45 minutes before serving. In an interview on 11/21/19 at 11:15 AM with S1Administrator and S4Regional Director of Quality, surveyor advised these staff members of food temperatures on steam table. S1Administrator stated the temperatures are not correct and would have S6Dietary Supervisor address. S4Regional Director of Quality confirmed temperatures of foods on steam table are too low except smothered pork chops and	F 800	(1) Food war reheated to proper temps prior to residents being served. (2) All residents had the potential to be affected. An audit was done on all residents hospitalized in the past 90 days and none were the result of food borne illnesses. (3) Dietary Staff were re-educated on proper food temps for tray line. Hot foods should have a temp of nothing less than 140¿F and cold foods should be nothing less than 41¿F. Dietary Manager/ Designee will record food temps daily for every meal and record on log. (4) Food Temp Log will be monitored 3 times weekly for six weeks, then twice monthly, and PRN by Administrator using a monitoring tool. Any concern identified will be corrected and handled accordingly at the time it's identified by the Administrator/Designee.	

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F 800	Continued From page 6 zucchini. S4Regional Director of Quality stated would have S6Dietary Supervisor re-heat the food. Observation and interview on 11/21/19 at 11:35 AM for the lunch meal revealed S6Dietary Supervisor removing white rice, and pureed smothered pork chops, pureed white rice, and pureed zucchini from stove and immediately checking temperatures and documented these temperatures on the Daily Food Temperature Log. S6Dietary Supervisor stated he usually documents temperatures from steam tables, except right now because of earlier low temperature readings he was documenting internal temperatures directly from the stove. S6Dietary Supervisor acknowledged food temperatures should be monitored and maintained in an acceptable range on steam table. In an interview on 11/21/19 at 12:53 PM, S1Administrator acknowledged S6Dietary Supervisor recorded the lunch internal food temperatures from the stove top and should have recorded the food temperatures from the steam table on the on the Daily Food Temperature Log dated 11/21/19. S1Administrator confirmed S6Dietary Supervisor did not record food temperatures appropriately.	F 800		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and	F 807		1/3/20

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F 807	Continued From page 7 preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure a resident received his diet as ordered for 1 of 40 sample residents on the investigation stage sample. This deficient practice had the potential to affect all 97 residents residing in the facility as documented on the facility's Resident Census and Conditions (CMS 672 Form). Findings: A record review of resident #63's physician's order dated November 2019 revealed an order for resident #63 to have milk with all meals. A record review of the Dietary Manger Nutrition Data Note (NDN) dated 10/14/19 revealed documentation for resident #63 to have milk with all meals. A record review of resident #63's dietary slip revealed special instructions to add milk with all meals. In an interview on 11/18/19 at 10:50am, resident #63's wife stated she feeds her husband every day for lunch, and he did not get milk today on his lunch tray. Resident #63's wife further stated her husband loves chocolate milk. An observation on 11/18/19 at 11:50am revealed resident #63's milk was not on his lunch tray. An observation on 11/19/19 at 12:10pm revealed resident #63's milk was not on his lunch tray.	F 807	(1) Resident #63 was provided with the proper diet as ordered at the time of discovery. Visual rounds were conducted to assure that meal trays and meal tickets matched. (2) All residents had the potential to be affected. On 11-19 -19 a diet order was conducted by Dietitian to assure that Diets are matching Physician Orders and Meal Tickets. If discrepancies are found, Physician will be notified, and orders will be clarified. (3) Dietary staff has been re-educated on assuring that the meal ticket and meal tray must match. Restorative Aide/ Designee will complete visual audits on 5 residents per day per meal to determine if proper diet is served. Audits will be documented. (4) Tray Checks will be monitored 5 times a week for 6 weeks, then 3 times a week for 2 weeks, then randomly as deemed necessary by Administrator. Any concerns identified will be corrected and handled accordingly at the time it's identified by the Administrator/Designee.	

