STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195620	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pointe Coupee Healthcare	1820 False River Road New Roads, LA 70760

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure services provided by the facility met professional standards of quality for 1 (#1) of 5 (#1, #2, #3, #R1, and #R2) residents reviewed for professional standards. The facility failed to ensure nursing staff:1.Accurately transcribed Resident #1's Lantus insulin order;2. Clarified blood glucose monitoring orders with the physician for Resident #1, a Diabetic resident receiving Insulin; and3. Obtained a blood glucose level when Resident #1 experienced a change in condition.This deficient practice resulted in an immediate jeopardy situation on 08/05/2025 when Resident #1's insulin order was inaccurately transcribed into his electronic medical record and MAR. Resident #1 admitted to the facility from a local hospital on [DATE] with an order for Lantus 100 unit/mL inject 5 units subcutaneously daily. S4LPN transcribed the order into Resident #1's electronic medical record and MAR as Lantus 100 unit/mL inject 30 units subcutaneously daily. S4LPN did not seek clarification from Resident #1's physician for blood glucose monitoring or implement standing orders for blood glucose monitoring. From 08/06/2025 through 08/11/2025, Resident #1 received 30 units of Lantus 100 unit/mL subcutaneously daily with no blood glucose monitoring. On 08/11/2025 at 1:30 p.m., Resident #1 experienced sleepiness and drooling. S7LPN did not obtain a blood glucose level on Resident #1. On 08/11/2025 at 3:34 p.m., S7LPN was alerted by Resident #1's family of a change in Resident #1's condition. S7LPN obtained an order to transfer Resident #1 to a local emergency department via ambulance. At 4:18 p.m., a paramedic obtained Resident #1's blood glucose level, which was 23 mg/dL. Resident #1 was administered 25 grams of intravenous Dextrose 50% and transferred to a local hospital where he was diagnosed with Hypoglycemia. The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the Lantus Pharmaceutical Insert with a revision date of 05/2019 revealed the following, in part:Warnings and Precautions:5.2 Hyperglycemia or Hypoglycemia with Changes in Insulin RegimenChanges in insulin strength, manufacturer, type, or method of administration may affect glycemic control and predispose to hypoglycemia or hyperglycemia. These changes should be made cautiously and only under close medical supervision, and the frequency of blood glucose monitoring should be increased.5.3 HypoglycemiaHypoglycemia is the most common adverse reaction associated with insulin, including Lantus. Severe Hypoglycemia can cause seizures, may be life-threatening or cause death. Review of the facility's Clinical Data Coordinator Job Description dated 2025 revealed the following, in part:Area of Supervision: Chart organization and physician order review.Job Summary: The Clinical Data Coordinator maintains record keeping according to the policies and procedures established for the nursing facility to comply with all regulations, bot state, federal, and other. This position also maintains information including accurate physician orders within the Electronic Medical Record and on the resident's physical medical record chart per regulations. Resident #1Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with (continued on next page)

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Review of Resident #1's admission MDS with an ARD of 08/11/2025 revealed a BIMS of 5, which indicated severe cognitive impairment. Review of Resident #1's Baseline Care Plan dated 08/06/2025 revealed, in part, services and treatment to include Diabetic monitoring. Review of Resident #1's Discharge Medication Reconciliation Order Report from a local hospital dated 08/05/2025 revealed, in part, to take Lantus 100 unit/mL 5 units subcutaneously daily and discontinue blood glucose test. Review of Resident #1's electronic Physician Orders revealed an order entry by S4LPN on 08/05/2025 to start on 08/06/2025 for Lantus 100 unit/mL inject 30 units subcutaneously daily. Further review revealed no order for blood glucose monitoring. Review of Resident #1's MAR dated August 2025 revealed 30 units of Lantus 100 unit/mL was administered daily from 08/06/2025 through 08/11/2025. Further review of the MAR revealed no documented blood glucose levels. Review of Resident #1's Nurses' Notes dated 08/11/2025 revealed the following, in part:At 1:30 p.m. by S7LPN: Certified Nursing Assistant reported to me that resident wasn't his normal self, not talkative as usual, went to the room and assessed the patient, vitals were Blood Pressure 136/71, Pulse 81, Temperature 97.6, Oxygen saturation 95% on room air, responding, no further concerns as of present, plan of care ongoing. Further review revealed no documentation a blood glucose level was obtained.At 3:34 p.m. by S7LPN: Resident #1's family came to the nurses' station