

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Villa Feliciana Chronic Disease		STREET ADDRESS, CITY, STATE, ZIP CODE 5002 Highway 10 Jackson, LA 70748	

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)
<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981</p> <p>Based on record review, observations, and interviews, the facility failed to prevent misappropriation of resident property by S4RN for 2 (#1 and #2) of 3 (#1, #2, and #3) sampled residents.</p> <p>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.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 02/01/2025 when S4RN withheld Resident #1 and Resident #2's 7:00 p.m. 01/31/2025 medications. Two staff members observed both Resident #1 and Resident #2's 7:00 p.m. 01/31/2025 dose of medications inside of S4RN's personal bag after S4RN verbalized the resident's refused the medications. These medications included cardiac, hypertension, seizure, diabetic, and psychiatric medications. Residents are likely to suffer serious harm, impairment, or death as a result of staff misappropriating of residents' property.</p> <p>S1DON was notified of the Immediate Jeopardy on 03/10/2025 at 4:50 p.m.</p> <p>Findings:</p> <p>Review of the facility's policy titled Abuse and Neglect Policy revised on 03/2023, revealed in part, the following:</p> <p>A. Purpose-It is the policy to prohibit neglect, exploitation of residents.</p> <p>Ciii. Examples:</p> <p>5. Exploitation: Some examples include taking money or other personal property from a resident for one's own use, taking residents medication for own personal use.</p> <p>Resident #1</p> <p>Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Schizoaffective Disorder, Dementia, Epilepsy, Hypertension, Diabetes Mellitus-Type 2, Chronic Embolism and Thrombosis, and Major Depressive Disorder.</p> <p>Review of Resident #1's MDS with an ARD of 12/18/2024 revealed a BIMS of 00, which indicated he was severely cognitively impaired.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195150
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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's Nursing Progress Note dated 02/01/2025 at 6:30 a.m. revealed S5LPN wrote: on 02/01/2025 at approx. 6:30 a.m., I observed S4RN placing Resident #1's medication packets into her personal bag.</p> <p>Review of Resident #1's January 2025 Physician Orders revealed in part, the following:</p> <p>Coreg Oral Tablet 6.25 mg, give 1 capsule by mouth two times a day.</p> <p>Depakote Oral Tablet Delayed Release 125mg, give one tablet by mouth two times a day.</p> <p>Docusate Sodium Oral Capsule 100mg, give 1 capsule by mouth two times a day.</p> <p>Eliquis Oral Tablet 2.5 mg, give 1 tablet by mouth two times a day.</p> <p>Keppra Oral Tablet 500mg, give 1 tablet by mouth two times a day.</p> <p>Metformin Oral Tablet 1,000mg, give 1 tablet by mouth two times a day.</p> <p>Risperdal Oral Tablet 2mg, give 1 tablet by mouth two times a day.</p> <p>Seroquel Oral Tablet 50mg, give 1 tablet by mouth two times a day.</p> <p>Unable to interview Resident #1 due to Resident #1's cognitive impairment.</p> <p>Resident #2</p> <p>Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE], with diagnoses which included Diabetes Mellitus-Type 2, Unspecified Dementia, Major Depressive Disorder, Epilepsy, Essential Hypertension, Aphasia Following Cerebral Infarction, and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Unspecified Side.</p> <p>Review of Resident #2's MDS with an ARD of 01/07/2025 revealed a BIMS of 99, which indicated he was severely cognitively impaired.</p> <p>Review of Resident #2's Nursing Progress Note dated 02/11/2025 at 2:29 p.m. revealed S5LPN wrote: Late entry: On 02/01/2025 at approx. 6:30 a.m., I observed S4RN placing Resident #2's medication packets into her personal bag.</p> <p>Review of Resident #2's January 2025 Physician Orders revealed in part, the following:</p> <p>Docusate Sodium Oral Capsule 250mg, give 1 capsule by mouth two times a day.</p> <p>Fibercon Oral Tablet 625mg, give 1 tablet by mouth two times a day.</p> <p>Keppra Oral Tablet 500mg, give 1 tablet by mouth two times a day.</p> <p>Crestor Oral Tablet 10mg, give 1 tablet by mouth at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Zoloft Oral Tablet 100mg, give 1 tablet by mouth at bedtime.</p> <p>Review of facility's Incident Investigation Report dated 02/01/2025, revealed in part, the following:</p> <p>Name of Resident: Resident #1</p> <p>Date Incident Occurred: 02/01/2025</p> <p>Time Incident Occurred: 6:30 a.m.</p> <p>Where Incident Occurred: Nurses' Station</p> <p>Description of Incident: I observed S4RN placing this resident's medication packet into her personal bag.