| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **195394** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **COLONIAL MANOR NURSING & REHABILITATION HOME** | **307 FOSTER STREET RAYVILLE, LA 71269** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews the facility failed to inform the physician of a resident's change in condition for 1 (#30) of 7 (#2, 7, 15, 30, 41, 47, and 316) residents reviewed for unnecessary medications. The facility failed to ensure the physician was notified when resident #30's [MED] was not administered as ordered. Findings: Review of the medical record revealed for sampled resident #30 revealed [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Brief Interview for Mental Status (BI[CONDITION]) revealed moderately cognitively impaired with daily decision making. Review of the care plan revealed the resident had diabetes mellitus and to encourage to practice good health, lose weight if needed, get adequate sleep and exercise, and wash feet daily with soap and water. Review of the physician orders [REDACTED]. Review of the February 2020 physician orders [REDACTED]. Further review of the physician orders [REDACTED]. Review of the December 2019 Medication Administration Record (MAR) for the [MEDICATION NAME] ([MED]) revealed 19 times a #4 was documented above the nurses' initials for administration of the [MED]. Review of the January 2020 MAR for [MEDICATION NAME] ([MED]) revealed 11 times a #4 was documented above the nurses' initials for administration of the [MED]. Review of the February 2020 MAR for [MEDICATION NAME] ([MED]) revealed 16 times a #4 was documented above the nurses' initials for administration of the [MED]. Review of the March 2020 MAR for [MEDICATION NAME] ([MED]) revealed two times a #4 was documented above the nurses' initials for administration of the [MED]. Further review of the December 2019, January 2020, February 2020 and March 2020 MAR revealed #4 indicated vitals outside of parameters for administration. On 03/04/2020 at 1:20PM an interview with S2DON (Director of Nursing) revealed the #4 documented on the MAR indicated that the medication was held due to it did not meet requirements. On 03/05/2020 at 9:30AM S2DON revealed there was no documentation that the physician was notified of the blood sugar levels and the [MED] being held. S2DON further revealed there were no parameters noted for when to hold the [MED]. On 03/05/2020 at 10:00AM a phone interview was conducted with the resident's nurse practitioner. The nurse practitioner confirmed she was not notified when the [MED] was not administered. |
| F 0756<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the pharmacist failed to identify and report irregularities to the physician and director of nursing for 3 (#2, #7, #30) of 7 (#2, #7, #15, #30, #41, #47, and #316) residents reviewed for unnecessary medications. The facility failed to monitor for side effects and behaviors for 2 (#2 and #7) residents that received [MEDICAL CONDITION] medications, and and resident #30's [MED] was not administered as ordered. Findings: Resident #30 Review of the medical record revealed for sampled resident #30 revealed [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Brief Interview for Mental Status (BI[CONDITION]) revealed moderately cognitively impaired with daily decision making. Review of the care plan revealed the resident had diabetes mellitus and to encourage to practice good health, lose weight if needed, get adequate sleep and exercise, and wash feet daily with soap and water. Review of the physician orders [REDACTED]. Review of the December 2019 Medication Administration Record (MAR) for the [MEDICATION NAME] ([MED]) revealed 19 times the [MED] was not administered. Review of the January 2020 Medication Administration Record (MAR) for the [MEDICATION NAME] ([MED]) revealed 11 times the [MED] was not administered. Review of the Medication Regimen Review Verification Log signed and dated by the pharmacist on [DATE] and 02/06/2020 revealed the pharmacist did not address the [MED] not being administered as ordered. On 03/05/20 at 9:30AM an interview with S2DON (Director of Nursing) revealed there was no order to hold the [MEDICATION NAME] ([MED]) and the pharmacist did not address the [MED] not administered on the monthly Drug Regimen Review.<br><br>Resident #7 On 03/04/2020 review of the record for Resident #7 revealed [DIAGNOSES REDACTED]. Review of the current physician orders [REDACTED]. Review of plan of care dated 0[DATE] revealed: Impaired cognition function/dementia or impaired thought processes related to dementia- Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Further review of the plan of care revealed the resident has mood problems related to anxiety. Resident will sit in room and holler out uncontrollably. Resident not easily redirected. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of the MAR (Medication Administration Record) for February 2020 and March 2020 revealed behavior monitoring- Monitor for the following: itching, picking at skin, restlessness (agitation) hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Document Y is monitored and none of the above observed. N if monitored and any of the above was observed, select chart code Other/ See Nurses' Notes and progress note findings every shift. On 03/04/20 at 03:00 PM interview with S2DON (Director of Nurses) confirmed the order on the MAR is a generic order set for antipsychotics and behavior monitoring and does not monitor for the specific targeted behavior for the resident. S2DON further confirmed the order for a Y means no behaviors and N means there were behaviors on the MAR and the nurses' were to document the specific behavior in the nurses' notes. Review of the MAR for February 2020 and March 2020 revealed the nurses' documented a N every day except for on [DATE]. Review of the nurses notes for February 2020 revealed no documentation of the specific behavior for each day an N was documented. Review of the March 1-4, 2020 MAR revealed the nurses' document an N every shift except the evening shift on 0[DATE] and 0[DATE]. Review of the nurses notes for March 2020 revealed no documentation of the specific behavior for each day and N was documented. On 03/04/2020 interview with S2DON revealed the nurses' were documenting an N which means resident was having behaviors daily and the nurses were to document in the nurses notes and note what the behaviors were; however the nurses were not documenting behaviors when a N was documented. Further interview with S2DON confirmed the monitoring was not done per the order. Further review of the record revealed no documentation of monitoring for side effects of the medication. Review of the Drug Regimen Review for December 2019, January 2020 and February 2020 revealed the Pharmacist did not report that there was no monitoring for the side effects of the [MEDICATION NAME] and the behavior monitoring was not accurate. On 03/05/20 at 10:12 AM interview with S2DON confirmed there was no side effect monitoring for [MEDICATION NAME]. S2 DON further confirmed the pharmacist did not report the behavior monitoring irregularity and failed to report that there was no side effect monitoring in place for the [MEDICATION NAME].<br><br>Resident #2 Record review revealed resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Most recent completed MDS |

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 0756<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>(minimum data set) under section C (cognitive function) revealed resident # 2 had a BI[CONDITION] (brief interview of mental status) score of 15 indicating he was cognitively intact. Review of the active physician orders [REDACTED]., picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Document N if monitored and none of the above was observed. Y if monitored and any of the above was observed, select chart code other/See Nurses Notes and progress note findings Review of the Medication Administration Record for March 2020 revealed behaviors had been documented as checked daily as directed by physician orders. Medications were also documented as given per physician orders. Further review revealed the nurses were documenting that behaviors were being observed on the medication administration record with no documentation in the nurses notes as directed by the physician orders [REDACTED]. Review of the monthly Medication Regimen Review revealed documentation that the pharmacist reviewed the medications ordered and administered every month for the past year without identifying and reporting irregularities to the facility's medical director and director of nursing. The pharmacist failed to report that the monitoring for side effects of an antipsychotic was not documented daily on the Medication Administration Record. On 03/05/2020 at 10:00 AM an interview with S2DON (director of nursing) confirmed there was inaccurate documentation on the medication administration record that was not reported by the pharmacist. S2DON also confirmed resident #2 was not being monitored for side effects of an antipsychotic on the medication administration record and the pharmacist did fail to report that finding. |
| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to adequately monitor the resident's behaviors for 3 (#7, #41, and #47) ) of 7 (#2, #7, #15, #30, #41, #47, and #316) residents reviewed for unnecessary medications. Findings: Resident #7 On 03/04/20 at 11:18 AM review of the record revealed [DIAGNOSES REDACTED]. Review of the current orders revealed and order dated 02/10/20 for [MED] 20-10 mg (milligrams) BID (twice a day) related to pseudobulbar affect, 11/02/19 for [MEDICATION NAME] [MED] ([MEDICATION NAME]) 50<br>mg QD (every day) for depression, and 10/01/19 for [MEDICATION NAME] 0.5 mg BID for anxiety. Review of plan of care dated 0[DATE] revealed: Impaired cognition function/dementia or impaired thought processes related to Dementia- Interventions: Administer medications as ordered, and monitor/document for side effects and effectiveness, Further review of the care plan revealed the resident has mood problems related to anxiety. The resident will sit in room and holler out uncontrollably.