asking for assistance to resident's room. Nurse went to the resident's room. Resident was lethargic and drooling. Nurse Practitioner and Registered Nurse notified. Called a local ambulance company to send resident to the hospital. Further review revealed no documentation a blood glucose level was obtained.At 4:46 p.m. by S7LPN: Resident left the building via ambulance to a local hospital. Review of Resident #1's Clinical Record revealed no documented blood glucose levels. Review of Resident #1's Ambulance Record dated 08/11/2025 revealed the following, in part:Vitals: At 4:18 p.m. - blood glucose level 23Treatments/Medications:4:33 p.m. - Medication: 25 grams intravenous dextrose 50% administered4:41 p.m. - Treatment - Assessment: returned to baseline Glasgow Coma Scale after intravenous Dextrose givenNarrative:Arrival: Contact was made in patient's room at a local nursing home. Patient was lying semi-Fowler in his bed and was ill-appearing with poor responsiveness. Patient's family member was at the bedside and requested crew check patient's blood glucose level as soon as crew entered the room, reporting that she had requested the nurse check but was denied. After obtaining a blood glucose reading of 23, I established intravenous access and administered intravenous Dextrose. Patient rapidly returned to baseline mental status before being moved onto stretcher to be secured for transport. Review of Resident #1's Hospital Paperwork from a local hospital dated 08/11/2025 revealed the following, in part:Triage Complaint: HypoglycemiaHistory and Physical: This patient is a resident of a local nursing home and had an altered mental status earlier this afternoon. The Emergency Medical Services personnel checked his blood glucose level. After giving him 50% Dextrose his Glasgow Coma Scale went up to 15. The nursing home said they did not have any orders to check his glucose daily so they just give him the insulin according to Emergency Medical Services personnel.Diagnosis: Hypoglycemia due to Diabetes Mellitus Type 2 1.An interview was conducted with S4LPN on 09/03/2025 at 3:05 p.m. She confirmed she transcribed Resident #1's hospital discharge orders into the electronic medical record on 08/05/2025. She confirmed Resident #1's insulin order should have been Lantus 100 unit/mL 5 units daily per his hospital discharge orders. She confirmed she entered the Lantus order into Resident #1's electronic record as 30 units daily. She stated she received education since the incident with Resident #1 on accurate transcription of orders and medication administration. An interview was conducted with S3CDC on 09/03/2025 at 3:18 p.m. She stated she was responsible to review all new orders, admission orders, and readmission orders daily. She stated she had (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	received training on reviewing all physician orders for accuracy and accurate transcription of orders and medication administration. An interview was conducted with S1DON on 09/04/2025 at 10:34 a.m. She stated Resident #1's hospital discharge orders, dated 08/05/2025, revealed he should have received 5 units of Lantus daily. She confirmed Lantus 100 unit/mL inject 30 units subcutaneously was transcribed into Resident #1's electronic record, which was the wrong dose. She confirmed, due to the transcription error, Resident #1 received 30 units of Lantus from 08/06/2025 through 08/11/2025 and should have received 5 units of Lantus daily. She stated all nursing staff had been educated on accurate transcription of orders, and the Clinical Data Coordinator was in-serviced to timely review all orders and admission/readmission orders for accuracy. She stated she audited all residents receiving insulin and reviewed all insulin orders with S2NP to ensure they were accurate. An interview was conducted with S2NP on 09/04/2025 at 10:02 a.m. She reviewed Resident #1's hospital discharge orders and confirmed Resident #1 should have received 5 units of Lantus daily instead of 30 units daily. She stated she would have expected the insulin order be transcribed accurately. She stated someone receiving Lantus 30 units who should have been receiving 5 units of Lantus could experience hypoglycemic episodes. 2.Review of the facility's Nursing Home Standing Orders revealed the following, in part:Diabetes Management:a. Accuchecks before meals and at bedtime if patient is on insulin until seen by Nurse Practitioner/Medical Doctor. An interview was conducted with S4LPN on 09/03/2025 at 3:05 p.m. She confirmed she transcribed Resident #1's hospital discharge orders into the electronic medical record on 08/05/2025. She confirmed Resident #1 had an order for insulin. She confirmed Resident #1 did not have an order for blood glucose monitoring. She stated Resident #1's hospital discharge orders were to discontinue blood glucose checks. She stated residents receiving insulin should have received blood glucose monitoring based on the doctor's order. She stated she did not contact