STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195257	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Manor Nursing and Rehab Center, LLC	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that licensed nurses assessed resident's needs for 1 (#14) of 1 (#14) resident sampled for urinary catheter or urinary tract infections (UTI). The failed practice was evidenced by Resident #14 being diagnosed with a UTI on 12/23/2025 with no record of assessments or interventions in the medical record by licensed nursing staff on 12/24/2024 or 12/25/2025 directly related to her diagnoses of a UTI. Findings:Resident #14Record review revealed Resident #14 was originally admitted to the facility on [DATE] and had a readmission from a hospital on [DATE]. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated she had no cognitive impairment. Review of diagnoses revealed Resident #14 had been diagnosed with type 2 diabetes mellitus, history of UTI, and chronic kidney disease.Further review of the medical record revealed the following nurses progress notes:12/23/2024 at 11:10 Lab / Radiology NoteNote Text: Lab results from 12/20 urinalysis (UA) - UA blood 3+, UA protein 2+, UA nitrite Positive, UA leukocytes 3+, UA white blood cells 40-50, UA red blood cells 40-50, UA bacteria 3+; Urine culture results from 12/20 greater than 2 organisms recovered, non-predominant. Greater than 10,000 colony units per milliliter. Please submit another sample if clinically indicated. Results given to S3Nurse Practitioner (NP).12/26/2024 at 10:48 General Nurses Note Note Text: received order per S3NP for Ciprofloxacin 500 milligrams 1 pill by mouth twice daily x 7 days for UTI. Further review of nurses progress notes revealed no documented evidence of Resident #14 being assessed for signs or symptoms of a UTI on 12/24/2024 or 12/25/2025. On 08/06/2025 at 9:13 a.m. an interview with Resident #14 was conducted in the day area. Resident #14 was alert and oriented. Resident #14 reported she went to the hospital on the day after Christmas (12/26/2024). Resident #14 reported that she got sick and was confused that evening so they sent her to the hospital. Resident #14 reported she received intravenous fluids and antibiotics at the hospital for over a week. Resident #14 reported she felt achy all over on Christmas Eve (12/24/2024) and Christmas day (12/25/2024). Resident #14 reported she did not get antibiotics for her Urinary Tract Infection (UTI) until the evening of 12/26/2024. On 08/06/2025 at 10:01 a.m., an interview with S3NP revealed she was aware of the abnormal UA and was monitoring symptoms but was waiting for clarification of culture results to start antibiotics since 2 organisms were growing. She reported Resident #14 was stable until the night of 12/26/2024. On 08/06/2025 at 11:25 a.m., an interview with S2Director of Nursing (DON) was conducted in her office. S2DON confirmed there was no record of nursing assessments in the progress notes or temperatures recorded on 12/24/2024 or 12/25/2025 to specifically monitor the severity of the urinary tract infection identified on 12/23/2024 for Resident #14.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure a resident was assessed quarterly for 1 (#37) of 4 (#30, #37, #43, and #124) residents sampled for medication administration. The facility failed to ensure 1) Resident #37 was assessed quarterly for self-administration of medications, 2) a specific order was obtained for self-administration of medications for Resident #37, and 3) the care plan for Resident #37's included self-administration of medications with the specified medications to be self-administered.Findings:Review of the facility's Self-Administration of Medication, undated, Policy and Procedure revealed the following, in part:It is the policy of this facility that each resident has the right to self-administer medications, but is the responsibility of the interdisciplinary team to determine that it is safe prior to the resident exercising that right.2. If the resident wishes to self-administer medications, the Interdisciplinary Team (IDT) must assess the resident's overall ability to safely administer his/her own medications.3. To assess whether the resident is able to self-administer medications, the criteria on the Assessment for self-administration of medications form will be used. If the Interdisciplinary Team determines that the resident is unable to self-administer medications, because this would be a danger to the resident or to others, then the Interdisciplinary Team may not grant the right to self-administer medications. If the right is granted, a specific order to self-administer must be obtained which includes how, when, and for what reason the medication can be used.4. When a resident self-administers medication, he/she will be reassessed at least quarterly for continued safety of this practice. The IDT will complete this assessment using the Assessment for self-administration of medications. If in the IDT's professional judgment, the resident is unable to safely self-administer his medication, the medical doctor will be contacted to discontinue the order for self-administration.7. Self-administration of bedside medications must be careplanned, including the specific order, granting of approval by IDT, and monitoring for compliance.Review of the record for Resident #37 revealed an admission date of 09/08/2024 with diagnoses including bilateral primary osteoarthritis of knee, cellulitis of unspecified part of limb, acute upper respiratory infection, dysphagia, pulmonary embolism, and chronic obstructive pulmonary disease.Review of Resident #37's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident's Brief Interview for Mental Status (BIMS) score was 15 indicating no cognitive impairment.During medication administration observation with S4Licensed Practical Nurse (LPN) on 08/06/2025 at 8:15 a.m. revealed Resident #37 had a Ventolin (Albuterol) inhaler and Nasonex (nasal spray) at his bedside. Resident #37 administered his nasal spray 1 spray in each nostril. S4LPN confirmed these 2 medications are kept in resident's room and are self-administered by the resident. An interview on 08/06/2025 at 8:15 a.m. with Resident #37 confirmed he has his Albuterol inhaler and nasal spray at his bedside, resident confirmed he does self-administer these medications as ordered. Resident #37 confirmed he uses his Albuterol inhaler 2 puffs every 6 hours as needed and his nasal spray 1 spray in each nostril daily.Review of Resident #37's August 2025 Physician's Orders revealed an order dated 01/15/2025 for a Ventolin Hydrofluoroalkane (HFA) Inhalation Aerosol Solution 108 (90 base) micrograms/actuate (Albuterol Sulfate) 2 puffs inhale orally every 6 hours as needed for wheezing related to chronic obstructive pulmonary