STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195374	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOSEPH OF HARAHAN	**405 FOLSE DRIVE HARAHAN, LA 70123**

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)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician as ordered when a blood sugar level was below 60 and/or failed to notify the Physician when a resident refused a [MEDICATION NAME] injection for 1 (Resident #5) of 5 sampled residents. This deficient practice had the potential to affect any of the 123 residents residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (Form CMS-672). Findings: Review of Resident #5's record revealed a [DIAGNOSES REDACTED]. Review of Resident #5's care plan revealed in part, a problem addressed for being prescribed multiple medications with an approach to administer my medications as ordered by my physician and report significant changes to my physician. Review of Resident #5's Physician order [REDACTED]. Further review reviewed an order to administer [MEDICATION NAME](medication used to lower blood sugar) per sliding scale if blood sugar levels were as follows: blood sugar level 0-60 give orange juice or glucose tablet and hold insulin; 61-200 administer no insulin, 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, and greater than 400 give 10 units then call physician. Further review revealed the nurse was to report to the Physician if a blood sugar level was less than 60 or greater than 350. Review of Resident #5's Medication Administration Record (MAR) dated June 2020 revealed in part, on 06/21/2020 at 6:00am Resident #5's documented blood sugar level was 43. Review of Resident #5's Nurses Notes dated 06/21/2020 at 6:13am revealed the nurse was called to Resident #5's room per Certified Nursing Assistant (CNA). Upon entering, the resident was noted lying in bed, awake and alert covered in feces and he stated he wasn't feeling well. Resident #5 was able to answer all questions appropriately. Resident #5's blood sugar level was assessed as 43. Resident was given a full cup of House Supplement and tolerated well. Further review revealed Resident #5's blood sugar level was reassessed as 83. In an interview on 07/06/2020 at 12:34pm, S12Licensed Practical Nurse (LPN) stated she was Resident #5's nurse and was familiar with him. She stated she recalled the morning of 06/21/2020 when Resident #5 had a blood sugar reading of 43. She stated she called the Physician because the facility did not have glucose tablets available and the Physician ordered a [MEDICATION NAME] injection. She stated she attempted the [MEDICATION NAME] (medication used to increase blood sugar level) injection and Resident #5 refused the injection and he stated he wanted the supplement instead. S12LPN stated Resident #5 was also eating a Snicker's candy bar. She stated she continued to check his blood sugar every 15 minutes and stated his blood sugar went back up to 98 from what she recalled. She stated she did not call the Physician back to inform him that she administered House Supplement instead of the [MEDICATION NAME] injection, and she should have. S12LPN's documentation was inconsistent with her interview. There was no documented evidence and the facility did not present any documented evidence Resident #5's Physician was notified of a blood sugar level of 43 and/or of Resident #5 refusing a [MEDICATION NAME] injection. In an interview on 07/06/2020 at 1:45pm, S2Director of Nursing (DON) stated the physician should have been notified of a blood sugar level of 43. S2DON reviewed Resident #5 MAR and nurse's notes and DON confirmed there was no documentation of notifying the physician of the low blood glucose of 43 and no documentation of Resident #5's refusal of the [MEDICATION NAME] injection.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to give baths and provide incontinence care in a timely manner. This deficient practice was identified for 2 (Resident #4 and Resident #5) of 5 sampled residents, but had the potential to effect all 123 residents as documented on the CMS Form-672, Resident Census and Conditions of Residents Form. Findings: Resident #4 Review of Resident #4's record revealed an admitted [DATE]. Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/20/2020 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 15 (score of 13-15 cognitive). Further review of the MDS revealed, in part, Resident #4 required total dependence of 1 person with bathing, personal hygiene, and was always incontinent of bowel and bladder. Review of Resident #4's Care Plan revealed, in part, Resident #4 has a problem with Activity of Daily Living with a approach of a bath or shower 3 times a week; problem of incontinent of urine with approach of assist with perineal cleansing as needed; problem of high risk for skin breakdown with an approach of keep skin clean and dry. Review of Resident #4's record revealed one Grievance dated 05/18/2020 with a complaint of incontinence care not occurring every 2 hours, and having to wait about 6 hours between incontinence cares. Resolution was instructing aides on incontinent checks every 2 hours and as needed. This resolution failed as evident in interview with Resident #4. Review of Resident #4's Completed Care revealed, in part, Resident#4 received 4 bath/showers for April 2020, 6 bath/showers for May 2020, and 7 bath/showers for June 2020. Review of Resident #4's Nurses Notes revealed, in part, Weekly Skin Assessments stating Red, irritated rash related to incontinence/ adult diapers noted to perineum, inner thighs and both buttocks documented on 05/08/2020, 05/15/2020, 05/22/2020, 06/05/2020, 06/12/2020, and 6/19/2020. In a FaceTime interview on 07/01/2020 at 2:50pm Resident #4 stated she had only received a bed bath once a week since admit, and had not had a bath or shower in 5 days. She stated she had not had a bath in 5 days. She stated she often has to wait a long time for incontinence care, sometimes up to 4 hours and this usually occurs on the day shift. Resident #4 stated most of the time it takes a long time for assistance. Resident #4 stated Monday when she returned from Physical Therapy (PT) she had to wait 4 hours to be transferred to her bed. The aide who answered her call bell told her PT was supposed to transfer her back to bed. An observation during a interview on 07/01/2020 at 2:50pm revealed Resident #4 was sitting up in her bed. Resident #4's hair appeared disheveled, and white to yellowish crust appeared around eyes. In a phone interview on 07/06/2020 at 9:28am S7License Practical Nurse (LPN) stated Resident #4 was scheduled for baths 3 times a week and incontinence checks should be every 2 hours. In a FaceTime interview on 07/06/2020 at 10:21am Resident #4 stated she had been waiting an hour to be changed due to having a bowel movement. Resident #4 stated she has to wait a long time often for help when activating her call bell. She stated she was changed that morning at 4:00am and was not changed again until 9:30am. She stated her bottom was feeling sore and raw. She stated that she should not be treated like this, and the staff does not care. In a phone interview on 07/06/2020 at 10:45am the surveyor informed S2Director of Nursing (DON) that Resident #4 had been waiting an hour for incontinence care. S2DON stated it was

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.

