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	195307	A. BUILDING _____ B. WING _____	02/21/2019

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MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

(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	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		3/29/19

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

Electronically Signed | 03/13/2019

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(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the physician for 1 of 1 residents reviewed for dialysis (Resident #90) and 1 of 1 residents reviewed for urinary tract infections (Resident #129) as evidenced by the facility failing to notify the resident's physician:
1. When a resident refused dialysis (Resident #90); and
2. Failed to follow up with the resident's physician for behaviors and foul smelling urine (Resident #129).
This deficient practice had the potential to affect any of the 119 residents who reside at the facility as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents.
Findings:

Resident #90
Record review Resident # 90 was admitted to the facility on 12/13/18 and readmitted to the facility on 1/28/19 for diagnoses in part: Renal Failure with hemodialysis and End Stage Renal Disease.

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Review of Resident # 90's Minimum Data Set (MDS) revealed (1/18/19) Resident #90's Special Treatment checked being on dialysis.

Review of Resident # 90's Care Plan (1/18/19) revealed Resident #90 was care planned for dialysis with approaches in part: if resident refuses dialysis, inform medical doctor.

Record review of Resident #90's nurse's notes on 2/5/19 8:00am revealed in part: Resident #90 refused dialysis. Further review revealed no documentation that Resident #90's Physician was notified that she refused dialysis.

Record review of Resident #90's nurse's notes on 2/12/19 8:00am revealed in part: Resident #90 refused dialysis "with documentation. I am not going." Further review revealed no documentation that Resident #90's Physician was notified that she refused dialysis.

Record review of Resident # 90's nurse's notes on 2/19/19 at 9:00am revealed in part: Resident #90 refused dialysis today, fluid overload noted with shortness of breath and face puffy. Further review revealed no documentation that Resident #90's physician was notified that she refused dialysis.

In an interview on 2/21/19 at 12:35pm, S9 LPN, stated she did not have documentation she notified the physician that Resident # 90 refused dialysis on 2/5/19, 2/12/19 and 2/19/19. She further stated she did not notify Resident #90's primary physician when Resident #90 refused to go to dialysis 2/5/19, 2/12/19 and 2/19/19.

In an interview on 2/21/19 at 12:39pm S2 DON

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confirmed Resident # 90's primary physician was not notified of Resident #90 refusing dialysis on 2/5/19, 2/12/19 and 2/19/19. S2 DON could not present any documented evidence Resident # 90's primary physician was notified when Resident #90 refused to go to dialysis on 2/5/19, 2/12/19 and 2/19/19.

Resident #129
Review of Resident #129's Face Sheet revealed Resident #129 was admitted on 01/11/19 with a diagnosis of, in part, urinary tract infection.

Review of Resident #129's Physician's Fax Notes dated 02/04/19 revealed the nurse notified the physician of current medications and included the resident's behaviors of: the resident getting out of bed and out of the wheelchair unassisted, the resident was resisting care, yelling, hitting, and the resident was unable to be redirect at times. Review revealed the nurse requested the physician to advise on the resident. Review revealed the nurse also requested to have an order to collect a urinalysis and urine culture and sensitivity due to the resident having foul smelling urine. Review revealed a second request fax was sent on 02/05/19, a third request fax was sent on 02/06/19, and a fourth request fax was sent on 02/07/19. Further review revealed the physician responded on 02/08/19 to resume the Klonopin (antianxiety medication) 0.5mg twice a day. Review revealed no response to the nurse's concern about Resident #129's foul smelling urine.

Review of Resident #129's Daily Skilled Nurse's Note dated 02/05/19 revealed the resident was yelling, cursing, swinging, hitting, and scratching staff.

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Review of Resident #129's Daily Skilled Nurse's Note dated 02/06/19 revealed the day and evening nurses documented foul smelling urine.

Review of Resident #129's Daily Skilled Nurse's Note dated 02/07/19 revealed the day and evening nurses documented strong dark yellow urine.

Review of Resident #129's Daily Skilled Nurse's Note dated 02/08/19 revealed Resident #129 was having behaviors of slapping, scratching, pinching, hitting staff, spitting out food at staff, and throwing her lunch tray.

Review of Resident #129's Daily Skilled Nurse's Note dated 02/11/19, 02/14/19, 02/15/19, 02/19/19, and 02/20/19 revealed resident continues with behaviors of attempting to get up without assistance, agitated, and unable to redirected easily.

Review of Resident #129's Physician Telephone Orders dated 02/18/19 revealed an order for urinalysis and culture and sensitivity.

Review of Resident #129's Urinalysis results which was collected on 02/19/19 revealed the following results, in part, small (normal result is negative) urine leukocytes esterase, positive (normal result is negative) urine nitrites, 100mg/dl (milligrams/deciliter) (normal is negative) urine protein, small (normal result is negative) urine blood, 5/hpf (high power field) (normal is 0-4/hpf) urine red blood cells, 50/hpf (normal is 0-5hpf) urine white blood cells, and many bacteria (normal is none to occasional).

