STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195632	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAFON NURSING FACILITY OF THE HOLY FAMILY	**6900 CHEF MENTEUR HWY NEW ORLEANS, LA 70126**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to implement the plan of care by failing to: 1.) Ensure a residents plan of care for notifying the responsible party (RP) of a residents condition was implemented (Resident #1); and 2.) Ensure a resident's plan of care for daily weights was implemented (Resident #5.) This deficient practice was identified in 2 (Resident #1 and Resident #5) of 5 sampled residents and the potential to affect the 99 residents as documented on the facility's census list. Findings: Resident #1 Resident #1 was admitted on [DATE] with a diagnoses, in part, of Cognitive Communication Deficit, Muscle Weakness, Age Related Physical Debility and Urinary Tract Infection. Review of Resident #1's plan of care revealed in part, a problem identified for a coccyx pressure ulcer with a goal of the wound would heal without signs and symptoms of infection by the next 90 days with a target date of 07/29/2020. Further review of the plan of care revealed one approach to notify RP of resident's condition and what actions are being taken. Review of Resident #1's nurse's note dated 06/07/2020 at 3:35pm revealed in part, summoned to resident's room per CNA (Certified Nursing Assistant). Further review revealed an open area noted to coccyx. Review of Resident #1's record revealed no documented evidence of Resident #1's Responsible Party being notified on 06/07/2020. Further review revealed no documented evidence that Resident #1's RP was notified of the new wound to Resident #1's coccyx area. In an interview on 08/28/2020 at 11:47am, S2Director of Nursing (DON) indicated she was unable to find documentation of Resident #1's RP being notified when the nurse identified the initial (coccyx) wound. S2DON further indicate she could not find documentation of the RP being updated after Resident #1 was seen by the wound care doctor on 06/17/2020 and 07/01/2020. In an interview on 08/28/2020 at 12:06pm, S5Registered Nurse (RN) was questioned if she had notified Resident's #1's RP when the wound to her coccyx was identified, and S5RN stated she could not remember. In an interview on 09/01/2020 at 10:38am, S2DON acknowledged Resident #1's RP should have been notified of Resident #1's wound when it was discovered and when the physician performed wound care. Resident #5 Review of Resident #5's record revealed he was admitted to the facility on [DATE] with diagnoses, in part, of Congestion Heart Failure, Hypertension (HTN), and Acute Kidney Failure. Review of Resident #5's Medication Review Report for August 2020 revealed a physician order [REDACTED]. Review of Resident #5's plan of care revealed in part, a problem identified on 03/31/2020 with an approach to weigh Resident #5 daily. Further review of the plan of care revealed a revision to the plan of care on 08/03/2020 for staff to weigh and record daily weights as ordered per physician. Review of Medication Administration Record (MAR) dated July and August 2020 revealed in part, no documentation of Resident #5's weights when he was not refusing to be weighed. Review of Weights and Vitals Summary revealed a weight recorded on 07/01/2020 and on 08/03/2020. In an interview on 08/28/2020 at 9:20am, S4Licensed Practical Nurse (LPN) stated Resident #5 had swelling to his lower extremities for which was why his weight was monitored and he was taking diuretics, and wearing compression stockings. S4LPN stated Resident #5 daily weights were not documented because they were not weighing Resident #5. In an interview on 08/28/2020 at 10:56am S2DON stated Resident #5 was compliant with care and did not refuse care. S2DON reviewed Resident #5's MAR for July 2020 and August 2020 and stated daily weights were not being done as ordered. S2DON stated there is documentation of his refusal. When asked if any notes of refusal reported to the doctor she stated there was no notification to the doctor to see about changing the order. S2DON was asked about the documentation of a 2, 5 and 9 on the MAR, S2DON stated the legend was on the bottom of the MAR but a 9 is other and see progress notes, a 2 is Drug refused and a 5 is hold/See Progress notes. S2DON in reviewed the MAR and the Nurse's Notes and stated there was no follow up documentation for refusal of weights. In an interview on 08/31/2020 at 12:00pm, S3LPN stated she was in charge of the weight program. S3LPN stated daily weights are done by the night nurse and recorded on the MAR. In reviewing Resident #5's record, S3LPN stated the only documented weights for July 2020 and August 2020 were on 07/01/2020 and 08/03/2020. In an interview on 08/31/2020 at 2:30pm, Resident #5 stated he had not been weighed for some time. Resident #5 denied any refusals of being weighed. In an interview on 08/31/2020 at 3:42pm, S2DON stated Resident #5 had an order for [REDACTED].
