STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195315	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaplan Healthcare Center	1300 W. Eighth Street Kaplan, LA 70548

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure the most recent survey results of the facility were posted in a place readily accessible to residents, family members, and legal representatives of residents. The facility's census was 71.Findings:On 12/02/2025 at 9:05 a.m., an observation and interview was conducted with S2DON (Director of Nursing). S2DON stated the survey results were pinned on the bulletin board in a packet outside of social service's office door only. S2DON confirmed the last survey results from 10/01/2025 were not in the packet and should have been posted in a place readily accessible to residents, family members, or legal representatives.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure staffing information posted daily was accurate and current. The facility's census was 71.Findings:On 12/02/2025 at 9:00 a.m., an observation and interview was conducted with S2DON (Director of Nursing). S2DON confirmed that the nurse staffing data was posted on a whiteboard upon entry into the facility at the nurse's station. S2DON stated the nurse staffing data was from 12/01/2025. S2DON confirmed the nurse staffing data should have been updated daily and was not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews, observation, and record reviews, the facility failed to develop a comprehensive person-centered care plan for 3 (Resident #2, Resident #27, Resident #31) out of 35 sampled residents. Resident #27 Review of Resident #27's EMR (Electronic Medical Record) revealed she was admitted to the facility on [DATE] with a diagnosis that included but not limited to polyosteoarthritis, neuropathy, vertebrogenic low back pain, muscle spasm of back, and cutaneous abscess of left lower limb. Further review of Resident #27's medical diagnosis did not reveal a diagnosis for left drop foot. Review of Resident #27 quarterly (Minimum Data Set) dated 10/08/2025 revealed BIMS (Brief Interview for Mental Status) of 14 which indicated Resident #27 was cognitively intact. Review of Resident #27's Medical Progress Note dated 05/14/2025 revealed a diagnosis of left foot drop.An interview was conducted on 12/01/2025 at 10:15 a.m. with Resident #27. Resident #27 stated she had left drop foot and had a brace to help her walk. An interview and record review on 12/03/2025 at 12:00 p.m. was conducted with S6MDS/LPN (Minimum Data Set/ Licensed Practical Nurse). S6MDS/LPN reviewed the EMR diagnosis list and care plan and confirmed left foot drop was not identified in the care plan. #3 Review of Resident #31's Electronic Health Records revealed an initial admission date of 01/10/2023 and a re-admission date of 11/03/2025, with diagnoses that included, but were not limited to idiopathic progressive neuropathy, benign prostatic hyperplasia with lower urinary tract symptoms, other obstructive and reflux uropathy, and retention of urine. Review of Resident #31's Minimum Data Set with an assessment reference date (ARD) of 01/10/2023 revealed in Section H that the resident had an indwelling catheter. Review of Resident #31's person centered care plan revealed no focus area and interventions to address the resident's indwelling catheter. On 12/01/2025 at 9:20 a.m., an observation was made of Resident #31. The resident had an indwelling catheter draining clear yellow urine to a urinary drainage bag hanging on his bed. On 12/02/2025 at 4:00 p.m., an interview and review of Resident #31's comprehensive person centered care plan was conducted with S4CN (Corporate Nurse). She confirmed there was no focus area and interventions to address the resident's indwelling catheter and stated that there should have been. On 12/02/2025 at 4:05 p.m., an interview and review of Resident #31's MDS and care plan was conducted with S6MDS/LPN. She confirmed there was no plan of care developed to address the resident's catheter. S6MDS/LPN stated that a care plan should have been developed to address Resident #31's indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 Resident #2 was admitted to the facility on [DATE] with diagnoses that included sequelae of cerebral infarction and atrial fibrillation. Review of Resident #2's active physician orders as of 12/02/2025 revealed an order for Apixaban (anticoagulant/blood thinner) give 1 tablet by mouth two times a day with a start date of 04/29/2025. Review of Resident #2's MAR (medication administration record) for October and November 2025 revealed that Apixaban was administered each day. Review of Resident #2 care plan failed to reveal any focus problem, goal, or interventions related to complications or side effects of anticoagulant use. On 12/03/2025 at 11:00 a.m., an interview was conducted with S6MDS/LPN. During the interview, she reviewed Resident #2's active physician orders and confirmed the resident was receiving an anticoagulant. She then reviewed the resident's care plan and confirmed the resident was not care planned for anticoagulant use.