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) unacceptable for Resident #4 to wait over an hour for her call bell to be answered and for her to have pericare. S2DON further stated Resident #4 should have received her bath as scheduled 3 times a week. An observation during FaceTime interview on 07/06/2020 at 10:21am revealed Resident #4 sitting in her bed. Resident #4's hair appeared not combed. Resident #4 appeared distressed and upset. She was wearing a blue top. In a phone interview on 07/06/2020 at 11:20am S4Certified Nursing Assistant stated incontinence checks are performed every 2 hours and as needed, and Resident #4 received bed baths 3 times a week. She stated residents on the COVID hall received bed baths because to use the whirlpool or shower the resident would have to be taken off the hall. Resident #5 Review of Resident #5's record revealed [DIAGNOSES REDACTED]. Review of Resident #5's [MEDICAL TREATMENT] communication forms revealed Resident #5 attended [MEDICAL TREATMENT] on Tuesday, Thursday and Saturdays. Review of Resident #5's Minimum Data Set with an Assessment Reference Date of 04/14/2020 revealed in part, a Brief Mental Status Score of 15 (score of 13-15 was cognitively intact). Further review revealed no rejection of care, no behaviors, and he required a one person physical assist with all activities of daily living. He had an impairment to the lower extremity on one side, used a walker and a wheelchair, was incontinent of bowel and bladder and received [MEDICAL TREATMENT] services. Review of Resident #5's task care plan revealed in part, Resident #5 was scheduled for a bath on Tuesday, Thursday and Saturdays. Review of Resident #5's care plan revealed a problem for staff assistance for activities of daily living with approaches in part, I prefer morning showers and assist me with bathing. Review of Resident #5's completed care revealed no documentation of a bath being given to Resident #5 on Tuesday, Thursday and Saturdays. Further review of Resident #5's completed care revealed in part, the following: 05/27/2020- documentation stated no bath given because he was at [MEDICAL TREATMENT] 05/30/2020- no documentation of a bath/shower given 05/31/2020- documentation stated no bath given because he was at [MEDICAL TREATMENT] 06/04/2020- computer not available 06/05/2020- no documentation of a bath/shower given 06/08/2020- documentation stated no bath given because he was at [MEDICAL TREATMENT] 06/13/2020- shower 06/14/2020- shower 06/16/2020- shower 06/21/2020- no documentation of a bath/shower given 06/23/2020- resists care- nurse notified. In a telephone interview on 07/01/2020 at 12:45pm, S4Certified Nursing Assistant stated she worked on the COVID-19 unit and she cared for Resident #5. She stated Resident #5 went to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday. She stated he was scheduled to receive a shower on Monday, Wednesday, and Friday's. In a telephone interview on 07/02/2020 at 9:30am S3Social Worker at [MEDICAL TREATMENT] Center stated Resident #5 attended [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday's since he has been receiving [MEDICAL TREATMENT] services. She stated Resident #5 was coming to [MEDICAL TREATMENT] with dirty clothing, no socks and shoes, appeared unclean and stated he was not receiving baths. In an interview on 07/02/2020 at 10:05am, S6Staff Developer indicated there was no shower or whirlpool room located on the Covid unit. S6Staff Developer further indicated red residents are residents on the Covid unit identified as being positive for Covid or suspicious for Covid. Red residents only get bed baths. Yellow residents are residents on the Covid unit that are under quarantine and being watched for the possibility of being exposed to Covid. Yellow residents have a choice of a bed bath or a shower. S6Staff Developer indicated if a yellow resident on the Covid unit request a shower, they are brought to the shower room located outside of the Covid unit. S6Staff Developer further indicated only one resident was allowed to shower room at a time, and the Certified Nursing Assistant (CNA) was responsible to sanitize the shower room afterwards, followed by housekeeping staff. In a telephone interview on 07/06/2020 at 10:31am, Resident #5 stated he was not refusing anything and he was only getting a bed bath once a week. He stated he felt like he was still dirty. He stated he could not go to the shower because his foot could not get wet. In an interview on 07/06/2020 at 11:05am S2Director of Nursing (DON) stated Resident #5 resided on the COVID-19 unit at the facility and was currently negative for having COVID-19. S2DON stated when COVID-19 first started they were giving bed baths every other day to the residents on the COVID-19 unit using Ready Bath LUXE antibacterial bathing cloths and Ready Bath Cap (conditioning/shampoo cap) for shampooing hair. She confirmed Resident #5 had a yellow sign on his door and he tested negative for COVID-19. She stated there were two CNA's working on the COVID-19 unit for the day shift and that was enough staff to care for the residents on that unit. She stated if a resident refused a bath, the CNA would document the refusal in completed care and then inform the nurse of the refusal and try returning at a later time. She stated there was no reason why a resident on the COVID unit would not receive a bath. When surveyor informed S2DON that Resident #5 stated he was getting a bed bath once a week, S2DON offered no response and did not present any evidence to dispute the above deficient practice.

