STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195541	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Ridge	5980 Cherry Ridge Rd Bastrop, LA 71220

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to electronically transmit encoded, accurate and complete Minimum Data Set (MDS) data to Centers for Medicare and Medicaid (CMS) in a timely manner for 2 (#30,#79) of 2 (#30, #79) residents reviewed for the completion of a 14 day discharge assessment. Findings: Record review revealed Resident #30 was admitted to the facility on [DATE] and discharged on 01/25/2025. The discharge assessment for 01/25/2025 was noted as being in process and had not been transmitted. Record review revealed Resident #79 was admitted to the facility on [DATE] and discharged on 01/03/2025. A discharge assessment for 01/03/2025 had not been completed therefore a discharge assessment had not been transmitted within 14 days. On 06/04/25 at 12:33 p.m., an interview with S7MDS coordinator confirmed Resident #30 was discharged on 01/25/2025 and Resident #79 was discharged on 01/03/2025. The discharge assessments had not been transmitted within 14 days of discharge for Resident #30 or Resident #79.

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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for 2 (#73 and #23) of 3 (#73, #23, and #13) residents reviewed for positioning and mobility. Findings: Resident #23 Record review revealed Resident # 23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism of unspecified cerebellar artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and reduced mobility. Review of most recent quarterly Minimum Data Set (MDS) data revealed as Brief Interview of Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. Review of June 2025 active orders revealed an order for a hand roll to right hand for contracture management and remove every shift to wash and dry thoroughly inside hand and replace. Every shift- day shift, evening shift, night shift. On 06/02/2025 at 4:36 p.m., Resident #23 was observed in bed with a contracture noted to right hand. No hand roll or brace was observed to the right hand. On 06/03/2025 at 3:21 p.m., Resident #23 was observed in a wheelchair at the bedside. His right hand was contracted with no hand roll in place. Resident #23 reported he does not have a hand roll for his right hand and staff does not place anything in his right hand. On 06/04/2025 at 8:12 a.m., Resident #23 was observed in the dining room eating breakfast with assistance. Right hand did not have a hand roll in place. Interview with S3 Licensed Practical Nurse (LPN) confirmed Resident # 23 should have a hand roll in place at all times other than when the hand is being cleaned. On 06/04/2025 at 9:08 a.m., an interview with S2Director of Nursing (DON) confirmed a hand roll to the right hand of resident #23 should have been in place as ordered. Resident #73 Review of the medical record for Resident #73 revealed an admission date of 07/10/2024 with diagnoses that included cerebral infarction, aphasia, right hand contracture, type 2 diabetes mellitus, and flaccid hemiplegia of the right dominant side. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed no Brief Interview for Mental Status score due to Resident #73's communication barriers. The MDS documented that Resident #73 was rarely or never able to be understood or understand others. Resident #73 was always incontinent of bowel and bladder and totally dependent upon staff for care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current Physician's Orders revealed no orders related to Resident #73's right hand contracture. Review of the Occupational Therapy Discharge summary dated [DATE] documented the presence of a right hand contracture, left hand grip strength within functional limits, and a goal of the use of a right hand orthotic. On 06/03/2025 at 2:26 p.m., it was observed that Resident #73 did not have an orthotic device in place to the right hand. On 06/04/2025 at 8:23 a.m., it was noted that Resident #73 did not have an orthotic device in place to the right hand. On 06/03/2025 at 2:08 p.m., an interview was conducted with S5Occupational Therapist (OT). S5OT confirmed that a recommendation was made for a palm protector to be placed in Resident #73's right hand. S5OT advised that once a recommendation is made, the nursing department is to ensure that the recommendation is implemented. On 06/04/2025 at 8:26 a.m., an interview was conducted with S3Licensed Practical Nurse (LPN) who advised that she has not noted a palm protector in place to Resident #73's right hand. On 06/04/2025 at 8:37 a.m., an interview was conducted with S6Certified Nursing Assistant (CNA) who advised that there is no order in place related to the use of a palm protector to the right hand. On 06/04/2025 at 8:43 a.m., an interview was conducted with S2Director of Nursing (DON) who confirmed that therapy recommendations are to be entered by the nursing department. S2DON was informed that the therapy recommendation for Resident #73 was not entered or implemented.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice by not having signage on the outside of the residents' room door to indicate oxygen was in use for 2 (#13, #60) of 2 (#13, #60) residents reviewed for oxygen. Findings: Review of the facility's Oxygen Administration policy and procedure, revised January 2025, revealed the following, in part: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Steps in the Procedure 2. Place an Oxygen in Use sign in a designated place outside resident room. Resident #13 Review of the medical record for Resident #13 revealed an admission date of 05/09/2025 with diagnoses that included the following: chronic obstructive pulmonary disease, major depressive disorder, fracture of unspecified part of left clavicle, subsequent encounter for fracture with routine healing, displaced intertrochanteric fracture of left femur, osteoporosis without current pathological fracture, bipolar disorder, and heart failure. Review of the admission Minimum Data Set assessment (MDS) dated [DATE] revealed the resident has a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident is cognitively aware and able to make daily decisions. Further review revealed the resident needs assistance with all activities of daily living. Review of the physician's orders dated June 2025 revealed administer continuous oxygen at 2 liters per nasal cannula. Review of the current plan of care for Resident #13 revealed the resident had oxygen therapy related to ineffective gas exchange, respiratory illness, give medications as ordered by the physician, and observe for signs and symptoms of respiratory distress. On 06/02/2025 at 9:20 a.m. and 06/03/2025 at 12:50 