STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195399	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jena Nursing and Rehabilitation Center, LLC	5877 Aimwell Road Jena, LA 71342

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the physician was notified of a change in condition for 1 (#3) of 4 sampled residents when Resident #3 experienced severe pain but no pain medication was available to administer. This deficient practice resulted in an actual harm on 04/02/2026 at 6:23 p.m. when Resident #3 was admitted with a diagnosis of ORIF to both Left Femur and Right Wrist on 03/25/2026. admission orders included Hydrocodone 10/325mg by mouth every 6 hours as needed for pain. At that time Resident #3 complained of leg pain at a level of 6 out of 10, indicating severe pain per facility parameters, and was unable to receive any pain medication because the facility had not acquired her pain medication from the pharmacy. The nurse caring for Resident #3 failed to notify the physician that pain medication was unavailable for Resident #3.Findings:Review of a facility policy titled Notification of a Change in A Resident's Status dated 11/07, revealed in part:Policy: The attending physician/physicians extender (Nurse Practitioner) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations. Responsibility: All Licensed Nursing PersonnelProcedure:1. Guideline for notification of physician/responsible party (not all inclusive):j. Abnormal complaints of pain, ineffective relief of pain from current regimen Review of Resident #3's medical record revealed an admit date of 04/02/2026 with diagnoses that included in part.Pain, Generalized Anxiety Disorder, Fracture of lower end of Left Femur and Fracture of Right Wrist S/P ORIF on 03/25/2026, Hypertension, Morbid obesity.Review of Resident #3's 5 day MDS with an ARD of 04/09/2026 revealed Resident #3 had a BIMS score of 15 (which indicated intact cognition) and was coded as requiring set up or clean-up assistance with eating, dependent for toileting, substantial/maximal assistance with shower/bath, and turning/repositioning. Further review revealed Resident #3 had lower extremity impairment on one side. Further review, Resident #3 had the presence of pain, pain intensity rating scale of 10,worst pain you can imagine, at the time of assessment and received PRN pain medications.Review of Resident #3's Care Plan with a target date of 07/19/2026 revealed the resident has a Potential for Alteration in Comfort related to Femur fracture, Coronary Artery Disease, Hypertension, Hyperlipidemia, Obesity, Anxiety, Hypokalemia, and a history of Edema, with interventions that included: Anticipate the resident's need for pain relief, Medications as ordered, Notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain, reposition PRN for comfort.Review of Resident #3's 04/2026 Physician's Orders revealed in part.Hydrocodone-Acetaminophen Oral Tablet 10-325 Milligram-Give 1 tablet by mouth every 6 hours as needed for pain (start date 04/02/2026), Tylenol Oral Capsule 325 MG Give 2 tablets by mouth every 6 hours as need for Pain unspecified (start date 04/03/2026).Review of a Nursing Progress note dated 04/02/2026 at 6:23 p.m. read in part.Resident arrived to facility via ambulance service via stretcher in stable condition from hospital with diagnoses: S/P ORIF (Open Reduction and Internal Fixation-a surgical procedure) to both Left Femur and Right Wrist on 03/25/2026. Resident notes to have pain 6/10.During an interview on 05/05/2026 at 10:44 a.m. Resident #3 revealed she arrived at the facility via ambulance on 04/02/2026 between (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 0580 Level of Harm - Actual harm Residents Affected - Few	6:00-6:30 p.m. and was hurting pretty bad. Resident #3 revealed she had surgery to her wrist and leg and had pain daily and received pain medication every six hours as needed. Resident #3 revealed upon admission into the facility she went a whole day without receiving her pain medication. Resident #3 revealed when she asked S3 LPN for pain medication, she was informed it had not arrived. Resident #3 revealed she had been hurting so badly the night of admission that she cried. Resident #3 stated her pain was 10 out of 10. Resident #3 revealed she was not offered any other pain medication such as Tylenol and was unable to recall if she had asked.During an interview on 05/06/2026 at 2:04 p.m. with S3 LPN revealed Resident #3 arrived to the facility by ambulance from the hospital on [DATE] between 6:00-6:30 p.m. S3 LPN revealed Resident #3 had a fractured Left Femur and Right Wrist which required surgical intervention. S3 LPN revealed Resident #3 had pain 6/10 on a pain scale of 1-10 upon arrival to the facility. S3 LPN further revealed Resident #3 continued to complain of pain to left leg and she provided comfort measures of repositioning and pillows, which did not relieve Resident #3's pain. S3 LPN confirmed she did not call Resident #3's physician to report Resident #3 had pain, but should have.During a telephone interview on 05/07/2026 at 10:27 a.m. S9 NP revealed he had not been notified of Resident #3's pain. S9 NP stated if had been notified, he would have ordered pain medication such as Tylenol to be administered until pain medications were available.During an interview on 05/11/2026 at 8:24 a.m. S1 Administrator, S2 Corporate Nurse and S4 DON confirmed the physician was not notified of Resident #3's pain but should have been.