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In interview on 02/21/19 at 12:12pm S4/LPN (Licensed Practical Nurse) stated when Resident #129 wants to get out the chair or the bed the resident will swing at staff, she had hit me in the face, yells, and spits at staff and the resident is not easily redirected. S4/LPN stated she called Resident #129's physician on 02/04/19 about the resident's behaviors and urine odor, and the physician's office instructed her to fax the information. S4/LPN stated when the facility did not get a response to the fax on 02/04/19, she continued to fax the physician. S4/LPN stated there was no documented evidence of the facility having called the physician to ensure he received the fax and/or speaking with the physician regarding the concerns. S4/LPN stated she could not remember if she had contacted the physician beside fax during the period of 02/04/19 to 02/08/19. S4/LPN stated after receiving the response from the physician on 02/08/19, the facility still did not have any response from the physician which addressed Resident #129's foul smelling urine. S4/LPN stated she did not contact the resident's physician regarding the resident's urine still having a strong, foul smelling urine, but she (S4/LPN) was communicating the concerns in report to the afternoon nurse. S4/LPN further stated the facility did not have any documented evidence of any staff having contacted the physician before 02/18/19 for the resident's urine concerns, and the resident did continue to have urinary symptoms. S4/LPN stated she had not yet contacted the physician about Resident #129's abnormal urinalysis results since the results were faxed.

In an interview on 02/21/19 at 1:05pm, S24/ADON (Assistant Director of Nursing) stated the facility was calling and requesting a return call

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F 580	Continued From page 6 but was not getting a call back from Resident #129's physician. S24/ADON stated the facility did not however have any documented evidence of any of the attempted contacts. S24/ADON stated when the facility was not receiving phone calls from the physician, the facility did not make other efforts to reach the medical director to have the facility's concerns addressed. S24/ADON stated the facility did not have any documented evidence of phone calls and/or faxes from 02/08/19 to 02/18/19 to Resident #129's physician for the resident's continued foul smelling urine. S24/ADON stated S4/LPN had come to her on 02/18/19 about not getting a response from the physician.	F 580		
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).	F 656		3/29/19

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(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 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 observation, record review, and interview, the facility failed to implement a comprehensive care plan for each resident for 1 of 2 investigation stage residents reviewed for accidents and 1 of 1 investigation stage residents reviewed for hydration in a total investigation sample of 49 (Resident #129) as evidenced by the facility failing to:
1. Ensure Resident #129 had her lap buddy (positioning device) applied when up in the wheelchair; and
2. Ensure Resident #129's fluids were served to her either heavily iced or hot per recommendations from a swallow study.
This failed practice had the potential to affect 119 residents residing in the facility as documented on the facility's Resident Census and Conditions

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of Residents form (CMS-672).
Findings:

Review of Resident #129's Hospital Important Swallowing Instructions dated 01/29/19 revealed, in part, liquids heavily iced or hot.

Review of Resident #129's Hospital Swallow Study Notes dated 01/29/19 revealed the resident was seen for a visual swallow study. Review revealed the resident had decreased sensation and does not automatically double swallow. Further review revealed recommendation of heavily iced/hot liquids.

Review of Resident #129's Physician Telephone Orders dated 02/04/19 revealed the resident was to use a lap buddy while in the wheelchair to assist with positioning due to poor control.

Review of Resident #129's Physician Telephone Orders dated 02/07/19 revealed add heavily iced or hot liquids only (no room temperature liquids).

Observation on 02/18/19 at 2:04pm revealed Resident #129's water pitcher in her room had no ice present in the water.

Observation on 02/20/19 at 9:50am revealed Resident #129's room had a water pitcher which was filled about one fourth full with water, but the water did not contain any ice.

Observation on 02/20/19 at 9:53am revealed Resident #129 was seated in her wheelchair without a positioning device/lap buddy present/applied.

Observation on 02/20/19 at 10:08am revealed

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Resident #129 stood up from her wheelchair and attempted to walk. Observation revealed the staff redirected the resident back to her wheelchair. Further observation revealed Resident #129 did not have a lap buddy applied.

Observation on 02/20/19 at 12:23pm revealed Resident #129 was being fed by S12CNA (Certified Nursing Assistant). Observation revealed Resident #129 was assisted to drink a purple juice and chocolate milk, neither fluid contained ice. Further observation revealed Resident #129 did not have a lap buddy present.

In an interview on 02/21/19 at 11:35am, S11CNA and S12CNA stated Resident #129 liked milk in morning and juices, and they give the resident juices throughout the day. S11CNA and S12CNA stated the resident did not have any positioning devices, or alarms while in the wheelchair or in the bed to their knowledge.

Observation on 02/21/19 at 11:43am revealed Resident #129 did not have a lap buddy present on the wheelchair while the resident was seated in her wheelchair.

Observation on 02/21/19 at 11:55am revealed Resident #129's water pitcher was half full with no ice present in the water pitcher.

Observation on 02/21/19 at 12:05am revealed S11CNA set up Resident #129 for her meal with the resident having a red liquid and water with a few pieces of ice in the liquids, and a sealed carton of milk with no ice present in the milk. Further observation revealed the milk carton was not contained in ice, and was cool to the touch.

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In an interview on 02/21/19 at 12:09am, S11CNA stated the milk had not come with ice unless ice would be requested by the resident. The surveyor then pointed out the meal ticket which stated liquids heavily iced, and S11CNA stated she would need to check with the nurse.

In an interview on 02/21/19 at 12:10pm, S12CNA stated she was not aware Resident #129's liquids were to be heavily iced. S12CNA stated all of Resident #129's fluids on her lunch tray yesterday did not contain any ice.

