STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195150	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Feliciana Chronic Disease	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status by failing to implement interventions for 2 (#11 and #65) of 4 residents reviewed for Tube Feeding/Nutrition. The facility failed to complete weekly weights for Resident #11 and #65.Review of the facility's policy titled Weights-Obtaining Accurate Weights, updated on 10/2022, revealed the following: Purpose: To insure that accurate body weights are obtained on all residents at admission, and at least monthly thereafter, unless ordered more frequently by the attending physician. Policy: B. The nursing staff.will be responsible for obtaining and documenting the weights on the Electronic Health Record (EHR). C. In addition to the above, all residents will be weighed once a month, unless ordered more frequently by the attending physician. Procedure: G. If a resident refuses to be weighed at any time, the nurse must document this in the resident's EHR in the Nursing progress notes. Resident #11 Review of the clinical record for Resident #11 revealed he admitted to the facility on [DATE] and had diagnoses which included the following: Type 2 DM, GERD, and Dysphagia. Review of Resident #11's Quarterly MDS with an ARD of 11/13/2025 revealed a Brief Interview for Mental Status (BIMS) of 99, which indicated severe cognitive impairment. Review of the current physician orders for Resident #11 revealed the following, in part: -Weekly weights – every day shift every Monday – Start date: 08/18/2025 Review of the Nutrition Services Care Plan for Resident #11 revealed the following: Problem: Need for Adequate Nutrition due to medical conditions. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: Resident's tube feeding will be nutritionally adequate Approach: Resident's nutrition needs – Monitor weight: Weekly Review of the Care Plan for Resident #11 revealed the following: Problem: I have the need for adequate nutrition due to my diagnoses Approaches: 08/11/2025 – Weekly weights Review of the weight log for Resident #11 revealed the following: 01/12/2026 – 139.5# 01/11/2026 – 139.5# 01/05/2026 – 142.9# 12/17/2025 – 145.6# 11/13/2025 – 145.1# 10/15/2025 – 142.3# 09/01/2025 – 142.2# 08/25/2025 – 140.6# 08/18/2025 – 142.4# On 01/22/2026 at 9:43 a.m., an interview was conducted with S5CNAS. S5CNAS stated CNAs were responsible for weighing residents and [NAME] clerks were responsible for transferring weights from the weight log into the computer. She reviewed Resident #11's documented weights and confirmed he had not received weekly weights. On 01/22/2026 at 11:15 a.m., an interview was conducted with S4RD. S4RD reviewed Resident #11's Physician's Orders and confirmed he should have been receiving weekly weights. On 01/22/2026 at 11:30 a.m., an interview was conducted with S3LPN. S3LPN reviewed the documented weights for Resident #11 and confirmed weights were not obtained weekly. Resident #65Review of the clinical record for Resident #65 revealed he admitted to the facility on [DATE] and had diagnoses which included the following: Malignant Neoplasm of the Prostate and Type 2 Diabetes Mellitus without Complications. Review of Resident #65's Annual MDS with an ARD of 10/02/2025 revealed a BIMS of 04, which indicated severe cognitive impairment. Review of the current physician orders for Resident #65 revealed the following, in part:11/05/2024 - (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekly weights Review of the Care Plan for Resident #65 revealed the following:Problem: I have a need for adequate nutrition/hydration due to my Metastatic Prostate Cancer. Interventions: weekly weights Review of the weight log for Resident #65 revealed the following:01/08/2026- 114.4#12/18/2025- 118.6#12/10/2025- 106.1#12/09/2025- 100.0#12/07/2025- 100.0#11/10/2025- 122.0#11/04/2025- 123.0#There were no weights documented for the following weeks: 11/17/2025, 11/24/2025, 12/01/2025, 12/22/2025, and 12/29/2025. On 01/22/2026 at 8:35 a.m., an interview was conducted with S8LPN. She stated Resident #65 had a weight loss and was weighed weekly. She reviewed Resident #65's clinical record at this time and confirmed he was not weighed weekly as ordered. On 01/22/2026 at 11:50 a.m., an interview was conducted with S4RD. S4RD reviewed Resident #65's Physician's Orders and confirmed he should have been receiving weekly weights. On 01/22/2026 at 3:10 p.m., an interview was conducted with S1DON. S1DON reviewed Resident #11's and #65's physician's orders and confirmed they should have been receiving weekly weights. S1DON further reviewed Resident #11's and #65's documented weights and confirmed they had not been receiving weekly weights according to physician's orders and should have been.