Resident #1's physician to clarify blood glucose monitoring and should have. She stated she did not refer to the facility's standing orders since there was a discontinue order for blood glucose monitoring from the hospital. She stated she received education on the new admission/readmission checklist, including Diabetic residents and residents on insulin, and implementing blood glucose monitoring for residents on insulin. An interview was conducted with S3CDC on 09/03/2025 at 3:18 p.m. She stated any Diabetic resident receiving insulin should have received blood glucose monitoring. She stated if a Diabetic resident admitted to the facility on Lantus, she would reach out to the physician to obtain an order for blood glucose monitoring. She stated she received education on the new admission/readmission checklist, including Diabetic residents and residents on insulin, and implementing blood glucose monitoring for residents on insulin. A telephone interview was conducted with S5LPN on 09/04/2025 at 9:16 a.m. She confirmed she administered 30 units of Lantus to Resident #1 on the mornings of 08/06/2025, 08/09/2025, 08/10/2025, and 08/11/2025. She stated Resident #1 did not have any orders to obtain a blood glucose level. She confirmed she never obtained a blood glucose level on Resident #1. She stated a resident receiving insulin should have had blood glucose monitoring ordered. She stated she received education on the new admission/readmission checklist, including Diabetic residents and residents on insulin, and implementing blood glucose monitoring for residents on insulin. A telephone interview was conducted with S6LPN on 09/05/2025 at 8:10 a.m. She confirmed she administered Lantus 30 units to Resident #1 on the mornings of 08/07/2025 and 08/08/2025. She stated Resident #1 did not have any orders to obtain a blood glucose level. She confirmed she never obtained a blood glucose level on Resident #1. She stated a resident receiving insulin should have had blood glucose monitoring ordered. She stated she received education on the new admission/readmission checklist, including Diabetic residents and residents on insulin, and implementing blood glucose monitoring for residents (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	on insulin. An interview was conducted with S1DON on 09/04/2025 at 10:34 a.m. She reviewed Resident #1's Clinical Record. She confirmed Resident #1 had no ordered or documented blood glucose levels. She stated a Diabetic resident receiving insulin should have had blood glucose monitoring. She stated the nurse transcribing the insulin order should have called the physician and gotten clarification on blood glucose monitoring for Resident #1. She stated S4LPN did not refer to the facility's standing order for blood glucose monitoring because she had a discontinue order from the hospital. She stated a new admission/readmission checklist was implemented to include residents receiving insulin. She stated all nursing staff had been educated on the new admission/readmission checklist to include blood glucose monitoring protocols when a resident was receiving insulin. She stated all nursing staff had been educated on blood glucose monitoring for Diabetic residents and residents receiving insulin. She stated she reviewed all residents receiving insulin and ensured they had blood glucose monitoring ordered. An interview was conducted with S2NP on 09/04/2025 at 10:02 a.m. She stated, on admission, Resident #1 should have been placed on blood glucose monitoring before meals and at bedtime per the standing orders since he was receiving insulin. She stated Resident #1 should have never received insulin without blood glucose monitoring. She stated a new process was put into place for all admissions/readmissions and blood glucose monitoring protocols based on the insulins the resident received. 3.A telephone interview was conducted with S8CNA on 09/04/2025 at 8:41 a.m. She stated Resident #1 required set-up for meals but could feed himself. She stated Resident #1 had a great appetite and ate 75-100% of meals. She stated Resident #1 was usually alert. She stated, around lunch time on 08/11/2025, Resident #1 was very sleepy. She stated she went into Resident #1's room and set-up his lunch tray, and he did not feed himself. She stated when she tried to feed Resident #1, Resident #1 mumbled he was fine. She stated at that time, she thought something was wrong so she immediately summoned S7LPN. She stated S7LPN went to Resident #1's room and assessed him. She stated S7LPN reported to her Resident #1's vital signs were fine and he said he was sleepy. She stated Resident #1 did not eat any of his lunch. She stated Resident #1's family came to the facility that afternoon and asked for S7LPN and S1DON. She stated she immediately notified S7LPN and S1DON. An interview was conducted with S7LPN on 09/03/2025 at 1:43 p.m. She stated Resident #1 was Diabetic. She stated Resident #1 was usually awake, alert, and talkative. She stated, around 1:30 