In an interview on 02/21/19 at 12:12pm, S4LPN (Licensed Practical Nurse) stated Resident #129 will try to get out of the wheelchair without assistance, and cannot always be redirected into the chair. S4LPN stated Resident #129 had a lap buddy but does not always wear it, because the resident will take the lap buddy off, so the resident will only use the lap buddy when needed. S4LPN stated the facility had not called the physician about the resident taking off the lap buddy, and had not had the order changed to using the lap buddy as needed and/or discontinuing the order for the lap buddy. S4LPN further confirmed Resident #129's fluids have to be heavily iced or hot.

In an interview, on 02/21/19 at 12:54pm S12CNA stated no one at the facility had ever informed her (S12CNA) of Resident #129 needing a lap buddy. S12CNA further stated she was not aware of the location of a lap buddy for Resident #129.

In an interview on 02/21/19 at 12:55pm, S11CNA stated she was not aware of Resident #129 having had a lap buddy, and the facility never gave us, the staff, a lap buddy to place on

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F 656	Continued From page 11 Resident #129's wheelchair. In an interview on 02/21/19 at 1:05pm, S2DON (Director of Nursing) and S24ADON (Assistant Director of Nursing) stated Resident #129 should be wearing the lap buddy. The surveyor then informed S2DON and S24ADON of the observations of Resident #129's fluids not being heavily iced or hot, and S2DON and S24ADON stated the resident's fluids should be heavily iced or hot at all times.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good grooming for 1 of 3 investigation stage residents reviewed for Activities of Daily Living in a total investigation sample of 49 (Resident #8) as evidenced by the facility failing to provide nail care to Resident #8, This failed practice had the potential to affect any of the 119 residents currently residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (CMS-672). Findings: Review of Resident #8's record revealed the resident was admitted to the facility on 02/18/15 with diagnosis of, in part, hemiplegia following	F 677		3/29/19

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cerebrovascular disease affecting left dominant side.

Review of Resident #8's MDS (minimum data set) with an ARD (assessment reference date) dated 02/04/19 revealed the resident required extensive assistance of one person for personal hygiene.

Review of Resident #8's care plan revealed a problem of self-care deficit/routine care with a goal date of 05/04/19. Further review revealed approaches of, in part, keep the resident's nails neat and trimmed and check daily.

Review of Resident #8's January 2019 CNA (Certified Nursing Assistant) Flow Sheet revealed, in part, nail care: clean nails daily and trim nails weekly with staff initials every day with the exception of 01/26/19 and 01/27/19.

Review of Resident #8's February 2019 CNA Flow Sheet revealed, in part, nail care: clean nails daily and trim nails weekly with no signatures documented for 02/12/19 thru 02/16/19 and 02/18/19 thru 02/19/19.

Observation on 02/19/19 at 11:41am, revealed Resident #8 had long toe nails to both feet.

In an observation and interview on 02/20/19 at 9:45am, Resident #8 was asked if they take good care of him and trimmed his nails, and Resident #8 laughed at surveyor and did not answer any further questions. Resident #8 then showed the surveyor his fingernails which were one-fourth inches long with dark brownish black debris under the nails, and toenails were one-half inches long and curved to the bottom of his toes.

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F 677	Continued From page 13 In an interview on 02/20/19 at 11:41am, S8LPN (Licensed Practical Nurse) stated Resident #8 needs extensive assistance, and has left sided paralysis. S8LPN stated the resident was compliant with most of his care and she (S8LPN) had not been informed of any refusals with nail care. In an interview on 02/20/19 at 11:45am, S16CNA (Certified Nursing Assistant) stated Resident #8 is dependent for most care. S16CNA stated the CNA staff are responsible for clipping his fingernails and toenails. S16CNA stated Resident #8 does not like his nails clipped, but had not refused care. In an interview on 02/20/19 at 11:58am, S24ADON (Assistant Director of Nursing) stated the staff had not notified her (S24ADON) of any refusals of care from Resident #8. S24ADON and the surveyor went and observed Resident #8 in his wheelchair with bare feet. S24ADON confirmed Resident #8's fingernails are usually longer than they are right now, but the staff needed to have the debris cleaned from under his fingernails. S24ADON stated his feet needed to have the toenails trimmed, and should have been trimmed.	F 677		
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	F 684		3/29/19

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practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview , the facility failed to ensure residents receive d treatment in accordance with professional standards of practice by failing to clarify orders for a resident admitted with a cervical collar for 1 (Resident #494) of 26 sampled residents reviewed in the investigation stage. This deficient practice had the potential to affect any of the 119 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form CMS-672.
Findings:

Resident #494 was admitted to the facility on 02/15/19 with diagnoses of, in part, Fracture of the Neck following a fall and a history of falling.
Observation of Resident #494 on 02/19/19 at 10:30am revealed he was up in a wheelchair with a cervical collar on his neck.
Observation of Resident #494 on 02/19/19 at 11:00am revealed he was on the hallway without a cervical collar on his neck.
Review of Resident #494's Admit Physicians Orders revealed no documentation of an order for a cervical collar.
Review of Resident #494's Admission Evaluation and Interim Care Plan dated 02/15/19 revealed, in part, the resident arrived to the facility at 7:51pm with a cervical collar in place.
Review of Resident #494's Baseline Care Plan created on 02/16/19 at 1:40pm revealed, in part, follow fracture associated precautions as appropriate and follow physician orders for immobilization devices.