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interviews, and record reviews, the facility failed to ensure there were sufficient numbers of Certified Nursing Assistants on a 24-hour basis to provide nursing care to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 3 (#14, #53 and #104) of 38 residents reviewed for staffing in the initial pool.Review of the facility's Resident Census dated 01/20/2026 revealed there were 162 residents who resided in the facility. Further review of the Census revealed there were 24 residents who resided on Unit 3 and 25 residents who resided on Unit 5. Review of the facility's daily Staffing Assignment Sheet for the 6:00 a.m. - 6:00 p.m. shift revealed the following number of required staff assignments:Unit 1 - 2 CNAs;Unit 2 - 2 CNAs;Unit 3 - 2 CNAs;Unit 4 - 2 CNAs;Unit 5 - 2 CNAs;Unit 6 - 2 CNAs;Unit 7 - 1 CNA; andUnit 8 - 1 CNA. Review of the facility's Staffing Assignment Sheets dated 01/01/2026 through 01/21/2026 revealed the following, in part:01/01/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3;01/02/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3;01/03/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 5;01/04/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 5;01/05/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 5;01/06/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3 and Unit 5;01/07/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3 and Unit 5;01/09/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 5;01/10/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3;01/11/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3 and Unit 5;01/12/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3;01/13/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 1, Unit 5, and Unit 6;01/14/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3, Unit 5, and Unit 6;01/15/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3 and Unit 5;01/16/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 1 and Unit 3;01/17/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 1, Unit 5, and Unit 6;01/18/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3, Unit 5, and Unit 6;01/19/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to each Unit 3, Unit 5 and Unit 6;01/20/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3; and01/21/2026 from 6:00 a.m. to 6:00 p.m. - 1 CNA was assigned to Unit 3. Resident #14Review of Resident #14's Clinical Record revealed an admission date of 06/17/2015 and diagnoses, which included Personal History of Traumatic Brain Injury and Morbid Obesity. Review of Resident #14's Quarterly MDS with an ARD of 12/14/2025 revealed she had a BIMS of 15, which indicated she was cognitively intact. Further review revealed Resident #14 was dependent on staff for activities of daily living and was incontinent of bladder and bowel. Review of Resident #14's current Care Plan revealed the following, in part:Problem: I cannot take care of myself. I am bed/chair bound and have Osteoarthritis and Morbid Obesity. I need the help of 2 plus staff members for transfers. I am able to make my needs known and make my own decisions. An interview was conducted with Resident #14 on 01/20/2026 at 9:46 a.m. Resident #14 resided on unit Resident #14 stated there were not enough CNAs to meet the needs of the residents on Unit 3. Resident #14 stated she required incontinence care. Resident #14 stated she was aware when she needed her brief changed. Resident #14 stated she called for staff to change her, and it often took them about one hour to provide incontinence care. An interview was conducted with S13CNAS on 01/21/2026 at 11:43 a.m. She stated she was the only CNA for Unit 3 today. She stated she had been working Unit 3 without the assistance of another CNA daily. She stated there were twenty-four residents on the unit. She stated there were not any residents on the unit who were completely independent. She stated there were 5 residents who required total care from the staff. She stated Unit 3 needed two CNAs. She stated there was sometimes