p.m. on 08/11/2025, S8CNA reported to her Resident #1 did not eat well for lunch and did not look like his usual self. She stated she assessed him. She stated Resident #1 was sleepy and had a small amount of drool on his shirt. She stated she asked Resident #1 if he wanted to go to the hospital, and Resident #1 told her he did not. She stated Resident #1 said he was tired. She stated she obtained vital signs, which were within normal parameters. She confirmed she did not obtain a blood glucose level. She stated, around 3:30 p.m., Resident #1's family reported to the nurses' station to ask for his clothing to be changed. She stated when she went to Resident #1's room, he was lethargic and his shirt was wet. She stated Resident #1 had never been sleepy during the day since admission. She stated she notified S2NP and received orders to send Resident #1 to the hospital. She stated the paramedics checked Resident #1's blood glucose level, which was low. She confirmed she did not obtain a blood glucose level on Resident #1 and should have. She stated the facility provided education on the standing orders for diabetic residents and obtaining a blood glucose level on Diabetic residents with a change in condition. An interview was conducted with S2NP on 09/04/2025 at 10:02 a.m. She stated she expected S7LPN to obtain a blood glucose level on Resident #1 since he was sleepier than normal and drooling. An interview was conducted with S1DON on 09/04/2025 at 10:34 a.m. She stated all nursing staff had been educated on obtaining a blood glucose level on any symptomatic resident since 08/11/2025. Throughout the (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	survey from 09/03/2025 to 09/05/2025, record reviews and staff interviews revealed staff received training on accurate transcription of medication orders, timely audit of new admit/readmit orders for accuracy, and blood glucose monitoring for Diabetic residents and residents receiving insulin. Interviews revealed staff were knowledgeable of the aforementioned trainings and new admission/readmission process to include Diabetics, residents receiving insulin, and blood glucose monitoring. Observations of records revealed accurate transcription of orders and blood glucose monitoring for residents receiving insulin. Observations of current insulin orders against insulin available on medication carts and pharmacy labels revealed accurate transcription of orders. The facility had implemented the following actions to correct the deficient practice:1. Corrective actions for the resident found the be affected include:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-service by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.1. All residents have the potential to be affected. Corrective actions for those residents include:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-service by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.e. S1DON or designee will audit admit/readmit charts for order accuracy dated for the last 30 days by 08/28/2025.f. S1DON and S2NP reviewed all insulin orders for accuracy by 08/12/2025.2. The measure that will be put into place to ensure the concern does not recur:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-serviced by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.e. S1DON or designee will audit admit/readmit charts for order (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	accuracy dated for the last 30 days by 08/28/2025.3. The facility plans to monitor its performance to ensure the results are sustained by:a. S1DON or designee will randomly audit 2 admits/readmits, 2 progress notes, and 2 orders twice per week for 6 weeks.b. Monitoring will be done via chart audit. Any issues found will be addressed immediately with staff re-education and progressive disciplinary action as applicable.Compliance date: 08/18/2025.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident was free from a significant medication error by failing to transcribe the accurate insulin order in the electronic medical record for 1 (#1) of 3 (#1, #2, and #3) residents reviewed receiving insulin.This deficient practice resulted in an immediate jeopardy situation on the morning of 08/06/2025 when Resident #1, a Diabetic resident, began receiving the incorrect dose of Lantus 100 unit/mL insulin. Resident #1 admitted to the facility from a local hospital on [DATE] with an order for Lantus 100 unit/mL inject 5 units subcutaneously daily. S4LPN transcribed the order into Resident #1's electronic medical record as Lantus 100 unit/mL inject 30 units subcutaneously daily. From 08/06/2025 through 08/11/2025, Resident #1 received 30 units of Lantus 100 unit/mL subcutaneously daily. On the afternoon of 08/11/2025, Resident #1 experienced a hypoglycemic episode, with a blood glucose level of 23 mg/dL. Resident #1 was administered 25 grams intravenous dextrose 50% and transferred to a local hospital where he was diagnosed with Hypoglycemia. The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the Lantus Pharmaceutical Insert with a revision date of 05/2019 revealed the following, in part:Warnings and Precautions:5.2 Hyperglycemia or Hypoglycemia with Changes in Insulin RegimenChanges in insulin strength, manufacturer, type, or method of administration may affect glycemic control and predispose to hypoglycemia or hyperglycemia. These changes should be made cautiously and only under close medical supervision, and the frequency of blood glucose monitoring should be increased.5.3 HypoglycemiaHypoglycemia is the most common adverse reaction associated with insulin, including Lantus. Severe Hypoglycemia can cause seizures, may be life-threatening or cause death. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Review of Resident #1's Discharge Medication Reconciliation Order Report from a local hospital dated 08/05/2025 revealed, in part, to take Lantus 100 unit/mL 5 units subcutaneously daily. Review of Resident #1's electronic Physician Orders revealed an order entry by S4LPN on 08/05/2025 to start on 08/06/2025 for Lantus 100 unit/mL inject 30 units subcutaneously daily. Review of Resident #1's MAR dated August 2025 revealed 30 units of Lantus 100 unit/mL was administered in the morning on the following dates by the following nurses:08/06/2025 by S5LPN,08/07/2025 by S6LPN,08/08/2025 by S6LPN,08/09/2025 by S5LPN,08/10/2025 by S5LPN, and 08/11/2025 by S5LPN. Review of Resident #1's Nurses' Notes dated 08/11/2025 revealed the following, in part:At 3:34 p.m., Resident #1's family came to the nurses' station asking for assistance to resident's room. Nurse went to the resident's room. Resident was lethargic and drooling. S2NP and Registered Nurse notified. Called a local ambulance company to send resident to the hospital.At 4:46 p.m., resident was leaving the building via ambulance to a local hospital. Review of Resident #1's Ambulance Record dated 08/11/2025 revealed the following, in part:Vitals: At 4:18 p.m. - blood glucose level 23Treatments/Medications:4:33 p.m. - Medication: 25 grams intravenous dextrose 50% administered4:41 p.m. - Treatment - Assessment: returned to baseline Glasgow Coma Scale after intravenous Dextrose givenNarrative:Arrival: Contact was made in resident's room at a local nursing home. Resident was lying semi-Fowler in his bed and was ill-appearing with poor responsiveness. After obtaining a blood glucose reading of 23, I established intravenous access and administered intravenous Dextrose. Resident rapidly returned to baseline mental status before being moved onto stretcher to be secured for transport. Assessment: Glasgow Coma Scale 9 at contact, with resident requiring painful stimuli to evoke a response. Resident responded to pain with incoherent sounds and withdrawal from painful stimuli. Resident's blood glucose, (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessed on EMS glucometer under standing order for altered mental status, reads 23. Resident's Glasgow Coma Scale improved rapidly from 9 to 15 shortly after administering intravenous Dextrose 50%. Review of Resident #1's Hospital Paperwork from a local hospital dated 08/11/2025 revealed the following, in part:Triage Complaint: HypoglycemiaHistory and Physical: This patient is a resident of a local nursing home and had an altered mental status earlier this afternoon. The Emergency Medical Services personnel checked his blood glucose level, and after giving him 50% Dextrose his Glasgow Coma Scale went up to 15.Diagnosis: Hypoglycemia due to Diabetes Mellitus Type 2 An interview was conducted with S4LPN on 09/03/2025 at 3:05 p.m. She confirmed she transcribed Resident #1's hospital discharge orders into the electronic medical record on 08/05/2025. She confirmed Resident #1's insulin order should have been Lantus 100 unit/mL 5 units daily per his hospital discharge orders. She confirmed she entered the Lantus order into Resident #1's electronic record as 30 units daily. She stated she received education since the incident with Resident #1 on accurate transcription of orders and accurate medication administration. An interview was conducted with S3CDC on 09/03/2025 at 3:18 p.m. She stated was responsible to review all new orders, admission orders, and readmission orders daily. She stated she had received training on reviewing all physician orders for accuracy, accurate transcription of orders, and accurate medication administration. A telephone interview was conducted with S5LPN on 09/04/2025 at 9:16 a.m. She stated if Resident #1 returned from the hospital with an order for Lantus 5 units, Lantus 5 units should have been entered into the electronic record, not Lantus 30 units. She confirmed Resident #1's MAR read to administer Lantus 100 unit/mL inject 30 units daily. She confirmed she administered 30 units of Lantus to Resident #1 on the mornings of 08/06/2025, 08/09/2025, 08/10/2025, and 08/11/2025. She stated she received recent training on accurate transcription of orders and accurate medication administration. A