STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195471	A. BUILDING _____ B. WING _____	**10/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEFFERSON MANOR NURSING AND RE	**9919 JEFFERSON HWY. BATON ROUGE, LA 70809**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** Based on record reviews, observations, and interviews, the facility failed to ensure needs were accommodated by not ensuring call lights were in reach for 4 (#3, R8, R9, R10) of 10 (#1, #2, #3, #4, #5, #6, #7, R8, R9, and R10) residents observed for call lights. Findings: Review of Resident R9's most recent Care Plan revealed three separate problems with an intervention of keep call light in reach related to High risk for falls, Sensory Perception Altered due to poor vision, and Thought Process Impaired. On 10/04/2020 at 12:41 a.m., an observation was made in Resident R9 and Resident #3's room with S17LPN present. Resident R9 and Resident #3 were in their beds sleeping. Both residents' call lights were located on the floor and not within the residents' reach. S17LPN stated both residents were capable of using their call lights and both residents used their call lights for assistance. She confirmed Resident R9's call light was on the floor and she would not be able to reach the call light to call for assistance. She confirmed Resident #3's call light was on the floor and she would not be able to reach the call light to call for assistance Review of Resident R10's most recent Care Plan revealed three separate problems with an intervention of keep call light in reach related to Sensory Perception Altered, Falls, and Chronic Idiopathic Constipation. On 10/04/2020 at 12:52 a.m., an observation was made in Resident R10's room with S17LPN present. Resident R10 was sleeping in her bed. Resident R10's call light was located in the top drawer of her bedside table. The call light and the call light cord was not within the resident's reach. S17LPN stated Resident R10 was capable of using her call light and used her call light for assistance. S17LPN confirmed Resident R10 would not be able to reach the call light to call for assistance. Review of Resident R8's most recent Care Plan revealed two separate problems with an intervention of keep call light in reach related to Thought Process Impaired and Visual Deficit. On 10/05/2020 at 9:17 a.m., an observation and interview was conducted with Resident R8. She was seated in a recliner chair. Resident R8's call light was on the floor on the far side of her oxygen concentrator and out of her reach. She stated she did not know where her call light was. She looked around and said she could not see it. On 10/05/2020 at 9:24 a.m., an interview was conducted with S16LPN in Resident R8's room. She confirmed Resident R8's call light was on the floor and was not within Resident R8's reach. She said Resident R8 was capable of using the call light. She confirmed Resident R8 would not be able to reach the call light. On 10/08/2020 at 9:46 a.m., an interview was conducted with S6ADON. She stated everyone working in the facility was responsible for making sure residents could reach their call lights. She said staff were expected to make rounds to ensure call lights were in reach for resident capable of using their call lights. She was made aware of the above findings and confirmed it was not acceptable for the call lights to be out of the residents' reach.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure services were provided to meet quality professional standards by administering a second dose of 12.5 milligrams of [MEDICATION NAME] intramuscularly without a physician's order for 1 (#4) of 7 (#1, #2, #3, #4, #5, #6, and #7) residents reviewed for unnecessary medications. Findings: Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses, which included [MEDICAL CONDITION], Type 2 Diabetes Mellitus, Vomiting, [MEDICAL CONDITION], Lack of Coordination, Repeated Falls, and Cognitive Communication Deficit. Resident #4 resided on Hall A. Review of the August 2020 Physician's Orders revealed, in part: 08/11/2020 5:00 p.m. [MEDICATION NAME] 25 mg/ml [MEDICATION NAME], Give 12.5 mg Intramuscular Injection one time dose now Review of the Departmental Notes revealed, in part: 08/11/2020 4:56 p.m., this nurse noted Resident #4 vomited coffee ground emesis. Spoke with the on call Nurse Practitioner and received a new order. Give one time dose of [MEDICATION NAME] 12.5 mg intramuscular injection now. 08/12/2020 12:20 a.m., Resident #4 was found with coffee ground emesis. [MEDICATION NAME] 12.5 mg intramuscular injection given in the right deltoid. Review of the August 2020 Medication Administration Record [REDACTED]. This medication was administered at 5:00 p.m. on 08/11/2020, which was indicated by S13LPN's initials and a check mark. An observation was made of the facility's emergency medication kit with S12MR present on 10/08/2020 at 11:40 a.m. S12MR removed a small plastic container with three multi-dose vials of [MEDICATION NAME]. Each vial contained 25 mg/1ml. After the observation, an interview was immediately conducted with S12MR. She confirmed the vial of [MEDICATION NAME] contained 25mg/ml and was a multi-dose vial. An interview was conducted with S2DON on 10/08/2020 at 12:45 p.m. She confirmed the nurse's note dated 08/12/2020 revealed a second dose of [MEDICATION NAME] was administered at 12:15 a.m. An interview was conducted with S13LPN on 10/08/2020 at 2:25 p.m. She confirmed she worked with Resident #4 on 08/11/2020 from 2:00 p.m. to 10:00 p.m. She stated she received an order for [REDACTED]. She stated she did not discard the remaining 12.5 mg of [MEDICATION NAME] and placed the vial in the top drawer of the medication cart. She stated she told S15LPN, in report at 10:00 p.m., she had administered 12.5 mg of [MEDICATION NAME] at 5:00 p.m. and kept the remaining 12.5 mg in case it was needed. She confirmed she did not waste the remaining 12.5 mg of [MEDICATION NAME] and made S15LPN aware the [MEDICATION NAME] was available in the medication cart if needed. An interview was conducted with S2DON on 10/08/2020 at 2:33 p.m. After reviewing Resident #4's clinical record, she verified there was no physician's order for the [MEDICATION NAME] 12.5 mg administered on 08/12/2020 at 12:20 a.m. An interview was conducted with S8CORP on 10/08/2020 at 3:08 p.m. She confirmed she provided copies of all the Physician's Orders for the month of August 2020, and there was no order for the [MEDICATION NAME] 12.5 mg to be administered on 08/12/2020 at 12:20 a.m. She stated obtaining a Physician's Order prior to administering a medication was in the LPN's scope of practice.

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.