F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to coordinate medication administration times for residents receiving [MEDICAL TREATMENT] and failed to ensure residents who received [MEDICAL TREATMENT] were administered medication as ordered. This deficient practice was for 3 of 3 [MEDICAL TREATMENT] residents (Resident #2, Resident #3, and Resident #5) in a total sample of 5 residents. The total census was 123 as documented on the facility's Resident Census and Conditions of Resident form (CMS-672). Findings Resident #2 Review of Resident #2's record revealed [DIAGNOSES REDACTED]. Review of Resident #2's June 2020 Physician order [REDACTED]. pressure) 10mg tablet take one tablet by mouth once every day; [MEDICATION NAME] (medication for depression) 50mg tablet take one tablet by mouth once a day; [MEDICATION NAME] (medication used to prevent gout) 100mg tablet give one tablet by mouth daily; [MEDICATION NAME] (medication to lower phosphorus levels) 800mg tablet take two tablets by mouth with meals; [MEDICATION NAME] (medication used to breakdown food into nutrients) 36,000 units capsule take three times a day with meals. Review of Resident #2's Care Plan revealed in part, the following: Problem: End Stage [MEDICAL CONDITION], receiving [MEDICAL TREATMENT] Monday, Wednesday and Friday at FMC Kenner, Approaches: administer mediations as ordered and Notify physician of any significant changes. Review of Resident #2's Medication Administration Record (MAR) dated 06/01/2020 through 06/30/2020 revealed the following medications were documented as not administered with no reason as to why the medications were not given. Further review of Resident #2's June 2020 MAR revealed in part, the following mediations were not administered as ordered with no documentation as to why: [MEDICATION NAME] HCL (mediation to lower blood pressure) 0.1 milligrams (mg) take one tablet by mouth two times every day- 37 doses documented with an N (not administered); [MEDICATION NAME] (medication to reduce extra fluid in the body) 2 milligram (mg) take one tablet by mouth two times every day- 11 doses documented with an N (not administered); [MEDICATION NAME] (mediation to lower blood pressure) 10mg take one tablet by mouth once every day- 21 doses documented with an N (not administered); [MEDICATION NAME] (medication to treat depression) 50mg take one tablet by mouth once a day- 11 doses documented with an N (not administered); [MEDICATION NAME] (medication used to prevent gout) 100mg give one tablet by mouth daily- 11 doses documented with an N (not administered); [MEDICATION NAME] (mediation to lower phosphorus levels) 800mg take two tablets by mouth with meals- 23 doses documented with an N (not administered); [MEDICATION NAME] (mediation used to breakdown food into nutrients) 36,000 units take three times a day with meals- 26 doses documented with an N (not administered). Review of Resident #2's Administration Record for June 2020 revealed medications documented with a N as not administered because resident not available or requirement not met. There was no documentation of the physician being notified, nor an effort to coordinate the medication times with Resident #2's [MEDICAL TREATMENT] days. Review of Resident #2's Nurses Notes for June 2020 revealed no documented evidence that nursing staff attempted to coordinate Resident #2's medication times with his [MEDICAL TREATMENT] days/times. In a telephone interview on 07/01/2020 at 1:09pm S7Licensed Practical Nurse (LPN) stated Resident #2 attends [MEDICAL TREATMENT] on Mondays, Wednesdays and Friday's. The Resident will leave the facility about 9 am. S7LPN further stated when resident #2 goes to [MEDICAL TREATMENT] not all her morning medications are given because of the time she leaves. In a telephone interview on 07/02/2020 at 9:20am resident #2 stated she attends [MEDICAL TREATMENT] three days a week on Monday, Wednesday and Friday's. Resident #2 stated on her [MEDICAL TREATMENT] days she only takes medications early in the morning and takes what the nurse gives her. In a telephone interview on 07/02/2020 at 8:25am S2DON stated the documented N on the MAR stands for Not Administered. When the nurse documents an N it could be for the refusal of medication, the requirement not met, the resident is not available or the medication is on hold. S2DON stated if the resident does not go to [MEDICAL TREATMENT] or a mediation is not given the nurse should document an N on the MAR and write a note explaining more detail. In a telephone interview on 07/06/2020 at 10:00am S7LPN stated the documented N on the MAR stands for Not administered. S7LPN stated she administers Resident #2's medications as ordered before she leaves for [MEDICAL TREATMENT]; however there are times Resident #2 may not get her mediations because she leaves before she can give them to her and the medication may dialyzed out her system. S7LPN stated she cannot explain why the other nurses did not administer Resident #2's medications as ordered, and did not see any documentation of why the medication was not administered. S7LPN stated she was looking at the resident's MAR and all that is documented was the resident not available. She stated she is not sure if medication is given when the resident returns from [MEDICAL TREATMENT]. S7LPN stated in reviewing the resident's nurses notes she did not see any documentation of

