STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195314	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeff Davis Living Center, LLC	1338 North Cutting Avenue Jennings, LA 70546

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 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** 47251 Based on interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status, for 1(#24) of 32 sampled residents Findings: A review of Resident #24's medical records revealed an admitted [DATE] with diagnoses which included but were not limited to Major Depressive Disorder and Bipolar Disorder. A review of Resident #24's Pre Admission Screening and Assessment Resident Review (PASRR) revealed a Level II determination that read, The individual has a serious mental illness and is recommended nursing home admission. A review of Resident #24's annual MDS with an ARD (Assessment Reference Date) of 02/06/2025 revealed the following: Section A1500 -Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The answer was coded 0 for no. On 04/29/2025 at 1:04 p.m., an interview and review of Resident #24's MDS was conducted with S2DON (Director of Nursing). She confirmed that the PASRR was incorrectly coded and did not reflect that the resident was considered by the state Level II PASRR process to have serious mental illness, and should have.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on observations and interviews and record review, the facility failed to ensure a resident's plan of care was implemented for 1 (#41) out of 1 (#41) residents investigated for positioning out of a total sample of 32 residents. Findings: A review of Resident #41's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, cerebral infarction, cerebrovascular disease, and hemiplegia and hemiparesis. A review of Resident #41's Care Plan revealed a care plan intervention initiated on 10/11/2022 that read, staff instructed to check on resident's body alignment when passing by room and or after care and turning and repositioning her. Further review of the resident's care plan dated 08/15/2022 read in part .provide pressure reduction/relief mattress on bed. Assist positioning for comfort. Monitor frequently, at least every two hours for pressure redistribution and assist with repositioning as indicated. Review of the air mattress manufactures manual read in part .Note- this product is only one element of care in the prevention and treatment of pressure ulcers by medical professionals and skilled caregivers to assist in the treatment and prevention of pressure ulcers. This product is not designed to and cannot replace good caregiving practices and treatment, including but not limited to: frequent positioning. On 04/28/2025 at 10:00 a.m., an observation was made of Resident #41 in her room. Resident was observed lying on her back. Subsequent observation of the resident at 12:35 p.m., revealed the resident was lying on her back. On 04/28/2025 at 12:36 p.m., an interview was conducted with S8CNA/T (Certified Nursing Assistant/Transportation) who stated that she had not repositioned the resident. She confirmed the resident should have been repositioned every two hours. On 04/28/2025 at 12:37 p.m., an interview was conducted with S7LPN (Licensed Practical Nurse) who stated that she had not repositioned the resident, and the resident did not need to be repositioned because she was on an air mattress. On 04/28/2025 at 4:03 p.m., an interview was conducted with S6CNASUP (Certified Nursing Assistant Supervisor) who stated Resident #41 should have been repositioned every two hours. On 04/29/2025 at 9:30 a.m., an interview was conducted with S5TX (Treatment Nurse) stated Resident #41 should have been turned and repositioned every two hours.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41868 Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) provided services for 8 consecutive hours a day, 7 days a week and ensure the DON (Director of Nursing) did not serve as a charge nurse when the facility had an average daily census over 60 residents. Findings: Review of RN staffing timesheets from 10/01/2024-04/27/2025 revealed the RN did not work 8 consecutive hours the following dates: 11/10/2024 7.75 hours worked 11/23/2024 7.75 hours worked 12/31/2024 7.75 hours worked 01/03/2025 7.32 hours worked 01/28/2025 no RN hours worked 02/05/2025 6.75 hours worked 02/28/2025 7.92 hours worked 03/28/2025 7.88 hours worked 04/15/2025 5.75 hours worked On 04/28/2025 at 10:00 a.m., an interview was conducted with S2DON and S3RN. S2DON stated that on Saturday and Sunday the weekend RN is scheduled to work an 8 hour shift each day. S2DON stated that Monday through Friday, S3RN is scheduled to work an 8 hour shift each day. S2DON and S3RN reported that when S3RN is not present in the facility for her scheduled weekday 8 hour shift, S2DON serves as the RN. S3RN stated that she was off on 01/28/2025, and came to work late and did not work for the 8 hours on 02/05/2025 and 04/15/2025. S2DON stated she was present on those days and served as the RN, but is salaried and does not utilize the electronic clock in/out reporting system. On 04/28/2025 at 10:20 a.m., an interview, review of S3RN's time sheets, and review of the facility census was conducted with S4ACCT (Accounting). She confirmed on 01/28/2025 there was no RN hours worked by S3RN, and on 02/05/2025 and 04/15/2025 S3RN worked less than 8 hours. She stated on those dates S2DON was classified as working under the DON role. She confirmed the census on 01/28/2025 was 79, on 02/05/2025 was 79, and on 04/15/2025 was 74. S4ACCT stated it had been years since the facility census was below 60. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/2025 at 1:10 p.m., an interview and review of RN staffing time sheets from 10/01/2024-04/27/2025 was conducted with S4ACCT. She confirmed the RN hours did not meet the requirement of 8 consecutive hours on the above listed dates. On 04/28/2025 at 1:20 p.m., an interview was conducted with S2DON, with S1ADM (Administrator) present. S2DON acknowledged the provider did not meet the requirement when RN staff provided less than 8 consecutive hours worked. S2DON and S1ADM verbalized they were unaware that S2DON could not act dually as the RN and DON if the facility census was greater than 60. They acknowledged the facility census had been greater than 60 since October 2024 through April 2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on observations, record review and interviews, the facility failed to implement policies and procedures for Enhanced Barrier Precautions (EBP) for 1 (#11) of 2 (#11, #27) residents sampled for wound care, with a total sample of 32 residents. Findings: Review of the facility's EBP policy revised on 03/2024 revealed the following, in part: EBP are used as in infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including peripheral vascular disease, and type 2 diabetes mellitus. Review of the March 2025 Physician's orders revealed an order dated 07/15/2024 which read in part enhanced barrier precautions. Further review revealed an order dated 03/26/2025, which read in part . venous stasis ulcer anterior right lateral lower leg: clean with normal saline, apply hydrofer blue dressing then cover. On 04/28/2025 at 10:20 a.m., an observation of wound care was conducted with S2DON (Director of Nursing) and S4TX (Treatment Nurse). Prior to S4TX beginning wound care, the resident was observed sitting in her recliner with her legs elevated. The resident had a brown colored covering over her chair that was visibly soiled. Further observation revealed the resident right lateral lower leg did not have a dressing, and the wound was exposed and resting on the brown colored soiled chair covering. A small amount of serosangenious fluid was observed on the wound. On 04/28/2025 at 10:30 a.m., an interview with S4TX confirmed she should have placed a protective barrier under the resident's right leg to prevent the open wound from touching the soiled chair covering. On 04/28/2025 at 10:30 a.m., S2DON confirmed that Resident #11 should have placed a protective barrier under her right leg, and the exposed wound should not have been touching the soiled chair covering.