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to make a prompt effort to resolve grievances filed by a resident's representative, for 1 (Resident #3) of 4 sampled residents. Findings:Review of the facility's policy titled Grievances/Missing Property, with a review date of 08/2017, revealed in part.Policy: Residents and resident representatives have the right to voice concerns or grievances, which affect their lives at this facility, without fear or discrimination or reprisal.Purpose: To provide an opportunity for residents, resident representatives, and/or family to present concerns or grievances of the proper authorities at the facility and to receive responses to the issues raised.Responsibility: All staff, monitored by Department Heads, Executive Director and Grievance Official.Section 504 Grievance Procedure:1. A grievance is to be in writing on the Grievance Form, contain the name and address of the person filing it, and briefly describe the action alleged to be prohibited by the regulations.3. The Coordinator, or his/her designee, shall conduct such investigation of a grievance as may be appropriate to determine its validity. The investigation shall afford all interested persons and their representatives, if any, an opportunity to submit evidence related to the grievance.Review of Resident #3's medical record revealed an admit date of 04/02/2026 with diagnoses that included in part.Pain, Generalized Anxiety Disorder, Fracture of lower end of Left Femur, Hypertension, Morbid obesity, and Fracture of Right Wrist.Review of Resident #3's 5 day MDS with an ARD of 04/09/2025 revealed Resident #3 had a BIMS score of 15 (which indicated intact cognition), and the resident understands and has the ability to understand others. The MDS revealed Resident #3 was coded as requiring set up or clean-up assistance with eating, dependent for toileting, substantial/maximal assistance with shower/bath, and turning/repositioning. The MDS revealed Resident #3 had lower extremity impairment on one side. The MDS revealed Resident #3 had the presence of pain, pain intensity rating scale =10 at the time of assessment and received PRN pain medications.Interview with Resident #3 on 05/05/2026 at 10:48 a.m. revealed when she admitted to the facility on [DATE], she didn't have any pain medications available for almost 24 hours, had been served raw chicken and had been spoken to rudely by S5 LPN. Resident #3 stated she had told her daughter about these issues.Telephone interview on 05/05/2026 at 3:29 p.m. with Resident #3's daughter stated the following: Her mother had been admitted to the facility on [DATE] with a broken leg and wrist and did not receive pain medication until the afternoon of 04/03/2026; Resident #3 had been served raw chicken; S5 LPN had spoken rudely to Resident #3; and Resident #3's hair was not being washed. Resident #3's daughter stated she had complained to S4 DON a few days after Resident #3 was admitted (couldn't recall exact date) about the above issues and again on 04/17/2026 related to S5 LPN speaking rudely to Resident #3, and about Resident #3's hair not being washed. Resident #3's daughter stated S4 DON told her to be patient.Interview on 05/11/2026 at 8:20 a.m. with S4 DON revealed she had spoken to Resident #3's daughter on 2 separate occasions on the phone. S4 DON stated Resident #3's daughter had concerns related to Resident #3 wanted her hair washed more frequently, undercooked chicken, S5 LPN speaking to Resident #3 rudely, and Resident #3's pain medications not being available upon admission. S4 DON revealed she did speak to Resident #3's daughter a second time over the phone on 04/17/2026 but couldn't understand what she was saying because of the poor phone connection.Interview on 05/11/2026 at 8:24 a.m. with S1 Administrator, S2 Corporate Nurse, and S4 DON revealed S1 Administrator was the Grievance Official. S1 Administrator revealed the above mentioned complaints from Resident #3's daughter were not brought to her attention. S4 DON confirmed she did not do a grievance on the above mentioned complaints from Resident #3's daughter because she thought she had taken care of the issues. S4 DON confirmed Resident #3's daughter had complained a second time on 04/17/2026 and she had not followed up with Resident #3's daughter, but should have. S1 Administrator confirmed a grievance should have been completed on the above mentioned complaints and had not been.