STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195324	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair City Health and Rehab	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)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility's binding arbitration agreement failed to explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it for 3 of 3 (#9, #31, and #102) Residents sampled for signing the facility's binding arbitration on admission. This deficient practice had to the potential to affect the 98 residents residing in the facility. Review of Resident #9's admission records revealed she was admitted to the facility on [DATE] and included a signed binding arbitration agreement which revealed it did not explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it as required. Review of Resident #31's admission records revealed he was admitted to the facility on [DATE] and included a signed binding arbitration agreement which revealed it did not explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it as required. Review of Resident #102's admission records revealed she was admitted to the facility on [DATE] and included a signed binding arbitration agreement which revealed it did not explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it as required. On 03/18/2026 at 7:50 a.m., an interview was conducted with S6AD. She stated she was responsible for the facility's admissions. She stated the facility had a binding arbitration agreement contained in its admissions documents. She reviewed Resident's #9, #31, and #102 admission documents and confirmed the binding arbitration agreements did not explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it as required.

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** 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. 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. 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. 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. 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. 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. 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.

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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 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 review and interviews, on readmission, the facility failed to accurately document a cardiopulmonary resuscitation code status in the resident's clinical record for 1 (#9) out of 3 residents reviewed for readmission clinical records.Review of Resident #9's clinical record revealed she was originally admitted on [DATE] and then readmitted to the facility on [DATE]. Review of Resident #9's admission MDS with the ARD of [DATE] revealed she had a BIMs score of 14, which indicated she was cognitively intact. Review of Resident #9's physical hard chart revealed a document titled Resident/Family Consent for Cardiopulmonary Resuscitation signed and dated [DATE] by Resident #9's representative, S6AD, and physician. Further review revealed Resident #9's representative initials next to the following statement:I understand that CPR constitutes an extraordinary measure and should not be done on this resident. However I wish that other interventions be performed unless specifically noted in advance directives this not be done. Review of Resident #9's local rehabilitation hospital Discharge Instructions revealed she was discharged on [DATE] with a physician order for a full code status.Review of Resident #9's current Physician Orders on [DATE] revealed she was readmitted with an order for a full code status. An interview was conducted on [DATE] at 2:29 p.m. with S12LPN. S12LPN reviewed Resident #9's physical hard chart and confirmed the aforementioned Resident/Family Consent for Cardiopulmonary Resuscitation dated [DATE] indicated Resident #9 was a DNR. S12LPN further reviewed Resident #9's current physician orders and confirmed an order for full code. S12LPN confirmed the physician order did not accurately reflect Resident #9's DNR consent and should have. An interview was conducted on [DATE] at 2:32 p.m. with S5QA. S5QA reviewed Resident #9's physical hard chart and confirmed the aforementioned Resident/Family Consent for Cardiopulmonary Resuscitation dated [DATE] indicated Resident #9 was a DNR. S5QA further reviewed Resident #9's current physician orders and confirmed an order for full code. S5QA confirmed the physician order did not accurately reflect Resident #9's DNR consent and should have. An interview was conducted on [DATE] at 2:40 p.m. with Resident #9. She stated she had not wanted to change her code status from a DNR to full code after returning from rehab. She stated her wishes are currently to be a DNR. An interview was conducted on [DATE] at 3:00 p.m. with S2DON. S2DON reviewed Resident #9's physical hard chart and confirmed the aforementioned Resident/Family Consent for Cardiopulmonary Resuscitation dated [DATE] indicated Resident #9 was a DNR. S2DON further reviewed Resident #9's current physician orders and confirmed an order for full code. S2DON confirmed the physician order did not accurately reflect Resident #9's DNR consent and should have. S2DON confirmed on readmission, the nurse was expected to identify the code status discrepancy and immediately clarify and document Resident #9's accurate code status and did not.