only one nurse and one CNA for Unit 3. She stated she would be able to address the needs of the residents more timely and effectively with two CNAs on Unit 3. She (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained overtime was taken away from the staff, and staff could only work extra shifts for compensatory leave time. She stated when overtime was taken away, it made the staffing situation for the facility worse because no staff wanted to work for straight compensatory leave time. An interview was conducted with S10RN on 01/21/2026 at 10:59 a.m. She confirmed she was assigned to Unit 3. She stated there were twenty-four residents who resided on the unit. She stated sometimes residents had to wait up to an hour for assistance with incontinence care or showering, which was too long. She stated residents' requests for care needed to be addressed as soon as possible, and within five minutes to meet their needs. She stated she often had to provide ADL care due to the CNA not being available, which took her away from her nursing duties. She stated half of the residents on the hall required assistance. She stated there should have been two nurses and two CNAs for Unit 3 to effectively meet the residents' needs. She stated today, there were two nurses and one CNA. An interview was conducted with S9RN on 01/21/2026 at 11:08 a.m. She confirmed she was assigned to Unit 3. She stated there were twenty-four residents on Unit 3. She stated there was one CNA for Unit 3 today. She stated all of the residents on the unit required some level of assistance. She stated the residents on Unit 3 had behaviors and psychological conditions which required direction, redirection, and assistance with tasks. She stated the residents' ADL care was not able to be met timely and effectively with one CNA and two nurses. She stated Unit 3 often only had one nurse and one CNA. She stated she assisted with CNA tasks when she was available, but she also had nursing duties. She stated there were three residents on Unit 3 who required two person assistance with ADLs and bed mobility. She stated when there was one CNA and one nurse, Resident #14 and other residents who required two person assistance often had to wait a long time for assistance because both staff had to be available to assist. She stated she often had to tell residents they would have to wait for incontinence care until someone else was available to assist. She stated she has reported to S11RNS that the unit needed at least two CNAs to carry out the functions of the unit timely. An interview was conducted with S15CNA on 01/22/2026 at 8:16 a.m. She confirmed she was assigned to Unit 3. She stated Unit 3 required two CNAs to meet the residents' needs effectively and timely. Unit 5An observation was conducted of unit 5 on 01/21/2026 from 11:00 a.m. to 11:40 a.m. Resident #53 was noted pacing up and down the hall, stating he wanted a shower. S17RN redirected Resident #53 multiple times during the observation. Resident #53 was noted with his face against the glass window and softly hitting the glass at the nurse's station. At 11:40 a.m., Resident #53 was noted looking through and hitting the glass of the locked doors leading into Unit 5. An interview was conducted with S18CNA on 01/21/2026 at 11:44 a.m. She stated it was not possible to complete all tasks for residents timely with only one CNA on Unit 5. An interview was conducted with S19CNA on 01/21/2026 at 11:52 a.m. She stated she could not complete every 30 minute rounding and every 2 hour incontinent care on Unit 5 with 1 CNA. She stated Unit 5 had 15 bed bound residents and 3 residents that required to be fed. An interview was conducted with S8LPN on 01/22/2026 at 8:30 a.m. She stated there was one CNA assigned to both halls on Unit 5 today. She stated there were 25 total residents, with 15 residents that required total care and 3 that required to be fed. She stated last night there was not a CNA on Unit 5. She stated rounding was not completed every 30 minutes when one CNA was scheduled on Unit 5. She stated residents had to wait 30 minutes to 2 hours for a bed bath or shower. She stated Resident #53 requested a shower daily and got agitated when he waited for 30 minutes or longer. She stated Resident #53 yelled and beat on the door when he was agitated while he waited for assistance. An interview was conducted with S20LPN on 01/22/2026 at 8:40 a.m. He stated Resident #53 requested a shower