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F 684	Continued From page 15 In an interview on 02/20/19 at 12:10pm, S18 Certified Nursing Assistant (CNA) stated she had not been instructed as to when Resident #494 should wear the cervical collar. In an interview on 02/20/19 at 12:15pm, S4 Licensed Practical Nurse (LPN) stated Resident #494 does not have an order for the cervical collar. S4 LPN confirmed he was admitted with a cervical collar. S4 LPN stated she did not clarify with the physician when the collar should have been used. In an interview on 02/20/19 at 12:25pm, S5 Corporate Nurse stated the physician should have been contacted for a clarification order for Resident #494's cervical collar. In an interview on 02/20/19 at 1:50pm, S4 LPN stated she contacted Resident #494's physician on 02/20/19, and he stated the cervical collar should be used while out of bed and discontinued on 03/23/19.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assess for pain and have ordered pain medications available for use for 1 (Resident #243) of 26 sampled residents reviewed in the investigation stage. This deficient practice had the potential to affect any of the 119 residents who resided in the facility	F 697		3/29/19

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

Review of Resident #243's record revealed an admit date of 02/14/19 with diagnoses, in part, of Peripheral Artery Disease and Rheumatoid Arthritis.

Review of Resident #243's baseline care plan revealed in part, a problem identified for pain with approaches, in part, to administer pain medications as ordered, report ineffectiveness to physician and monitor pain levels as appropriate.

Review of Resident #243's Medication Administration Record (MAR) dated 02/14/19 revealed in part, an order for Norco (medication for pain) 10 milligrams (mg)/325mg one tablet by mouth three times a day for pain.

In an interview and observation on 02/18/19 at 11:18am Resident #243 was observed in her bed rocking back and forth with a facial grimace. Resident #243 stated she was in pain and was told her pain medication would be delivered at 1:00pm. Resident #243 stated she only received two Tylenol tablets over the weekend, which did not relieve her pain.

Review of Resident #243's MAR dated February 2019 revealed no documentation of Tylenol given to Resident, along with no documentation of a pain assessment. Further review of Resident #243's MAR revealed the 1st dose of pain medication given was on 02/18/19 at 2:25pm.

Further review of Resident #243's February 2019 MAR revealed no documentation of Tylenol listed

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on the MAR.
Review of Resident #243's record revealed no nurse's notes documented from 02/15/19 through 02/18/19 and no assessment of pain.

In an interview on 02/20/19 at 9:30am, S23 Licensed Practical Nurse (LPN) stated Tylenol was a facility standing order for pain, and the standing order should be written on the MAR when administered to a Resident. S23 LPN further stated residents were assessed for pain every shift and confirmed Resident #243 did not have any documentation of being assessed for pain every shift and there was no documentation on the MAR that Tylenol was given.

In an interview on 02/20/19 at 11:50am, S2 Director of Nursing (DON) stated she was unaware of the policy on assessing Residents for pain and was unaware of the protocol if pain medication was unavailable.

In an interview on 02/20/19 at 2:11pm, S23 LPN confirmed Resident #243 did not have her pain medication (Norco) available for use until 02/18/19 and the medication was on the admission orders dated 02/14/19.

In a telephone interview on 02/20/19 at 2:28pm, S21 Local Pharmacist stated he did not receive any prescription request for pain medicine for Resident #243 from 02/14/19 through 02/17/19. S21 Local Pharmacist confirmed the faxed prescription for Norco was sent to the pharmacy on 02/18/19.

The facility did not present any documented evidence that Resident #243 had her pain medication available on 02/14/19 and had no

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F 697	Continued From page 18 documentation of a pain assessment from 02/15/19 through 02/21/19. In an interview on 02/21/19 at 1:38pm, S2 DON confirmed and acknowledged the above findings and had no additional documentation to present.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		3/29/19

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order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to maintain accurate records of controlled medication dispensing for 5 (Resident #47, #65, #114, #129 and #134) residents who received controlled medications. This deficient practice had the potential to affect any of the 119 residents who reside in the facility as per the facility's Resident Census and Conditions of Residents Form (CMS- Form 672).
Findings:

Observation of the Front Nursing Station Medication Cart on 02/21/19 at 11:00am revealed the following:
1. Observation of Resident #47's Lyrica 150milligrams (mg) (a pain medication used to treat nerve and muscle pain) revealed there were 14 tablets in the package . Review of Resident #47's Individual Resident's Controlled Substance Record for Lyrica 150mg revealed there were 15 capsules remaining;
2. Observation of Resident #114's Oxycodone - Acetaminophen 5-325mg (a pain medication) revealed there were 3 tablets in the package. Review of Resident #114's Individual Resident's Controlled Substance Record for Oxycodone-Acetaminophen 5-325mg revealed there were 4 tablets remaining;
3. Observation of Resident #134's Lyrica 150mg revealed there were 18 tablets in the package. Review of Resident #134's Individual Resident's Controlled Substance Record for Lyrica 150mg revealed there were 19 capsules remaining;
4. Observation of Resident #65's Alprazolam 0.5mg (a medication used to treat anxiety)

