STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195318	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Village Nursing & Rehabilitation Center	315 Harry Guilbeau Road Opelousas, LA 70570

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician documented a Gradual Dose Reduction (GDR) was attempted or a clinical rationale for not reducing psychotropic medication recommended for GDR for 1 (#2) out of 5 (#1, #2, #4, #7, and #99) residents sampled for unnecessary medication review.Findings: A review of Resident #2's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included in part, generalized anxiety disorder, bipolar disorder, and depression.A review of Resident #2's Pharmaceutical Consultant Report dated 10/24/2025 and signed by S2DON (Director of Nursing) read in part, Please evaluate the routine use of the following psychoactive medications and consider a dose reduction. If a dose reduction is not desired, please indicate below a rationale for the continued use. This resident is prescribed the following psychoactive medications:Benadryl 25 mg (milligrams) q6hrs prn itching (every 6 hours as needed)Divalproex DR (delayed release) 250 mg hs (hour of sleep)Meclizine 12.5 mg q12hrs prn dizziness (every 12 hours as needed)Rexulti 0.5mg qd (every day)Further review of the report revealed that the physician failed to indicate if a dose reduction was indicated or not. Further review of the report also revealed that, according to CMS (Center for Medicare and Medicaid Services) Interpretive Guidelines for Long Term Care Facilities, justification for not reducing a psychoactive must be documented (either on this form or within the clinical record) as to why a dose reduction is clinically contraindicated and not currently desired. Review of Resident #2's EHR revealed a psychiatric progress note for 11/03/2025 which read in part, Treatment plan: routine follow-up and med (medication) management. Current medications: reviewed. Patient's current medications were obtained, updated, and/or reviewed: yes. Further review of Resident #2's EHR failed to reveal evidence that a GDR was attempted or a clinical rationale as to why a dose reduction was contraindicated.On 12/03/2025 at 1:39 p.m., a review of Resident #2's EHR was conducted with S2DON. S2DON confirmed the Pharmaceutical Consultant Report dated 10/24/2025 was not completed by the physician. S2DON stated the physician had addressed the client's medication in the physician's progress notes. The physician's progress notes were reviewed with S2DON. S2DON neither agreed nor denied that the physician completed and documented that a dose reduction was attempted or a rationalization for continued use of medication.

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
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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to notify the State's Long-Term Care Ombudsman of emergency transfers in writing for 1 (#7) out of 4 (#7, #62, #89, #105) residents reviewed for accidents. Findings:Review of Resident #7's Electronic Medical Record (EMR) revealed, in part, Resident #7 was admitted to the facility on [DATE]. Further review of the EMR revealed Resident #7 had an emergency transfer to a local hospital on [DATE].Review of the facility's Ombudsman notification lists of emergency transfers dated July 2025 and August 2025, failed to reveal Resident #7's transfer on 08/20/2025 and there was no further evidence the Ombudsman had been notified of the transfer. On 12/03/2025 at 12:45 p.m., a concurrent record review and interview was conducted with S1AADM (Assistant Administrator). S1AADM stated that she was partially responsible for the accuracy of the State's Long-Term Care Ombudsman list of emergency transfers. S1AADM reviewed the emergency transfer forms and confirmed they failed to identify Resident #7's emergency transfer on 08/20/2025.On 12/03/2025 at 1:00 p.m., a concurrent records review and interview was conducted with S2DON (Director of Nursing). S2DON stated S1AADM was solely responsible for the accuracy of the State's Long-Term Care Ombudsman list of emergency transfers. S2DON confirmed Resident #7 had an emergency transfer on 08/20/2025 that was not listed on the State's Long-Term Care Ombudsman list and should have been as required.