every day and got agitated when he waited for 30 minutes or longer. He stated Resident #53 yelled and beat on the door when he was agitated while he waited for assistance. He further stated non facility security officers redirected Resident #53 from entering other resident's rooms when the facility staff was not available. An interview was conducted with a non-facility security officer on 01/22/2026 at 3:45 p.m. She stated the facility did not have enough staff on Unit 5 to provide residents with timely assistance. She stated residents on Unit 5 did not get (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perineal care every 2 hours due to short staffing. She stated the residents received perineal care at 6:00 a.m. and 3:00 p.m. She stated Resident #104 became agitated when his brief was wet and attempted to get up. She stated the security officers would stand outside his room to ensure his safety when staff were not available. She stated, on 01/22/2026, Resident #104 stood up, and his brief was soaked and fell to the ground. She further stated non facility security officers stopped Resident #53 from entering other residents' rooms when staff were not available. A telephone interview was conducted with S11RNS on 01/22/2026 at 10:44 a.m. She stated the facility needed more CNAs to timely and effectively meet the needs of the residents. She stated the following nurse staffing was needed on the following units: Unit 1 - 2 nurses; Unit 2 - 1 nurse; Unit 3 - 2 CNAs; Unit 4 - 1 CNA; Unit 5 - 2 CNAs; Unit 6 - 2 CNAs; Unit 7 - 1 CNA; Unit 8 - 1 CNA. She stated there were twenty-four residents on Unit 3. She explained there were multiple residents residing on Unit 3 with psychological conditions and extensive behaviors, therefore, she preferred to have 2 nurses on the unit if the staff were available. She stated the extra nurse on Unit 3 was not put there to perform CNA duties. She stated S13CNAS had been assigned to Unit 3 due to there not being another CNA available. She stated there were fifteen bed bound residents on Unit 5 who were totally dependent on staff for ADLs. She stated Unit 5 needed two CNAs and Unit 6 needed two CNAs. She stated S13CNAS needed to be rounding and not assigned to a unit. An interview was conducted with S12RNM on 01/22/2025 at 11:33 a.m. He stated the following nursing staff on the following units were needed to effectively meet the needs of the residents: Unit 1 - 2 CNAs; Unit 2 - 2 CNAs; Unit 3 - 2 CNAs; Unit 4 - 2 CNAs; Unit 5 - 2 CNAs; Unit 6 - 2 CNAs; Unit 7 - 1 CNA; Unit 8 - 2 CNAs. He confirmed the facility was not currently staffed at the aforementioned numbers and barely ever was. He stated there have been times when residents' requested incontinence care, the CNA and nurses were busy, and the resident had to wait thirty minutes to one hour to receive the care. He stated the facility needed to be staffed fully to meet the needs of the residents effectively and timely. He confirmed the facility had a nurse and CNA staffing problem. He explained overtime was taken away from staff, and staff could only work extra shifts for compensatory leave time. He stated when overtime was taken away, it made the staffing situation for the facility worse because no staff wanted to work for straight compensatory leave time. An interview was conducted with S1DON and S14ADON on 01/22/2026 at 3:14 p.m. S1DON and S14ADON stated the following number of CNAs were needed on the following units: Unit 1 - 2 CNAs; Unit 2 - 2 CNAs; Unit 3 - 2 CNAs; Unit 4 - 2 CNAs; Unit 5 - 2 CNAs; Unit 6 - 2 CNAs; Unit 7 - 1 CNA; and Unit 8 - 2 CNAs. S1DON explained overtime was taken away from staff, and staff could only work extra shifts for compensatory leave time. S1DON stated when overtime was taken away, it made the staffing situation for the facility worse because no staff wanted to work for straight compensatory leave time. S1DON stated it was impossible for one CNA to be able to carry out the ADLs of all residents on unit 5 timely and effectively. S1DON and S14ADON confirmed the facility was unable to staff enough CNAs each shift to meet the acuity of the facility's residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications were stored properly in accordance with currently accepted professional principles. The facility failed to ensure expired medications were not available for use for Resident #71 and Resident #131 in Medication Cart a, and for Resident #65 in Medication Cart