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a copy of the written notice of discharge was sent to the Office of the State Long-Term Care Ombudsman for Resident 1 (#1) of 1 residents reviewed for facility-initiated discharge.Findings:Record review of the facility's undated policy regarding Subject: Discharge and Transfer Policy read in part.Procedure: 2. Documentation will be entered into the resident's medical records regarding the transfer/discharge reason(s) and the appropriate transfer/discharge information will be communicated to the receiving healthcare center, provider, resident and/or Resident Representative.a. Documentation includes: 14. Prior to resident being transferred or discharged , the facility must provide a written notice (B.3 (a) or State Required Form) to the resident, and if known, a family member or legal representative of the resident and the LTC ombudsman. This must be issued at least 30 days before the resident is transferred to discharge or as soon as practicable for immediate transfer or the resident has not resided in the facility for 30 days.Review of Resident #1's medical record revealed she was admitted on [DATE] with primary admission diagnosis of Acute and Chronic Respiratory Failure with hypoxia. Review of Resident #1's discharge summary indicated the resident was discharged on 03/23/2026.Review of Ombudsman Notification log for March 2026 failed to reveal that the Ombudsman was notified that Resident #1 was discharged from the facility. During an interview on 05/06/2026 10:46 a.m. with S10 LPN she stated, I have not done it at all, I have not reported discharges to the Ombudsman since August 2025. S10 LPN confirmed she was responsible for submitting the Notification log to the Ombudsman for the facility.In an interview on 05/06/2026 at 4:25 p.m., S1 Administrator confirmed, We don't provide 30-day notices to the Ombudsman. S1 Administrator acknowledged the facility had not provided documentation that the resident's discharge was reported to the Office of the State Long-Term Care Ombudsman as required.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, and the comprehensive person-centered care plan, for 1 (Resident #3) of 4 residents reviewed for pain.This deficient practice resulted in an actual harm for Resident #3 on 04/02/2026 at 6:23 p.m., when the resident was admitted with an order for Hydrocodone 10/325 MG every 6 hours as needed for pain, and did not receive any pain medication. Resident #3 had diagnoses of status post ORIF to Left Femur fracture on 03/25/2026 and, ORIF of Right Wrist fracture on 03/25/2026 and pain. Resident #3 who complained of leg pain that hurt so bad it caused her to cry, stated the facility had not acquired her pain medication from the pharmacy, and her pain level was 10 out of 10 on a pain scale, indicating very severe pain, during that time. Findings:Review of a facility policy titled Pain Management with a review date of 12/17/2023 revealed in part:Policy: The facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being .1. Evaluate the resident for pain upon admission and with change in condition or status .2. Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to .K. Sighing, groaning, crying, and breathing heavily .4. If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified.Review of Resident #3's medical record revealed an admit date of 04/02/2026 with diagnoses that included in part.Pain, Generalized Anxiety Disorder, Fracture of lower end of Left Femur and Fracture of Right Wrist both requiring surgical intervention on 03/25/2026, Hypertension, and Morbid Obesity. Review of Resident #3's 5 day MDS with an ARD of 04/09/2026 revealed Resident #3 had a BIMS score of 15 (which indicated intact cognition), and the resident understands and has the ability to understand others. The MDS revealed Resident #3 was coded as requiring set up or clean-up assistance with eating, dependent for toileting, substantial/maximal assistance with shower/bath, and turning/repositioning. The MDS revealed Resident #3 had lower extremity impairment on one side. The MDS revealed Resident #3 had the presence of pain, pain intensity rating scale =10, worst pain you can imagine, at the time of assessment and received PRN pain medications.Review of Resident #3's Care Plan with a target date of 07/19/2026 revealed the resident has a Potential for Alteration in Comfort related to Femur fracture, Coronary Artery Disease, Hypertension, Hyperlipidemia, Obesity, Anxiety, Hypokalemia, and a history of Edema, with interventions that included: Anticipate the resident's need for pain relief, Medications as ordered, Notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain, reposition PRN for comfort.Review of a Nursing Progress note dated 04/02/2026 at 6:23 p.m. read in part.Resident arrived to facility via ambulance service via stretcher in stable condition from hospital with diagnoses: S/P ORIF (Open Reduction and Internal Fixation-a surgical procedure) to both Left Femur and Right Wrist on 03/25/2026. Resident notes to have pain 6/10. Resident had a fall on 03/23/2026 (before admission into the facility). Resident is non-weight bearing. Resident #3 requested to be transferred to the hospital because of pain medication having not arrived from pharmacy, called ambulance services