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure coordination of care between the physical therapy department and nursing services for a resident who had leg prosthetic devices that no longer fit for 1 (#4) out of 35 sampled residents reviewed for quality of care.Findings:Review of Resident #4's EMR (Electronic Medical Record) revealed, in part, Resident #4 was admitted to the facility on [DATE] with medical diagnoses that included complete traumatic amputation at level between knee and ankle, left lower leg and right lower leg, and type 2 diabetes mellitus. Review of the quarterly MDS (Minimum Data Set) dated of 10/18/2025 revealed a BIMS (Brief Interview for Mental Status) of 14 which indicated the resident was cognitively intact. Functional Abilities and Goals (GG) revealed ADL (activities of daily living) as self care deficit and lower extremity impairment on both sides.Review of Resident #4's care plan revealed bilateral (both sides) BKA (below knee amputation), with the following interventions: monitor bilateral (both sides) BKA every other day for any signs and symptoms of skin break down and Physical Therapy/ Occupational Therapy evaluation and treatment as per MD orders. The Care Plan failed to reference that Resident #4 had bilateral leg prosthetics.During an interview with Resident #4 on 12/01/2025 at 10:25 a.m., Resident #4 stated he was sent to the nursing home to heal his wounds and get prosthetics for both legs. He said his goal was to learn how to walk on his prosthetics and then return home. He stated his prosthetics are in his closet and they did not fit because he gained weight and his amputation stumps were swollen.During an interview on 12/02/2025 at 1:00 p.m. with S5SSD/LPN (Social Service Director/ Licenses Practical Nurse), she revealed had no knowledge that Resident #4 was in possession of leg prosthetics.During an interview on 12/02/2025 at 1:20p.m. with S8PTA (Physical Therapy Assistant), he stated that the physical therapy department had obtained Resident#4's leg prosthetics after his admission to the facility. He further stated that S9PO (Third Party Prosthetic Company) was scheduled to assess the resident for larger prosthetics. He reported that he was not aware that this information should have been communicated to nursing services. During an interview on 12/03/2025 at 4:00 p.m. with S4CN (Corporate Nurse) and S1ADM (Administrator), both stated that the Physical Therapy Department did not notify or communicate with any of the facility's staff that Resident #4 received leg prosthetics. They both stated the Physical Therapy Department should have collaborated with the facility regarding Resident #4 receiving bilateral leg prosthesis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to maintain a clean and sanitary kitchen, as evidenced by: 1. Equipment: A. Build-up of debris and brown substance inside the ice machine. B. Build-up of debris and food particles inside the microwave.2. Food storage: A. Walk-in Refrigerator 1. [NAME] and fuzzy patches on the inside and outside of a honey mustard container. 2. A container of lemon juice with an expiration date of 09/28/2025. B. Stand-up Refrigerator 1. A bag of bread not labeled with the date it was opened. 2. A piece of pie not labeled with the date it was prepared. C. Dry Storage 1. A bag of rice bag opened with an expiration date of 04/23/2025. This deficient practice had the potential to affect 68 residents who ate out of the kitchen.Findings:A review of the facility's policy titled, Food Receiving and Storage with a last review date of 06/23/2025, reads in part, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).A review of the facility's policy titled, Sanitization with a last review date of 08/2025, reads in part, Fixed equipment: food contact equipment will be cleaned and sanitized after every use. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy.On 12/01/2025 at 8:29 a.m., an initial tour and interview was conducted with S3DM (Dietary Manager). She confirmed that all opened food items should have been labeled with the date it was opened and prepared and all expired items should be discarded. S3DM also confirmed that the microwave and ice machine should have been cleaned, and any food items with green and fuzzy patches should have been discarded immediately.

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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 interview and record review, the facility failed to accurately code a resident's MDS (Minimum Data Set) assessment for 1 (Resident #14) out of 1 (Resident #14) investigated for resident assessments.Review of Resident #14's EHR (electronic health record) revealed she was admitted to the facility 07/14/2022 with diagnoses which included unspecified dementia, bipolar disorder, major depressive disorder and anxiety disorder.Review of Resident #14's most recent MDS (significant change) dated 09/11/2025 revealed under Section A1500 Preadmission Screening and Resident Review (PASRR) was coded as no to the question Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?Review of Resident #14's PASRR Level II Evaluation dated 09/16/2024 under the determination results section revealed Serous Mental Illness present. On 12/02/2025 2:30 p.m., an interview with S6MDS/LPN. During the interview, she reviewed Section A1500 of Resident #14's MDS dated [DATE] as well as the resident's state PASRR Level II screening and confirmed the resident's MDS was inaccurately coded.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene. This was evidenced by 1 (Resident #62) having untrimmed and unclean fingernails out of 2 Residents #61 and #62) investigated for ADLs. Findings:Review of Resident #62's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease; dementia in other diseases classified elsewhere; and unspecified osteoarthritis. Review of Resident #62's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/15/2025 revealed in Section GG that the resident required partial/moderate assistance with personal hygiene.Review of Resident #62's care plan revealed in part, the resident has an ADL self-care performance deficit, with an intervention that read: Bathing/Showering: check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.On 12/03/2025 at 10:19 a.m., an observation was made of resident #62. The resident had long, untrimmed