STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195373	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rayville Nursing and Rehabilitation	294 Hwy 3048 Rayville, LA 71269

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 4 (#17, #23, #29 and #44) of 6 (#17, #22, #23, #28, #29, #44) residents reviewed for Activities of Daily Living (ADL) care. The facility failed to ensure 1.) residents' fingernails were kept clean and trimmed for #17, #23, #29 and #44 , and 2. resident #23 received oral hygiene and grooming. Findings: Resident #44 Review of the medical record for resident #44 revealed diagnoses of hyperlipidemia, cerebral infarction, hemiplegia, hemiparesis, protein calorie malnutrition, hypertension, and cognitive communication deficit. Review of the care plan revealed a problem for self-care deficit and required assistance with activities of daily living, provide a whirlpool bath three times a week and bed bath on the other days, clean and check fingernails/toenails, and provide nail care weekly and as needed. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was independent with cognition for daily decision making and required moderate assistance with bathing and personal hygiene. On 07/30/2024 at 10:02 a.m. and on 07/31/2024 at 8:50 a.m., observations of resident #44 revealed his fingernails were long and were in need of trimming. On 07/31/2024 at 9:00 a.m., S2Director of Nursing (DON) observed resident #44's fingernails with the surveyor and confirmed his nails were long and needed to be trimmed. 32231 Resident #17 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic health record revealed resident #17 was admitted to the facility on [DATE] with diagnoses including chronic diastolic (congestive) heart failure, pseudobulbar affect, disorientation, cognitive communication deficit, muscle weakness (generalized), lack of coordination, abnormalities of gait and mobility, dementia, and glaucoma. Review of the Significant Change MDS assessment dated [DATE] revealed resident #17 had a brief interview for mental status score of 05. A score of 00-07 indicated that resident #17 was severely cognitively impaired with daily decision making skills. Further review of the assessment revealed that resident #17 required supervision or touching assistance with eating. On 07/30/2024 at 10:15 a.m., an observation revealed resident #17 sitting in the common area. Further observation revealed resident #17 had food particles in between his teeth and his fingernails were dirty underneath the nail beds on both hands. On 07/30/2024 at 4:38 p.m., an observation revealed resident #17 sitting in the dining room. Further observation revealed resident #17 was holding a tuna sandwich with his bare hand, while feeding himself. The resident's fingernails on both hands remained dirty. S8Certified Nursing Assistant (CNA) and S9CNA were sitting at a table next to resident #17. They did not address resident #17's fingernails being dirty. On 07/30/2024 at 5:00 p.m., an observation revealed S10CNA assisting resident #17 to his room. S10CNA was notified of resident #23's fingernails being dirty. S10CNA confirmed that resident #17's fingernails were dirty and needed to be cleaned. On 07/31/2024 at 5:00 p.m., S1Administrator, S2DON, and S3Corporate Administrator were notified of resident #17 feeding himself while his fingernails were dirty. Resident #23 Review of the electronic health care record revealed resident #23 was admitted to the facility on [DATE] with diagnoses including, Pseudobular affect, muscle weakness (generalized), vascular dementia, and a cognitive communication deficit. Review of the annual MDS assessment dated [DATE] revealed that resident #23 had a brief interview for mental status score of 05 indicating that the resident had severe cognitive impairment with daily decision making skills. Review of the plan of care revealed resident #23 had a self-care deficit that required her to need assistance with activities of daily living including oral care. On 07/30/2024 at 9:42 a.m., an observation of resident #23 revealed her teeth looked un-brushed with old food particles observed in between the teeth, she had long white hairs observed on her chin and her fingernails were dirty underneath the nail beds of both hands with the nails untrimmed. On 07/30/2024 at 2:00 p.m., an observation of resident #23 revealed the resident had old food particles in between her teeth, the long hairs remained on her chin, and her fingernails remained dirty and untrimmed. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 9:53 a.m., an observation of resident #23 revealed the resident had old food particles in between her teeth, the long hairs remained on her chin, and her fingernails remained dirty and untrimmed. On 07/31/2024 at 12:30 p.m., S2DON was notified of the observations of resident #23 having food particles in between her teeth, long chin hair, and dirty fingernails. An observation of resident #23 with S2DON revealed there was no tooth brush in the resident's room. S2DON confirmed that resident #23 needed her teeth brushed and the chin hairs removed. On 07/31/2024 at 5:00 p.m., S1Administrator, S5Corporate Administrator, and S2DON were notified of resident #23 having food particles between her teeth, long chin hair, and dirty, untrimmed fingernails. Resident #29 Review of the electronic health record revealed that resident #29 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, muscle weakness (generalized), other abnormalities of gait and mobility, lack of coordination, and low back pain. On 07/31/2024 at 9:53 a.m., an observation revealed resident #29 lying in bed. Further observation revealed resident #29 had long hairs on her chin and her fingernails were untrimmed and dirty underneath the nail beds on both hands. On 07/31/2024 at 12:30 p.m., S2DON was notified of the observations of resident #29's fingernails being long, untrimmed, and dirty underneath the nailbeds. S2DON confirmed resident #29's fingernails needed to be cleaned and the hair on the resident's chin needed to be removed. On 07/31/2024 at 5:00 p.m., S1Administrator, S5Corporate Administrator, and S2DON were notified of the above findings.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observations, interviews, and record reviews, the facility failed to provide, based on the comprehensive assessment, care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities for 4 (#1, #23, #29 and #43) of 5 (#1, #23, #29, #30, and #43) residents reviewed for activities. Findings: Resident #1 Review of the medical record for resident #1 revealed an admitted [DATE] with diagnoses including cystitis without hematuria, heart failure, ileus, muscle spasms, convulsions, reflux, aphasia, heart failure, anxiety, gastrostomy status, hypoglycemia, and quadriplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment for daily decision making. Review of the care plan revealed the resident had impaired thought processes/cognitive dysfunction related to aphasia, being understood or understanding others secondary to history of a brain injury. Further review of the care plan revealed the resident was at optimal level in activity attendance. The resident was bedbound and had a diagnosis of quadriplegia. The Activity Director was to visit the resident three times a week for in room activities such as reading and music. Review of the in room activity binder revealed there was no documented evidence of in room activities for resident #1 since February 2024. Observations of resident #1 during the survey dates of 07/29/2024 - 07/31/2024 revealed no in room activities were provided for the resident. On 07/31/2024 at 11:45 a.m., an interview with S3Activity Director (AD) revealed she had been employed with the facility for about a month and she had not been into resident #1's room to provide any in room activities. 32231 Resident #23 Review of the electronic health care record revealed resident #23 was admitted to the facility on [DATE] with diagnoses including, Pseudobulbar affect, muscle weakness (generalized), vascular dementia, and a cognitive communication deficit. Review of the annual MDS assessment dated [DATE] revealed resident #23 had a BIMS score of 5 indicating that he had severe cognitive impairment with daily decision making skills. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care revealed resident #23 had a self-care deficit that required her to need assistance with activities of daily living. Review of the in-room activities binder revealed there was no documented evidence of in-room activities provided to resident #23. Observations of resident #23 during the suvey dates of 07/29/2024 - 07/31/2024 revealed no in room activities were provided for the resident. On 07/31/2024 at 1:28 p.m., S3AD further revealed that she was supposed to visit with resident #23 three times a week. S3AD confirmed that she had not been consistently visiting in-room with resident #23 to offer the resident in-room activities. Resident #29 Review of the electronic health record revealed that resident #29 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, muscle weakness (generalized), other abnormalities of gait and mobility, lack of coordination, and low back pain. Review of the record revealed that resident #29 was care planned for the potential for alteration in mood related to depression. The documented approaches included that resident #29 enjoyed staff visibility and talking with her. Review of the in-room activities binder revealed there was no documented evidence of in-room activities provided to resident #29. Observations of resident #29 during the suvey dates of 07/29/2024 - 07/31/2024 revealed no in room activities provided for the resident. On 07/31/2024 at 1:28 p.m., S3AD revealed that resident #29 did not like to go out her room for activities, but she did like to visit with staff, in her room. S3AD further revealed that she was supposed to visit with resident #29 three times a week. S3AD confirmed that she had not been consistently visiting in-room with resident #29 to offer the resident in-room activities. On 07/31/2024 at 5:00 p.m., S1Administrator, S5Corporate Administrator, and S2Director of Nursing were notified of the above findings. 