</p> <p>Witness: S13CGT</p> <p>Other Resident Involved: Resident #2</p> <p>Signature Person Completing This Form: S5LPN</p> <p>An observation was made on 03/03/2025 at 9:18 a.m. with S5LPN of photography provided by the facility dated 02/01/2025 revealed in part, the following:</p> <ol style="list-style-type: none"> 1. Medication packets which included resident names: Resident #1 2. 01/31/2025, 7:00 p.m. doses, and medication listed present: <ul style="list-style-type: none"> Coreg Oral Tablet 6.25 mg Depakote Oral Tablet Delayed Release 125mg Docusate Sodium Oral Capsule 100mg Eliquis Oral Tablet 2.5 mg Keppra Oral Tablet 500mg Metformin Oral Tablet 1,000mg Risperdal Oral Tablet 2mg Seroquel Oral Tablet 50mg 3. Medication packets which included resident names: Resident #2 4. 01/31/2025, 7:00 p.m. doses, and medication listed present: <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Docusate Sodium Oral Capsule 250mg</p> <p>Fibercon Oral Tablet 625mg</p> <p>Keppra Oral Tablet 500mg</p> <p>Crestor Oral Tablet 10mg</p> <p>Zolofit Oral Tablet 100mg</p> <p>5. Multiple opened medication packets.</p> <p>6. 1 clear medication crush bag with white residue inside.</p> <p>Unable to interview Resident #2 due to Resident #2's cognitive impairment.</p> <p>An interview was conducted on 03/03/2025 at 9:18 a.m. with S5LPN. She stated on 02/01/2025 around 6:00 a.m. shift change, she and S4RN conducted a medication cart count. She stated S4RN had her left hand closed during the count and was acting erratically with incoherent speech. She stated S4RN reported Resident #1 and Resident #2 refused their 01/31/2025 7:00 p.m. medications. She stated S4RN went into the nurses' station after the count was completed. S5LPN stated she and S13CGT witnessed S4RN open her left hand and remove pills, which she then placed into a medication crush bag. S4RN then rolled the bag up, and placed it in her pocket. She stated she observed S4RN place resident medication packets into her personal bag and then enter the restroom. She stated while S4RN was in the restroom, she and S12RN looked into S4RN's personal bag and observed unopened medication packets with Resident #1 and Resident #2's names, dated 01/31/2025 7:00 p.m. doses. She stated they also observed multiple empty medication packets and a medication pill crush bag with white residue inside S4RN's personal bag. She stated pictures were taken of the contents of S4RN's personal bag. She stated she notified S11RNS around 6:30 a.m. of S4RN's impairment, unopened medication packets inside S4RN's personal bag, and documented the incident. She stated she immediately assessed Resident #1 and Resident #2, obtained vital signs, notified the nurse practitioner, and RP. She stated Resident #1 and Resident #2 had no negative outcomes, however both were likely to have a seizure or serious injury due to staff misappropriating their property and not continually receiving their prescribed medications. She stated S4RN documented Resident #1 and #2's 01/31/2025 7:00 p.m. medications were administered on the MARs. She stated S4RN remained in the restroom for hours before security escorted her to the local hospital for a drug screen. She stated S4RN did not return for any further shifts. She stated she received in-services related to medication administration, documentation of administration, neglect, exploitation, and reporting in February 2025. She stated S2DON and a pharmacy consultant conducted audits and monitored all medication carts since this incident. S5LPN reviewed the pictures with surveyor and stated you could see Resident #1 and Resident #2's name, the medications listed in the packets, and the medications were due to be administered on 01/31/2025 at 7:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted on 03/05/2025 at 8:50 a.m. with S13CGT. She stated on 02/01/2025 around 6:00 a.m., S5LPN and S4RN conducted a medication cart count. She stated S4RN spoke to her and was acting erratically and her words were incoherent. She stated S4RN went into the nurses' station. She stated she and S5LPN witnessed S4RN place medications from her left hand into a medication crush bag, roll the bag up, and place the bag in her pocket. She stated she observed S4RN place medication packets into her personal bag and then enter the restroom. She stated while S4RN was in the restroom, she and S5LPN looked into S4RN's personal bag and observed unopened medication packets with Resident #1 and Resident #2's names, dated 01/31/2025 7:00 p.m. doses. She stated they also observed multiple empty medication packets and a medication pill crush bag with white residue inside of it in S4RN's personal bag. She stated pictures were taken of the contents of S4RN's personal bag. She stated Resident #1 and Resident #2 did not have negative outcomes. She stated S4RN remained in the restroom for hours before security escorted her to the local hospital for a drug screen. She stated S4RN did not return for any further shifts. She stated she received in-services related to neglect, exploitation, and reporting in February 2025. She stated S2DON and a pharmacy consultant conducted audits and monitored all medication carts since this incident.