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F 755	Continued From page 20 revealed there were 14 tablets in the package. Review of Resident #65's Individual Resident's Controlled Substance Record for Alprazolam 0.5mg revealed there were 15 tablets remaining; and 5. Observation of Resident #129's Clonazepam 0.5mg revealed there were 9 tablets in the package. Review of Resident #129's Individual Resident's Controlled Substance Record for Clonazepam 0.5mg revealed there were 10 tablets remaining. In an interview on 02/21/19 at 11:05am, S4 Licensed Practical Nurse (LPN) stated she did not sign the Individual Resident's Controlled Substance Record at the time the medication was administered. S4 LPN stated her practice was to sign out all narcotics on the Individual Resident's Controlled Substance Record at the end of the shift. S4 LPN confirmed the medication counts did not match the count on the Individual Resident's Controlled Substance Record for Residents #47, #65, #114, #129 and #134. In an interview on 02/21/19 at 11:30am, S3 Consultant Pharmacist stated the Individual Resident's Controlled Substance Record should be completed at the time a medication was administered. S3 Consultant Pharmacist confirmed the medication counts did not match the count on the Individual Resident's Controlled Substance Record for Residents #47, #65, #114, #129 and #134.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		3/29/19

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licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure drug regimen irregularities identified by the pharmacist was acted upon by

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the resident's physician, with documentation in the resident's medical record that the identified irregularity had been reviewed and the action taken to address the irregularity for 1 of 5 investigation stage residents reviewed for Unnecessary Medications in a total investigation sample of 49 (Resident #121) as evidenced by the facility failing to ensure Resident #121's physician acted upon a recommendation for a dose reduction for an antipsychotic. This failed practice had the potential to affect the 43 residents receiving antipsychotics as documented on the facility's Residents Census and Conditions of Residents form (CMS-672).
Findings:

Review of Resident #121's Record revealed Resident #121 was admitted on 07/30/12 and readmitted on 04/17/17 with diagnoses of dementia without behavioral disturbance, anxiety disorders, and major depressive disorder.

Review of Resident #121's MDS (Minimum Data Set) ARD (Assessment Reference Date) dated 01/19/19 revealed, in part, the resident had no signs and symptoms of delirium, and no behaviors present in the lookback period.

Review of Resident #121's February 2019's Physician's Orders revealed, in part, Zyprexa (antipsychotic) 2.5mg (milligrams) one tablet by mouth every night. Further review revealed an order date of 01/07/19, and an original order date of 04/17/17.

Review of Resident #121's Pharmacy Consultant Review Sheet dated 02/08/18 revealed a recommendation to please consider discontinuing the order for Zyprexa 2.5mg every night due to

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the resident's age. Further review revealed no response from Resident #121's physician for the requested dose reduction.

Review of Resident #121's Pharmacy Consultant Review Sheet dated 06/11/18 revealed a recommendation to please consider discontinuing the order for Zyprexa 2.5mg every night due to the resident's age. Further review revealed no response from Resident #121's physician for the requested dose reduction.

Review of Resident #121's Pharmacy Consultant Review Sheet dated 11/05/18 revealed a recommendation to please consider discontinuing the order for Zyprexa 2.5mg every night due to the resident's age. Further review revealed no response from Resident #121's physician for the requested dose reduction.

Review of Resident #121's November 2018, December 2018, and February 2019's Medication Administration Record revealed the resident was not documented as having any behaviors during all three shifts.

In interview on 02/21/19 at 9:55am S13CNA (Certified Nursing Assistant) stated Resident #121 is a real sweet person, and she (S13CNA) had never witnessed Resident #121 have any behaviors.

In interview on 02/21/19 at 10:02am, S9LPN stated Resident #121 does not have behaviors with her.

In interview on 02/21/19 at 10:13am, S3Consultant Pharmacist stated Resident #121's physician will usually respond to the pharmacy

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F 756	Continued From page 24 reviews in his progress notes. S3Consultant Pharmacist reviewed Resident #121's physician progress notes and could not locate any response to the gradual dose reduction recommendation. In an interview on 02/21/19 at 11:11am, S7Corporate Nurse and S2DON (Director of Nursing) stated the previous DON should have ensured the physician was following up on pharmacy recommendations. S7Corporate Nurse further stated there was no documented evidence of Resident #121's physician having responded to the pharmacist's recommendations.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		3/29/19

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all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

(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 842	Continued From page 26	F 842		

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to maintain resident medical records on each resident that were complete and accurately documented for 1 of 3 investigation stage residents reviewed for activities of daily living in a total investigation sample of 49 (Resident #8) as evidenced by the facility failing to ensure an accurately documented record. This failed practice had the potential to affect the 119 residents residing in the facility as documented on the facility's Residents Census and Conditions of Residents form (CMS-672).
Findings:

Review of Resident #8's February 2019 CNA (Certified Nursing Assistant) Flow Sheet, reviewed by the surveyor on 02/20/19 at 11am, revealed, in part, nail care clean nails daily and trim nails weekly with no staff signatures for 02/12/19 thru 02/16/19, 02/18/19, and 02/19/19.

Review of copies obtained from the facility of Resident #8's February 2019 CNA Flow Sheet, reviewed by the surveyor on 02/20/19 at 1:00pm, revealed the staff signatures for nail care daily. Further review revealed 02/12/19 thru 02/16/19, 02/18/19, and 02/19/19 had S17CNA's initials, however the other ADLs for the above mentioned dates were signed by another CNA.