disease. Further review revealed an order dated 07/18/2024 for Nasonex 24 hour nasal suspension 1 spray in both nostrils one time a day for acute upper respiratory infection. Resident #37's Physician's Orders did not specify that each of these medications were to be kept at bedside and self-administered by the resident.Review of Resident #37's Assessment for Self-Administration of Medications dated 01/15/2025 revealed resident was determined to be safe and able to self-administer medications but did not identify the specific medications that the resident was determined to be safe to administer.Review of the July and August 2025 Medication Administration Records (MAR) for Resident #37 revealed the 2 medications listed above do not specify that each of these medications are kept at the bedside and should be (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered by the resident.Review of Resident #37's current care plan revealed no documentation identifying that resident was determined to be safe to self-administer any of his medications.An interview on 08/06/2025 at 10:05 a.m. with S5LPN revealed that Resident #37 does have his nasal spray and Albuterol inhaler at his bedside and self-administers these 2 medications. S5LPN confirmed that Resident #37's physician's orders did not identify that these 2 medications were to be self-administered by Resident #37. S5LPN reported she completed the Assessment for Self-Administration of Medications on 01/15/2025 for Resident #37 but has not completed this assessment quarterly.An interview on 08/06/2025 at 2:35 p.m. with S2Director of Nursing (DON) confirmed the facility failed to ensure Resident #37 was assessed for self-administration of medications quarterly. S2DON confirmed the facility failed to ensure documentation of self-administration of bedside medications including specific order and monitoring for compliance was added to Resident #37's care plan. S2DON confirmed the facility failed to ensure Resident #37's physician's orders included a specified order to self-administer medications including how, when, and for what reason the medications can be used.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident with a new diagnosis of schizophrenia was referred to the appropriate state agency for Preadmission Screening and Resident Review (PASARR) Level II evaluation as required for 1 (#12) of 2 (#12, #13) residents reviewed for PASARR requirements. Findings:Record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominate side, depression, gastroesophageal reflux disease without esophagitis, dysphagia following unspecified cerebrovascular disease, muscle wasting and atrophy both thighs, generalized muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility, and other lack of coordination. Further review revealed Resident #12 was diagnosed with schizoaffective disorder, bipolar type, on 04/01/2025.Review of Form142 (Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification) revealed Resident #12 was approved for Medicaid/Private medical eligibility services effective 02/21/2022. Further review of the Form 142 revealed a Level II decision was not required on 03/02/2022. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated Resident #12 had moderate cognitive impairment for daily decision making. Review of section N revealed Resident #12 received antipsychotic medication and antidepressant medication. Review of the active August 2025 Physician Orders revealed an order dated 04/01/2025 for Risperdal 0.5 milligram (mg) tablet give 1 tablet by mouth two times daily for schizoaffective disorder, bipolar type.On 08/05/2025 at 9:49 a.m., during an interview with S2Director of Nursing (DON), surveyor requested the PASARR Level II for Resident #12 and the facility's policy for obtaining a PASARR II.Review of Resident #12's record revealed no documented evidence that a Level II PASARR was completed after Resident #12 was diagnosed with schizoaffective disorder, bipolar type, on 04/01/2025. On 08/05/2025 at 3:25 p.m., an interview with S2DON confirmed a PASARR Level II screening had not been submitted to the appropriate state agency for Resident #12 after the new diagnoses of schizoaffective disorder, bipolar type, on 04/01/2025.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interview the facility failed to ensure drugs and biologicals were stored properly by having medications at resident's bedside for 1 (#71) of 1 resident reviewed for medication storage. Findings: Review of the facility's Medication Storage in the Facility policy (undated) revealed the following in part: Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing or medical personnel and pharmacy personnel. 2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer mediations are allowed access to medications. Review of the medical record for Resident #71 revealed an admission date of 01/09/2025. Resident #71 had diagnoses that included altered mental status, hypertensive heart disease, depression, reflux, heart failure, atrial fibrillation, rhabdomyolysis, dementia, muscle wasting, and cognitive communication deficit.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated intact cognition for daily decision making. Review of the current care plan for Resident #71 revealed impaired cognitive function/dementia or impaired thought processes related to dementia. Further review of the care plan revealed to administer medications as ordered, communicate with the resident/family/caregivers regarding resident's capabilities and needs. The resident needed specific supervision assistance with all decision making. On 08/04/2025 at 9:00 a.m. observation of Resident #71 revealed she was in the room lying in bed, and one bottle of Tums (antacid) and one bottle of Systane complete eyedrops (eye lubricant) was located on top of Resident #71's refrigerator beside her bed. At that time an interview with Resident #71 revealed she thought a friend had brought her the medications and she will take the medications when needed. On 08/05/2025 at 8:45 a.m. observation of Resident #71 revealed she was lying in bed, and one bottle of Tums and one bottle of Systane complete eyedrops was noted on top of the refrigerator beside her bed.Review of the Resident #71's August 2025 physician's orders revealed no documented evidence of an order for Tums or Systane eyedrops. On 08/05/2025 at 8:55 a.m. S2Director of Nursing (DON) was notified of medications at Resident #71's bedside. At that time observation of Resident #71's room with S2DON revealed Resident #71 had a bottle of Tums and a bottle of Systane eyedrops located on top of the refrigerator in her room. S2DON confirmed Resident #71 did not have a physician's order for the medications and the medications should not be stored at Resident #71's bedside available for use.