fingernails to her right hand. Underneath the resident's fingernails was a dark caked substance. On 12/03/2025 at 10:26 a.m., an observation of Resident #62's fingernails was conducted with S10CNA (Certified Nursing Assistant). She confirmed the resident's right hand fingernails were long, untrimmed, and unclean. S10CNA was asked who was responsible for cleaning and trimming the resident's fingernails. S10CNA stated that she or the shower aids cleaned and trimmed the resident's nails. On 12/03/2025 at 10:34 a.m., an observation of Resident #62's fingernails was conducted with S11LPN (Licensed Practical Nurse). She confirmed the resident's right hand fingernails were long and dirty and should not be like that. S11LPN stated that residents' nails were trimmed and cleaned on shower days.On 12/03/2025 at 10:40 a.m., a follow up interview was conducted with S10CNA. She stated that yesterday (12/02/2025) the resident stated she wasn't feeling well enough to take her shower. She stated that the resident had been showered on Sunday (11/30/2025) and Resident #62's fingernails should have been cleaned and trimmed at that time.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to follow professional standards of practice and the comprehensive person-centered care plan to remove the AV (arteriovenous) shunt pressure dressing for 1 (Resident #28) out of 1 (Resident #28) resident reviewed for dialysis.Findings:Resident #28 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction due to thrombosis of right middle cerebral artery, end stage renal disease and dependence on renal dialysis.Review of Resident #28's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/21/2025 revealed in Section C that the resident had a brief interview for mental status (BIMS) score of 15, indicating the resident had normal thinking and memory.Review of Resident #28's December 2025 physician's orders revealed an order written on 12/15/2023 which read in part, dialysis M-W-F (Monday-Wednesday-Friday).Review of Resident #28's care plan revealed an intervention initiated on 04/26/2021 which read, Monitor AV shunt pressure dressing to (lt (left) arm) for excessive bleeding q (every) shift upon return from dialysis and remove dressing morning after dialysis. On 12/02/2025 at 9:20 a.m., an observation and an interview was conducted with Resident #28. The resident stated that she went to dialysis yesterday (12/01/2025). The resident pulled up the left arm sleeve of her gown revealing a white pressure dressing covering her AV shunt. The resident stated that the nurse was supposed to have checked and removed the dressing from her shunt.On 12/02/2023 at 3:00 p.m., a second observation was made of Resident #28's left arm. The resident's dressing remained covering her AV shunt. The resident stated the nurse had not removed her dressing.On 12/02/2025 at 3:05 p.m., an observation, record review, and an interview was conducted with S7LPN (Licensed Practical Nurse). She confirmed Resident #28's AV Shunt pressure dressing was not removed according to Resident #28's plan of care and stated that it should have been removed by the morning nurse on 12/02/2025.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received a mechanically altered diet as ordered by the physician for 1 (#21) out of 5 (#1, #21, #31, #56, #67) residents reviewed for dining.Findings: Review of Resident #21's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, non-infective gastroenteritis and colitis, dysphagia and gastro-esophageal reflux disease. Review of Resident #21's December 2025 physician's orders revealed an order dated 04/02/2025 that read, NAS (No Added Salt) diet, Chopped Meat Texture, Thin Consistency, Bite sized Meats. On 12/02/2025 at 11:41 a.m., an observation was made of Resident #21's meal tray. Resident #21's meal tray revealed a piece of rotisserie chicken leg. The meat item was not chopped or bite sized. On 12/03/2025 at 8:08 a.m., an observation was made of Resident #21's meal ticket and meal tray. Resident #21's meal ticket read in part, Chopped Meat. Meal tray revealed 2 slices of fried bacon, meat item was not chopped or bite sized. On 12/03/2025 at 8:35 a.m., an interview and record review was conducted with S2DON (Director of Nursing). S2DON confirmed that Resident #21 was on a chopped meat texture, bite sized meats diet as ordered by the physician and she confirmed the items on her meal tray were not chopped meat or bite sized.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to maintain accurate documentation across the resident's record that the resident was discharged from hospice services for 1 (#6) out of 35 sampled residents. Findings: Review of Resident #6's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis, and cachexia. Review of Resident #6's December 2025 physician's orders revealed an order dated 09/10/2025 that read, Admit to contracted hospice provider related to CVA (cerebrovascular accident) dx (diagnosis. Further review of physician's orders revealed an order dated 09/11/2025 that read, Accucheck (blood sugar check) daily. Notify contracted hospice provider nurse if greater than 200. Review of Resident #6's October 2025 progress notes revealed a nurses note dated 10/16/2025 that read in part.resident seen by facility's medical director today post hospice D/C (discharge). On 12/03/2025 at 11:14 a.m., an interview and record review was conducted with S4CN (Corporate Nurse). S4CN confirmed Resident #6 was discharged from hospice services and the orders should have been discontinued and were not. On 12/03/2025 at 11:45 a.m., the hospice provider document titled Hospice Provider Discharge Notice was provided and revealed in part .current hospice service has/will end effective: 10/15/2025.