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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 interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #1, and Resident #43) residents out of 41 sampled residents. Findings: Resident #1 Review of Resident #1's EMR (Electronic Medical Record) revealed an admission date to facility on 05/28/2025 with diagnoses including major depressive disorder, recurrent, severe with psychotic symptoms; and bipolar disorder, severe, with psychotic features. Review of Resident #1's Form 142 dated 05/08/2025 and 08/16/2025 revealed the resident was approved for admission by Level II authority. Review of Resident #1's admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 06/05/2025 revealed: Section A1500 PASARR: the answer was 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 #1's Significant Change MDS with an ARD 08/08/2025 revealed: Section A1500 PASARR: the answer was 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? On 12/03/2025 at 8:30 a.m., an interview was conducted with S4SSD (Social Service Director), she reviewed Resident #1's Form 142 dated 05/08/2025 and 08/16/2025 and confirmed the resident did have a Level II PASARR. On 12/03/2025 at 8:49 a.m., a record review and subsequent interview was conducted with S3MDS (Minimum Data Set). S3MDS reviewed Resident #1's admission MDS dated [DATE] and significant change MDS dated [DATE]. She confirmed that Section A1500 for preadmission screening and resident review (PASRR) on each assessment was answered no. She confirmed the assessments were incorrectly coded. Resident #43A review of Resident #43's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included in part, cerebral infarction and atrial fibrillation. A review of Resident #43's Quarterly MDS with an Assessment Reference Date (ARD) of 10/02/2025 revealed Section N0415 N0415 - Medications, High Risk Drug Classes, Use and Indication (I) Antiplatelet was coded No, which indicated the resident did not receive an antiplatelet during the 7-day lookback period. A review of Resident #43's Medication Administration Records (MAR) revealed the resident was administered aspirin (antiplatelet) during the 7- day lookback period from 09/26/2025 through 10/02/2025. On 12/03/2025 at 9:35 a.m., a review of Resident #43's Quarterly MDS with an ARD of 10/2/2025 was conducted with S3MDS. She confirmed antiplatelet was coded No and should have been coded Yes.

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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. Based on record review and interviews, the facility failed to develop and implement a comprehensive careplan for 2 (Resident #4 and Resident #62) of 41 sampled residents as evidenced by failing to: 1. ensure physician orders were implemented for wound care for Resident #4 and 2. develop a careplan for bed rails for Resident #62Findings:Review of Resident #4's electronic health record revealed an admission date of 06/24/2021 with diagnoses that included but were not limited to, age-related osteoporosis, cognitive communication deficit, and hereditary and idiopathic neuropathy. Review of Resident #4's TAR (Treatment Administration Record) for September 2025, October 2025, and November 2025 revealed an order dated 09/07/2025 for Cleanse excoriated area to left buttock with normal saline, and apply zinc oxide bid (twice a day) until resolved. Further review of Resident #4's TARs failed to reveal nurses initials or evidence that treatments were performed on the following dates: 1. September 2025 a. AM- 09/10/2025 and 09/15/2025 b. HS (at bedtime) - 09/07/2025, 09/18/2025, 09/21/2025, 09/23/2025, 09/24/2025, 09/26/2025, 09/27/2025, 09/29/2025, and 09/30/20252. October 2025 a. AM- 10/07/2025, 10/12/2025 b. HS- 10/01/2025, 10/04/2025, 10/06/2025, 10/12/2025, 10/13/2025, 10/14/2025, 10/15/2025, 10/17/2025, 10/18/2025, 10/19/2025, 10/21/2025, 10/22/2025, 10/24/2025, 10/27/2025, 10/30/2025, and 10/31/20253. November 2025 a. AM- 11/24/2025, 11/25/2025, 11/26/2025, 11/27/2025, and 11/30/2025 b. HS- 11/01/2025, 11/02/2025, 11/04/2025, 11/06/2025, 11/07/2025, 11/10/2025, 11/11/2025, 11/29/2025, and 11/30/2025 On 12/03/2025 at 03:00 p.m., a review of Resident #4's September 2025, October 2025, and November 2025 TARs and subsequent interview was conducted with S2DON (Director of Nursing). Resident #4's TARs revealed the respective missing signatures for the above dates for wound care. S2DON confirmed that the nurses' initials on the above respective dates were missing, and agreed that the nurses should have initialed Resident #4's TAR in order to provide evidence that the wound care was completed as ordered. Resident #62Review of Resident #62's electronic health record revealed and admission date of 02/07/2025 with diagnoses that included but were not limited to, chronic kidney disease and acute diastolic (congestive) heart failure. Review of