Review of the facility's CNA Assignment Sheets revealed in part:
-02/12/19 S17CNA was not assigned to Resident

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F 842	Continued From page 27 #8's unit; -02/13/19, 02/14/19, 02/18/19, and 02/19/19 S17CNA was not assigned to Resident #8; and -02/15/19 and 02/16/19 S17CNA was not signed in as having worked at the facility. In an interview on 02/20/19 at 1:43pm, S17CNA was informed of the above reviews and was asked about her initials on 02/12/19 thru 02/16/19, 02/18/19, and 02/19/19. S17CNA stated "she" came to her (S17CNA) this morning and asked her to sign for the days left blank because with the explanation of some days the resident would allow her to check his nails and clip them and some days he would not. S17CNA stated she then initialed the dates. S17CNA was then asked by the surveyor who the "she" was that asked her this morning to sign the blank dates, and S17CNA stated she could not remember who the person was who requested her to initial the documentation. In an interview on 02/20/19 at 1:49pm, S24ADON (Assistant Director of Nursing) and S7Corporate Nurse stated the facility's policy was, if the staff remembers providing the care then the staff member can sign for the care similar to a late entry. S7Corporate Nurse further stated the document should not, however, be altered once the surveyor requested the documentation.	F 842		
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	F 880		3/29/19

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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 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.

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(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.

§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:
1.) failed to ensure staff transported linen in a sanitary manner (S18Certified Nursing Assistant (CNA);
2.) failed to ensure resident whirlpool and/or shower areas were maintained in a sanitary manner (room "a" and room "b"); and
3.) failed to ensure staff tracked and/or trended all resident infections.
This deficient practice was identified for the facility, but had the potential to affect any of the 119 residents who reside at the facility as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents.
Findings:

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Review of the facility's Antibiotic Stewardship policy and procedures revealed in part, that the purpose was to monitor the use of antibiotics in our residents and that orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents. Further review revealed antibiotic use and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. The facility's policy and procedures further indicated that all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. Further review revealed all resident antibiotic regimes will be documented on the facility approved antibiotic surveillance tracking form and will include: resident name, room number, date symptoms appear, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome, and adverse events.

Observation on 02/20/19 at 7:53am, revealed S18CNA was observed carrying soiled linen down hall with gloves from room "a" to a soiled linen barrel that was located in an alcove down the hallway.

Observation of room "b" on 02/21/19 at 12:45pm, revealed five unidentifiable used razors and one unidentifiable hairbrush on top of whirlpool and an unknown white substance lying on the surface of bathing equipment.

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In interview on 02/21/19 at 12:47pm, S10CNA Supervisor indicated housekeeping did not get a chance to clean yet, and CNA staff should dispose of razors in red bags and clean up after use.

Observation on 02/21/19 at 12:50pm, revealed four cups of an unidentifiable substance was seen in room "c".

In interview on 02/21/19 at 12:53pm, S10CNA Supervisor indicated that the substance in the cups was soap and she will come up with a system to make sure the area was cleaned up after each use.

Review of the facility's September 2018 infection surveillance forms revealed they were incomplete and inconsistent with 31 infections identified on the colored tracking facility map, and 29 infections identified on the monthly infection surveillance information form. Further review revealed the date the infections cleared was blank, not all infections had the symptoms documented, whether it was a community acquired or in-house infection, what type of infection all residents had, the date the culture was done and the results, the antibiotic treatment the infection was being treated with, and/or not all infections had the date of onset documented.

Review of the facility's October 2018 infection surveillance forms revealed they were incomplete and inconsistent with 33 infections identified on the colored tracking facility map, and 32 infections identified on the monthly infection surveillance information form. Further review revealed the date the infections cleared was blank, and not all infections had the symptoms

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documented, whether it was a community acquired or in-house infection, the date and lab results of a culture, and/or what type of infection a resident had.

Review of the facility's November 2018 infection surveillance forms revealed they were incomplete and inconsistent with 28 infections identified on the colored tracking facility map, and 29 infections identified on the monthly infection surveillance information form. Further review revealed the date the infections cleared was blank, and not all infections had the symptoms documented.

Review of the facility's December 2018 infection surveillance forms revealed they were incomplete and inconsistent with 26 infections identified on the colored tracking facility map, and 31 infections identified on the monthly infection surveillance information form. Further review revealed the date the infections cleared was blank, not all of the infections had the date of onset documented, not all infections had the symptoms documented, whether it was a community acquired or in-house infection, had the date and culture site documented and/or not all infections had the antibiotic treatment documented.
Review of the facility's Physician's Order List of residents who received antibiotics from 12/01/18 through 02/21/19 revealed in part that there were 4 instances where residents received antibiotics, and those infections were not placed on the facility's surveillance forms for the month of December 2018.

Review of the facility's January 2019 infection surveillance forms revealed they were incomplete

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and inconsistent with 27 infections identified on the colored tracking facility map, and 28 infections identified on the monthly infection surveillance information form. Further review revealed the date the infections cleared was blank, not all infections had the symptoms documented, whether it was a community acquired or in-house infection, what type of infection a resident had, and/or what antibiotic treatment the infection was being treated with.
Review of the facility's Physician's Order List of residents who received antibiotics from 12/01/18 through 02/21/19 revealed in part that there were 7 instances where residents received antibiotics, and those infections were not placed on the facility's surveillance forms for the month of January 2019.