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure a resident's medical record was accurately documented in accordance with professional standards for the following: wound care, vital signs every shift, monitored for flu like symptoms and oxygenation saturations. This deficient practice was identified for 1(Resident #1) of 5 sampled residents but had the potential to affect any of the 99 residents who were on the facility's census list. Findings: Resident #1 was admitted on [DATE] with diagnoses, in part of, Cognitive Communication Deficit, Muscle Weakness, Age Related Physical Debility and Urinary Tract Infection. Review of Resident#1's Physician orders [REDACTED].#1's Stage 2 coccyx pressure injury with [MEDICATION NAME], pat dry, and apply honey dressing. Cover with dry bordered dressing. Change every day and as needed. Review of Resident#1's Physician orders [REDACTED]. Further review of Resident #1's order to discontinue previous treatment order and cleanse with [MEDICATION NAME], apply honey alginate, cover with dry dressing, change every day and as needed. Review of Resident#1's Physician orders [REDACTED]. Further review of the order revealed to change to Stage 4 pressure injury to coccyx extending to bilateral buttocks, discontinue previous orders, cleanse with [MEDICATION NAME], pat dry, apply santyl, and cover with calcium alginate and dry dressing. Change every day and as needed. Review of Resident#1's Physician orders [REDACTED]. Further review of the Resident #1's orders revealed to cleanse with normal saline, pat dry, apply santyl, pack with gauze moist 0.125% Dakin's solution, cover with dry gauze dressing. Change daily and as needed. Further review of Resident #1's orders revealed in part, left heel deep tissue injury, discontinue previous treatment orders, cleanse with [MEDICATION NAME], pat dry, apply [MEDICATION NAME], pat or air dry completely and cover with dry gauze dressing. Change daily and as needed. Review of Resident #1's June and July 2020 orders revealed in part, vital signs every shift and monitor for flu like symptoms. Further review of Resident #1's orders revealed in part, to notify physician of temperature greater than 100.4 and oxygen saturations below 90% every shift for COVID prevention. Review of Resident #1's Electronic Treatment Administration Record (eTAR) dated June 2020 revealed in part, no daily documentation of wound care on to resident #1's coccyx on the following dates: 06/12/2020; 06/16/2020; 06/18/2020; 06/20/2020; 06/21/2020; 06/23/2020; 06/24/2020; 06/25/2020; 06/27/2020; and 06/29/2020. Review of Resident #1's Electronic Treatment Administration Record (eTAR) dated July 2020 revealed no daily documentation of wound care to Resident #1's coccyx on the following dates:

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 07/03/2020; 07/04/2020; 07/05/2020; and 07/06/2020. Review of Resident #1's Electronic Treatment Administration Record (eTAR) dated July 2020 revealed no daily documentation of wound care to Resident #1's left heel on the following dates: 07/03/2020; 07/04/2020; 07/05/2020; and 07/06/2020. Review of Resident #1's Electronic Medication Administration dated July 2020 revealed in part, no documentation of Resident #1's vital signs every shift, temperature and oxygen saturations on the following dates: 07/02/2020 on the evening shift; 07/03/2020 on evening shift; 07/04/2020 on day and night shifts; 07/05/2020 on day, evening and night shifts; and 07/06/2020 on day and evening shifts. In an interview on 09/01/2020 at 10:38am, S2Director of Nurses (DON) acknowledged the nurses should have documented Resident #1's wound care as ordered when it was done. There was no documented evidence reviewed and the facility provided no documented evidence of Resident #1's wound care, and vital sign documentation for the above mentioned dates.