

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2026
NAME OF PROVIDER OR SUPPLIER  The Lodge at Tangi Pines		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and record review, the facility failed to store foods under sanitary conditions. The facility failed to ensure:1. Food requiring refrigeration after opening was refrigerated, and2. Food items were dated after opening. This deficient practice had the potential to affect 92 residents who were provided meals from the facility's kitchen.Review of the facility's policy titled Date Marking for Food Safety dated 2026 revealed in part, the following:2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or prepared.During the initial tour of the facility's kitchen on 04/13/2026 at 8:12 a.m. with S5DM, the following observations were made:Snack/Nourishment Refrigerator:27-uncovered, undated serving cups of ranch dressing.1-uncovered, undated large cup filled with a dark brown substance.Pantry:1-opened, partially used gallon container of teriyaki sauce, no open date, with a label which read Refrigerate after opening.An interview was conducted on 04/13/2026 at 8:16 a.m. with S5DM. She confirmed the above findings. She confirmed all opened food items should be covered and labeled with an open date. She confirmed food items requiring refrigeration after opening should be refrigerated.An interview was conducted on 04/15/2026 at 12:05 p.m. with S1ADM. He confirmed all opened food items should be covered and labeled with an open date. He confirmed food items requiring refrigeration after opening should be refrigerated.</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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to ensure nursing staff sanitized insulin vial stoppers prior to extracting insulin for 3 (#3, #7, and #97) of 4 residents observed for insulin administration. Review of the facility's policy titled Medication Administration dated 2025, revealed in part, the following: Policy: Medications are administered by licensed nurses in a manner to prevent contamination or infection. Review of Insulin Manufacturer's Insert revealed in part, the following: For insulin vials (and other multi-dose vials), the rubber stopper is not sterile and can harbor microorganisms. Therefore, cleaning before use is essential to reduce contamination risk. Resident #3 Review of Resident #3's Clinical Record revealed the resident was admitted to the facility on [DATE]. Further review revealed an active Physician's Order for Humalog Insulin 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made of S4LPN administering Humalog Insulin 100 unit/mL to Resident #3 on 04/13/2026 at 3:25 p.m. S4LPN extracted insulin from the insulin vial without sanitizing the insulin vial stopper. S4LPN administered the insulin. Resident #7 Review of Resident #7's Clinical Record revealed the resident was admitted to the facility on [DATE]. Further review revealed an active Physician's Order for Humalog Insulin 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made of S4LPN administering Humalog Insulin 100 unit/mL to Resident #7 on 04/13/2026 at 3:17 p.m. S4LPN extracted insulin from the insulin vial without sanitizing the insulin vial stopper. S4LPN administered the insulin. Resident #97 Review of Resident #97's Clinical Record revealed the resident was admitted to the facility on [DATE]. Further review revealed an active Physician's Order for Humalog Insulin 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made of S4LPN administering Humalog Insulin 100 unit/mL to Resident #97 on 04/13/2026 at 3:42 p.m. S4LPN extracted insulin from the insulin vial without sanitizing the insulin vial stopper. S4LPN administered the insulin. An interview was conducted on 04/13/2026 at 3:45 p.m. with S4LPN. She confirmed she did not sanitize the insulin vial stopper prior to extracting the insulin for Residents #3, #7, and #97. An interview was conducted with on 04/14/2026 at 9:28 a.m. S2DON. He stated insulin vial stoppers should always be sanitized prior to extracting insulin.</p>		

