STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195349	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Tangi Pines	10746 Hwy 16 Amite, LA 70422

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 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. (continued on next page)

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident's plan of care was revised by failing to update fall interventions for each fall for 3 (#1, #2 and #3) of 3 residents reviewed for falls. Findings: Resident #1Review of the Clinical Record for Resident #1 revealed the resident was admitted to the facility on [DATE]. The resident had diagnoses which included Repeated Falls, Progressive Neurological Condition and Parkinson's Disease with Dyskinesia. Review of the most recent MDS with an ARD of 10/07/2025 revealed Resident #1 had a BIMS of 3, which indicated severe cognitive impairment.Review of the facility's Incident Reports revealed Resident #1 had witnessed falls on 09/30/2025, 10/27/2025 and 11/11/2025. Review of Resident #1's Nurse's Notes revealed the following:09/30/2025 at 8:14 p.m. - The nurse entered the resident's room to offer her a snack. When she got out of bed she lost her balance and hit her head on the floor.10/27/2025 at 4:30 a.m. - Resident's daughter called and stated that resident was on the floor as she had seen on resident's camera in her room. She stated the resident was trying to get out of bed and got tangled in her blankets and rolled out of bed and bumped her head on the floor. The nurse entered the room and resident was observed served sitting on the floor.11/11/2025 at 12:05 a.m. -CNA reported to nurse that resident was on the floor. The nurse entered the resident's room and she was sitting on the floor away from her bed. Review of Resident #1's Care Plan revealed it was not revised to include interventions to address Resident #1's fall on 09/30/2025, 10/27/2025 and 11/11/2025. On 12/19/2025 at 10:35 a.m., an interview was conducted with S4STAFF. She reviewed and confirmed Resident #1 had a fall on 09/30/2025, 10/27/2025 and 11/11/2025. S4STAFF reviewed Resident #1's care plan and confirmed it was not revised to reflect Resident #1 falls which occurred on 09/30/2025, 10/27/2025 and 11/11/2025 prior to the survey team entry on 12/17/2025 and should have been. On12/17/2025 at 2:11 p.m., an interview was conducted with S5MDS. She reviewed and confirmed Resident #1 had a fall on 10/27/2025. S5MDS reviewed Resident #1's care plan and confirmed it was not revised to reflect Resident #1 fall which occurred on 10/27/2025 prior to the survey team entry on 12/17/2025 and should have been. On 12/19/2025 at 11:37 a.m., an interview was conducted with S1DON. He reviewed Resident #1's care plan and confirmed it was not revised to reflect Resident #1's falls on 09/30/2025, 10/27/2025 and 11/11/2025 prior to the survey team entry and should have been. Resident #2Review of the Clinical Record for Resident #2 revealed the resident was admitted to the facility on [DATE]. The resident had diagnoses which included Alzheimer's Disease, Malignant Neoplasm of Pelvic Bones, Sacrum, and Coccyx. Review of the most recent MDS with an ARD of 10/28/2025 revealed Resident #2 had a BIMS of 3, which indicated severe cognitive impairment. Review of the facility's Incident Reports revealed Resident #2 had a witnessed fall on 11/26/2025. Review of Resident #2's Nurse's Notes revealed the following:11/26/2025 at 11:56 a.m.- the CNA called me to the memory care unit, upon entry resident was lying on her left side on floor. The CNA stated that the resident was in her wheelchair when she started to fall asleep and fell forward out of wheelchair. Review of Resident #2's Care Plan revealed it was not revised to include interventions to address Resident #2's fall on 11/26/2025. On 12/19/2025 at 10:35 a.m. , an interview was conducted with S4STAFF. She reviewed and confirmed Resident #2 had a fall on 11/26/2025. S4STAFF reviewed Resident #2's care plan and confirmed it was not revised to reflect Resident #2 fall which occurred on 11/26/2025 prior to the survey team entry on 12/17/2025 and should have been. On 12/19/2025 at 11:37 a.m., an interview was conducted with S1DON. He reviewed Resident #2's care plan and confirmed it was not revised to reflect Resident #2's falls on 11/26/2025 prior to the survey team entry and should have been. Resident #3Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included Fractures and Other Multiple Fractures, Right Foot Fracture, History of Falling, Hereditary and Idiopathic Neuropathy, Displaced Fracture of 2nd Metatarsal Bone, Right Foot and Displaced Fracture of 3rd Metatarsal Bone, Right Foot. Review of the facility's Incident Report revealed Resident #3 had an unwitnessed falls on the 09/14/2025, 09/17/2025, 10/13/2025, and 11/13/2025.Review of Resident #3's Nurse's Note revealed the following:09/14/2025 at 3:21 p.m. -The CNA called me, the nurse, to resident's room because resident was on the floor in bathroom. Upon entering the room resident noted to be in the bathroom on the floor next to the toilet. Resident reports she needed to use the toilet and did not call for assistance. When transferring from wheelchair to toilet she started to wet herself causing her feet to become slippery. 09/17/2025 at 12:55 a.m.-Upon entering the room at approximately 00:30, resident was seen sitting on the floor beside her bed. Resident has noticeable swelling & bruising to

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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 observations, interviews, and record reviews, the facility failed to ensure interventions for falls were implemented as identified on the care plan for 1(#1) of 3 residents reviewed for falls. Findings: Review of the clinical record for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses which included Repeated Falls, Progressive Neurological Condition, and Parkinson's Disease with Dyskinesia. Review of the most recent MDS with an ARD of 10/07/2025 revealed Resident #1 had a BIMS of 3, which indicated severe cognitive impairment. Review of the most current Care Plan revealed the following:Problem: Potential for falls related to history of falls, decreased mobility, medication effects, confusion, poor safety awareness and impaired mobility. On 05/22/2024 Resident #1 slid off her bed and had a fall.Intervention: 05/22/2024: Resident given non-skid socks instead of wearing regular socks. On 12/17/2025 at 11:10 a.m., an observation was made of Resident #1 awake, sitting up in a wheelchair. An observation was made of white socks on Resident #1's feet without non-skid bottoms. On 12/17/2025 at 11:11 a.m., an interview was conducted with S2STAFF. She stated Resident #1 was a fall risk. She observed and confirmed Resident #1 was not wearing non-skid socks. On 12/17/2025 at 11:25 a.m., an interview was conducted with S3STAFF. She stated Resident #1 was a fall risk. She stated an intervention used to prevent falls for Resident #1 was to place non-skid socks on the resident. On 12/17/2025 at 11:29 a. m., an observation and interview was conducted with S3STAFF. She observed and confirmed Resident #1 was not wearing non-skid socks and should have been. On 12/17/2025 at 12:00 p.m., an interview was conducted with Resident #1's Representative. She stated she visited Resident #1 once or twice a week. She Resident #1 had a history of falls. She stated Resident #1 does not wear non-skid socks. On 12/17/2025 at 2:50 p.m., an interview was conducted with S1DON. He stated he expected all staff to follow a resident's care plan and implement fall interventions to prevent further falls. He reviewed Resident #1's care plan and confirmed Resident #1 had a fall intervention to place non-skid socks.