STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195398	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Carroll Care Center, Inc	706 Ross Street Oak Grove, LA 71263

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observations, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 1 (#22) of 1 resident sampled for urinary catheter. The facility failed to document intake and output records, document character and consistency of urine daily, and report unusual appearance of urine/signs and symptoms of a urinary tract infection to the Director of Nursing (DON) and physician immediately for Resident #22.Findings:Review of the facility's undated Catheter Care, Urinary policy and procedure revealed the following, in part:PurposeThe purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.Complications1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately:b. if urine has unusual appearance (example color, blood),e. if signs and symptoms of urinary tract infection or urinary retention occur. Review of Resident #22's record revealed an admission date of 03/31/2022 with diagnoses including urinary tract infection, obstructive and reflux uropathy, unspecified disorder of prostate, and chronic kidney disease stage 3.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Further review of the MDS revealed obstructive uropathy, renal insufficiency, and indwelling urinary catheter were marked, and resident required setup or clean up assistance with toileting.An observation on 08/12/2025 at 10:03 a.m. of Resident #22 revealed the urine in the resident's urinary catheter tubing was cloudy with sediment present.An observation on 08/13/2025 at 8:30 a.m. of Resident #22 revealed the urine in the resident's urinary catheter tubing was blood tinged and cloudy with sediment present.An interview on 08/13/2025 at 8:20 a.m. with S4Certified Nursing Assistant (CNA) revealed she provided catheter care to Resident #22 every shift. S4CNA reported she emptied the resident's catheter every shift but only documented his output sometimes.An interview on 08/13/2025 at 8:25 a.m. with S4Licensed Practical Nurse (LPN) revealed Resident #22 had a urinary catheter. S4LPN reported she has not documented the color, clarity, and consistency of Resident #22's urine. An observation with S4LPN on 08/13/2025 at 8:35 a.m. of Resident #22's catheter tubing revealed his urine was blood-tinged and cloudy with sediment present. S4LPN confirmed that the resident's urine was blood-tinged and cloudy with sediment present. Review of the August 2025 Physician's Orders revealed an order dated 09/27/2024 for intake every shift, serve estimated fluid needs every day (1919 cubic centimeters). Further review of the physician's orders revealed no order for monitoring of urine every shift. Review of the record for Resident #22 revealed no documented evidence of monitoring for consistency, color, clarity of urine on the July or August 2025 Medication Administration Records (MAR) or Treatment Administration Records (TAR).Review of Resident #22's current care plan revealed the resident had an indwelling catheter related to obstructive and reflux uropathy and an unspecified disorder of prostate. The interventions included: check tubing for kinks each shift, monitor and document intake and output as per facility policy, monitor for signs and symptoms of discomfort on urination and frequency.Review of Resident #22's nurses notes for July (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and August 2025 revealed the staff failed to document the quality and character of resident's urine daily.Review of Resident #22's record revealed no documentation in the electronic health record notifying the Director of Nursing (DON) or physician regarding the unusual appearance of urine for Resident #22 on 08/12/2025 and 08/13/2025 after observations on 08/12/2025 and 08/13/2025 revealed Resident #22's urine had an unusual appearance. Further review of the record revealed the nurses failed to notify the DON and physician immediately with unusual appearance of urine as per policy.An interview on 08/13/2025 at 10:40 a.m. with S2DON revealed Resident #22 had a urinary catheter on admission. S2DON reported that Resident #22 has had abnormal urine such as blood-tinged and cloudy with sediment present frequently and the nurse practitioner was aware of this. S2DON reported the nurse documents on the character of Resident #22's urine weekly, not daily. An interview on 08/13/2025 at 2:00 p.m. with S2DON confirmed that the facility documents on Resident #22's urine weekly and failed to notify the physician or supervisor immediately of unusual appearance of urine and signs and symptoms of urinary tract infections for Resident #22 as per the facility's policy. S2DON further confirmed the facility failed to document Resident #22's intake and output as per the physician's order.