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F 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)

Resident #2's mediations being administered and no coordination with the physician for time changes. S7LPN further stated the physician should definitely be notified if a medication is not given. LPN stated the doctor should be made aware of conflict times and the resident not getting her medications. In a telephone interview on 07/06/2020 at 12:17pm S2DON stated she did see multiple documentation of a N documented on Resident #2's MAR; therefore Resident #2 did not get those mediations. S2DON stated Resident #2's mediations scheduled in the morning on Mondays, Wednesdays and Fridays were not administered because the resident was at [MEDICAL TREATMENT]. S2DON stated if Resident #2's medications were not administered there should have been coordination with the physician. S2DON stated there was no documentation of the doctor being notified. Resident #3 Review of Resident #3's record revealed diagnoses, in part, of [MEDICAL CONDITION] following Cerebral Infarction affecting right dominant side, End Stage [MEDICAL CONDITION], [MEDICAL TREATMENT] three times a week,
[MEDICAL CONDITION], Type 2 Diabetes Mellitus, Hypertension, and [MEDICAL CONDITION]. Review of Resident #3's Minimum Data
Set (MDS) with an Assessment Reference Date (ARD) of 05/22/2020 revealed, in part: BIMS of 0 (severely cognitively impaired); No refusal of behavior noted; [MEDICAL TREATMENT]. Review of Resident #3's physician's orders [REDACTED]. 1 tablet by mouth twice a day (for [MEDICAL CONDITION]); [MEDICATION NAME] 0.4 mg 1 capsule by mouth daily (for Enlarged
Prostate);[MEDICATION NAME] 60 mg. 1 tablet by mouth daily (for Hypertension); Allopuriol 100 mg. 1 tablet by mouth daily (for Gout); Aspirin EC 81 mg. 1 tablet by mouth daily (due to history of Stroke); [MEDICATION NAME] 800 mg.1 tablet by mouth with meals (for End Stage [MEDICAL CONDITION]). Review of Resident #3's Care Plan revealed, in part, the following problems and interventions: Problem: [DIAGNOSES REDACTED]. Problem: History of [MEDICAL CONDITIONS] with [MEDICAL
CONDITION]; Approach: Administer my medications as ordered by my physician. Problem: [DIAGNOSES REDACTED]. Problem: At risk for injury related to [MEDICAL CONDITION] disorder; Approach: Administer my anti convulsion medication as ordered. Problem: [DIAGNOSES REDACTED]. Problem: [DIAGNOSES REDACTED]. Problem: [DIAGNOSES REDACTED]. Review of Resident #3's Medication
Administration Record (MAR) from 06/01/2020 through 06/30/2020 revealed Resident #3 missed the following: 22 doses of his [MEDICATION NAME] 6 units subcutaneous injection four times a day (medication for Diabetes Mellitus); 10 doses of Prostat 30 millilters (nutritional supplement); 10 doses of [MEDICATION NAME] EC 325mg tablet (for [MEDICAL CONDITION]); 19 doses
of [MEDICATION NAME] 12.5 milligrams (mg) tablet (for Hypertension); 11 doses of [MEDICATION NAME] 759 mg. tablet (for [MEDICAL CONDITION]); 11 doses of [MEDICATION NAME] 0.4 mg capsule (for Enlarged Prostate); 11 doses [MEDICATION NAME] 60
mg. tablet (for Hypertension); 11 doses of Allopuriol 100 mg. tablet (for Gout); 11 doses of Aspirin EC 81 mg. tablet (due to history of Stroke); 21 doses of [MEDICATION NAME] 800 mg. tablet (for End Stage [MEDICAL CONDITION]). Review of Resident #3's nurses notes revealed no refusal of medications, activity of daily living, or treatments for April, May or June of 2020. In a phone interview on 07/02/2020 at 4:20pm, S9License Practical Nurse (LPN) stated if medications for Resident #3 were not given during her shift it was due to either low blood pressure, low blood sugar, or resident was not in the facility. In a phone interview on 07/06/2020 at 9:28am, S7LPN stated the only time Resident #3 would not receive medications as ordered was if he was not in the facility when medications are due or if he was not feeling well at which time she would do a blood glucose and blood pressure before administering his scheduled medications. If low she would hold the dose and document this on the MAR. In a phone interview on 07/06/2020 at 1:30pm, S2Director of Nursing (DON) stated that all medications not given should be documented on the MAR as not given with a reason for this action. Any documentation explaining the missed medication was requested but was never received by the surveyor. Resident #5 Review of Resident #5's record revealed [DIAGNOSES REDACTED]. Review of Resident #5's June 2020 [MEDICAL TREATMENT] communication
