

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Fair City Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Main Street Franklinton, LA 70438	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure staff accurately implemented the comprehensive care plan requiring a 2-person total body mechanical lift transfer for 1 (#85) of 21 residents reviewed for care plans. Review of Resident #85's medical record revealed he was admitted to the facility on [DATE] with diagnoses which included Lack of Coordination, Dementia, Parkinsons, Repeated Falls, Transient Cerebral Ischemic Attack, Abnormalities of Gait and Mobility, Forms of Tremor, and Muscle Weakness.</p> <p>Review of Resident #85's MDS with an ARD of 12/22/2026 revealed a BIMS of 15, which indicated the resident was cognitively intact.</p> <p>Review of Resident #85's medical record revealed Transfer/Mobility Criteria assessment dated [DATE] revealed he was totally dependent on staff for activities of daily living support and the total mechanical lift with full body sling to be used.</p> <p>Review of Resident #85's current Plan of Care revealed he was at risk for falls with an ADL intervention that included total body mechanical lift with 2 staff members for transfers.</p> <p>An interview was conducted on 03/16/2026 at 11:20 a.m. with Resident #85. He stated S8CNA worked the night shift last night and transferred him from the wheelchair to the bed with the mechanical lift. He stated during the transfer when he was in the mechanical lift, he began to have jerking movements and felt like he was going to fall. He stated during the entire transfer, S8CNA was the only staff in the room.</p> <p>An interview was conducted on 03/18/2026 at 2:11 p.m. with S8CNA. S8CNA stated she worked on 03/15/2026 during the night shift. She stated on 03/15/2026 at 6:30 p.m., Resident #85 requested to be transferred from the wheelchair to the bed, and she requested assistance from another CNA. She stated while waiting for the CNA to assist with the transfer, Resident #85 started showing signs of anxiousness and began to rock back and forth and tried to sling or slide himself out of the wheelchair. She stated Resident #85 was at risk for falling on the floor, so she transferred him with the total body mechanical lift without a second staff person. S8CNA confirmed when the total body mechanical lift was used to transfer Resident #85, she should have had another staff present to assist with the transfer.</p> <p>An interview was conducted on 03/18/2026 at 3:20 p.m. with S2DON. S2DON was made aware of the above mentioned circumstance with Resident #85. She stated a total body mechanical lift transfer with 1 staff member was not safe for Resident #85. S2DON confirmed for all residents, the total body mechanical lift transfers should always be completed with 2 staff members for any circumstance.</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
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