STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195213	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard of Natchitoches	708 Keyser Avenue Natchitoches, LA 71457

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews and record review the facility failed to ensure the interdisciplinary team assessed and determined if a resident was clinically appropriate for self-administration of medication for 1 resident of 1 (Resident #48) sampled residents. Total sample size was 28. Findings: Review of a facility policy titled Resident Self-Administration of Medications with a review date of 02/2025 revealed in part.Policy Explanation and Compliance Guidelines: 3. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility. 4. The results of the interdisciplinary team assessment are recorded on the Self-Administration Assessment form, which is placed in the resident's medical record. Review of Resident #48's Clinical Record revealed an admit date of 05/12/2025 with diagnoses which included: Chronic Obstructive Pulmonary Disease, Primary Insomnia, Depression, and Nicotine Dependence. Review of Resident #48's Quarterly MDS with an ARD of 11/19/2025 revealed a BIMS score of 15, which indicated intact cognition. Resident #65 was independent for bed mobility, transfers, eating, and toileting. Review of Resident #48's care plan with a target date of 02/04/2026 and revision date of 11/06/2025 revealed in part .Focus: The resident has a physician's order for (unsupervised) self-administration of the following medications: Carboxymethylcellulose Eye drops (initiated 09/04/2025) Further review of the medical record revealed there were no physician's orders to allow Resident #48 to store any medications in the room at the bedside. Review of Self-Administration of Medication assessment form dated 08/19/2025 revealed Resident #48 was fully capable to self-administer eye drops. Topical medications (including patches) were not selected for Resident #48 being capable to self-administer. In an interview and observation on 01/05/2026 at 11:09 a.m. revealed Diclofenac Arthritis Cream placed on Resident #48's bedside table. Resident #48 stated she was running low on this cream and needed some more. In an interview and observation on 01/07/2026 at 11:13 a.m., Resident #48 stated she would like some more cream for her left side. Accompanied Resident #48 to her bathroom and observed Diclofenac Arthritis Cream, Nystatin Cream, and Hydrocortisone Cream placed on a table next to Resident #48's toilet. Resident #48 stated she administers the creams herself and that she got them from a nurse (didn't remember which nurse). Resident #48 stated a nurse would give her some cream in a medicine cup. In an observation and interview on 01/07/2026 at 12:19 p.m., S2 ADON accompanied surveyor to Resident #48's bedroom. S2 ADON confirmed that the Diclofenac Arthritis Cream, Nystatin Cream, and Hydrocortisone Cream should not be left unattended in Resident #48's bathroom. S2 ADON reviewed Self-Administration of Medications assessment with Surveyor and confirmed that Resident #48 was only allowed to self-administer eye drops and not topical creams.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview the facility failed to ensure the resident's right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The facility failed to ensure 1 (Resident #54) of 28 sampled residents was provided a wheelchair appropriate for her size. Findings: Review of Resident #54's medical record revealed an admit date of 02/26/2024 with diagnoses that included in part.Edema, Quadriplegia Unspecified, Acute Pain, Muscle Spasm, Central Cord Syndrome At Unspecified Level Of Cervical Spinal Cord, and Seizures.Review of Resident #54's Quarterly MDS with an ARD of 10/22/2025 revealed she had a BIMS score of 15 indicating intact cognition. The MDS revealed Resident #54 had bilateral upper and lower extremity impairments, and used a wheelchair for mobility. The MDS revealed Resident #54 required set up or clean up assistance with eating, and was dependent for 2 person assistance with personal hygiene, transfers and toileting.Review of Resident #54's care plan with a Target Date of 01/21/2026 revealed in part.1. The resident has limited physical mobility related to Central Cord Syndrome with interventions that included in part.Monitor/document/report PRN any signs and symptoms of immobility; contractures forming or worsening.2. The Resident is at risk for pressure ulcers/injuries with interventions that included in part.Avoid scratching and keep hands and body parts from excessive moisture. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Observation and interview on 01/05/2026 at 10:30 a.m. with Resident #54 revealed she was in her room sitting in a wheelchair. Resident #54 had no space between her hips and the sides of the wheelchair. Resident #54 stated her wheelchair was too small and was rubbing against her hips. Resident #54 stated she had notified S1 Administrator, over a month ago, that her wheelchair was too small because she had gained weight. Interview on 01/06/2026 at 9:00 a.m. with S10 CNA revealed Resident #54 had complained of her wheelchair being too small and rubbing against her hips. Interview on 01/06/2026 at 9:16 a.m. with S11 CNA revealed. Resident #54 had notified her over a month ago about her wheelchair being too small and it was hurting her hips. S11 CNA stated she notified S1 Administrator of Resident #54's complaint. S11 CNA stated S1 Administrator went to Resident #54's room and she showed her Resident #54's wheelchair was too small. Observation of Resident #54 on 01/06/2026 at 1:10 p.m. revealed 3 CNA assisting her from wheelchair via Hoyer lift onto her bed. Resident #54 observed to have redness and indentions to bilateral hips from pressing against the sides of her wheelchair. Observation and Interview on 01/06/2025 at 1:15 p.m. with S9 LPN in Resident #54's room confirmed Resident #54 had redness and indentions to bilateral hips from her wheelchair pressing against the side of her hips. Interview on 01/06/2026 at 1:30 p.m. with S12 RCNA revealed she had noticed Resident #54's wheelchair being too small for her. S12 RCNA revealed resident had edema sometimes and she had gained weight. Interview on 01/06/2026 at 1:35 p.m. with S13 PTA revealed residents are screened every 3 months and as needed. S13 PTA stated Nursing had not notified Therapy of Resident #54's wheelchair being too small. Interview on 01/06/2026 at 1:40 p.m. with S1 Administrator revealed she had filled out a requisition form and had sent it to the hospital for approval, so Resident #54 could get a bigger wheelchair. S1 Administrator stated the requisition had been cancelled (the hospital did not approve the new wheelchair). S1 Administrator confirmed no other measures had been implemented to obtain an appropriate sized wheelchair for Resident #54, and it should have.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interviews and record reviews, the facility failed to provide education to the resident or resident representative and obtain consent from a resident's responsible party prior to administering the influenza vaccination for 1 (Resident #98) of 6 sampled residents reviewed for influenza vaccines.Findings: Review of the facility's policy titled, Pneumonia/Influenza Vaccinations with a revision date of 01/2025 revealed in part.Policy: In keeping with the policies of a hospital as a whole, the facility has adopted the following protocol regarding Pneumonia and Influenza vaccinations. 1. Contact Resident and Family and explain importance of vaccinations. 2. Obtain signed consent from resident and/or family. Review of Resident #98's clinical record revealed an admission date of 04/15/2015 with a re-entry date of 09/04/2025 with diagnoses that included in part.Chronic Kidney Disease, Stage 5; End Stage Renal Disease; Pneumonia, Schizophrenia; and Bipolar Disorder. Further review revealed Resident #98's Responsible Party was listed as her Health Care Proxy. Review of Resident #98's Significant Change MDS with an ARD of 09/10/2025 revealed a BIMS summary score of 03, which indicated severe intact cognition. Review of Resident #98's Physician's Orders revealed in part. start date-10/06/2025--Fluzone High-Dose Intramuscular Suspension Prefilled Syringe 0.5 ML (Influenza Virus Vaccine Split High-Dose Preservative Free. Inject 0.5 ml intramuscularly one time only for vaccine until 10/06/2025. Review of Resident #98's 10/2025 eMAR revealed Resident #98 was administered Fluzone High-Dose Influenza Virus Vaccine on 10/06/2025 at 1:00 p.m. Review of Resident #98's Care Plan read in part.Focus: Refuses vaccines: allergic to some components. Interventions: Assess for consent or refusal of vaccines upon admit and periodically with resident and responsible party (initiated: 08/08/2024). Focus: Short term memory deficit (date initiated: 08/08/2024). Intervention: assess mental status every shift and as needed; Reorient and redirect as needed. Review of Resident #98's Influenza Vaccination Request and Consent form dated on 10/10/2025 and signed by Resident #98's Responsible Party read in part.NO: I do not wish to receive the Influenza vaccine at this or any other time on an annual basis. Review of Resident #98's medical records revealed no documented evidence of a signed consent form signed by Resident #98 or her Health Care Proxy, a refusal of the vaccination, or education explaining the benefits/risks prior to Resident #98 receiving the Influenza vaccine on 10/06/2025. In an interview on 01/06/2026 at 2:37 p.m., S7 LPN stated that on 10/06/2025 she was given instructions from S5 IC Nurse to administer vaccinations to all the residents in the facility. S7 LPN stated she was given a list from S5 IC Nurse of all the residents who consented to receive the Influenza vaccine. S7 LPN confirmed she administered the Influenza vaccine to Resident #98 on 10/06/2025 but did not to ensure a consent was signed prior to administering the vaccine. In an interview on 01/06/2026 at 3:21 p.m., S2 ADON reviewed Resident #98's Influenza vaccination consent form dated 10/10/2025 and confirmed that Resident #98's Responsible Party signed the refusal after Resident #98 received the Influenza vaccination on 10/06/2025. In an interview on 01/07/2026 at 10:17 a.m., S5 IC Nurse acknowledged that an Influenza Vaccination consent/refusal and education should had been obtained for Resident #98 prior to administration of the vaccine on 10/06/2025, but was not.