</p> <p>Multiple attempts to interview S4RN during survey dates 03/03/2025-03/10/2025 were made. All attempts were unsuccessful.</p> <p>An interview was conducted on 03/05/2025 at 9:10 a.m. with S3ADON. She stated S5LPN notified her on 02/01/2025 of residents' medication packets in S4RN's personal bag and possible impairment. She stated it was S11RNS's responsibility to report this incident to S1ADM. She stated S5LPN immediately assessed Resident #1 and Resident #2, obtained vital signs, notified the nurse practitioner, and RP. She stated Resident #1 and Resident #2 had no negative outcomes, however both were likely to have a seizure or serious injury due to staff misappropriating their property and not receiving their prescribed medications. She stated S4RN documented 01/31/2025 7:00 p.m. medications as administered for both Resident #1 and Resident #2 MARs. She stated in the photography of the unopened medication packets, you could see the resident's name, dosage, date, and time to be administered which was 01/31/2025 7:00 p.m. She stated you could see empty medication packets and a clear pill crush bag. She stated S4RN remained in the restroom for hours before security escorted her to the local hospital for a drug screen. She stated S4RN did not return for any further shifts. S3ADON stated she received in-services related to medication administration, documentation of administration, neglect, exploitation, and reporting in February 2025. She stated S2DON and a pharmacy consultant conducted audits and monitored all medication carts since this incident.</p> <p>An interview was conducted on 03/05/2025 at 11:21 a.m. with S21NP. He stated Resident #1 and Resident #2 both had the likelihood of suffering from potential serious harm by not receiving their prescribed medications.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted on 03/10/2025 at 3:57 p.m. with S11RNS. He stated on 02/01/2025 around 6:30 a.m. he was notified of possible impairment of S4RN. He stated a drug screen was ordered for S4RN and S1ADM was notified of possible impairment of S4RN. He stated later around 3:00 p.m., he was notified of residents' medication packets in S4RN's personal bag. He stated Resident #1 and Resident #2 had no negative outcomes, however both were likely to have a seizure or serious injury due to staff misappropriating their property and not receiving their prescribed medications. He stated S4RN did not return for any further shifts. He stated he received in-services related to medication administration, documentation of administration, neglect, exploitation, and reporting in February 2025. He stated S2DON and a pharmacy consultant conducted audits and monitored all medication carts since this incident.</p> <p>An interview was conducted on 03/10/2025 at 2:00 p.m. with S2DON. She stated S3ADON notified her on 02/01/2025 of residents' medication packets in S4RN's personal bag and possible impairment. She stated S5LPN immediately assessed Resident #1 and Resident #2, obtained vital signs, notified the nurse practitioner, and RP. She stated Resident #1 and Resident #2 had no negative outcomes, however both were likely to have a seizure or serious injury due to staff misappropriating their property and not receiving their prescribed medications. She stated S4RN documented 01/31/2025 7:00 p.m. medications as administered for both Resident #1 and Resident #2 MARs. She stated S4RN remained in the restroom for hours before security escorted her to the local hospital for a drug screen. She stated S4RN did not return for any further shifts. She reviewed the photography with surveyor which was taken on 02/01/2025 and confirmed Resident #1 and Resident #2's name could be seen as well as the medications and date of 01/31/2025 7:00 p.m. She stated she received in-services related to medication administration, documentation of administration, neglect, exploitation, and reporting in February 2025. She stated she and a pharmacy consultant conducted audits and monitored all medication carts since this incident.