<br>Resident not easily redirected. Interventions: Administer medications as ordered and to monitor/document for side effects and effectiveness. Review of the MAR (Medication Administration Record) for February 2020 and March 2020 revealed behavior monitoring- Monitor for the following: itching, picking at skin, restlessness (agitation) hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Document Y is monitored and none of the above observed. N if monitored and any of the above was observed, select chart code Other/ See Nurses' Notes and progress note findings every shift. Review of the MAR for February 2020 and March 2020 revealed the nurses' documented a N (no) every day except for on [DATE] when a Y (yes) was documented. Review of the nurses notes for February 2020 revealed no documentation of the specific behavior for each day an N was documented. Review of the March 1-4, 2020 MAR revealed the nurses' document an N every shift except the evening shift on 0[DATE] and 0[DATE]. Review of the nurses notes for March 2020 revealed no documentation of the specific behavior for each day and N was documented. On 03/04/20 at 03:00 PM interview with S2DON confirmed the order on the MAR is a generic order set for behavior monitoring and the order does not state to monitor for the specific targeted behavior for the resident. S2DON further confirmed the order for a Y means no behaviors and N means there were behaviors on the MAR and the nurses' were to document the specific behavior in the nurses' notes. On 03/04/2020 interview with S2DON revealed the nurses were documenting an N which means resident was having behaviors daily and the nurses were to document in the nurses notes and note what the behaviors were; however the nurses were not documenting behaviors when a N was documented. Further interview with S2DON confirmed the monitoring was not done per the order.<br><br>Resident #41 Record review revealed resident #41 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of quarterly Minimum (MDS) data set [DATE] revealed the resident's BI[CONDITION] (Brief Interview for Mental Status) score was 6 which represents severe cognitive impairment. The resident received antidepressant medication seven days a week. Review of the March 2020 physician orders [REDACTED]. Further review of the orders revealed to monitor behavior every shift - monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increased in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Document: 'Y' if monitoring and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'other/see nurses notes' and progress note findings. (order start date was 0[DATE]). Review of the February 2020 and March 2020 EMAR (Electronic Medication Administration Record) revealed the resident had received the [MEDICATION NAME] 10 mg by mouth as ordered by the physician. Further review of the February 2020 and March 2020 EMARs revealed the nurses' documented a N or NO for every day. Review of the February 2020 and March 2020 nurses notes and the progress notes revealed no documentation of any specific behavior for each day N or NO was documented. On 03/05/2020 at 10:00 AM an interview with S2DON (Director of Nursing) revealed the nurses were documenting an N or NO which means resident was having behaviors daily and the nurses were to document in the nurses notes and note what the behaviors were; however the nurses were not documenting behaviors when a N or NO was documented. S2DON confirmed that the behavior monitoring documentation for resident #41 was not done per the order. Resident #47 Record review revealed resident #47 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of active March 2020 physician orders [REDACTED]. Review of the MAR (Medication Administration Record) for February 2020 and March 2020 revealed monitor behaviors-monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increased in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, [MEDICAL CONDITION], aggression, refusing care. Document: 'Y' if monitoring and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'other/see nurses notes' and progress note findings every shift. Review of the MAR for February 2020 and March 2020 revealed the nurses documented a N or NO every day except for the following dates: February 1, 2, 12, and 28 of 2020. Review of the nurses notes for February 2020 and March 2020 revealed no documentation of the specific behavior for each day an N or NO was documented. On 03/05/2020 at 10:00AM interview with S2DON revealed the nurses were documenting a N or NO which means resident was having behaviors daily and the nurses were to document in the nurses notes and note what the behaviors were; however the nurses were not documenting behaviors when a N or NO was documented. Further interview with S2DON confirmed the monitoring was not done per the order. |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to ensure that each residents medication regimen was free from unnecessary medications by failing to monitor for side effects for [MEDICAL CONDITION] medications for 3 (#2, #47 and #316) of 7 (#2, #7, #15, #30, #41, #47, and #316) residents reviewed for unnecessary medications. Findings: Resident #316 On 03/05/2020 review of the record for Resident #316 revealed [DIAGNOSES REDACTED]. history of falling, dementia without behavioral disturbance, unspecified [MEDICAL CONDITION] and mood disorder. Review of the current MEDICATION ORDERS FOR<br>[REDACTED]. Review of the record revealed no documentation of monitoring for the side effects of [MEDICATION NAME]. On 03/05/20 at 10:12 AM interview with S2DON (Director of Nursing) confirmed there was no side effect monitoring for the [MEDICATION NAME].<br><br>Resident #2 Record review revealed resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the March 2020<br>active physician orders [REDACTED]. Document N if monitored and none of the above was observed. Y if monitored and any of |