forms revealed Resident #5 attended [MEDICAL TREATMENT] on Tuesday, Thursday and Saturdays. Review of Resident #5's Physician order [REDACTED]. daily; [MEDICATION NAME] (medication used to lower blood pressure) 20mg by mouth three times a
day; [MEDICATION NAME] (medication used to lower blood pressure) 25mg take one tablet by mouth twice daily; [MEDICATION
NAME] (medication used to treat depression) 50mg one tablet daily; [MEDICATION NAME] (diuretic medication used for swelling/[MEDICAL CONDITION]) 80mg take one tablet by mouth once every Sunday, Tuesday, Thursday, and Saturday; Losartan Potassium (medication used to lower blood pressure) 50mg take one tablet by mouth daily at 9:00am; Aspirin (medication used to prevent platelet formation) 81mg one tablet by mouth daily at 8:00am; Prostat (sugar-free liquid protein supplement)
30ml by mouth twice daily at 8:00am and 4:00pm for 30 days (order dated 06/03/2020); and House Supplement (oral nutritional supplement) give four ounces by mouth daily at 9:00am. Review of Resident #5's Medication Administration Record (MAR) dated 06/01/2020 through 06/23/2020 revealed multiple doses of medications were documented as not administered with no documentation of reason dose was missed. Further review of Resident #5's June 2020 MAR revealed in part, the following medications and dosages missed: [MEDICATION NAME] N [MEDICATION NAME] 100 unit/milliliter (ml) inject ten units subcutaneous twice daily scheduled at 2:00pm and 10:00pm - 9 doses documented with an N (not administered-resident not available). [MEDICATION NAME] 800 milligrams take 3 tablets by mouth three times daily with meals at 8:00am, 12:00pm and 4:00pm- 19 doses documented with an N (not administered-resident not available). [MEDICATION NAME] 5mg take two tablets once daily at 9:00am- 12 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (medication used to lower blood pressure) 20mg by mouth three times a day at 8:00am, 12:00pm and 4:00pm- 17 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (medication used to lower blood pressure) 25mg take one tablet by mouth twice daily at 9:00am- 17 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (medication used to treat depression) 50mg one tablet daily at 8:00am- 10 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (diuretic medication used for swelling/[MEDICAL CONDITION]) 80mg take one tablet by mouth once every Sunday, Tuesday, Thursday, and Saturday at 8:00am- 10 doses documented with an N (not administered-resident not available). Losartan Potassium (medication used to lower blood pressure) 50mg take one tablet by mouth daily at 9:00am - 13 doses documented with an N (not administered-resident not available). Aspirin (medication used to prevent platelet formation) 81mg one tablet by mouth daily at 8:00am- 10 doses documented with an N (not administered-resident not available). Prostat (sugar-free liquid protein supplement) 30ml by mouth twice daily at 8:00am and 4:00pm for 30 days (order dated 06/03/2020) - 11 doses documented with an N (not administered-resident not available). House Supplement (oral nutritional supplement) give four ounces by mouth daily at 9:00am- 9 doses documented with an N (not administered-resident not available). Review of Resident #5's entire MAR dated June 2020 revealed no documentation of coordinating Resident #5's medication times with his [MEDICAL TREATMENT] days/times. Further review of MAR dated June 2020 revealed reason medications not administered was resident not available; however the medications were not administered when the resident returned from [MEDICAL TREATMENT]. Review of Resident #5's nurse's notes for June 2020 revealed no documentation of the reason medications were not administered when Resident #5 returned from [MEDICAL TREATMENT] and no refusals of medications. Further review of nurse's notes for June 2020 revealed no documentation of notifying the physician to change times of Resident #5's medications or changing times of his once a day medications. In a telephone interview on 07/01/2020 at 3:04pm, S9Licensed Practical Nurse (LPN) stated she worked on the COVID unit and was Resident #5's nurse on the 3:00pm to 11:00pm shift. She stated Resident #5 went to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday's and he would normally return from [MEDICAL TREATMENT] between 3:00pm and 5:00pm. S9LPN stated she was only
responsible for administering Resident #5's medications on his MAR that were scheduled on her 3:00pm to 11:00pm shift. When questioned if she administered the once a day medications scheduled when Resident #5 was at [MEDICAL TREATMENT], she stated no. In a telephone interview on 07/01/2020 at 3:38pm, S10Registered Nurse (RN) stated Resident #5 went to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday's and the medications that were scheduled when Resident #5 was at [MEDICAL TREATMENT] were not given on the days he went to [MEDICAL TREATMENT]. S10RN stated she did not recognize this as a problem
