STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195342	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Healthcare and Rehabilitation	405 Milton Road Maurice, LA 70555

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and review of the facility's policies and procedures, the facility failed to ensure staff implemented the facility's policy for advanced directives for 1 (#95) of 1 (#95) resident investigated for advance directives. Findings:On 09/29/2025, a review of the facility's policy titled Advance Directives Policy and Procedure with a last reviewed date of 02/14/2025, read in part, Policy: The facility will adhere to state and federal regulations regarding advance directives.1. Resident and/or responsible party will be notified upon admission of resident's right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. A. The facility will complete LaPOST with residents if applicable.3. The resident's advance directives will be recorded in the resident clinical record. 4. An order for the code status will be obtained on admission or with change of code status and updated in the resident electronic record.Review of Resident #95's Electronic Health Record (EHR) revealed a return admission date of 05/23/2025, with diagnoses that included, but were not limited to hypertension, diabetes mellitus, and Alzheimer's disease.Review of Resident #95's face sheet revealed a code status of full code.Review of Resident #95's Advance Directive dated 05/23/2025, revealed a code status of DNR (Do Not Resuscitate). Review of Resident #95's Louisiana Physician Order for Scope of Treatment (LaPOST) that was signed by the resident's physician and the resident's representative (RP) on 05/23/2025, revealed DNR/Do Not Attempt Resuscitation (Allow Natural Death).Review of Resident #95's current care plan revealed a focus area dated 06/17/2025, which read in part, I am a full code.Goal listed was the staff will adhere to my choices made in my advance directive. Interventions in part, I need the nursing staff to have knowledge of my advance directives.On 09/29/2025 at 2:30 p.m., an interview and review of Resident #95's records was conducted with S3RNCorp (Corporate Registered Nurse). She confirmed the inconsistencies with the resident's LaPOST, face sheet, and care plan.On 09/29/2025 at 2:40 p.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated the facility's nursing staff was responsible for ensuring resident's advance directive choices were up to date. S1DON confirmed Resident #95's care plan and face sheet were not correct and should have been updated.On 09/29/2025 at 2:50 p.m., a follow up interview was conducted with S3RNCorp. She stated the resident was hospitalized and came back from the hospital on [DATE] with discharge paperwork stating she was a full code. S3RNCorp stated the family changed Resident #95's status to DNR that night, but no staff member followed up and made the changes on the resident's face sheet nor care plan.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure that nurses possessed competencies and skill sets necessary to provide nursing services to meet the residents' needs safely as evidenced by S2LPN (Licensed Practical Nurse) failing to administer medications according to the facility's policies and procedures and rights of medication administration. Findings:A review of the facility's policy titled, Medications - Administration Policy and Procedure with a last review date of 06/27/2025, reads in part, Purpose: To administer medications to residents as prescribed by physicians. Policy: To administer medications in a safe and effective manner. Procedure: . 3. Review Medication Administration Rights - Right resident, right drug, right dose, right route, and right time applied for each medications being administered. A triple check of these rights is recommended at three steps in the process of preparation of a medication for administration: b. Prior to removing the medication from the container. i. Check the label against the order on the eMAR.A review of facility training and in-service records revealed S2LPN participated in a competency and an in-service training for nurses on 07/06/2025 and 09/18/2025 regarding medication administration and rights of medication administration. A review of Resident #100's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Paroxysmal Atrial Fibrillation and Chronic Diastolic (Congestive) Heart Failure.A review of Resident #100's physician's orders revealed an order dated 08/05/2025 that read: Rythmol (antiarrhythmic medication) SR (Sustained-Release) Oral Capsule Extended Release 12 Hour 225 mg (Milligram) (Propafenone); Give 0.5 capsule by mouth one time a day. On 09/30/2025 at 8:04 a.m., an observation was conducted of S2LPN performing medication administration. S2LPN reviewed Resident #100's EHR (Electronic Health Record) for which medications were needed to be administered to the resident. She then took the medication card for Rhythmol (Propafenone) 225 mg Extended Release, and put 1 capsule into the medication cup. The surveyor then compared the order printed on the resident's medication card and the order in the EHR. The EHR read: Rythmol SR Oral Capsule Extended Release 12 Hour 225 MG (Propafenone HCl); Give 0.5 capsule by mouth one time a day. The medication card read: Rhythmol (Propafenone) 225 mg Extended Release, take one capsule by mouth once daily. S2LPN proceeded to walk towards Resident 100's room with the medication cup in her hand to administer the resident her medications. At this time, she was stopped by the surveyor, and a medication reconciliation was conducted with S2LPN. After comparing Resident #100's physician's order in her EHR and medication card, S2LPN confirmed the dosage was different. On 09/30/2025 at 8:15 a.m., an observation and record review was conducted with S1DON (Director of Nursing). S1DON confirmed Resident #100's physician's order in the EHR stated to administer 0.5 capsule of Rythmol SR Oral Capsule Extended Release 225 mg by mouth one time a day, and the medication card stated to administer one capsule by mouth one time per day. She confirmed the physician's order in the EHR and the medication card had two different dosages, and S2LPN should not have put the capsule in the medication cup to administer to the resident. She further stated that S2LPN should have called the M.D. (Doctor of Medicine) or NP (Nurse Practitioner) to clarify the physician's order.On 09/30/2025 at 9:08 a.m., an interview was conducted with S2LPN. She stated that before putting the Rhythmol capsule into the medication cup, she was unsure if she had compared the medication card to the physician's order in the EHR because she was in the habit of administering the medications per what was printed on the medication card. She confirmed that before putting the medication in the medication cup, she should have compared the medication card to the physician's orders in the EHR, but she did not.On 09/30/2025 at 2:05 p.m., a follow-up interview was conducted with (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S2LPN. She stated she was hired in July 2025, and upon hire, she was trained on medication administration. She stated that in this training she was instructed to compare the medication card to the physician's order in the EHR prior to administering a medication. She stated she also received training at the facility on 9/18/2025, which consisted of administrative staff observing her perform medication administration for two residents. She stated that at the time of this observation, she was further reminded to compare the medication card to the physician's order in the EHR prior to administering a medication to a resident. S2LPN confirmed that she was trained that if there were any discrepancies between the medication card and the physician's order in the EHR, that she should double check the order again, hold the medication, and call the M.D. or NP for clarification.On 10/01/2025 at 9:15 a.m., a second interview was conducted with S1DON. She stated that upon hire, nurses participated in the facility's medication administration training which included instructions to compare the physician's order in the EHR to the medication card and the 5 rights of medication administration (right resident, drug, dose, route, and time). She stated on 9/18/2025, the staff received medication administration training which consisted of an in-person demonstration of comparing the medication card to the physician's orders. She stated S2LPN should have compared all medication cards to the physician's order in the EHR before removing the medication from the packaging.