41829 Resident #43 Record review revealed resident #43 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus without complication, hemiplegia following cerebral infarction affecting left non dominant side, unspecified dementia, dysphagia, cardiomegaly, contracture, cachexia, gastrostomy, generalized anxiety disorder, aphasia, restless agitation, and generalized muscle weakness. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE] revealed the BIMS was blank. Resident #43 was unable to complete BIMS due to severe cognitive impairment. Resident #43 was totally dependent on staff for all activities of daily living. Review of the care plan revealed the resident was at optimal level in activity attendance. The Activity Director (AD) was to visit the resident three times a week for in room activities such as reading and music. Review of the in room activity binder revealed there was no documented evidence of in room activities for resident #43. Observations of resident #43 during the survey dates 07/29/2024 - 07/31/2024 revealed no in room activities were provided for the resident. On 07/31/2024 at 1:22 p.m., an interview with S3AD revealed she started working at the facility one month ago. S3AD reported she had not provided any in room activities with resident #43.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review, observation, and interviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice by failing to administer eye drops as ordered for 1 (#32) of 1 (#32) residents reviewed for vision. Findings: Review of the medical record for resident #32 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, anorexia, lack of coordination, unspecified glaucoma, and heart disease. Review of the care plan revealed resident #32 had impaired vision related to glaucoma and to administer eye drops as prescribed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) of 11, which indicated the resident had moderate cognitive impairment for daily decision making. On 07/29/2024 at 12:06 p.m., an interview with resident #32 revealed he had not received his eye drops today. Review of the July 2024 physician's orders revealed an order dated 01/01/2023 for Dorzolamide 2% eye drops and to apply 1 drop to both eyes three times a day. Review of the July 2024 Medication Administration Record (MAR) revealed there was no documented evidence that Dorzolamide 2% eye drops were administered on 07/26/2024, 07/28/2024 and 07/30/2024 at 2:00 p.m., and 07/28/2024 and 07/29/2024 at 6:00 a.m. On 07/30/2024 at 4:25 p.m., an interview with S6Licensed Practical Nurse (LPN) revealed the resident was out of the eye drops and she called the pharmacy today and they still have not sent the medication. On 07/30/2024 at 4:35 p.m., S2Director of Nursing (DON) was notified that resident #32 did not have the eye drops in the medication cart or medication room for administration. On 07/30/2024 at 4:45 p.m., an interview with S2DON revealed she called the pharmacy and they stated the medication was on back order and not available for the resident. S2DON confirmed resident #32's medication was not available for administration.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record review, observations, and interviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 1 (#42) of 2 (#10 and #42) residents reviewed for respiratory care. The facility failed to ensure resident #42 was administered oxygen via nasal cannula per the physician's orders. Findings: Review of the record for resident #42 revealed an admitted [DATE] with diagnoses including chronic heart failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, shortness of breath, anxiety disorder, paroxysmal atrial fibrillation, and cardiomyopathy. Review of the July 2024 physician's orders revealed an order dated 03/07/2023 for Oxygen at 4 Liters per nasal cannula continuously. Review of the July 2024 Medication Administration Record (MAR) revealed documentation that resident #42 received Oxygen at 4 Liters per nasal cannula on 07/29/2024 and 07/30/2024. Review of the record revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 indicating no cognitive impairment. Review of the current care plan dated 03/01/2023 revealed the resident was at risk for shortness of breath and/or respiratory distress, chronic obstructive pulmonary disease, chronic sinusitis, COVID-19, and other variants. Further review of the care plan revealed an intervention for continuous Oxygen at 4 Liters per nasal cannula. Observations of resident #42 on 07/29/2024 at 8:55 a.m., 07/30/2024 at 8:40 a.m., and 07/31/2024 at 8:50 a.m. revealed resident #42 was not wearing oxygen per nasal cannula and there was no oxygen concentrator in the resident's room. An interview on 07/31/2024 at 8:50 a.m. with resident #42 revealed she had not been wearing oxygen and did not have an oxygen concentrator in her room. An interview on 07/31/2024 at 8:55 a.m. with S4Registered Nurse (RN) confirmed that resident #42 had a current physician's order for Oxygen at 4 Liters per nasal cannula continuously. S4RN further confirmed that there was no oxygen concentrator in the resident's room. An interview on 07/31/2024 at 9:00 a.m. with S2Director of Nursing (DON) confirmed resident #42 had a current order for Oxygen at 4 Liters per nasal cannula continuously. S2DON revealed the staff had documented administration of oxygen continuously on the July 2024 MAR on 07/29/2024 and 07/30/2024. S2DON further confirmed resident #42 did not receive oxygen on 07/29/2024 and 07/30/2024.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record reviews, observations, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails and received a written order from the physician for bed rails prior to installation for 6 (#1, #16, #17, #23, #29, and #30) of 6 (#1, #16, #17, #23, #29, and #30) residents reviewed for accident hazards. Findings: Review of the facility's policy for Physical Restraints, Side Rails (undated) revealed in part: Purpose The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: c. Risk of entrapment from the use of side rails. Review of the facility's Physical Restraint Record of Informed Consent form (undated) revealed in part: I fully understand that should the use of a restraint be necessary, it will only be considered to treat a medical condition or symptom that endangers my physical safety or the safety of other residents and will: 2. Only to be used upon the written order of my attending physician. Resident #1 Review of the medical record for resident #1 revealed an admitted [DATE] with diagnoses including heart failure, ileus, muscle spasms, convulsions, aphasia, heart failure, anxiety, hypoglycemia, and quadriplegia. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment skills for daily decision making. Further review of the MDS revealed resident #1 was dependent on staff for activities of daily living. During the survey dates of 07/29/2024 - 07/31/2024, observations of resident #1 revealed she was in the bed with quarter bed rails raised on both sides of the bed. Review of the July 2024 physician's orders revealed no order for the use of bed rails. Review of the care plan revealed resident #1 had impaired mobility due to the resident was bedbound and was a quadriplegic. The approaches were to turn and reposition, and to use a geo ultra max reactive pressure distribution mattress to the bed. Review of the Electronic Health Record (EHR) and paper chart revealed no documented evidence the facility assessed resident #1 for the risk of entrapment from bed rails prior to installation and there was not a physician's order obtained for bed rails. On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2Director of Nursing (DON), and S1Administrator revealed there was no documented evidence of an assessment for the risk of entrapment and a physician's order for bed rails prior to the installation. 32231 Resident #17 Review of the electronic health record revealed resident #17 was admitted to the facility on [DATE] with diagnoses including chronic diastolic (congestive) heart failure, pseudobulbar affect, disorientation, abnormality of gait, lack of coordination, cognitive communication deficit, muscle weakness (generalized), lack of coordination, abnormalities of gait and mobility, dementia, and glaucoma. Review of the significant change MDS assessment dated [DATE] revealed resident #17 had a BIMS score of 5. A score of 00-07 indicated that resident #17 was severely cognitively impaired with daily decision making skills. Further review revealed resident #17 required substantial assistance from staff with activities of daily living including roll left and right, sit to lying, and chair/bed to chair transfer. During the survey dates of 07/29/2024 - 07/31/2024, observations revealed that resident #17 had quarter side rails on both sides of the bed that were raised at various times. Review of the July 2024 physician's orders revealed no order for the use of bed rails. Review of the electronic health record and paper chart revealed no documented evidence the facility assessed resident #17 for the risk of entrapment from bed rails prior to installation and there was not a physician's order obtained for side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2DON, and S1Administrator revealed there was no documented evidence of an assessment for risk of entrapment, and a physician's order for bed rails prior to the installation. Resident #23 Review of the electronic health record revealed resident #23 was admitted to the facility on [DATE] with