p.m., observations of Resident #13 revealed she was in the bed and received oxygen at 2 liters per nasal cannula. Observations of the outside of the resident's door revealed there was no sign to indicate the resident received oxygen therapy. On 06/04/2025 at 9:25 a.m. observation of the outside of resident #13's door with S4Licensed Practial Nurse (LPN) revealed there was no signage to indicate the resident was on oxygen. On 06/04/2025 at 1:30 p.m. S2Director of Nurses (DON) confirmed the signage for oxygen use was not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the outside of Resident #13's room. Resident #60 Review of the medical record for sampled Resident #60 revealed an admission date of 03/28/2025 with diagnoses of acute and chronic respiratory failure, chronic obstructive pulmonary disease, interstitial pulmonary disease, hypertensive heart disease with heart failure, and chronic kidney disease, stage three. Review of the physician's orders dated June 2025 revealed administer continuous oxygen at 4 Liters per nasal cannula. Review of the admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 15 which indicates the resident is independently cognitively aware and able to make daily decisions. Review of the current care plan for Resident #60 revealed the resident had oxygen therapy related to ineffective gas exchange, respiratory illness, give medications as ordered by the physician, and observe for signs and symptoms of respiratory distress. On 06/02/2025 at 9:25 a.m. and 06/03/2024 at 12:55 p.m., observations of Resident #60 revealed she was in the bed and received oxygen at 4 Liters per nasal cannula. Observations of the outside of the resident's door revealed there was no sign to indicate the resident received oxygen therapy. On 06/04/2025 at 9:20 a.m. observation of the outside of resident #60's door with S4LPN revealed there was no signage to indicate the resident was on oxygen. On 06/04/2025 at 1:30 p.m.,S2DON confirmed the signage for oxygen use was not on the outside of Resident #60's room and it should have been.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations of the medication administration, record review, and interview, the facility failed to ensure that it was free from a medication error rate of 5% or greater. The facility had a 5.26% medication error rate with 2 medication errors out of 37 opportunities. Findings: Resident #40 Observation of the medication pass for Resident #40 on 06/03/2025 at 7:15 a.m. revealed S3Licensed Practical Nurse (LPN) administered one eye medication, Dorzolamide 2%, 1 drop in each eye. Review of the physician orders for Resident #40 revealed an order for the glaucoma eye medication Brimonidine 0.2, 1 drop in both eyes three times daily at 8:00 a.m., 1:00 p.m. and 6:00 p.m. This medication was not administered. Review of the Medication Administration Record for Resident #40 revealed that S3 LPN documented that she administered Brimonidine eye medication at 7:15 a.m., at the same time as she administered Dorzolamide eye medication. Resident #67 Observation of the medication pass for Resident #67 on 06/03/2025 at 7:57 a.m. revealed S4LPN administered 8 medications. Review of the physician orders for Resident #67 revealed an order for the anti-depressant medication, Venlafaxine, extended release 24 hour capsule, 37.5 milligram (mg), 1 capsule every morning. This medication was not administered. Interview with S4LPN on 06/03/2025 at 11:40 a.m. confirmed that she did not administer the medication Venlafaxine (Effexor) 37.5mg during medication pass for Resident #67 this morning as ordered. Interview with S2Director of Nursing (DON) on 06/03/2025 at 12:45 p.m. confirmed she was aware of the omission of the medication Venlafaxine for resident #67. Further interview with S2DON revealed that she was unaware of eye medication omission for Resident #40. Explained to S2DON that 2 medication errors (omission) were made during the medication pass resulting in a medication error rate greater than 5%.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to maintain an infection control program to help prevent the development and transmission of communicable diseases and infections by failing to implement its policy for enhanced barrier precautions for 2 (#50 , #57) of 3 (#50, #57, #77) residents reviewed for transmission based precautions. Findings: Review of the Enhanced Barrier Precautions (EBPs) policy dated August 2022 revealed in-part: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident rooms. Resident #50 On 06/02/2025 at 2:00 p.m., an observation of Resident #50 revealed an ace wrap dressing noted to his left shin and foot. There were metal rods was a black knob and metal rods protruding from the ace wrap on the anterior aspect of left shin. Resident #50 reported he has a device implanted to try to increase the circulation in his foot. Observation of Resident #50's door revealed there was no signage indicating a need for EBP. Further observation revealed there was no PPE available outside Resident #50's room. Record review revealed Resident #50 was admitted to the facility on [DATE]. Resident #50's diagnoses included but not limited to the following: Type 2 diabetes mellitus, history of osteomyelitis left ankle foot, status post amputation toes left foot, and stage 2 pressure ulcer sacral region. On 06/03/2025 at 11:06 a.m. an interview with S2Director of Nursing (DON) revealed Resident #50 should have been on Enhanced Barrier Precautions related to his wounds. S2DON confirmed the facility did not implement their enhanced barrier precautions policy by failing to place signage and PPE near the door of Resident # 50's room. Resident #57 On 06/02/2025 at 9:09 a.m. and 06/03/3035 at 8:55 a.m., observation of Resident #57 revealed a dressing on his right foot. Observations of Resident #57's door revealed there was no signage indicating EBP. Further observations revealed there was no PPE available outside Resident #57's room. Record review revealed Resident #57 was admitted to the facility on [DATE] with diagnoses that included but not limited to the following: osteomyelitis ankle and foot acquired absence of right great toe, type 2 diabetes mellitus with diabetic neuropathy, and type 2 diabetes mellitus with diabetic neuropathy. On 06/03/2025 at 10:50 a.m., an observation conducted with S2DON outside Resident # 57's room revealed there was no signage indicating Resident #57 was on EBPs. Further observation revealed there was no PPE available outside Resident #57's room. S2 DON revealed Resident #57 should be on EBP related to right foot wound. S2DON confirmed the facility did not implement their enhanced barrier precautions policy by failing to place signage and PPE near the door of Resident # 57's room.