telephone interview was conducted with S6LPN on 09/05/2025 at 8:10 a.m. She confirmed Resident #1's MAR read to administer Lantus 100 unit/mL inject 30 units daily. She confirmed she administered Lantus 30 units to Resident #1 on the mornings of 08/07/2025 and 08/08/2025. She stated she received recent training on accurate transcription of orders and accurate medication administration. An interview was conducted with S1DON on 09/04/2025 at 10:34 a.m. She stated Resident #1's hospital discharge orders dated 08/05/2025, revealed he should have received 5 units of Lantus daily. She confirmed Lantus 100 unit/mL inject 30 units subcutaneously was transcribed into Resident #1's electronic record, which was the wrong dose. She confirmed Resident #1 received 30 units of Lantus from 08/06/2025 through 08/11/2025 and should have received 5 units of Lantus daily. She stated a new admission/readmission checklist was put into place specifically for Diabetics and insulin. She stated all nursing staff had been educated on accurate transcription of orders, medication errors, and the Clinical Data Coordinator was in-serviced to timely review all orders and admission/readmission orders for accuracy. She stated she audited all residents receiving insulin and reviewed all insulin order with S2NP to ensure they were accurate. She stated disciplinary action was imposed related to the medication error. An interview was conducted with S2NP on 09/04/2025 at 10:02 a.m. She stated she was aware of the Lantus medication error with Resident #1. She reviewed Resident #1's hospital discharge orders and confirmed Resident #1 should have received 5 units of Lantus daily. She stated she would have expected the insulin order be transcribed accurately. She stated someone receiving Lantus 30 units who should have been receiving 5 units of Lantus could experience hypoglycemic episodes. Throughout the survey from 09/03/2025 to 09/05/2025, record reviews and staff interviews revealed staff received training on accurate transcription of medication orders, medication errors, and timely audit of new admit/readmit orders for accuracy. Interviews revealed staff were knowledgeable of the aforementioned trainings and new admission/readmission (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195620	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pointe Coupee Healthcare	1820 False River Road New Roads, LA 70760

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	process to include Diabetics and residents receiving insulin. Observations of records revealed accurate transcription of orders. Observations of current insulin orders against insulin available on medication carts and pharmacy labels revealed accurate transcription of orders. The facility had implemented the following actions to correct the deficient practice:1. Corrective actions for the resident found the be affected include:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-service by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.1. All residents have the potential to be affected. Corrective actions for those residents include:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-service by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.e. S1DON or designee will audit admit/readmit charts for order accuracy dated for the last 30 days by 08/28/2025.f. S1DON and S2NP reviewed all insulin orders for accuracy by 08/12/2025.2. The measure that will be put into place to ensure the concern does not recur:a. Nursing staff was in-serviced by 08/14/2025 on accurate transcription of medication orders ensuring the computer added order matches the original received order and written order. Nursing staff completed in-service on 08/14/2025 to request order for glucose checks to all resident with insulin orders. Nursing staff in-service by 08/14/2025 to check an as needed glucose on symptomatic residents and notify the physician of change in condition. Nursing staff in-serviced by 08/14/2025 on updated admit/readmit checklist with added DM diagnosis/accucheck verification section.b. CDC was in-serviced on 08/12/2025 on timely audit of all admits/readmits, all orders, and all progress notes for accuracy.c. S1DON investigated medication error on 08/12/2025 and appropriately in-serviced staff and disciplinary action was imposed where applicable by 08/14/2025.d. S1DON performed audit of residents with insulin orders to assure orders contain glucose checks by 08/18/2025. This will be repeated on all future admits.e. S1DON or designee will audit admit/readmit charts for order accuracy dated for the last 30 days by 08/28/2025.3. The facility plans to monitor its performance to ensure the results are sustained by:a. S1DON or designee will randomly audit 2 admits/readmits, 2 progress notes, and 2 orders twice per week for 6 weeks.b. Monitoring will be done via chart audit. Any issues found will be addressed immediately with staff re-education and progressive disciplinary action as applicable.Compliance date: 08/18/2025.