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	08/20/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 2 (#12 and #45) of 2 residents reviewed for environment, and by having an area in the kitchen that was in need of repair. The failed practice was evidenced by having an air conditioner and a wheelchair that was in need of repair, and by having a part of the wall missing in the kitchen behind the three-compartment sink.Findings: On 08/18/2025 at 8:06 a.m., an initial tour of kitchen was conducted. Observation of the three compartment sink area revealed the wall behind the three compartment sink area was in need of repair. The wall tile above the three compartment sink was loose and there was a large hole in the wall beneath the three compartment sink. On 08/18/2025 at 8:10 a.m. an interview and observation with S4Dietary Manager confirmed the wall behind the three compartment sink was in need of repair. Resident #12 On 08/18/2025 at 1:32 p.m., and 08/19/2025 at 8:20 a.m., observations of Resident #12's air conditioning unit revealed the unit was missing the air diverting grill and needed to be repaired. On 08/19/2025 at 9:10 a.m., an observation of Resident #12's air conditioning unit with S4Maintenance Director confirmed the air diverting grill was missing and needed to be repaired. Resident #45 On 08/18/2025 at 12:44 p.m., an observation of Resident #45's wheelchair revealed the bilateral arm rests were cracked, and foam was exposed. On 08/19/2025 at 9:30 a.m. observation of Resident #45's wheelchair with S6Assistant Director of Nursing (ADON) confirmed the arm rests were cracked with foam exposed and the armrests needed to be replaced.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure an accurate assessment was completed for 3 (#2, #4, and #8) of 3 (#2, #4, and #8) residents reviewed for physical restraints. The failed practice was evidenced by Residents #4 and #8 having an inaccurate assessment related to the use of bed rails. Resident #2 had an an inaccurate assessment related to the use of bed rails and a pommel cushion. Findings: Resident #2 On 08/18/2025 at 9:00 a.m. and 08/19/2025 at 8:15 a.m., Resident #2 was observed lying in bed with bilateral 1/4 bed rails in the upright position. On 08/19/2025 at 9:50 a.m., Resident #2 was observed sitting in a high back manual wheelchair. There was a pommel cushion noted in the seat of the wheelchair. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus without complications, muscle wasting and atrophy, osteoarthritis left hip, abnormalities of gait and mobility, need assistance with personal care, generalized muscle weakness, end stage renal disease, dependence on renal dialysis, paroxysmal atrial fibrillation, and pain left hip. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9 which indicated Resident #2 had moderate cognitive impairment for daily decision making. Further review revealed in section P (Restraints and Alarms), that Resident #2 had bed rails used daily as a physical restraint and other used daily in chair or out of bed as a physical restraint. Review of the August 2025 Physician Orders revealed the following active orders: Bilateral 1/4 side rails up x 2 to assist with bed mobility related to muscle weakness and osteoarthritis to left hip. Pommel cushion to wheelchair to improve posture and prevent from sliding forward. On 08/19/2025 at 2:25 p.m. an interview with S2Director of Nursing (DON) revealed Resident #2's bilateral 1/4 bed rails are used to assist Resident #2 with bed mobility. S2DON revealed Resident #2 had a pommel cushion in the seat of his wheel chair to improve posture and prevent him from sliding forward. S2DON revealed Resident #2 had part of his left hip removed and was not able to transfer or walk on his own. S2DON was informed the bed rails and the pommel cushion was coded as a physical restraint and she confirmed that was an inaccurate assessment. On 08/19/2025 at 2:30 p.m. S5MDS Coordinator revealed she coded the use of bed rails and the pommel cushion as a restraint in error. Resident #8 On 08/19/2025 at 8:05 a.m., Resident #8 was observed lying in bed with bilateral 1/4 bed rails in the up position. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, type 2 diabetes mellitus, atrial fibrillation, chronic systolic heart failure, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypertension, anemia, generalized muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility, other lack of coordination, and primary generalized osteoarthritis. Review of quarterly MDS assessment dated [DATE] revealed BIMS score of 6 which indicated Resident #8 was severely cognitively impaired for daily decision making. Further review revealed in section P (Restraints and Alarms), that Resident #8 had bed rails used daily as a physical restraint. Review of the August 2025 Physician Orders revealed the following active order: Bilateral 1/4 side rails up x 2 to assist with bed mobility related to muscle weakness. On 08/19/2025 at 3:10 p.m., an interview with S2DON revealed Resident #8's bilateral 1/4 bed rails were used to assist with bed mobility. S2DON was informed the bed rails was coded as a physical restraint and she confirmed that was an inaccurate assessment. On 08/19/2025 at 3:15 p.m., an interview with S5MDS Coordinator revealed she coded the use of bed rails as a restraint in error. Resident #4 On 08/18/2025 at 11:52 a.m., Resident #4 was observed in bed with left side bed rail in the