</p> <p>An interview was conducted on 03/10/2025 at 12:57 p.m. with S1ADM. He stated on 02/01/2025, S11RNS notified him of possible impairment of S4RN. He stated he was not made aware of residents' medication packets in S4RN's personal bag until 02/04/2025. He stated Resident #1 and Resident #2 had no negative outcomes. He stated S4RN remained in the restroom for hours before security escorted her to the local hospital for a drug screen. He stated S4RN did not return for any further shifts. He stated all staff received in-services related to medication administration, documentation of administration, neglect, exploitation, and reporting in February 2025. He stated S2DON and a pharmacy consultant conducted audits and monitored all medication carts since this incident.</p> <p>Throughout the survey from 03/03/2025 to 03/10/2025, observations, record review, and staff interviews revealed staff received training on the facility's medication administration, documentation of administration, neglect, exploitation, and reporting policies and procedures. Interviews revealed staff were knowledgeable of the types of neglect and exploitation, and were aware to report these incidents to administration immediately.</p> <p>The facility had implemented the following actions to correct the deficient practice:</p> <p>1. Corrective actions were accomplished on 02/27/2025 for residents found to be affected by the alleged to include:</p> <p>a. S4RN was ordered to undertake a drug screen.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>b. S4RN placed on investigatory leave.</p> <p>c. Case reported to Adult Protective Services, Registered Nursing Board, Pharmacy Consultant, and law enforcement. Responsible parties of all potential victims were notified.</p> <p>2. All staff in-serviced on abuse, neglect, medication administration, and controlled drug policy.</p> <p>3. Medication carts were randomly audited by administrative staff and pharmacy consultant.</p> <p>4. Medication carts remain audited on monthly basis or as needed.</p> <p>5. Corrective action will be completed by 02/27/2025 with 100% staff trained.</p> <p>48912</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981</p> <p>Based on record review and interviews, the facility failed to ensure allegations of neglect/misappropriation of property were reported in the required timeframe for 2 (#1 and #2) of 5 (#1, #2, #3, R1, and R2) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's policy titled Abuse and Neglect Policy revised on 03/2023, revealed in part, the following:</p> <p>5. Exploitation: Some examples include taking money or other personal property from a resident for one's own use, taking residents medication for own personal use.</p> <p>7. Neglect: Acts of omissions by a person responsible for providing care of treatment which placed the resident at risk for harm, or which deprived a resident of sufficient or appropriate services, treatment or basic care.</p> <p>Civ. Procedure to Report Neglect-Any Employee:</p> <p>1. To the Immediate Supervisor: Immediately, but in no case later than one hour after knowledge or suspicion.</p> <p>5. If unable to report face to face or by phone to supervisor or any supervisor, report immediately by phone or face to face to Client Rights Officer.</p> <p>Cv. Responsibility of RN Supervisor:</p> <p>2. Immediately, but in no case later than one hour, after knowledge or suspicion, make a verbal report to the Administrator.</p> <p>11. Notify local law enforcement for any allegations of any allegation of exploitation.</p> <p>Resident #1</p> <p>Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE], with diagnoses which included Schizoaffective Disorder, Dementia, Epilepsy, Hypertension, Diabetes Mellitus-Type 2, Chronic Embolism and Thrombosis, and Major Depressive Disorder.</p> <p>Review of Resident #1's Nursing Progress Note dated 02/01/2025 at 6:30 a.m. S5LPN wrote: on 02/01/2025 at approx. 6:30 a.m., I observed nursing supervisor placing this resident's medication packets into her personal bag.</p> <p>Resident #2</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE], with diagnoses which included Diabetes Mellitus-Type 2, Unspecified Dementia, Major Depressive Disorder, Epilepsy, Essential Hypertension, Aphasia Following Cerebral Infarction, and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Unspecified Side.</p> <p>Review of Resident #2's Nursing Progress Note dated 02/11/2025 at 2:29 p.m. S5LPN wrote: Late entry: On 02/01/2025 at approx. 6:30 a.m., I observed nursing supervisor placing this resident's medication packets into her personal bag.</p> <p>Review of facility's Incident Investigation Report dated 02/01/2025, revealed in part, the following:</p> <p>Name of Resident: Resident #1</p> <p>Date Incident Occurred: 02/01/2025</p> <p>Time Incident Occurred: 6:30 a.m.