diagnoses including pseudobular affect, muscle weakness (generalized), vascular dementia, and cognitive communication deficit. Review of the annual MDS assessment dated [DATE] revealed that resident #23 had a BIMS score of 5 indicating that she had severe cognitive impairment with daily decision making skills. Review of the plan of care revealed resident #23 had a self-care deficit that required her to need assistance with activities of daily living. During the survey dates of 07/29/2024 - 07/31/2024 observations revealed that resident #23 was in the bed with quarter bed rails raised on both sides of the bed. Review of the July 2024 physician's orders revealed no order for the use of bed rails. Review of the electronic health record and paper chart revealed no documented evidence the facility assessed resident #23 for the risk of entrapment from bed rails prior to installation and there was not a physician's order obtained for bed rails. On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2DON, and S1Administrator revealed there was no documented evidence of an assessment for risk of entrapment, and a physician's order for bed rails prior to the installation. Resident #29 Review of the electronic health record revealed that resident #29 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, muscle weakness (generalized), other abnormalities of gait and mobility, other lack of coordination, and low back pain. Review of the quarterly MDS assessment dated [DATE] revealed resident #29 required supervision or touching assistance with bed mobility and transfers. During the survey dates of 07/29/2024 - 07/31/2024 observations of resident #29 revealed she was in the bed with quarter bed rails raised on both sides of the bed. Review of the July 2024 physician's orders revealed no order for the use of bed rails. Review of the electronic health record and paper chart revealed no documented evidence the facility assessed resident #29 for the risk of entrapment from bed rails prior to installation and there was not a physician's order obtained for bed rails. (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2DON, and S1Administrator revealed there was no documented evidence of an assessment for the risk of entrapment, and a physician's order for bed rails prior to the installation. 43405 Resident #16 Review of the record for resident #16 revealed an admitted [DATE] with diagnoses including bipolar disorder, transient ischemic attack, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, major depressive disorder recurrent severe with psychotic symptoms, generalized anxiety disorder, falls, schizoaffective disorder bipolar type, and dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe cognitve impairment. Review of the July 2024 physician's orders revealed no order for the use of bed rails. Review of the plan of care revealed resident #16 had a self-care deficit that required her to need assistance with activities of daily living. Observations on 07/29/2024 at 9:55 a.m. and 07/30/2024 at 8:55 a.m. of resident #16 revealed quarter bed rails were raised on both sides of the bed. Review of the electronic health record and paper chart revealed no documented evidence the facility assessed resident #16 for the risk of entrapment for bed rails prior to installation and there was not a physician's order obtained for bed rails. On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2DON, and S1Administrator revealed there was no documented evidence of an assessment for risk of entrapment, and a physician's order for bed rails prior to the installation. Resident #30 Review of the record for resident #30 revealed an admitted [DATE] with diagnoses including cerebral atherosclerosis, insomnia, hypothyroidism, vascular dementia, unspecified convulsions, anxiety disorder, and dementia. Review of the July 2024 physician's orders revealed no orders for the use of bed rails. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 99 indicating the facility was unable to determine resident #30's cognitive status. Review of the plan of care revealed resident #30 had a self-care deficit that required her to need assistance with activities of daily living. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195373	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rayville Nursing and Rehabilitation	294 Hwy 3048 Rayville, LA 71269