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| F 0758<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>the above was observed, select chart code 'other/See Nurses Notes and progress note findings. Review of the Medication Administration Record [REDACTED]. On 03/05/20 at 10:00AM an interview with S2DON (director of nursing) confirmed the side effects of [MEDICAL CONDITION] drugs had not been documented daily on the Medication Administration Record [REDACTED].<br><br>Resident #47 Record review revealed resident #47 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the active March 2020 physician orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Further review of the record revealed no documentation of the monitoring for the side effects of [MEDICATION NAME], or [MEDICATION NAME]. On 03/05/2020 at 10:00AM an interview with S2DON (Director of Nursing) confirmed there was no side effect monitoring for the antipsychotic medications. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, record reviews and interviews the facility failed to 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. The facility failed to ensure a resident's catheter tubing was not touching the floor for 1 (#20) of 1 (#20) residents reviewed for catheters, and the facility failed to ensure resident's respiratory care equipment was replaced every two weeks for 2 (#28 and #49) of 2 (#28 and #49) residents reviewed for respiratory care. Findings: Resident #49 Review of the medical record for sampled resident #49 revealed [DIAGNOSES REDACTED]. Review of the care plan revealed the resident has a [MEDICAL CONDITION] related to malignant neoplasm of the larynx. On 03/02/2020 at 9:45AM and 1:00PM, observations of the resident's room revealed an [MED]gen mask, suction [MEDICATION NAME], and a bottle of humidified water were stored in separate bags and the storage bags were dated 02/05/20. On [DATE]20 at 9:35AM, observation of the resident's room revealed an [MED]gen mask, suction [MEDICATION NAME], and a bottle for humidified water were stored in separate bags and the bags were dated [DATE]. On 03/04/2020 at 7:30AM observation of the resident's room revealed the [MED]gen mask and bottle for humidified water were stored in separate bags and the bags were dated [DATE]. On 03/04/2020 at 12:45PM an interview with S2DON (Director of Nursing) revealed the [MED]gen mask, bottle for humidified water and suction [MEDICATION NAME] should have been replaced/changed every two weeks.<br>Resident #28 On 03/02/2020 at 09:55 AM, observation revealed resident #28 had nebulizer tubing in a bag on the floor with both the bag and tubing dated 0[DATE]. Record Review revealed resident #28 was admitted [DATE] with active [DIAGNOSES REDACTED]. An active physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of the policy related to changing respiratory care tubing revealed the nebulizer should be changed at least every 2 weeks. On 03/04/20 12:38PM an interview with S2DON (director of nursing) confirmed the nebulizer tubing should have been changed every two weeks as directed per facility policy.<br><br>Resident #20 Review of the medical record for resident #20 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of quarterly Minimum (MDS) data set [DATE] revealed a BI[CONDITION] (Brief Interview for Mental Status) score was 8, which indicated resident had moderate cognitive impairment. The resident required extensive assistance of one person physical assistance with bed mobility, transfers, hygiene, bathing, dressing, and toileting. The resident has an indwelling foley catheter and was incontinent of bowels. Review of March 2020 physician orders [REDACTED]. On 03/02/2020 at 1:30PM an observation of the resident revealed he was sitting in a manual wheel chair in his room and had an indwelling foley catheter. Further observation revealed the catheter tubing was touching the floor. On 03/02/2020 at 1:42PM an observation revealed that S4AD (Activities Director) assisted the resident by pushing him from his room to the day room in his wheel chair. The catheter tubing dragged on the floor as the resident went down the hallway and remained on the floor when the resident arrived to the day room. On [DATE]20 at 11:40AM an observation of the resident revealed that the foley catheter tubing was looped downward and was touching the floor. On 03/04/2020 at 2:00PM an interview with S2DON (Director of Nursing) confirmed that resident #20's foley catheter tubing should not be touching the floor. |