</p> <p>Date Incident Discovered: 02/01/2025</p> <p>Time Incident Discovered: 6:30 a.m.</p> <p>Where Incident Occurred: Nurses' Station</p> <p>Type of Incident: Alleged Neglect</p> <p>Description of Incident: I observed nursing supervisor placing this resident's medication packet into her personal bag.</p> <p>Witness: S13CGT</p> <p>Other Resident Involved: Resident #2</p> <p>Signature Person Completing This Form: S5LPN</p> <p>Review of facility's email to Adult Protective Services revealed in part, the following:</p> <p>Date: 02/04/2025</p> <p>Time: 1:57 p.m.</p> <p>Notification of allegation of possible exploitation against a resident(s) by a staff member.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 03/03/2025 at 9:18 a.m. with S5LPN. She stated on 02/01/2025 around 6:00 a.m. during shift change, she and S4RN conducted a medication cart count. She stated S4RN had her left hand closed the entire time she was speaking to her and was acting erratically and speaking incoherently. She stated S4RN reported to her that Resident #1 and Resident #2 refused their 01/31/2025 7:00 p.m. medications. She stated S4RN then went into the nurses' station. S5LPN stated she and S13CGT witnessed S4RN place medications from her left hand into a medication crush bag, roll the bag up, and place the bag in her pocket. She stated she was unsure what medications S4RN placed into the medication crush bag. She stated she observed S4RN place medication packets into her personal bag and then enter the restroom. She stated while S4RN was in the restroom, she and S12RN looked into S4RN's personal bag and observed unopened medication packets labeled with Resident #1 and Resident #2's names and dated 01/31/2025 7:00 p.m. doses. She stated they also observed multiple empty medication packets and a medication pill crush bag with white residue inside S4RN's personal bag. S5LPN stated pictures were taken at this time of the contents of S4RN's personal bag. She stated she notified S11RNS around 6:30 a.m. of S4RN's impairment, medication packets located inside S4RN's personal bag, and documented the incident.</p> <p>An interview was conducted on 03/05/2025 at 9:10 a.m. with S3ADON. She stated S5LPN notified her on 02/01/2025 of residents' medication packets observed in S4RN's personal belonging bag and possible impairment. She stated she notified S2DON of residents' medication packets observed in S4RN's personal belonging bag and possible impairment on 02/01/2025. She stated it was S11RNS's responsibility to report this incident to S1ADM.</p> <p>An interview was conducted on 03/10/2025 at 3:57 p.m. with S11RNS. He stated on 02/01/2025 around 6:30 a.m. he was notified of possible impairment of S4RN. He stated a drug screen was ordered at the local hospital for S4RN and S1ADM was notified of possible impairment of S4RN. He stated later around 3:00 p.m. , he was notified of residents' medication packets observed in S4RN's personal bag. He confirmed he did not notify S1ADM of this and should have. He stated S1ADM was not made aware of the residents' medication packets observed in S4RN's personal bag until 02/04/2025.</p> <p>An interview was conducted on 03/10/2025 at 2:00 p.m. with S2DON. She stated S3ADON notified her on 02/01/2025 of residents' medication packets observed in S4RN's personal bag and possible impairment. She stated it was S11RNS's responsibility to report this incident to S1ADM.</p> <p>An interview was conducted on 03/10/2025 at 12:57 p.m. with S1ADM. He stated on 02/01/2025, S11RNS notified him of possible impairment of S4RN. He stated he was not made aware of residents' medication packets observed in S4RN's personal bag until 02/04/2025 and should have been notified by S11RNS on 02/01/2025. He stated this incident was not reported to the state survey agency until 02/04/2025.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER Villa Feliciana Chronic Disease		STREET ADDRESS, CITY, STATE, ZIP CODE 5002 Highway 10 Jackson, LA 70748	