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observations, the facility failed to ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible for 1 (#47) of 4 (#3, #6, #35, and #47) residents sampled for nutrition. The facility failed to document meal intake for each meal and update care plan with a significant weight loss for Resident #47. Findings:Review of facility's Weighing and Measuring the Resident policy and procedure, revised March 2011, revealed the following, in part:Reporting1.) Report significant weight loss/weight gain to the nurse supervisor.2.) The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria (where percentage of body weight loss = (usual weight-actual weight) divided by the usual weight and multiply by 100):a. 1 month-5% weight loss is significant; greater than 5% is severe.b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe.c. 6 months- 10% weight loss is significant; greater than 10% is severe. Review of Resident #47's record revealed an admission date of 08/02/2024 with diagnoses including unspecified dementia unspecified severity with other behavioral disturbance, urinary tract infection, anorexia, hypertensive heart disease without heart failure, hyperlipidemia, major depressive disorder, and gastro-esophageal reflux disease without esophagitis.Review of Resident #47's Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment. Further review of the MDS revealed resident required substantial/maximal assistance with eating and weight loss was marked.Review of Resident #22's August 2025 Physician's Orders revealed an order dated 10/01/2024 for a regular diet, regular texture, with regular/thin consistency. Further review of the physician's order revealed no orders for supplements or appetite stimulants ordered for this resident.Review of Resident #47's weights revealed a weight of 119.1 pounds on 01/06/2025, a weight of 107.0 pounds for 06/2025 and a weight of 107 for 7/08/2025, indicating a weight loss of 10.16% in a 6-month period.Review of Resident #47's current care plan revealed the resident had the potential for a nutritional problem related to vitamin deficiency. Further review of the care plan revealed interventions included: administer medications as ordered, monitor/document for side effects and effectiveness, allow me ample time to consume food, provide assistance as needed, cueing, and/or feeding assist, ask family/significant other about my food preferences, dietary noted weight loss, Director of Nursing (DON) noted the family happy with the resident's weight and physician aware, dietician to evaluate and follow up annually and as needed, encourage me to dine in dining room for meals to encourage socialization, monitor food intake at each meal and record and report any decline to physician and dietician, observe and document my nutritional status every month and report any negative trends to physician, obtain lab work as ordered by physician. Report results to physician when available, promptly offer me food alternatives when appropriate for any meal served, provide, and serve diet as ordered, monitor intake and record every meal.An observation of Resident #47 on 08/11/2025 at 11:40 a.m. revealed the resident was being fed lunch by S5CNA in the dining room. The lunch meal included fried pork chop, pinto beans, greens, cornbread, chocolate pie, and tea, and her meal card revealed resident was on a regular diet. S5CNA confirmed that Resident #47 does not eat at times.Observation on 08/12/2025 at 11:45 a.m. revealed Resident #47 was being fed lunch in the dining room by S5CNA. Resident's meal consisted of meatloaf, mashed potatoes, roll, peas, tea, water and lemon pie, Resident #47 ate about 50-75% of her lunch meal. Interview on 08/12/2025 at 1:30 p.m. with S2DON revealed Resident #47 had a history of weight loss, but resident's daughter refused an appetite stimulant back in January 2025. S2DON reported resident's daughter has been pleased with resident's weight loss and does not want the resident on an appetite stimulant or supplement. S2DON confirmed Resident #47's care plan was not updated for the resident's significant weight loss in July 2025. S2DON confirmed resident #47 did not have any (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplements or appetite stimulants ordered.Review of Resident #47's record revealed no documented evidence of meal intake documented with each meal for July and August 2025.An interview on 08/13/2025 at 8:35 a.m. with S3Licensed Practical Nurse (LPN)/MDS Coordinator revealed she was unable to provide surveyor with the individual meal intake of each meal for Resident #47 for July and August 2025.An interview on 08/13/2025 at 2:00 p.m. with S2DON confirmed the facility failed to document meal intake for each meal for Resident #47 for July and August 2025 and failed to update Resident #47's care plan with weight loss for July 2025.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observations, the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (#6) of 1 resident sampled for dialysis. The facility failed to document intake and output records as specified in plan of care for Resident #6.Findings:Review of the record for Resident #6 revealed an admission date of 06/16/2025 with diagnoses that included end stage renal disease, edema, hypertensive heart disease with heart failure, and type 2 diabetes mellitus with chronic kidney disease.