Review of the facility's February 2019 infection surveillance forms revealed in part they were incomplete and inconsistent with the date of the onset and when the infection was cleared being left blank when applicable. Further review revealed not all infections were identified as being community acquired or an in-house infection, and/or the dose and length of antibiotic treatment the infection was being treated with.
Review of the facility's Physician's Order List of residents who received antibiotics from 12/01/18 through 02/21/19 revealed in part that there were 5 instances where residents received antibiotics, and those infections were not placed on the facility's surveillance forms for the time period of 02/01/19 - 02/21/19.

Review of the facility's antibiotic stewardship and infection control in-service dated 01/15/19 revealed a total of 28 employees attended. Review of the facility's list of employees revealed

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in part there were 46 nurses and 66 CNAs employed.

There was no documented evidence and the facility did not present any documented evidence that all resident infections were being tracked from October 2018 through February 18, 2019. There was no documented evidence and the facility did not present any documented evidence which identified the facility was identifying the trending of infections and taking appropriate corrective actions from October 2018 through February 18, 2019.

In interview on 02/21/19 at 10:20am, S5Corporate Nurse indicated that the surveillance information was to be reviewed, a monthly report completed, then the reports were put together and reviewed for the quarterly quality assurance meeting.

Review of the facility's Quarterly Quality Assurance Meeting infection control documentation for October-December 2018, revealed in part: 34 infections were identified for the month of October 2018, 31 infections for the month of November 2018, and 32 infections for the month of December 2018.

There was no documented evidence and the facility did not present any documented evidence that January 2019 infection control report was completed.

In interview on 02/21/19 at 1:22pm, S2DON indicated she was in charge of infection control for one month prior to her becoming DON two weeks ago and was currently still responsible for tracking and trending infections until they find

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F 880	Continued From page 35 someone. S2DON reviewed the infection control tracking and trending documentation with the surveyor and verified that it was incomplete, inaccurate, but was unable to say that it was not done per policy and procedures because she didn't know the infection control policy and procedures. S2DON indicated she was never shown how to do all of the infection control paperwork and had never even seen some of the paperwork. S2DON further indicated she had not done the monthly infection control report for January 2019, had nothing to present which showed the trending of infections, and verified that not all staff attended the infection control in-service. S2DON was also informed of the above observations and indicated that it should not have been happened.	F 880		

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K 000	INITIAL COMMENTS Maison De' Ville Nursing Home is in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The facility is sprinklered, licensed for200 beds and a census of 122 at time of survey.	K 000		
K 000	INITIAL COMMENTS Maison De'Ville Nursing Home is in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The facility is sprinklered, licensed for 200 beds and a census of 122 at time of survey.	K 000		
K 521 SS=C	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the heating, ventilation and air conditioning system was installed in accordance with NFPA 90A. The system could re-circulate smoke originating from one part of the building into other parts of the building otherwise unaffected. The deficient practice had the potential to affect 21 of 122 residents.	K 521		2/22/19

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

Electronically Signed | 03/13/2019

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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K 521	Continued From page 1 Findings: During the facility tour, between the hours of 9:00am and 2:30pm it was revealed the corridors 100 and 200 HVAC system was using the corridors as a return air plenum. Interview with the administrator revealed the facility was aware of the HVAC system was using the corridors as a return air plenum but a waiver was approved by SFM until 1/11/2020; this was also confirmed by the Administrator during the exit meeting.	K 521		

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F 000	INITIAL COMMENTS Complaint Survey #LA00051039. No deficiencies cited as a result of this complaint.	F 000		

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted for all previous deficiencies cited on 02/21/2019. All deficiencies from this survey have been corrected.	{F 000}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

(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 #LA00052828	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accurately assess a resident for the use of a wander-guard elopement alarm device. This deficient practice was identified for 1 (Resident #5) of 5 sampled residents, and had the potential to affect any of the 124 residents who resided in the facility as documented on the facility's Resident Census and Condition of Residents Form CMS-672. Findings: Review of Resident #5's record revealed she was admitted to the facility on 03/11/19 with diagnoses which included, in part, Major Depressive Disorder and Bipolar Disorder. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/19 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Further review revealed Resident #5 had no wandering behaviors in the 7 day prior assessment period. Review of Section P, restraints, revealed a wander/elopement alarm was not used. Review of Resident #5's care plan with a next goal date of 10/24/19 revealed no documented	F 641	Please accept plan of correction as credible allegation of compliance. Preparations and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because the Federal and State laws requires it Review of resident□s #5-- order was obtained for wander-guard to be discontinued on 9-12-19. MDS and risk assessments were reviewed for affected residents 2) All other residents on wandering program were reviewed for accuracy to include risk assessments, care plans, and section P and physician□s orders. 3) In-service to be conducted with MDS/care plan team, ADON, and social service, floor nurses reeducated on proper and timely documentation of wander guard policy and procedure by the DON on 9-20-19. 4) A QA monitoring tool will be completed	10/10/19

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

Electronically Signed | 09/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195307	A. BUILDING _____ B. WING _____	C 09/12/2019