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46981</p> <p>Based on record review, interviews, and observations, the facility failed to have sufficient certified nursing assistant staff to provide direct care and related services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 (Unit 2B) of 2 (Unit 1A and Unit 2B) resident units reviewed for staffing.</p> <p>This had the potential to affect the 20 residents residing on Unit 2B.</p> <p>Findings:</p> <p>Review of the facility's Nursing Staffing Pattern revealed the facility required 2 CNA's assigned per shift for Unit 2B.</p> <p>Review of the facility's census dated 03/03/2025 revealed there were 20 residents residing on Unit 2B.</p> <p>Review of the facility's Daily Assignment Sheet dated 03/03/2025 revealed the following, in part:</p> <p>6:00 a.m. to 6:00 p.m.:</p> <p>S9CNA - Unit 2B</p> <p>Further review revealed no other CNA assigned to Unit 2B.</p> <p>Review of the facility's Daily Assignment Sheet dated 03/05/2025 revealed the following, in part:</p> <p>6:00 a.m. to 6:00 p.m.:</p> <p>S10CNA - Unit 2B</p> <p>Further review revealed no other CNA assigned to Unit 2B.</p> <p>An observation was made on 03/03/2025 at 9:00 a.m. of Unit 2B. Observed 5 residents tapping their hands against the nurses' station glass windows. Observed 2 staff nurses, preparing medications inside the nurses' station and ask the residents if there was anything they required help with. Observed 1 CNA, S9CNA, on Unit 2B. Observed S9CNA attempt to redirect a resident into his room for a brief change. Observed this resident refusing to go into his room while 2 other residents ask for S9CNA to change them. Observed the 5 residents continue to tap the glass windows on the nurses' station for 15 minutes.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted with S9CNA on 03/03/2025 at 9:36 a.m. She stated she was a full time CNA on Unit 2B from 6:00 a.m. to 6:00 p.m. She confirmed she was often the only CNA assigned to Unit 2B on her shift. She explained the acuity and behaviors on Unit 2B were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated it often took a while to find someone to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An interview was conducted with S5LPN on 03/03/2025 at 9:45 a.m. She confirmed there was often only one CNA assigned to Unit 2B during her shifts. She explained the acuity and behaviors on Unit 2B were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated S9CNA had to wait for the nurse to complete their task before they were available to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An interview was conducted with S8LPN on 03/03/2025 at 9:55 a.m. She confirmed there was often only one CNA assigned to Unit 2B during her shift. She explained the acuity and behaviors on Unit 2 were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated S9CNA had to wait for the nurse to complete their task before they were available to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An interview was conducted with S10CNA on 03/05/2025 at 9:18 a.m. She confirmed she was often the only CNA assigned to Unit 2B on her shift. She explained the acuity and behaviors on Unit 2B were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated sometimes it took a while to find someone to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An observation was made on 03/05/2025 at 4:10 p.m. of Unit 2B. Observed 4 residents tapping their hands against the nurses' station glass windows. Observed 2 staff nurses, preparing medications inside nurses' station and ask the residents if there was anything they required help with. Observed 1 CNA, S10CNA, on Unit 2B. Observed S10CNA attempt to redirect a resident to the day room. Observed this resident refuse to go to the day room while 3 other residents asked for S10CNA to change them. Observed the 4 residents continue to tap the glass windows on the nurses' station for 20 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted with S6LPN on 03/05/2025 at 4:12 p.m. She confirmed there was often only one CNA assigned to Unit 2B during her shift. She explained the acuity and behaviors on Unit 2 were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated S10CNA had to wait for the nurse to complete their task before they were available to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An interview was conducted with S7LPN on 03/05/2025 at 4:15 p.m. She confirmed there was often only one CNA assigned to Unit 2B during her shift. She explained the acuity and behaviors on Unit 2 were too much for one CNA to complete all care timely. She stated multiple residents required two staff members for ADL assistance due to behaviors. She stated residents initiated their call lights and she had to explain she would return after she completed another residents' task. She stated S10CNA had to wait for the nurse to complete their task before they were available to assist. She stated residents would have to wait 20 to 30 minutes before they received assistance. She stated twenty to thirty minutes was too long for any resident to have to wait, especially residents on Unit 2B with behaviors. She stated one CNA was not sufficient staff for this unit.