up position. On 08/19/2025 8:11 a.m., Resident #4 was observed in bed with left side bed rail in the up position. Review of quarterly MDS assessment dated [DATE] revealed in section P, (Restraints and Alarms) that Resident #4 had bed rails used daily as a physical restraint. Review of August 2025 orders revealed the following active order: Bed against wall for increased room mobility with left quarter bed rails up times one to aid in bed mobility secondary to muscle weakness. On 08/19/2025 12:58 p.m., an observation interview was conducted with S2DON in Resident #4`s room. S2DON reported the left upper bed rail was used only as an assistive device used to reposition. S2DON was informed the bed rail was coded as a physical restraint and she confirmed that was an inaccurate assessment. On 08/19/2025 2:29 p.m., an interview with S5MDS Coordinator revealed she coded the use of bed rails as a restraint in error.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's needs by not having documentation of meal percentage intakes for 1 (#55) of 3 (#2, #47 and #55) residents reviewed for nutrition. Findings: Review of the medical record for Resident #55 revealed an admission date of 08/02/2024. Resident #55 had diagnoses that included psychosis, muscle weakness, lack of coordination, anxiety, dysphagia, depression, and abnormal weight loss.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55's Brief Interview for Mental Status (BIMS) score was 13 which indicated intact cognition for daily decision making. Further review of the MDS revealed the resident required setup assistance for eating, and Resident #55 had malnutrition and weight loss. Review of the current care plan revealed Resident #55 was at risk for weight loss related to poor appetite, monitor and record meal intake, and to administer medications as ordered. Further review of the care plan revealed the Certified Nursing Assistants (CNAs) were responsible for documenting the meal percentage intakes.Review of the medical record revealed no documented evidence of meal percentage intakes documented daily for July 2025. Further review of the record revealed no documented evidence of meal intake percentages documented for August 1, 2025 - August 14, 2025, August 18, 2025, August 19, 2025, and August 20, 2025.On 8/20/2025 at 10:15 a.m., interview with S8CNA whom worked with Resident #55 on 08/20/2025, revealed she had not documented meal intake percentages for Resident #55. On 08/20/2025 at 12:45 p.m., interview with S2Director of Nursing (DON) confirmed the CNAs were responsible for documenting meal intake percentages for Resident #55. Further interview with S2DON revealed there was no documentation of meal percentage intakes daily for Resident #55 for the month of July 2025 and the days listed above in August 2025.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews the facility failed to ensure each resident environment remains as free of accident hazards as is possible for 1 (#36) of 4 (#8, #10, #33, #36) residents reviewed for accident hazards. The facility failed to ensure the water temperature in Resident #36's bathroom was not greater than 120 degrees Fahrenheit. Findings:On 08/18/2025 at 10:45 a.m., an observation of Resident #36's bathroom sink revealed the water felt hot to surveyor touch. On 08/18/2025 at 11:13 a.m., an observation of S4Maintenance Director's check of the hot water temperature in Resident #36's bathroom sink revealed the temperature was 121 degrees Fahrenheit. Surveyor then checked the hot water temperature using his own thermometer revealed the temperature was 123.4 degrees Fahrenheit. S4Maintenance Director confirmed the water temperature in Resident #36's bathroom sink was greater than 120 degrees Fahrenheit. On 08/19/2025 at 4:30 p.m., S1Administrator was informed of hot water temperature greater than 120 degree in Resident #36's bathroom sink. S1Administrator confirmed the hot water in Resident #36's sink should not exceed 120 degrees.

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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. Based on observation and record review the facility failed to provide care and services that is in accordance with physician's orders and facility policy for 1 (#35) of 1 resident reviewed for respiratory care by not ensuring the nebulizer and tubing were changed weekly. Findings:Review of the facility's policy and procedure on administering medications through a small volume (handheld) nebulizer dated October 2010 revealed the following:Steps in the procedure:30. Change equipment and tubing every seven days. Review of Resident #35's medical record revealed an admission date of 04/14/2025 with diagnoses that include hypertensive heart disease with heart failure, wheezing, and other specified diseases of upper respiratory tract. On 08/18/2025 at 9:25 a.m. and 08/19/2025 at 8:27 a.m., observations of Resident #35's room revealed nebulizer and tubing were being stored on bedside table in a bag dated 08/04. Further observation revealed that the nebulizer and tubing were not dated. On 08/19/2025 at 9:30 a.m., a record review of Resident #35's active August 2025 physician orders revealed an order to change nebulizer tubing every week on Thursdays. On 08/19/2025 at 9:50 a.m., an observation of Resident #35's nebulizer with S2Director of Nursing (DON) confirmed that the nebulizer and tubing were stored in a bag dated 08/04 and that the nebulizer and tubing were not dated.