STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195210	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wynhoven Community Care Center	1050 Medical Center Marrero, LA 70072

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews, observations, and record reviews, the facility failed to ensure a resident's enabler bar was not an accident hazard for 1 (Resident #1) of 3 sampled residents reviewed for accident hazards. This deficient practice resulted in actual harm on 02/28/2026 at 7:33PM for Resident #1, when S3Certified Nursing Assistant (CNA) transferred Resident #1 from her wheelchair to the bed. Resident #1's left leg hit the enabler bar, with a missing end cap, which resulted in a laceration to Resident #1's left lower leg. Resident #1 was then transported to a local Emergency Department (ED) where she was assessed as having a large stellate (a star-shaped or irregular, multi-angled tear in the skin) laceration to the left lower leg, received 6 interior sutures, 27 exterior sutures, a tetanus shot, and pain medication. Resident #1 required daily wound care and 14 days of antibiotics. 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 facility's Bed and Side Rails policy and procedure, dated 11/28/2017, revealed, in part, a facility designee shall inspect all bed frames, mattresses, and bed rails as part of a regular maintenance program. Further review revealed examples of bed rails included but were not limited to, grab bars and assist bars.Review of the facility's undated Maintenance Supervisor (MS) job description revealed, in part, the MS should identify and correct hazardous facility conditions. Further review revealed the MS should tour the property daily to look for needed maintenance and liability hazards and report to the administrator.Review of Resident #1's medical record revealed an admission date of 12/05/2024, and diagnoses which included, in part, Peripheral Vascular Disease, Malnutrition, Chronic Kidney Disease, Depression, and Alzheimer's Disease.Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/2026 revealed, in part, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5. A score of 5 indicated Resident #1 had severe cognitive impairment. Further review of Resident #1's MDS revealed Resident #1 received hospice services.Review of Resident #1's care plan revised on 03/02/2026 revealed, in part, Resident #1 required extensive assistance of 1 staff person with transfers.Review of Resident #1's nurses notes dated 02/28/2026 at 7:33PM revealed, in part, S3CNA called S4Licensed Practical Nurse (LPN) to Resident #1's room. S4LPN observed Resident #1 with a large laceration to her left lower leg with bleeding. Further review revealed S3CNA indicated the laceration occurred during transfer. Further review revealed S4LPN provided first aide and called Emergency Medical Services (EMS). Further review revealed Resident #1 was transferred to the local ED on 02/28/2026 at 7:47PM for evaluation and treatment of a left lower leg laceration.Review of Resident #1's ED records, dated 02/28/2026, revealed, in part, Resident #1 arrived to the ED on 02/28/2026 at 8:13PM via EMS. Further review revealed Resident #1 had a very large stellate laceration to the lateral left lower leg which measured 25.5 centimeters (cm). Resident #1's laceration required an extensive amount of cleaning. Further review revealed the laceration was deep to the fascia (a thin sheath of connective tissue which surrounds and supports muscle) and required a complicated repair of 6 internal and 27 external sutures. Further review revealed Resident #1 required a tetanus vaccination update. Further review revealed Resident #1 had a history of multidrug resistant pseudomonas which had previously caused (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195210	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wynhoven Community Care Center	1050 Medical Center Marrero, LA 70072

