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	05/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to ensure a resident's comprehensive person-centered care plan was reviewed and revised for 1 (#1) of 3 (#2, #3) sampled resident's care plans reviewed. The facility had a total census of 86 according to the Daily Census provided by the facility administrator.Findings:Review of Resident #1's electronic record revealed an admit date of 10/08/2025 with diagnoses including Pulmonary Embolus, Anorexia, Hypertension, Urinary Tract Infection, and Unspecified Dementia. On 03/17/2026 a new diagnosis was added for Pressure Ulcer of Sacral Region, unstageable.Review of Resident #1's hospice record revealed that a visit was conducted by hospice and a new wound to the sacrum was found. S1 Facility Nurse was present at the time and was made aware of a new wound order for Dakin's gauze to the wound bed.Review of Resident #1's handwritten Physician's Telephone Orders revealed in part:03/14/2026 at 12:30 p.m. Dakin's gauze to wound bed-sacrum written by the hospice nurse.03/16/2026, 4:50 p.m. Turn and reposition side to side only every 2 hours per posted turn schedule written by S2 Treatment Nurse.03/17/2026, 12:00 p.m. Unstageable pressure ulcer to sacrum: cleanse with Vashe, pat dry with gauze, apply Dakin's Solution moistened gauze and cover with dry dressing daily and prn (as needed) soilage or dislodgment written by S2 Treatment Nurse.Review of Resident #1's Care Plan reflected in part, a mild risk for pressure ulcer/pressure injury initiated 01/27/2025. There were no additional/revisions of the Care Plan to include an actual pressure ulcer, nor did it include the intervention of turning and repositioning side to side only every 2 hours per posted turn schedule.During an interview on 05/13/2026 at 1:44 p.m., S3 RN/MDS (Registered Nurse/Minimum Data Set) revealed Resident #1's Care Plan should have been revised to include the unstageable sacral pressure ulcer, discovered on 3/14/26 including the change of the intervention to turn and reposition side to side only every 2 hours per posted turn schedule, but was not.

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

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	05/13/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident received the necessary treatment and services to promote healing of a pressure ulcer for 1 (#1) of 3 (#2, #3) residents reviewed for Pressure Ulcer/Injury. The facility had a total census of 86 according to the Daily Census provided by the facility administrator.Findings:Review of Resident #1's electronic record revealed she was admitted to the facility on [DATE] with diagnoses including Pulmonary Embolus, Anorexia, Hypertension, UTI (Urinary Tract Infection), and Unspecified Dementia. On 03/17/2026 a new diagnosis was added for Pressure Ulcer of Sacral Region, unstageable.Review of Resident #1's hospice record revealed that a visit was conducted by hospice and a new wound to the sacrum was found on 03/14/2026. S1 Facility Nurse was present at the time and was made aware of a new wound order for Dakin's gauze to the wound bed.Review of Resident #1's handwritten Physician's Telephone Orders revealed in part:03/14/2026 at 12:30 p.m. Dakin's gauze to wound bed-sacrum written by the hospice nurse.03/17/2026, 12:00 p.m. Unstageable pressure ulcer to sacrum: cleanse with Vashe, pat dry with gauze, apply Dakin's Solution moistened gauze and cover with dry dressing daily and prn (as needed) soilage or dislodgment written by S2 Treatment Nurse.03/16/2026, 4:50 p.m. Turn and reposition side to side only every 2 hours per posted turn schedule written by S2 Treatment Nurse.Review of S2 Treatment Nurse's Progress Note dated 03/18/2026 at 9:50 a.m. revealed a skin evaluation reflecting in part, a Pressure Ulcer/Injury to the sacrum, unstageable, with a length of 4.5, a width of 5.0, and depth of 0 (Measurements did not include the type unit used for measuring, such as centimeters). Slough to wound bed with serosanguinous drainage, and erythema to the peri-wound area.Review of Resident #1's March 2026 TAR (Treatment Administration Record) revealed the wound care order for the unstageable pressure ulcer on 03/18/2026. There was no documentation reflecting turning and repositioning side to side only every 2 hours per posted turn schedule.During an interview on 05/12/26 at 9:25 a.m., S2 Treatment Nurse stated that on 03/16/2026 she was notified by the hospice nurse that Resident #1 had a new sacral wound with new wound care orders. S1 Facility Nurse was present with the hospice nurse when the pressure ulcer was discovered and the hospice nurse notified S1 Facility Nurse of the wound care orders. S2 Treatment Nurse stated the hospice nurse called her on Monday, 03/16/2026 to discuss the pressure ulcer findings.During a telephone interview on 05/12/2026 at 3:39 p.m. with the hospice nurse, she confirmed that Resident #1's sacral pressure ulcer was discovered on 03/14/26, that she received a telephone order for wound care that date, and that she informed S1 Facility Nurse of the new order on that date.During a telephone interview on 05/12/2026 at 3:59 p.m. with S1 Facility Nurse, she revealed that she worked weekends as the treatment nurse. She confirmed that she was present on 3/14/26 when the hospice nurse assessed Resident #1's sacral pressure ulcer and that orders were received for wound care that date.Review of Resident #1's hospice records dated 03/23/2026 at 10:40 a.m. and 03/24/2026 at 9:25 a.m. reflected the resident was found lying in her hospital bed on her back.During a telephone interview with the hospice nurse on 05/12/2026 at 3:45 p.m., she confirmed she had found Resident #1 lying on her back when she made some of her visits. The hospice nurse confirmed Resident #1 should not have been lying on her back due to the sacral pressure ulcer, and due to a physician's order for turning side to side only every 2 hours.During an interview on 05/13/2026 at 1:18 p.m. with S2 Treatment Nurse, she confirmed that the wound care documentation for Resident #1's sacral ulcer did not begin until 03/18/2026, and it should have started on 03/14/2026. S2 Treatment Nurse confirmed a new order was received on 03/16/2026 for Resident #1 to be turned and repositioned every 2 hours from side to side only. S3 Treatment Nurse confirmed there was no documentation on the March Treatment Administration Record of this change, and it should have been.