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F 807	Continued From page 8 In an interview on 11/20/19 at 11:20am, resident #63's wife stated her husband did not get his milk today on his lunch tray. An observation on 11/20/19 at 4:49pm revealed no milk was on resident #63's dinner tray. In an interview on 11/21/19 at 12:05pm, resident #63's wife stated her husband did not get milk for lunch today. An observation on 11/21/19 at 12:05pm revealed resident #63's lunch tray without milk. In an interview on 11/21/19 at 12:46pm, S13LPN(Licensed Practical Nurse) stated resident #63 had an order to have milk with all meals, and it should be on his tray. S13LPN confirmed the milk was not on resident #63's tray.	F 807		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		1/3/20

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	195591	A. BUILDING ______ B. WING ______	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST JEFFERSON HEALTH CARE CENTER	**1020 MANHATTAN BLVD HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 10 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain an effective infection prevention and control program by: I. failing to ensure staff were knowledgeable about sanitizing/disinfection procedures for the facility showers and whirlpools (shower rooms a and b); and II. failing to ensure a glucometer (a blood glucose monitoring device) was properly cleaned. This deficient practice had the potential to affect any of the 97 residents currently residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (CMS-672). Findings: I. Observation of the shower room "a" on 11/21/19 at 8:35am with S15CNA (Certified Nurse Assistant) revealed a spray bottle on labeled "Shampoo/Body Wash" with a purple tinted liquid noted in the spray bottle. S15CNA confirmed she uses this liquid to bathe residents and to disinfect the shower between residents. Observation of the shower room "b" on 11/21/19 at approximately 8:45am with S15CNA revealed a squeeze bottle labeled "Soothe and Cool Cleanse Shampoo and Body Wash" sitting on a shelf.	F 880	(1) Shower was disinfected while survey was being conducted. New glucometers were provided and Correct cleaning wipes were obtained from sister facility for immediate use to properly clean glucometers before and after use. (2) All residents had the potential to be affected. None were found to affected by the deficient practice. (3) CNA’s and Housekeeping staff were in-serviced on 11-21-19 on proper cleaning techniques for shower room and frequency. Visual Rounds will be completed daily and results will be recorded. Visual rounds will be conducted daily to assure proper cleaning of glucometer. Results are recorded on monitoring tool. (4) Shower rooms and glucometer Cleaning will be monitored by Admin/DON/ Designee 5 times a week for 6 weeks, then 3 times a week for 2 weeks then randomly as deemed necessary by Administrator. Any concerns identified will be corrected and handled accordingly at the time it’s identified by the Administrator/Designee.	

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F 880	Continued From page 11	F 880		

S15CNA demonstrated how she squeezes the pink tinted liquid throughout therapeutic whirlpool and rinses with hot water to disinfectant between residents. S15CNA confirmed she also uses this liquid to bathe residents.

Review of instructions on how to clean the shower/whirlpool posted on back of shower room "b" door revealed, in part, utilize Neutral Disinfectant after each shower/whirlpool, let disinfectant stand for 10 minutes and rinse surface completely.

In an interview on 11/21/19 at 9:00am, S2Director of Nurses (DON) acknowledged S15CNA was not properly cleaning showers/whirlpools after each resident. S2DON confirmed S15CNA should be using Neutral Disinfectant to disinfect showers/whirlpools after each resident use instead of the soap she uses to bathe residents.

II. Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" revealed, in part, 'reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions.

In an interview on 11/18/19 at 11:57am, S9LPN stated she cleans the glucometer with alcohol wipes after resident use.

In an interview on 11/18/19 at 2:50pm, S4Regional Director of Quality stated the facility used CaviWipe towelettes, not alcohol wipes, to disinfectant the glucometer between resident use. S2DON confirmed the facility used Caviwipes towelettes to clean the glucometer. S2DON

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F 880	Continued From page 12 stated S9LPN should not have used alcohol wipes to clean glucometer.	F 880		

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	195591	A. BUILDING **01** B. WING ______	R **12/16/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{K 000}	INITIAL COMMENTS	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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.