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<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>Based on interviews and record review, the facility failed to implement a comprehensive person-centered care plan for 1 (#68) of 3 residents reviewed for falls. The facility failed to ensure Resident #68's care plan was implemented for transfers with a mechanical lift. Review of Resident #68's Clinical Record revealed an admission date of 06/29/2017. Further review revealed Resident #68 had diagnoses which included a fracture of an unspecified part of neck of right femur, generalized muscle weakness, and Alzheimer's Disease. Review of Resident #68's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/03/2026, revealed Resident #68 was dependent on staff for chair/bed-to-chair transfers. Further review revealed a Brief Interview for Mental Status (BIMS) of 03, indicating severe cognitive impairment. Review of Resident #68's current Care Plan revealed the following: Self-care deficit related to needing assistance with activities of daily living (ADLs), decreased mobility, dementia diagnosis, and non-ambulatory status. Uses a mechanical lift for all transfers with 2 staff. Review of the Facility's Incident Log from 12/01/2025 to 04/13/2026 revealed Resident #68 had a witnessed fall on 03/24/2026. Review of Resident #68's Incident Report, dated 03/24/2026, revealed a witness statement from unnamed staff, dated 03/24/2026, indicating Resident #68 rolled out of bed with the staff member present and was transferred back to bed by the staff member prior to nurse notification or assessment. An interview was conducted on 04/14/2026 at 11:39 a.m. with S6CNA. S6CNA stated Resident #68 required a two-person mechanical lift for transfers. S6CNA confirmed use of the mechanical lift required two staff members. S6CNA stated he worked on 03/24/2026 and wrote the witness statement regarding Resident #68's fall. S6CNA stated he witnessed the fall and was the only staff member present. S6CNA confirmed, after the fall, he did not use the mechanical lift to transfer Resident #68 from the floor to the bed. S6CNA confirmed he manually transferred Resident #68 to the bed by himself and should not have. An interview was conducted on 04/15/2026 at 9:40 a.m. with S10LPN. S10LPN stated she responded to Resident #68's fall on 03/24/2026. S10LPN stated S6CNA transferred Resident #68 from the floor to the bed before she assessed the resident. S10LPN stated she did not assist S6CNA with Resident #68's transfer. An interview was conducted on 04/14/2026 at 3:00 p.m. with S3ADON. S3ADON stated she supervised the CNA staff. S3ADON confirmed Resident #68 required the mechanical lift for all transfers and 2 staff members needed to be present for the operation of the mechanical lift. S3ADON confirmed S6CNA transferred Resident #68 by himself and should not have.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on interviews and record review, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies for 1 (#68) of 3 residents reviewed for falls. Review of Resident #68's Clinical Record revealed an admission date of 06/29/2017 with diagnoses including fracture of unspecified part of neck of right femur dated 03/25/2026. Review of Facility's Incident Log, dated December 2025 to present, revealed in part, the following:Witnessed Fall Incident:Resident #68, 03/24/2026 at 6:15 a.m.Incident Location: Resident RoomPerson Preparing Report: S10LPN Review of Resident #68's Nurse Progress Notes, dated 03/25/2026, revealed, in part, the following:03/25/2026, 4:30 p.m., signed S11LPN: Resident noted to be screaming from bed. Upon entry into resident room, swelling was noted to Resident Right upper thigh area. Resident guarded area from touch, stating that it hurt. Resident was unable to answer simple questions regarding possible injury due to cognitive impairment. MD notified of finding. New order for x-ray of right thigh/pelvis and knee. Order noted and Express Ray notified of new order. Responsible Party notified of resident change in status. 03/25/2026, 6:43 p.m., signed S11LPN: Express Ray x-ray of right hip and knee completed, with fracture noted. MD notified at 6:50 p.m. New order to send to ER for evaluation and treatment. Responsible Party notified of new order to send to ER and stated understanding. Acadian Ambulance notified of transport. Review of Resident #68's Physician's Progress Notes, dated 03/25/2026, revealed, in part, the following:Diagnostic Studies/Radiology:XR Femur Right 2+ ViewsResult Date: 03/25/2026Findings: Oblique fracture through the proximal femoral diaphysis just below the femoral neck. Review of Resident #68's Care Plan, dated 04/16/2026, revealed, in part, the following:Focus: Potential for falls related to history of falls05/29/2025 - Fell after rolling out of bed while being assisted03/24/2026 - Rolled out of bed to floor; injuries notedInterventions:05/29/2025 - Will use 2 certified nursing assistants (CNAs) for all care.03/24/2026 - Bed placed against wall, feet to door. Review of facility's Quality Improvement Corrective Action Plan, dated 02/15/2026, revealed, in part, the following: Problem Area Identified: Care plans: Interventions not being entered by MDS nurse for falls, care plans not being updated in general. Information is not being communicated to CNA staff about care plan changes concerning resident care.Recommended Plan of Action:1. Started entering CNA tasks in point-of-care (POC) so CNAs could sign off on them each day.Date of Follow-up: 03/15/2026CNAs can now sign off on resident care for falls in POC, and it is being done. S3ADON checks random ADL charting.Recurring Problems:Some resident care not updated, but it is being worked on.Date of Follow-up: 04/15/2026All April 2026 ADL charting (with POC sign-offs) is being done 100% per staff. Review of the facility report, dated 04/15/2026, titled Documentation Survey Report v2 Apr-26, revealed, in part, the following: Resident: Resident #68Intervention/Task: 05/29/2025 - Will use 2 CNAs for all care04/01/2026 through 04/13/2026 revealed X for both 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. shifts on all dates.04/14/2026, shift 6:00 a.m. to 6:00 p.m. - blank04/14/2026, shift 6:00 p.m. to 6:00 a.m. - 30, S8CNA, 8:13 p.m.Was task performed? 30 - Yes, 31 - No An interview was conducted on 04/14/2026 at 11:39 a.m. with S6CNA. S6CNA stated he was assigned to Resident #68. S6CNA stated he did not know two-person care was a fall intervention for Resident #68. S6CNA further reviewed Resident #68's chart on the facility's tablet and was unable to locate information indicating Resident #68 required two-person care as a fall intervention. An interview was conducted on 04/15/2026 at 11:00 a.m. with S7MDS. S7MDS stated the intervention/task, dated 05/29/2025, will use 2 CNAs for all Resident #68's care, was not placed into the CNA POC until 04/14/2026. S7MDS stated it should have been loaded into the CNA POC on 01/08/2026 and was not. S7MDS stated the error was not identified in the above referenced care plan quality assurance (QA). S7MDS confirmed she had no record, log, or monitoring documentation of which resident care plans or interventions had been reviewed during the QA or still need to be reviewed. S7MDS stated she was not aware any such (continued on next page)</p>		

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F 0867  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	documentation should have been kept. An interview was conducted on 04/15/2026 at 2:35 p.m. with S1ADM. S1ADM stated all documents related to the above-mentioned QA had been provided and confirmed there was no documentation where they had been monitoring their QA.		