until S2DON called her today. In an interview on 07/01/2020 at 2:45pm, S2Director of Nursing (DON) confirmed a N documented on the MAR signified a medication was not administered. S2DON stated all medications should be administered when Resident #5 returns from [MEDICAL TREATMENT] and the MAR should be documented when the medications are administered. S2DON reviewed
Resident #5's MAR dated June 2020 and confirmed there were multiple medications that were scheduled while Resident #5 was at [MEDICAL TREATMENT] and those medications were not documented as given once he returned. She confirmed the medication times were not adjusted to coordinate with his [MEDICAL TREATMENT] times and agreed it was a good idea to get the times changed for Resident #5's medications.

F 0756

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0756

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 3)
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to ensure the Pharmacist conducted a thorough medication regimen review which identified and reported [MEDICAL TREATMENT] residents not receiving medications as ordered by the Physician for 3 (Resident #2, Resident #3 and Resident #5) out of the 5 sampled residents. This deficient practice had the potential to affect any of the 123 residents residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (Form CMS-672). Findings: Resident #2 Review of Resident #2's record revealed [DIAGNOSES REDACTED]. Review of Resident #2's June 2020 Physician order [REDACTED]. pressure) 10mg tablet take one tablet by mouth once every day; [MEDICATION NAME] (medication for depression) 50mg tablet take one tablet by mouth once a day; [MEDICATION NAME] (medication used to prevent gout) 100mg tablet give one tablet by mouth daily; [MEDICATION NAME] (medication to lower phosphorus levels) 800mg tablet take two tablets by mouth with meals; [MEDICATION NAME] (medication used to breakdown food into nutrients) 36,000 units capsule take three times a day with meals. Review of Resident #2's Care Plan revealed in part, the following: Problem: End Stage [MEDICAL CONDITION], receiving [MEDICAL TREATMENT] Monday, Wednesday and Friday at FMC Kenner, Approaches: administer mediations as ordered and Notify physician of any significant changes. Review of Resident #2's Medication Administration Record (MAR) dated 06/01/2020 through 06/30/2020 revealed the following medications were documented as not administered with no reason as to why the medications were not given. Further review of Resident #2's June 2020 MAR revealed in part, the following mediations were not administered as ordered with no documentation as to why: [MEDICATION NAME] HCL (mediation to lower blood pressure) 0.1 milligrams (mg) take one tablet by mouth two times every day- 37 doses documented with an N (not administered).; [MEDICATION NAME] (medication to reduce extra fluid in the body) 2 milligram (mg) take one tablet by mouth two times every day- 11 doses documented with an N (not administered). ; [MEDICATION NAME] (mediation to lower blood pressure) 10mg take one tablet by mouth once every day- 21 doses documented with an N (not administered).; [MEDICATION NAME] (medication to treat depression) 50mg take one tablet by mouth once a day- 11 doses documented with an N (not administered).; [MEDICATION NAME] (medication used to prevent gout) 100mg give one tablet by mouth daily- 11 doses documented with an N (not administered).; [MEDICATION NAME] (mediation to lower phosphorus levels) 800mg take two tablets by mouth with meals- 23 doses documented with an N (not administered).; [MEDICATION NAME] (mediation used to breakdown food into nutrients) 36,000 units take three times a day with meals- 26 doses documented with an N (not administered). Review of Resident #2's Administration Record for June 2020 revealed medications documented with a N as not administered because resident not available or requirement not met. There was no documentation of the physician being notified, nor an effort to coordinate the medication times with Resident #2's [MEDICAL TREATMENT] days. Review of Resident #2's Nurses Notes for June 2020 revealed no documented evidence that nursing staff attempted to coordinate Resident #2's medication times with his [MEDICAL TREATMENT] days/times. In a telephone interview on 07/01/2020 at 1:09pm S7Licensed Practical Nurse (LPN) stated Resident #2 attends [MEDICAL TREATMENT] on Mondays, Wednesdays and Friday's. The Resident will leave the facility about 9 am. S7LPN further stated when resident #2 goes to [MEDICAL TREATMENT] not all her morning medications are given because of the time she leaves. In a telephone interview on 07/02/2020 at 8:25am S2DON stated the documented N on the MAR stands for Not Administered. When the nurse documents an N it could be for the refusal of medication, the requirement not met, the