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 0689 Level of Harm - Actual harm Residents Affected - Few	cellulitis of the same leg; therefore, Resident #1 would require close monitoring. Further review revealed Resident #1 was discharged to the nursing facility on 02/28/2026 at 10:59PM.Review of Resident #1's Physician Orders dated 03/07/2026 revealed an order for Bactrim Double Strength (DS) (an antibiotic) tablet 800-160 milligram (mg), take 1 tablet by mouth every 12 hours for 7 days.Review of Resident #1's March 2026 electronic Medication Administration Record (eMAR) revealed Bactrim DS 800-160mg was administered every 12 hours as ordered from 03/07/2026 through 03/13/2026.Review of Resident #1's Physician's Progress Note dated 03/13/2026 revealed, in part, on 02/28/2026 Resident #1 suffered an injury to her left leg which resulted in a large laceration and required repair in the ED. Further reviewed revealed Resident #1 was placed on antibiotics for prophylactic treatment of the wound due to the extent and depth of the laceration. Further review revealed Resident #1's wound was assessed 10 days post injury, but was not adequately healed. Further review revealed half of Resident #1's sutures were removed on this day, due to the delayed healing of the wound with some surrounding erythema (superficial reddening of the skin) which was mildly increased from the last inspection 3 days prior. Further review revealed scant discharge was observed from the central non healed portion of Resident #1's wound. Further review revealed Resident #1's Physician ordered Bactrim DS for 7 additional days. Review of Resident #1's Physician Orders dated 03/13/2026 revealed an order for Bactrim DS tablet 800-160mg take 1 tablet by mouth every 12 hours for 7 days.Review of Resident #1's March 2026 electronic Medication Administration Record (eMAR) revealed Bactrim DS Tablets 800-160mg were administered every 12 hours as ordered as ordered from 03/13/2026 through 03/20/2026.Review of Resident #1's record revealed on 03/16/2026 Resident #1's physician removed 7 additional sutures.Review of Resident #1's Nurse's Notes dated 03/25/2026 at 7:04PM revealed Resident #1's remaining sutures were removed by Resident #1's physician.In a telephone interview on 03/30/2026 at 9:13AM, S4LPN indicated she Resident #1's nurse when Resident #1 sustained the laceration to her left lower leg. S4LPN indicated she observed Resident #1's enabler bar had a missing end cap which caused the enabler bar to have a sharp edge. S4LPN further indicated during Resident #1's transfer her left lower leg rubbed on the enabler bar which caused the left lower leg laceration. In a telephone interview on 03/30/2026 at 10:00AM, S3CNA indicated she was Resident #1's CNA on 02/28/2026. S3CNA indicated when she assisted Resident #1 with a transfer from her wheelchair to her bed, Resident #1's left leg rubbed against the enabler bar which resulted in a laceration to Resident #1's left lower leg. S3CNA indicated S4LPN observed Resident #1's enabler bar had a missing end cap. In an interview on 03/30/2026 at 2:07PM, S5Treatment Nurse indicated Resident #1's left lower leg laceration required daily wound care.In an interview on 03/30/2026 at 3:22PM, S1Administrator indicated at the time of Resident #1's incident S1Administrator was not aware Resident #1's enabler bar had a missing end cap, and she should have been.Review of the facility's corrective action response revealed, in part, S3CNA was suspended pending an investigation.Review of the facility's corrective action response revealed S6Maintenance Supervisor assessed Resident #1's bed on 03/01/2026 and noted the enabler bars were missing the end caps and corrected the issue. S6MS assessed all resident enabler bars in the building for missing caps and all beds found to have a defect were immediately corrected.Review of the facility's corrective action response revealed all facility enabler bars were reviewed to ensure no other residents were affected because all the residents who used enabler bars had the potential to be affected. Record review revealed all residents had a side rail/bed mobility/lift assessment completed on 03/03/2026, care plans and over-bed signage were verified for accuracy.Review of the facility's corrective action response revealed on 03/03/2026 nursing staff were in-serviced on the transfer/lift policy and procedure and the bed side rail policy and procedure.Review of the facility's corrective action response revealed the maintenance department was educated. Further review revealed on 03/05/2026 padding was added to all enablers in the facility.A monitoring tool was implemented to monitor transfer status to ensure ongoing alignment with the MDS, care plan and over-bed signage.The above was confirmed by the surveyor through observations, record review, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195210	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wynhoven Community Care Center	1050 Medical Center Marrero, LA 70072

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 0689 Level of Harm - Actual harm Residents Affected - Few	interviews which verified the corrective action was put into place and the noncompliance was corrected before the surveyor entered the facility.Throughout the survey from 03/26/2026 to 03/27/2026 observations revealed all enablers were intact and accident hazards related to enablers were not observed. Record reviews revealed staff received training on the facility's repositioning, transfer, bed side rail, and lift policies and procedures. Interview conducted while onsite on 03/26/2026 and 03/27/2026 revealed nurses and CNAs confirmed trainings were completed. Nurses and CNAs were knowledgeable of the need to assess enabler bars and beds for accident hazards prior to a transfer, ensuring transfers were completed properly, not proceeding with a transfer if was deemed unsafe, and reporting any accident hazard to the maintenance department. The facility has implemented the following actions to correct the deficient practice:Action was obtained for the resident identified:Resident #1 was assessed on 02/28/2026 for injuries and bruising, and S4LPN noted a laceration to the left lower lateral leg;Pressure was applied to Resident #1's leg, vital signs were obtained, Resident #1's Responsible Person, Resident #1's physician and Resident #1's hospice provider were notified;Resident #1 was transferred to the hospital for evaluation and treatment;On 02/28/2026 S4LPN padded Resident #1's enabler bar with foam prior to Resident #1's return; and,Wound care and pain monitoring were initiated per Physician Orders. Other residents who had the potential to be affected:Any resident who resided in the facility and used an enabler bar had the potential to be affected.No other residents were found to be affected by this incident.The facility placed the following actions in place to ensure the incident does not recur:S6MS assessed Resident #1's bed and put a new end cap on Resident #1's enabler bar;S6MS assessed all resident enabler bars on 03/01/2026. Audit results revealed no missing end caps;On 03/03/2026 side rail/bed mobility/lift assessments were completed on all residents;All residents' care plans and over bed signage were verified on 03/03/2026;The maintenance department re-inspected structural integrity and proper function of all resident beds on 03/03/2026;S2Director of Nursing (DON) and the therapy department in-serviced licensed nurses and CNAs on repositioning, transfer, bed side rail, and lift policy and procedure; and,On 03/05/2026 all enabler bars were padded.The plan the facility has implemented to ensure the incident does not reoccur:S6MS or designee would monitor all enabler bars daily for 1 week starting on 03/03/2026;S2DON or designee would audit 10 random resident transfers for 1 week starting on 03/03/2026;Audit findings would be reviewed in Quality Assurance Performance Improvement (QAPI), and corrective action would be implemented immediately if non-compliance was identified; and,Any non-compliance would result in immediate correction, re-education, and/or progressive discipline.The facility was in compliance on 03/08/2026.The facility conducted on going monitoring for a total of 1 week.