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of resident #30 on 07/29/2024 at 9:20 a.m. and 07/30/2024 at 9:10 a.m. revealed quarter bed rails were raised on both sides of the bed. Review of the electronic health record and paper chart revealed no documented evidence the facility assessed resident #30 for the risk of entrapment from bed rails prior to installation and there was not a physician's order obtained for bed rails. On 07/31/2024 at 5:00 p.m., an interview with S5Corporate Administrator, S2DON, and S1Administrator revealed there was no documented evidence of an assessment for risk of entrapment, and a physician's order for bed rails prior to the installation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195373	A. Building B. Wing	07/31/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32231 Based on observations and interviews, the facility failed to store, distribute, and serve food in accordance with professional standards with food service safety by: 1) having opened food items stored in the freezers, exposed to air and not being labeled with an opened date, 2) having dirt and grime buildup in the kitchen and 3) storing employee personal items in the food preparation area. Findings: On 07/29/2024 at 8:30 a.m., an observation of the kitchen with S11Dietary Manager (DM) revealed a small chest style freezer that contained five small cups of ice cream. The cups were turned over and/or partially turned on the side with the ice cream coming out of the cups and some of the cup lids stuck together. Further observation revealed one small pizza inside of a zip lock bag. The bag was not labeled with an opened date. S11DM confirmed the ice cream should have been removed from the freezer and the bag of pizza was not labeled with an opened date. There was an ice machine located next to a large food prep table. The outside lid of the ice machine was dirty. Further observation revealed a strip of old, thick grime buildup and a filter had a thin layer of dust buildup. Further observation of the ice machine revealed an area between the lid and the compressor that had a strip of grime buildup and dust on the machine's filter. Observation further revealed a large insulated drink container located to the side of the ice machine and next to the food prep table. S11DM confirmed the ice machine was dirty and needed be cleaned. She further confirmed the drink container belonged to a staff member and should not have been in the kitchen. Observation of the large walk-in freezer revealed the following: one ham wrapped in clear wrap and opened bags containing finger steaks, meat pies, hamburger patties, large link sausages, chicken bites, and fajita chicken. The bags were not labeled with an opened date. Observation of the kitchen further revealed a large three compartment sink located in the back of the kitchen. Further observation of the Polvinyl Chloride (PVC) pipes that were located underneath the 3 compartment sink revealed the pipes had a large amount of old grime and dust on them. The area containing the pipes was open and the PVC pipes were exposed for viewing. There was also a second three compartment sink that was located in the kitchen and next to the large dishwashing machine. There was a buildup of dust and grime on the flooring underneath the sink. Further observation of the area revealed approximately four to five long screws, a small packet of salt, and a black ring type object that were located in a pile of broken pieces of dirt and grime. S11Dietary Manager confirmed the kitchen needed to be cleaned, all opened food items should be labeled with an opened date, and employee personal items should not be stored in the kitchen. On 07/29/2024 at 9:41 a.m., after touring and observing the kitchen with S1Administrator and S12Maintenance Supervisor, they confirmed the kitchen needed to be cleaned. On 07/31/2024 at 5:00 p.m., S3Corporate Administrator was notified of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 18118 Based on observations and interviews, the facility failed to maintain all mechanical equipment in safe operating condition by having: 1.) a microwave in the secured unit that contained rust and 2.) a deep fryer located in the kitchen that contained dust and grime. Findings: 1.) On 07/29/2024 at 9:20 a.m., an observation of the secured unit revealed a microwave was located in a cabinet in the day room and exposed rust was observed on the inside of the microwave. On 07/29/2024 at 2:30 p.m., an interview with S7Certifiied Nursing Assistant (CNA) that worked in the secured unit revealed that she used the microwave to reheat the residents' food when needed. On 07/30/2024 at 8:54 a.m., S2Director of Nursing (DON) observed the microwave with the surveyor and confirmed that the inside of the microwave contained rust and needed to be replaced. 32231 2.) On 07/29/2024 at 8:30 a.m., an observation revealed a large deep fryer centrally located in the kitchen. The fryer had a lower compartment that housed the gas piping system. Observation of the inner compartment revealed there was a buildup of dust and grime on a portion of the pipes. On 07/29/2024 at 8:41 a.m., S1Administrator and S12Maintenance Supervisor were notified of the dust and grime buildup on the pipes of the fryer. After an observation of the deep fryer, S1Administrator and S12Maintenance Supervisor confirmed the deep fryer was not in safe working condition and needed to be cleaned. On 07/31/2024 at 5:00 p.m., S5Corporate Administrator was notified of above findings.