resident is not available or the medication is on hold. S2DON stated if the resident does not go to [MEDICAL TREATMENT] or a mediation is not given the nurse should document an N on the MAR and write a note explaining more detail. In a telephone interview on 07/02/2020 at 9:20am resident #2 stated she attends [MEDICAL TREATMENT] three days a week on Monday, Wednesday and Friday's. Resident #2 stated on her [MEDICAL TREATMENT] days she only takes medications early in the morning and takes what the nurse gives her. Review of Resident #2's Pharmacy Review revealed the pharmacist consultant did not include the irregularities on Resident #2's MAR. Resident #2's drug regimen review was done monthly; however the drug regimen review must include a review of resident #2's medical record to include the MAR. In a telephone interview on 07/06/2020 at 12:17pm S2DON stated she did see multiple documentation of a N documented on Resident #2's MAR; therefore Resident #2 did not get those mediations. S2DON stated Resident #2's mediations scheduled in the morning on Mondays, Wednesdays and Fridays were not administered because the resident was at [MEDICAL TREATMENT]. S2DON stated if Resident #2's medications were not administered there should have been coordination with the physician. S2DON stated the pharmacist was reviewing resident records remotely because he had access to the resident's electronic records, including the MARs. S2DON stated she did not recall the consulting pharmacist reporting any irregularities concerning Resident #2's MAR. Resident #3 Review of Resident # 3's record revealed an admitted [DATE] with diagnoses, in part, of [MEDICAL CONDITION] following Cerebral Infarction affecting right dominant side, End Stage [MEDICAL CONDITIONS], Type 2 Diabetes Mellitus, Hypertension, [MEDICAL CONDITION]. Review of Resident #3's MDS with an ARD of 05/22/2020 revealed, in part: BIMS of 0 (severely cognitively impaired); No refusal of behavior noted; Insulin used 7 out of 7 days and Opioids 1 out of 7 days; [MEDICAL TREATMENT]. Review of Resident #3's physician's orders [REDACTED].) 1 tablet by mouth daily; [MEDICATION NAME] EC 325 mg. 1tablet by mouth daily; [MEDICATION NAME] 12.5mg. 1tablet by mouth twice a day; [MEDICATION NAME] 750mg. 1 tablet by mouth twice a day; [MEDICATION NAME] 0.4mg. 1 capsule by mouth daily;[MEDICATION NAME] 60 mg. 1 tablet by mouth daily; [MEDICATION NAME] 100 mg. 1 tablet by mouth daily; AspirinEC 81 mg. 1 tablet by mouth daily; [MEDICATION NAME] 800 gm. 1 tablet by mouth with meals. Review of Resident #3's Medication Administration Record (MAR) from 06/01/2020 through 06/30/2020 revealed Resident #3 missed the following: 22 doses of his [MEDICATION NAME] medication subcutaneous injection (medication for Diabetes Mellitus); 10 doses of Prostat 30 millilters (nutritional supplement); 10 doses of [MEDICATION NAME] EC 325mg tablet (for [MEDICAL CONDITION]); 19 doses of [MEDICATION NAME] 12.5 milligrams (mg) tablet (for Hypertension); 11 doses of [MEDICATION NAME] 759 mg. tablet (for [MEDICAL CONDITION]); 11 doses of [MEDICATION NAME] 0.4 mg capsule (for Enlarged Prostate); 11 doses [MEDICATION NAME] 60 mg. tablet (for Hypertension); 11 doses of Allopuriol 100 mg. tablet (for Gout); 11 doses of Aspirin EC 81 mg. tablet (due to history of Stroke); 21 doses of [MEDICATION NAME] 800 mg. tablet (for End Stage [MEDICAL CONDITION]). Resident #5 Review of Resident #5's record revealed [DIAGNOSES REDACTED]. Review of Resident #5's [MEDICAL TREATMENT] communication forms revealed Resident #5 attended [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday's. Review of Resident #5's Physician order [REDACTED]. once daily; [MEDICATION NAME] (medication used to lower blood pressure) 20mg by mouth three times a day; [MEDICATION NAME] (medication used to lower blood pressure) 25mg take one tablet by mouth twice daily; [MEDICATION NAME] (medication used to treat depression) 50mg one tablet daily; [MEDICATION NAME] (diuretic medication used for swelling/[MEDICAL CONDITION]) 80mg take one tablet by mouth once every Sunday, Tuesday, Thursday, and Saturday; Losartan Potassium (medication used to lower blood pressure) 50mg take one tablet by mouth daily at 9:00am; Aspirin (medication used to prevent platelet formation) 81mg one tablet by mouth daily at 8:00am; Prostat (sugar-free liquid protein supplement) 30ml by mouth twice daily at 8:00am and 4:00pm for 30 days (order dated 06/03/2020); and House Supplement (oral nutritional supplement) give four ounces by mouth daily at 9:00am. Review of Resident #5's MAR dated 06/01/2020 through 06/23/2020 revealed multiple doses of mediations were documented as not administered with no reason dose was missed. Further review of Resident #5's June 2020 MAR revealed in part, the following medications and dosages missed: [MEDICATION NAME] N [MEDICATION NAME] 100 unit/milliliter (ml) inject ten units subcutaneous twice daily scheduled