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 15 which indicated the resident is cognitively intact for daily decision making. The MDS also documented that the resident required dialysis.Review of the August 2025 Physician's Orders revealed an order to document intake every shift and serve estimated fluid needs daily. There was no order noted to document output. The active plan of care that addressed Resident #6's end stage renal disease and need for dialysis included interventions for nursing staff to monitor intake and output. Review of the intake and output record revealed that no intakes were documented for 14 days from 07/01/2025-08/11/2025. There were no outputs documented from 07/01/2025-08/11/2025.On 08/12/2025 at 9:55 a.m., an interview was conducted with S6Certified Nursing Assistant (CNA) who voiced that CNA staff were responsible for documenting intake and output. S6CNA also confirmed that Resident #6 produced a small amount of urine outputs and the outputs were to be documented in the resident's record.On 08/13/2025 at 12:49 p.m., an interview was conducted with S4Licensed Practical Nurse (LPN) who voiced that CNA staff were responsible for documenting intake and output. S4LPN also confirmed that Resident #6 produced a small amount of urine. On 08/13/2025 at 1:59 p.m., an interview was conducted with S2Director of Nursing (DON) related to the documentation of intake and output. S2DON confirmed that the intake and output had not been documented as specified in the plan of care and provided no other documentation for review.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure there was sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services. The facility had excessively low weekend staff during Fiscal Year Quarter 2 2025 dated 01/01/2025 to 03/31/2025. Findings:Review of the facility's Payroll-Based Journal (PB&J) Staffing Report revealed the facility triggered excessively low weekend staff for Fiscal Year Quarter 2 2025 dated 01/01/2025 to 03/31/2025. Review of the facility's February 2025 weekend personnel staffing pattern revealed insufficient staff for the following date: 02/16/2025.Review of the facility's March 2025 weekend personnel staffing pattern revealed insufficient staff for the following dates: 03/08/2025 and 03/23/2025. An interview on 08/12/2025 at 11:25 a.m. with S1Administrator confirmed the facility had low staffing for the dates listed above and did not meet the required hours.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the pharmacist failed to identify and report irregularities to the physician and DON (Director of Nursing) for 1(#39) of 5 (#1, #2, #38, #39, #47) residents reviewed for unnecessary medications. The pharmacist failed identify irregularities for Resident #39. Resident #39 was not being monitored for signs and symptoms of bleeding while receiving an anticoagulant medication.Findings: Record review revealed Resident # 39 was admitted to the facility on [DATE]. Resident #39's diagnoses included the following: hypertensive heart disease without heart failure, abnormal findings on diagnostic imaging of heart and coronary circulation, long term use of anticoagulants, type 2 diabetes mellitus unspecified dementia, unspecified severity, with other behavioral disturbance, chronic kidney disease stage 3, and hypothyroidism. Review of active August 2025 Physician Orders revealed Coumadin 4 milligrams (mg) tablet give1 tablet by mouth (po) at bedtime every Monday, Wednesday, and Friday. Coumadin 5 mg tablet give 1 tablet po every Tuesday, Thursday, Saturday, and Sunday. Coumadin is an anticoagulant medication. Review of the Electronic Medication Administration Record (EMAR) August 2024 through August 2025 revealed documentation Resident #39 received Coumadin as ordered by the physician. Further review of the EMARs revealed there was no documentation Resident #39 was monitored daily for signs and symptoms of bleeding while receiving Coumadin. Review of the current care plans revealed Resident #39 received anticoagulant therapy (Coumadin). Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date.Interventions included the following:Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift.Bleeding precautions every shift.Monitor/document/report as needed (PRN) adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review of the Monthly Medication Regimen Reviews from August 2024 through August 2025 for Resident #39 revealed the consultant pharmacist failed to identify the facility was not monitoring Resident #39 for signs and symptoms of bleeding while receiving Coumadin. Further review revealed the consultant pharmacist did not make any recommendations to the Physician and Director of Nursing (DON) that Resident #39 needed to be monitored for signs and symptoms of bleeding while receiving Coumadin. On 08/13/2025 at 1:30 p.m., an interview with S2DON revealed Resident #39 has been receiving Coumadin since being admitted to the facility in August 2024. S2DON confirmed there was no documentation Resident #39 was being monitored for signs and symptoms of bleeding while receiving Coumadin. S2DON further confirmed Resident #39 should have been monitored for signs and symptoms of bleeding every shift while receiving Coumadin. 08/13/2025 1:32 PM an interview with S2DON confirmed the consultant pharmacist failed to identify that the facility was not monitoring Resident #39 for bruising or bleeding while receiving Coumadin.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that each resident was free from unnecessary medication use for 1 (#39) of 5 (#1, #2, #38, #39, #47) residents reviewed for unnecessary medications. The facility failed to monitor Resident #39 for signs and symptoms of bleeding while receiving an anticoagulant medication.Findings:Record review revealed Resident # 39 was admitted to the facility on [DATE]. Resident #39's diagnoses included the following: hypertensive heart disease without heart failure, abnormal findings on diagnostic imaging of heart and coronary circulation, long term use of anticoagulants, type 2 diabetes mellitus unspecified dementia, unspecified severity, with other behavioral disturbance, chronic kidney disease stage 3, and hypothyroidism. Review of active August 2025 Physician Orders revealed Coumadin 4 milligrams (mg) tablet give1 tablet by mouth (po) at bedtime every Monday, Wednesday, and Friday. Coumadin 5 mg tablet give 1 tablet po every Tuesday, Thursday, Saturday, and Sunday. Coumadin is an anticoagulant medication. Review of the Electronic Medication Administration Record (EMAR) August 2024 through August 2025 revealed documentation Resident #39 received Coumadin as ordered by the physician. Further review of the EMARs revealed there was no documentation Resident #39 was monitored daily for signs and symptoms of bleeding while receiving Coumadin. Review of the current care plans revealed Resident #39 received anticoagulant therapy (Coumadin). Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date.Interventions included the following:Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift.Bleeding precautions every shift.Monitor/document/report as needed (PRN) adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. On 08/13/2025 at 1:30 p.m., an interview with S2Director of Nursing (DON) revealed Resident #39 has been receiving Coumadin since being admitted to the facility in August 2024. S2DON confirmed there was no documentation Resident #39 was being monitored for signs and symptoms of bleeding while receiving Coumadin. S2DON further confirmed Resident #39 should have been monitored for signs and symptoms of bleeding every shift while receiving Coumadin.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 (# 45) of 1 sampled residents reviewed for environmental concerns. The facility failed to ensure that the resident's air conditioning vent remained clean and free of mold like substance.Findings:Review of Resident #45's record revealed an admit date of 09/30/2021 with diagnoses including cerebral infarction, unspecified; allergic rhinitis, unspecified; shortness of breath; and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.On 08/11/2025 at 9:45 a.m. and 08/12/2025 at 8:25 a.m., observations of Resident #45's air conditioner revealed a mold like substance on the surface of the vent.On 08/12/2025 at 8:50 a.m., an observation made with S1Administrator confirmed the presence of a mold like substance on Resident #45's air conditioner vent.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to electronically transmit encoded, accurate and complete Minimum Data Set (MDS) data to Centers for Medicare and Medicaid (CMS) in a timely manner for 1 (#43) of 2 (#11, #43) residents reviewed for the completion of a seven day discharge assessment. Findings:Record review revealed Resident #43 was admitted to the facility on [DATE] and discharged on [DATE]. The last transmitted MDS assessment in the electronic health record was a Quarterly and State Optional-Other assessment completed on [DATE] in the batch accepted on [DATE].On [DATE] at 12:55 p.m. an interview with S3Licensed Practical Nurse (LPN)/MDS nurse revealed she failed to complete and transmit the discharge MDS assessment for Resident #43. S3LPN/MDS nurse reported Resident #43 expired at facility on [DATE] and should have submitted the MDS discharge assessment to the state by [DATE] within 7 days of discharge.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 1 (#71) of 1 (#71) resident reviewed for respiratory care. The facility failed to ensure Resident #71's nebulizer tubing and t-piece was properly stored in a plastic bag.Findings:Review of the facility's Administering Medications through a Small Volume (Handheld) Nebulizer policy dated August 2025 revealed in-part: 18. When the treatment is complete, turn off nebulizer and store in a plastic bag with the resident's name and date on it. On 08/11/2025 at 9:50 a.m. and 08/12/2025 at 8:20 a.m., observations of Resident #71's room revealed the nebulizer tubing and t-piece was dated 08/10/2025 and secured to a nebulizer machine sitting on dresser. The nebulizer tubing and t-piece was not stored in a plastic bag. Resident #71 reported she received breathing treatments several times daily. Record review revealed Resident #71 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #71's diagnoses included chronic obstructive pulmonary disease, shortness of breath, cough, wheezing, generalized epilepsy, anemia, chronic pain. Review of the active August 2025 Physician Orders revealed the following: Albuterol Sulfate inhalation nebulization solution (2.5 milligrams (mg)/3 milliliters (ml) 0.083% inhale 1 vial orally via nebulizer every 4 hours as needed for cough. May leave neb at bedside (order date 07/29/2025).Monitor Nebulizer (Neb) tubing and setup every (q) shift for proper storage q shift (order date 07/30/2025). Review of the August 2025 Electronic Medication Administration Record (EMAR) revealed documentation Resident #71 received Albuterol sulfate 2.5 mg/3ml 1 vial per nebulizer on 08/04/2025 at 8:52 a.m. and 6:52 p.m. and on 08/09/2025 at 6:35 p.m.Further review of the August 2025 EMAR revealed documentation of the monitoring Neb tubing and setup q shift for proper storage every shift was signed off by the nurses 08/01/2025 through the day shift on 08/12/2025. On 08/12/2025 at 11:15 a.m. an observation of Resident #71's room with S2Director of Nursing (DON) revealed the nebulizer tubing and t-piece was secured to the nebulizer machine that was sitting on the dresser. The nebulizer tubing and t-piece was not stored in a plastic bag. S2DON confirmed the nebulizer tubing and t-piece should be stored in a plastic bag.