</p> <p>An interview was conducted with S16RNS on 03/05/2025 at 10:26 a.m. She stated she was responsible for staffing Unit 2B. She stated she based staffing on her knowledge of the facility's residents and their acuity. She stated there was no specific method the supervisors used to determine staffing. She stated Unit 2B did have residents with behaviors, and should be staffed with 2 CNAs. She was informed of surveyors' observation on 03/03/2025 of Unit 2B having only one CNA. She stated she did not think one CNA on Unit 2B was sufficient staffing.</p> <p>An interview was conducted with S15RNS on 03/10/2025 at 11:56 a.m. She stated Unit 2B contained residents that were at risk for elopement, escaping, and had schizophrenia. She stated Unit 2B should be staffed with two CNAs at all times.</p> <p>48912</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981</p> <p>Based on record reviews and interviews, the facility failed to ensure residents' Medication Administration Record (MAR) were accurately documented for 2 (#1 and #2) of 3 (#1, #2, and #3) residents reviewed for pharmaceutical services. This deficient practice had to the potential to affect any of the 153 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's policy titled Medication Administration with revision date of August 2018 revealed the following, in part:</p> <p>Procedure:</p> <p>M. The nurse must document medication administration on the resident's MAR/electronic MAR immediately after administering the medications.</p> <p>N. If a resident refuses a medication, indicate on MAR/electronic MAR noting the specific date/time, document in resident's clinical record on the nurses' notes, and notify physician.</p> <p>Resident #1</p> <p>Review of Resident #1's Clinical Record revealed an admitted [DATE], with diagnoses which included Schizoaffective Disorder, Dementia, Epilepsy, Hypertension, Diabetes Mellitus-Type 2, Chronic Embolism and Thrombosis, and Major Depressive Disorder.</p> <p>Review of Resident #1's February 2025 Physician Orders revealed in part, the following:</p> <p>Amlodipine Oral Tablet 10 mg, give 1 tablet by mouth one time a day.</p> <p>Cymbalta Oral Capsule 30mg, give 1 capsule by mouth in the morning.</p> <p>Flomax Oral Capsule 0.4 mg, give 1 capsule by mouth one time a day.</p> <p>Neurontin Oral Capsule 300 mg, give 1 capsule by mouth one time a day.</p> <p>Coreg Oral Tablet 6.25 mg, give 1 capsule by mouth two times a day.</p> <p>Depakote Oral Tablet Delayed Release 125mg, give one tablet by mouth two times a day.</p> <p>Docusate Sodium Oral Capsule 100mg, give 1 capsule by mouth two times a day.</p> <p>Eliquis Oral Tablet 2.5 mg, give 1 tablet by mouth two times a day.</p> <p>Keppra Oral Tablet 500mg, give 1 tablet by mouth two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Metformin Oral Tablet 1,000mg, give 1 tablet by mouth two times a day.</p> <p>Risperdal Oral Tablet 2mg, give 1 tablet by mouth two times a day.</p> <p>Seroquel Oral Tablet 50mg, give 1 tablet by mouth two times a day.</p> <p>Insulin Regular Solution inject as per sliding scale: if 151 -200 = 2 units, sliding scale less than 60 =8 ounces of juice and call MD; 201 -250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units recheck in 2 hours, if not less by 50mg/dL call MD, subcutaneously before meals and at bedtime.</p> <p>Review of Resident #1's February 2025 MAR revealed in part, the following:</p> <p>-No documented evidence Resident #1 received or refused the above-mentioned medications on 02/08/2025 through 02/10/2025 at 7:00 a.m.</p> <p>-No documentation of insulin administration or blood glucose check being completed or refused on 02/08/2025 through 02/10/2025 at 7:00 a.m.</p> <p>-No documentation of insulin administration or blood glucose check being completed or refused on 02/08/2025 and 02/09/2025 at 11:00 a.m.</p> <p>-No documentation of insulin administration or blood glucose check being completed or refused on 02/08/2025 through 02/10/2025 at 4:00 p.m.</p> <p>Review of Resident #1's physical Clinical Record revealed no paper MARs.</p> <p>On 03/05/2025 at 1:33 p.m., a telephone interview was conducted with S14RN. She stated she provided care for Resident #1 on 02/08/2025 and 02/09/2025 from 6:00 a.m. to 6:00 p.m. She stated she was responsible for the administration of Resident #1's 6:00 a.m. and 7:00 a.m. medications on her shifts. S14RN stated she did not have access to the facility's electronic software for those shifts. She stated she documented the medication administration for Resident #1 in his physical Clinical Record on a paper MAR. S14RN was informed of Resident #1's February 2025 MAR findings, and she confirmed the appropriate way to document medication administration or refusal should be done on MAR.