Resident #62's medical record revealed no careplan for the use of bed rails. On 12/01/2025 at 9:53 a.m., an observation was made of Resident #62's bed with top quarter bed rails.On 12/02/2025 at 12:36 p.m., an interview was conducted with S6CNA (Certified Nursing Assistant). She stated that she had been caring for Resident #62 and that she had bed rails on her bed for months.On 12/02/2025 at 1:22 p.m., an interview was conducted with S7CNA. She stated that she had been caring for the Resident #62 and that she had bed rails for at least a month.On 12/03/2025 at 1:48 p.m., an observation was made of Resident #62 in bed with upper quarter bed rails up on both sides. On 12/03/2025 at 2:54 p.m., an interview was conducted with S2DON (Director of Nursing). She stated that Resident #62 had utilized bed rails since her admit on 02/07/2025. She confirmed that Resident #62's careplan had no mention of bed rails.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to develop a person-centered comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 (Resident #16) out of 41 sampled residents. Findings:Review of the facility's policy titled, Care Plan Process, with a last reviewed dated of 12/2024, revealed in part, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care. The RAI (Resident Assessment Instrument) will be used to determine guidelines for revisions and completion dates for the Comprehensive Care Plan.Review of the CMS (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual revealed in part, Assessment Type: admission (Comprehensive).CAA (Care Area Assessment) completion date: no later than the 14th calendar day of the resident's admission (admission date + 13 calendar days).Care Plan Completion Date: no later than CAAs completion date +7 calendar days.Review of Resident #16's admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, acute respiratory failure with hypoxia, type 2 diabetes mellitus and essential hypertension.Review of Resident #16's admission MDS (Minimum Data Set) assessment revealed an ARD (Assessment Reference Date) of 10/08/2025 and CAA completion date of 10/09/2025.A review of Resident #16's Care Plan was conducted. The review revealed 3 focused areas with interventions which were initiated on 10/02/2025 which included: Full Code, Resident Lifting Plan, LA bed hold notice upon transfer/leave. Further review of Resident #16's Care Plan failed to include focused areas with interventions regarding the resident's medical conditions.On 12/02/2025 at 2:08 p.m., an interview was conducted with S3MDS (Minimum Data Set Nurse). S3MDS failed to provide evidence that a comprehensive person-centered care plan was completed for Resident #16 within 7 calendar days of the CAA completion.On 12/02/2025 at 4:10 p.m., an interview was conducted with S2DON (Director of Nursing). S2DON confirmed that the MDS nurses were responsible for creating care plans for the residents. S2DON could not provide evidence that a comprehensive person-centered care plan was completed for Resident #16 within 7 calendar days of the CAA completion.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure accurate administration of all drugs by failing to administer the correct dose of Zinc for 1 (Resident #79) out of 4 residents observed form medication administration. Findings: A review of the facility's policy titled Administration of Medications which was last reviewed on 03/2025, read in part, Oral Medication Administration Procedure, 3. Verify the physicians order, comparing the medication label to the MAR (Medication Administration Record) to verify the following, b. right dosage. Review of Resident #79's health record revealed he was admitted to the facility on [DATE] diagnoses which included, but were not limited to chronic kidney disease and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Nursing Home Progress Note on 11/17/2025 for Resident #79 revealed a physician order for Zinc Sulfate 220 mg (milligrams) one by mouth once a day.Review of Resident #79's MAR (Medication Administration Record) for December 2025 revealed an order dated 11/18/2025 for Zinc oral tablet, Give 1 tablet by mouth one time a day for wound healing. There was no dosage on the order for this medication in the MAR.On 12/02/2025 at 8:44 a.m., S5LPN was observed administering medications to Resident #79. S5LPN was observed administering Zinc 50mg to Resident #79. A review of Resident #79's MAR was conducted with S5LPN. S5LPN confirmed that there was no dosage on the order for Zinc in the MAR, and that she should have known the correct dose for Zinc before administering the medication to the resident. On 12/03/2025 at 3:55 p.m., and interview and review of Resident #79's Nursing Home Progress Note dated 11/17/2025 was conducted with S2DON. SDON confirmed that Zinc 220mg was the current order. She further confirmed that Zinc 220mg should have been administered to Resident #79.