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MAISON DE'VILLE NURSING HOME	107 SOUTH HOLLYWOOD DRIVE HOUMA, LA 70360

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F 641	Continued From page 1 identified problems regarding wandering or elopement risk, or the use of a wander-guard elopement alarm device. Review of Resident #5's Risk of Elopement and/or Wandering Review dated 07/24/19 revealed in part, the following: Potential Risk Factors: Is the resident cognitively impaired - yes Summary: Resident is NOT at risk for wandering/elopement at this time - checked Resident is AT RISK for wandering/elopement, as evidenced by - checked Appropriate interventions have been initiated - checked Plan of care updated - checked Potential interventions: Personal safety alarm devices - checked Observation on 09/10/19 at 12:10pm revealed Resident #5 had a wander-guard elopement alarm device on her left ankle. Observation on 09/11/19 at 10:45am revealed Resident #5 had a wander-guard elopement alarm device on her left ankle. Observation on 09/12/19 at 11:00am revealed Resident #5 had a wander-guard elopement alarm device on her left ankle. In an interview on 09/11/19 at 2:15pm, S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) reviewed Resident #5's MDS with an ARD of 07/24/19 with this surveyor and stated she did not feel Resident #5 was cognitively intact, and was an elopement risk. S3LPN/MDS confirmed the MDS read that a	F 641	3 times a week for 6 weeks to ensure proper wander guard placement, proper documentation of risk assessments and all care planning and section P of all wander guard residents.	

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F 641	Continued From page 2 wander/elopement alarm was not used. S3LPN/MDS reviewed Resident #5's Elopement Risk Assessment with this surveyor and confirmed the summary had Resident #5 as both at risk, and not at risk for wandering/elopement. S3LPN/MDS confirmed Resident #5's Elopement Risk Assessment dated 07/24/19 read that a wander/elopement alarm was used. S3LPN/MDS confirmed Resident #5's Elopement Risk Assessment of 07/24/19, and her MDS with an ARD of 07/24/19 had conflicting information, and were inaccurate. In a joint interview on 09/11/19 at 2:30pm, S1Administrator and S2Director of Nurses reviewed the above referenced assessments regarding Resident #5, and confirmed the assessments were inaccurate. In an interview on 09/12/19 at 11:00am, Resident #5 stated the wander-guard elopement alarm device had been on her ankle for "months."	F 641		
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	F 656		10/10/19

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F 656	Continued From page 3 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 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 observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan for the use of a wander-guard elopement alarm device. This deficient practice was identified for 1 (Resident #5) of 5 sampled residents, and had the potential to affect any of the 124 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form CMS-672.	F 656	Please accept plan of correction as credible allegation of compliance. Preparations and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because	

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F 656	Continued From page 4 Findings: Review of Resident #5's record revealed she was admitted to the facility on 03/11/19 with diagnoses which included, in part, Major Depressive Disorder and Bipolar Disorder. Review of Resident #5's Risk of Elopement and/or Wandering Review dated 07/24/19 revealed in part, the following: Potential Risk Factors: Is the resident cognitively impaired - yes Summary: Resident is NOT at risk for wandering/elopement at this time - checked Resident is AT RISK for wandering/elopement, as evidenced by - checked Appropriate interventions have been initiated - checked Plan of care updated - checked Potential interventions: Personal safety alarm devices - checked Review of Resident #5's care plan with a problem onset date of 07/24/19, and a next goal date of 10/24/19 revealed no documented identified problems regarding wandering or elopement risk, or the use of a wander-guard elopement alarm device. Observation on 09/10/19 at 12:10pm revealed Resident #5 had a wander-guard elopement alarm device on her left ankle. Observation on 09/11/19 at 10:45am revealed Resident #5 had a wander-guard elopement alarm device on her left ankle. Observation on 09/12/19 at 11:00am revealed	F 656	the Federal and State laws requires it. 1.) Resident #5 physician orders were reviewed, wander-guard discontinued on 9-12-19. 2.) Other residents at risk to be affected identified by review of care-plan, risk assessment, section P on residents on wander guard program. Review by DON/ADON. 3.) In-service on appropriate documentation of behaviors provided to MDS/care-plan nurses by DON 9-20-19 for resident on the wander guard program. 4.) QA monitoring tool for Sec P for 3 times a week for 6 weeks or until compliance reached by DON/ADON.	

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F 656	Continued From page 5 Resident #5 had a wander-guard elopement alarm device on her left ankle. In an interview on 09/11/19 at 2:15pm, S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) reviewed Resident #5's care plan with this surveyor and confirmed there was no identified documented problems or approaches regarding an elopement risk, or the use of a wander-guard elopement alarm device for Resident #5. In a joint interview on 09/11/19 at 2:30pm, S1Administrator and S2Director of Nurses reviewed the above referenced care plan regarding Resident #5, and confirmed the care plan did not comprehensively include Resident #5's elopement risk, wandering behaviors, or the use of a wander-guard elopement alarm device. In an interview on 09/12/19 at 11:00am, Resident #5 stated the wander-guard elopement alarm device had been on her ankle for "months."	F 656		

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{F 000}	INITIAL COMMENTS An evidence review was conducted for all previous deficiencies cited on 9/12/19. All deficiencies from this survey have been corrected.	{F 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.