</p> <p>On 03/10/2025 at 12:02 p.m., an interview was conducted with S17LPN. She stated she provided care for Resident #1 on 02/10/2025 from 6:00 a.m. to 6:00 p.m. She stated she was responsible for the administration of Resident #1's 6:00 a.m. and 7:00 a.m. medications on her shift. S17LPN confirmed she did not document Resident #1's administration or refusal of medications and blood glucose checks on the MAR and should have.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/10/2025 at 11:56 a.m., an interview was conducted with S15RNS. She stated staff should accurately document medication administration during medication pass. She stated the process if nurses could not access the facility's electronic software was to notify S2DON and use the paper MARs in the binder at the nurse's station. She stated when paper MARs are used nurses should document medication administration or refusals on the paper forms. S15RNS stated she was made aware of S14RN not having access to facility's electronic software on 02/05/2025 and S2DON reset her password immediately. S15RNS stated she did not recall S14RN informing her of not having access on 02/08/2025 or 02/09/2025, she further stated if she did not S14RN should have documented medication administration on paper MARs. S15RNS reviewed Resident #1's February 2025 MAR, and she confirmed aforementioned findings were blank and administrations or refusals were not documented.</p> <p>On 03/10/2025 at 12:16 p.m., an observation interview was conducted with S15RNS. S15RNS reviewed the binder in which she stated should contain the units paper MARs for all residents, and it failed to contain any current paper MARs for any residents. Further review revealed paper MARs were dated December 2024. She stated the process was for the night shift nurses to remove all old MARs from the binder and place them on the resident's physical Clinical Record on the last day of the month. S15RNS reviewed Resident #1's physical Clinical Record, and confirmed it failed to reveal any paper MARs. S15RN further confirmed she could not provide documentation of medications being administered or refused for Resident #1 for 02/08/2025 through 02/10/2025 and she should have.</p> <p>Resident #2</p> <p>Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE], with diagnoses which included Diabetes Mellitus-Type 2, Dementia, Major Depressive Disorder, Epilepsy, Hypertension, Aphasia, Hemiplegia and Hemiparesis, and Constipation.</p> <p>Review of Resident #2's February 2025 Physician Orders revealed in part, the following:</p> <p>Hydrochlorothiazide Oral Capsule 12.5mg, give 1 capsule by mouth in the morning.</p> <p>Norvasc Oral Tablet 10mg, give 1 tablet by mouth in the morning.</p> <p>Plavix Oral Tablet 75mg, give 1 tablet by mouth in the morning.</p> <p>Docusate Sodium Oral Capsule 250mg, give 1 capsule by mouth two times a day.</p> <p>Fibercon Oral Tablet 625mg, give 1 tablet by mouth two times a day.</p> <p>Keppra Oral Tablet 500mg, give 1 tablet by mouth two times a day.</p> <p>Review of Resident #2's February 2025 MAR revealed in part, the following:</p> <p>- No documented evidence Resident #2 received or refused the above-mentioned medications on 02/13/2025 at 7:00 a.m.</p> <p>Review of Resident #2's physical Clinical Record revealed no paper MARs.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/05/2025 at 4:15 p.m., an interview was conducted with S6LPN. She stated she provided care for Resident #2 on 02/13/2025 from 6:00 a.m. to 6:00 p.m. S6LPN stated she was responsible for administering Resident #2's 7:00 a.m. medications on her shift. S6LPN reviewed Resident #2's February 2025 MAR, and confirmed she did not document these medications as administered and should have.</p> <p>On 03/10/2025 at 1:53 p.m., an interview was conducted with S2DON. She stated she expected all staff to accurately document medication administration on the MAR at the time of administration. S2DON stated there was no current process for staff to use in the event in which they could not access facility's electronic software. She stated S14RN should have had access to facility's electronic software on 02/08/2025 and 02/09/2025 and there was no excuse for her to not properly document her medication administration on the MAR. She further stated she reset S14RN's password and educated her on how to gain access if she were to get locked out again. S2DON was informed of all the aforementioned findings for Resident #1 and #2, and she confirmed all medication administered and glucose checks completed or refused should have been documented on the resident's MARs, and they were not.</p> <p>48912</p>		