

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Plantation Manor Nursing and Rehab Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6340 Highway 4 Winnsboro, LA 71295	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40238</p> <p>Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and hygiene for 1 (#56) of 1 (#56) resident reviewed for activities of daily living.</p> <p>Findings:</p> <p>Record review revealed resident #56 was admitted to the facility on [DATE] with diagnoses including cerebrovascular accident, congestive heart failure, edema, and glaucoma.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for resident #56 revealed a brief interview of mental status could not be completed due to memory problems, and severely impaired cognitive skills for daily decision making. Further review of the MDS data revealed resident #56 was dependent on staff for activities of daily living care which included personal hygiene.</p> <p>On 07/08/2024 at 1:55 p.m., observation revealed resident #56 had long fingernails with jagged edges to both hands. The right hand was noted to be contracted.</p> <p>On 07/09/2024 at 11:43 a.m., an observation with S5Certified Nurse Aide (CNA) was conducted in the room of resident#56. S5CNA confirmed resident #56's fingernails were long and jagged to both hands. S5CNA confirmed resident #56 was dependent on staff for activities of daily living (ADL) care. S5CNA partially opened resident #56's contracted right hand and there was a foul odor coming from his right hand.</p> <p>On 07/10/2024 at 8:32 a.m., observation of resident #56 was conducted in his room with S5CNA. Both hands still had long jagged fingernails and the right hand was contracted. A foul odor was noted when S5CNA partially opened resident #56's contracted right hand.</p> <p>On 07/10/2024 at 08:32 a.m., S2Director of Nurses (DON) was informed resident #56 had long jagged nails and his contracted right hand had an odor. S2DON agreed resident #56's nails should have been trimmed and his contracted right hand should not have an odor.</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: 195257
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256</p> <p>Based on record review, observations and interviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 (#73) of 2 (#71 & #73) residents reviewed for positioning. The facility failed to address the positioning needs for resident #73.</p> <p>Findings:</p> <p>Review of the record for resident #73 revealed the resident was admitted on [DATE] with diagnoses of Down syndrome, myocardial infarction, atrial fibrillation, diabetes, muscle wasting and atrophy, congestive heart failure, incontinence without sensory awareness, and hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had modified independent cognitive skills for daily decision making. The resident's mobility device was a wheelchair. The resident required partial/moderate assistance with toilet hygiene and dressing and the resident required substantial/maximal assistance with personal hygiene and shower/bathe. The resident was always incontinent of bowel and bladder. The resident had no speech and was rarely/never understood.</p> <p>An interview with S4Certified Nursing Assistant (CNA) on 07/10/2024 at 12:30 p.m. revealed resident #73 used his wheelchair for mobility daily.</p> <p>Observation on 07/08/2024 at 11:56 a.m. revealed resident #73 was up in his wheelchair in the day area on his hall and his feet were not touching the floor. Resident #73 was unable to be interviewed.</p> <p>Observation on 07/08/2024 at 1:20 p.m. revealed resident #73 was up in his wheelchair in the dining room and his right foot was not touching the floor.</p> <p>Observation on 07/09/2024 at 11:26 a.m. and 3:37 p.m. revealed resident #73 was up in his wheelchair in the dining room. His feet were not touching the floor.</p> <p>Observation on 07/10/2024 at 8:05 a.m. revealed the resident was propelling his wheelchair down the hall using his upper body and his feet were not touching the floor.</p> <p>Observation on 07/10/2024 at 11:37 a.m. revealed the resident up in his wheelchair in the dining room. His right foot was not touching the floor and part of his left foot was touching the floor.</p> <p>An interview with S2Director of Nurses on 07/10/2024 at 2:45 p.m. confirmed resident #73 should have support for his lower extremities.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>19098</p> <p>Based on observation, record review and interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>The facility failed to date multi dose insulin pens when first used for 6 (#33, #39, #50, #100, #104, #225) of 6 (#33, #39, #50, #100, #104, #225) insulin pens observed without a date and by not discarding 1 (#225) of 1 (#225) insulin pens within 28 days after the first use.</p> <p>Findings:</p> <p>On 07/10/2024 at 3:07 p.m. observation of Hall A medication cart revealed the following insulin pens were not dated upon first use:</p> <p>Resident #33: Novolog and Basaglar (Lantus) pens were not dated when first used.</p> <p>Resident #39: Novolog and Basaglar (Lantus) pens were not dated when first used.</p> <p>On 07/10/2024 at 3:15 p.m., an interview with S3Licensed Practical Nurse (LPN) confirmed the insulin pens should have been dated when first used and were not for resident #33 and resident #39.</p> <p>On 07/10/2024 at 3:25 p.m. observation of Hall B medication cart revealed the following insulin pens were not dated upon first use:</p> <p>Resident #50: Lantus pen was not dated when first used.</p> <p>Resident #100: Lantus pen and Novolog pen were not dated when first used.</p> <p>Resident #104: Lantus pen was not dated when first used.</p> <p>Resident #225: Lantus pen was not dated when first used.</p> <p>Further observation of Hall B medication cart revealed resident #225's Lispro Kwik Pen was dated 09/06/2023.</p> <p>On 07/10/2024 at 3:40 p.m., an interview with S3LPN confirmed the insulin should have been dated when first used for resident #50, #100, #104, and #225, and the insulin for resident #225 dated 09/06/2023 should have been discarded.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/10/2024 at 4:35 p.m., an interview with S2Director of Nurses (DON) confirmed the facility's written policy and procedure for insulin guidelines did not have any instructions regarding dating of insulin when it is first used, however it is standard practice to date the insulin when it is first used.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>18118</p> <p>Based on observations and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure random and personal items were not stored in the laundry department.</p> <p>Findings:</p> <p>On 07/08/2024 at 3:00 p.m., an observation of the laundry department revealed the following items were observed on a shelf that was designated for clean mops:</p> <p>1-large pair of scissors,</p> <p>1-insulated pink colored drinking glass,</p> <p>4-sharpies,</p> <p>1-pair of ear pods, and</p> <p>1-pair of eye glasses.</p> <p>Further observation revealed the following:</p> <p>1-large hand held tape dispenser and a purse were stored on a shelf with clean clothing.</p> <p>1-long cord and cell phone charger was stored on a table that was designated for folding resident clean clothing and linens. The cell phone charger and cord was laying on top of and in direct contact with the table top.</p> <p>1-gray tote bag was on the floor between a large and small washing machines.</p> <p>After the observation was completed, S6Laundry Worker revealed the cell phone cord/charger were her personal belongings. S6Laundry Worker reported that the gray tote bag belonged to S7Laundry Worker.</p> <p>On 07/08/2024 at approximately 3:15 p.m., an observation of the laundry department with S1Administrator and S8Laundry Supervisor was conducted. S1Administrator confirmed the items listed above should not have been kept in laundry room.</p>