b of 5 medication carts reviewed. On 01/20/2026 at 1:55 p.m., an observation was made of Medication Cart a with S6LPN. The following was observed:One bottle of Latanoprost Ophthalmic Solution 0.005% with an expiration of 12/2025 for Resident #71; andOne bottle of Latanoprost Ophthalmic Solution 0.005% with an expiration of 12/2025 for Resident #131. On 01/20/2026 at 2:03 p.m., an interview was conducted with S6LPN. She confirmed the Latanoprost Ophthalmic Solution 0.005% bottles for Resident #71 and Resident #131 were expired and available for use. S6LPN confirmed expired medications should not have been available for use. On 01/21/2026 at 8:51 a.m., an observation of was made of Medication Cart b with S7LPN. The following was observed: One bottle of Latanoprost Ophthalmic Solution 0.005% with an expiration of 12/2025 for Resident #65. On 01/21/2026 at 9:04 a.m., an interview was conducted with S7LPN. She confirmed the bottle of Latanoprost Ophthalmic Solution 0.005% for Resident #65 was expired and available for use. S7LPN confirmed an expired medication should not have been available for use. On 01/22/2026 at 3:44 p.m., an interview was conducted with S1DON. S1DON stated nurses were responsible for checking the medication carts for expired medications. S1DON confirmed expired medications should not have been available for use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store food in accordance with professional standards for food service safety. This deficient practice had the potential to affect the residents who were served food from the facility's kitchen. Review of the facility's policy with a revision date of 02/2023, titled Food Storage: Cold Foods revealed in part, the following:Procedures5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. On 01/20/2026 at 8:52 a.m., an observation of the dry storage room in Kitchen b revealed the following:1 opened, 1/2 full, gallon container of soy sauce, with no open date, with a label which read Refrigerate after opening. On 01/20/2026 at 8:59 a.m., an observation of Kitchen b revealed the following: 1opened, 16 ounce block of margarine, with no open date, unsealed. On 01/20/2026 at 9:00 a.m., an interview was conducted with S16DM. S16DM confirmed the above findings. S16DM confirmed the container of soy sauce should have been refrigerated after opening, and the block of margarine should have been sealed, labeled, and dated. On 01/22/2026 at 11:55 a.m., an interview was conducted with S4RD. S4RD confirmed the container of soy sauce should have been refrigerated after opening, and the block of margarine should have been sealed, labeled, and dated.

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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, interviews, and record review, the facility failed to ensure the oxygen tubing was labeled with the date and time for 1(#54) of 5 residents reviewed for respiratory care.Review of the facility's undated policy titled Oxygen Administration revealed the following, in part, Procedure: O. Document date, time, oxygen flow rate, route and frequency and duration of treatment. S. Replace tubing, cannula or mask at least every week when oxygen is used intermittently or as needed. Resident #54 was admitted to the facility on [DATE] with diagnoses that included, in part, Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbations, Pleural Effusion, and Atrial Fibrillation. Review of Resident #54's Care Plan revealed the following, in part: Problem: The resident has oxygen therapy related to diagnosis of COPD, Pleural effusion Intervention: Monitor for signs/symptoms of respiratory distress and report to MD as needed. O2 via Nasal Cannula as needed, keeps sats >93%. Problem: The resident is at risk for altered respiratory status/difficulty breathing related to diagnosis of COPD, Allergic rhinitis, and Pleural effusion Interventions: Monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. On 01/20/2026 at 10:30 a.m. an observation revealed no date and time on Resident #54's oxygen tubing. On 01/20/2026 at 1:50 p.m. an observation revealed no date and time on Resident #54's oxygen tubing. On 01/20/2026 at 2:00 p.m., an observation made with S2LPN. S2LPN confirmed Resident #54's O2 tubing was not labeled and should have been. On 01/22/2026 at 3:10 p.m., an interview was conducted with S1DON. S1DON stated she expected staff to label oxygen tubing with the date and time that it was changed.