at 2:00pm and 10:00pm - 9 doses documented with an N (not administered- resident not available). [MEDICATION NAME] 800 milligrams take 3 tablets by mouth three times daily with meals at 8:00am, 12:00pm and 4:00pm- 19 doses documented with an N (not administered- resident not available). [MEDICATION NAME] 5mg take two tablets once daily at 9:00am- 12 doses documented with an N (not administered- resident not available). [MEDICATION NAME] (medication used to lower blood pressure) 20mg by mouth three times a day at 8:00am, 12:00pm and 4:00pm- 17 doses documented with an N (not administered- resident not available). [MEDICATION NAME] (medication used to lower blood pressure) 25mg take one tablet by mouth twice daily at 9:00am- 17 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (medication used to treat depression) 50mg one tablet daily at 8:00am- 10 doses documented with an N (not administered-resident not available). [MEDICATION NAME] (diuretic medication used for swelling/[MEDICAL CONDITION]) 80mg take one tablet by mouth once every Sunday, Tuesday, Thursday, and Saturday at 8:00am- 10 doses documented with an N (not administered- resident not available). Losartan Potassium (medication used to lower blood pressure) 50mg take one tablet by mouth daily at 9:00am - 13 doses documented with an N (not administered- resident not available). Aspirin (medication used to prevent platelet formation) 81mg one tablet by mouth daily at 8:00am- 10 doses documented with an N (not administered- resident not available). Prostat (sugar-free liquid protein supplement) 30ml by mouth twice daily at 8:00am and 4:00pm for 30 days (order dated 06/03/2020) - 11 doses documented with an N (not administered resident not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195374	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOSEPH OF HARAHAN	**405 FOLSE DRIVE HARAHAN, LA 70123**

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)
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) available). House Supplement (oral nutritional supplement) give four ounces by mouth daily at 9:00am- 9 doses documented with an N (not administered- resident not available). In an interview on 07/02/2020 at 12:25pm, S2Director of Nursing (DON) stated the consulting pharmacist was doing a remote review of resident records because of COVID-19 and he reviewed all Medication Administration Records (MARS) during his monthly review. S2DON stated the consulting pharmacist had full access to their electronic records and MARS. S2DON stated the consulting pharmacist did not inform her of any irregularities or missing medication doses with Resident #5. S2DON stated she was not aware that Resident #5 was not receiving medications on his [MEDICAL TREATMENT] days. In an interview on 07/06/2020 at 11:05am, S2DON stated no one was reviewing the resident MARs for accurate medication administration. S2DON stated she had three different staff that were only reviewing the MARs with the physician orders [REDACTED]. S2DON assumed the pharmacy consultant was reviewing the MARs. In an interview on 07/02/2020 at 1:30pm, S11Pharmcy Consultant stated since March 2020 he was working remotely. S11Pharmacy Consultant stated he had access to the facility's electronic record, but was only reviewing physician's orders [REDACTED]. S11Pharmacy Consultant confirmed he was not reviewing any MARs because he did not know how to work the facility's electronic system. When questioned if he had asked the facility to show him how to access the resident MARs, he stated he had not asked anyone. When surveyor questioned S11Pharmacy Consultant about any concerns with [MEDICAL TREATMENT] residents having missed doses of medications, S11Pharmacy Consultant stated he was not aware that was going on and the physician should be notified. S11Pharmacy Consultant stated, I got my hands tied and it should be reported to the physician. When surveyor informed S11Pharmacy Consultant that Resident #5 had multiple medication dosages that were documented as not given he stated he was not aware that was going on and that should be addressed. When surveyor referred to his Consultant Pharmacist Monthly Reports stating he reviewed medication administration documentation he stated yes, I should change that because I'm just reviewing physician orders. In a joint interview with S1Administrator and S2DON on 07/02/2020 at 1:55pm, S2DON stated since COVID-19 the pharmacy consultant was working remotely and he was given access to the facility's medical record, including the MARs. S1Administrator and S2DON confirmed the pharmacy consultant did not ask either of them for assistance in accessing the electronic MARs. When surveyor referred them to the Consultant Pharmacist Monthly Reports, S2DON stated if it was on his report, then he did it. When surveyor informed S1Administrator and S2DON that the consulting pharmacist confirmed he was only reviewing physician orders [REDACTED].