for transportation, resident made aware, also called after hours pharmacy and canceled request for medications to be filled.During an interview on 05/05/2026 at 10:44 a.m. Resident #3 revealed when she arrived at the facility via ambulance on 04/02/2026 between 6:00-6:30 p.m. she was hurting pretty bad. Resident stated she had a fall in late March 2026 and fractured her Right Wrist and Left Femur. Resident #3 revealed she had surgery to her wrist and leg and was non-weight bearing. Resident #3 revealed upon admission into the facility she went a whole day without her pain medication. Resident #3 revealed when she asked S3 LPN for pain medication, she was informed it had not arrived. Resident #3 revealed she had been hurting so badly she cried on her first night at the facility and asked to be sent to the hospital to receive pain medication. Resident #3 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	stated her pain was a 10 out of 10, during the night of 04/02/2026. Resident #3 revealed she was not offered nor administered any medications to manage her pain on the night of 04/02/2026. Review of Resident #3's 04/2026 Physician's Orders revealed in part.Hydrocodone-Acetaminophen Oral Tablet 10-325 Milligram-Give 1 tablet by mouth every 6 hours as needed for pain (start date 04/02/2026). Review of Resident #3's Medication Administration Record revealed in part.04/03/2026 at 1:27 p.m. Hydrocodone-Acetaminophen Oral Tablet 10-325 Milligram-Give 1 tablet by mouth every 6 hours as needed for pain. Pain level 8, very severe pain. Medication initialed as administered by S5 LPN. During an interview on 05/05/2026 at 10:50 a.m. S4 DON revealed Resident #3 had admitted to the facility with diagnoses of Left Femur Fracture and Right Wrist Fracture. S4 DON revealed Resident #3 was non-weight bearing and had staples to the Left Femur Fracture. S4 DON revealed while making rounds on 04/03/2026 between 6:00-6:30 a.m. Resident #3 had complained of Pain to her Wrist (unable to recall pain level). S4 DON revealed she had inquired with nursing staff regarding Resident #3's pain medication, but had not notified the physician of Resident #3's pain. During an interview on 05/06/2026 at 2:04 p.m. S3 LPN revealed Resident #3 arrived to the facility by ambulance from the hospital on [DATE] between 6:00-6:30 p.m. S3 LPN revealed Resident #3 had a fractured Left Femur and Right Wrist which required surgical interventions. S3 LPN revealed upon arrival Resident #3 had pain 6/10 on a pain scale of 1-10. S3 LPN stated Resident #3's pain medication had already been ordered from the pharmacy. S3 LPN revealed Resident #3 continued to complain of pain to left leg and she provided comfort measures of repositioning and pillows. S3 LPN revealed on 04/03/2026 at approximately 2:00 a.m. Resident #3 and her family requested to send her to the ER for pain medication. S3 LPN revealed she notified the ambulance to transport Resident #3 to the hospital. S3 LPN revealed when the ambulance arrived Resident #3 refused to go. S3 LPN confirmed she did not call Resident #3's physician to report Resident #3 had increased pain and had requested to go to the hospital for pain management, but should have.Telephone interview on 05/07/2026 at 9:47 a.m. with S6 CNA revealed she provided care for Resident #3 on 04/02/2026-04/03/2026 on the 7:00 p.m.-7:00 a.m. shift. S6 CNA stated when she arrived to work on 04/02/2026 at 7:00 p.m. and made rounds, Resident #3 was complaining of everything, but mainly of her leg hurting. S6 CNA revealed she observed S3 LPN attempting to make Resident #3 comfortable by repositioning and pillows, but she continued to complain of pain. S6 CNA revealed Resident #3 didn't want to be moved because she was hurting and had cried all night.Telephone interview on 05/07/2026 at 10:30 a.m. with S7 CNA revealed she provided care for Resident #3 on 04/03/2026 on the 7:00 a.m.-7:00 p.m. shift. S7 CNA revealed Resident #3 stated she was in a lot of pain, and she had staples in her leg. S7 CNA revealed Resident #3 had complained of not receiving her pain medication during the night. During an interview on 05/07/2026 at 2:45 p.m. S5 LPN revealed she provided care for Resident #3 on 04/03/2026 on the 7:00 a.m. to 7:00 p.m. shift. S5 LPN revealed she had received report on Resident #3 from the night nurse S3 LPN. S5 LPN revealed she was made aware of Resident #3's pain. Telephone interview on 05/07/2026 at 10:27 a.m. with S9 NP revealed he had not been notified of Resident #3's increased pain. S9 NP stated if he had been notified, he would have ordered pain medication such as Tylenol to be administered until her pain medications were available.During an interview on 05/11/2026 at 8:24 a.m. S1 Administrator, S2 Corporate Nurse and S4 DON confirmed the physician should have been notified of Resident #3's increased pain and he had not been. S2 Corporate Nurse confirmed Resident #3 had not been administered anything for pain since 04/02/2026 at 1:50 p.m. when she left the hospital until 04/03/2026 when S5 LPN administered Tylenol at 1:15 p.m.