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	06/03/2026

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

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure the Medical Director participated in the Quality Assessment and Assurance Process Quarterly meetings. Total sample size 41. Findings:Review of the Monthly and Quarterly Quality Assessment and Assurance Process revealed no documented evidence of the Medical Director attending any Quality Assessment and Assurance program meetings from 12/2025 through May 2026.During an interview on 06/03/2026 at 3:10 p.m., S1 Administrator confirmed the previous Medical Director had not attended any Quality Assessment and Assurance program meetings from 12/2025 through 05/2026, but should have.During a telephone interview on 06/03/2026 at 3:26 p.m., with previous Medical Director confirmed she had not attended any Quarterly Quality Assessment and Assurance meetings for 12/2025 to 05/2026.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection by failing to practice Enhanced Barrier Precautions for 5 (Resident #7, Resident #17, Resident #31, Resident #34, and Resident #73) of 41 sampled residents. Findings: Review of the facility's policy titled, Enhanced Barrier Precautions with a review date of 03/01/2026, revealed in part, Enhanced Barrier Precautions applies to all residents with any of the following: indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator); When a resident is placed on Enhanced Barrier Precautions, gown and gloves will be used during high-contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: a. Dressing; b. Bathing/Showering; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy; and, h. Wound care. Resident #7 Review of Resident #7's EHR revealed in part, an admission date of 08/08/2025 with diagnoses of Acute Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia; and Encounter for Attention to Tracheostomy. Review of Resident #7's 06/2026 physician's orders revealed in part.Enhanced Barrier Precautions dated 05/01/2026. Observation on 06/02/2026 at 3:30 p.m., revealed S7 RT suctioning Resident #7 without wearing any PPE. EBP signage was observed on Resident #7's bedroom door upon entrance into their room. PPE for staff was available in a plastic bin in the hallway or on the back of the resident's door. Resident #34 Review of Resident #34's EHR revealed in part an initial admission date of 05/18/2026 with diagnoses of Acute Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia; and Encounter for Attention to Tracheostomy. Review of Resident #34's 06/2026 physician's orders revealed in part.Enhanced Barrier Precautions dated 05/29/2026. Observation on 06/01/2026 at 10:12 a.m., revealed S7 RT suctioning Resident #34 without wearing any PPE. EBP signage was observed on Resident #34's bedroom door upon entrance into their room. PPE for staff was available in a plastic bin in the hallway or on the back of the resident's door. Resident #73 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #73's Electronic Health Record (EHR) revealed in part an admission date of 05/29/2026 with a diagnosis of Acute Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia. Review of Resident #73's 06/2026 physician's orders revealed in part.Enhanced Barrier Precautions dated 05/29/2026. Observation on 06/01/2026 at 10:00 a.m. revealed S7 RT suctioning Resident #73 without wearing any Personal Protection Equipment (PPE). EBP signage was observed on Resident #73's bedroom door upon entrance into their room. PPE for staff was available in a plastic bin in the hallway or on the back of the resident's door. Interview on 06/02/2026 at 3:40 p.m. with S7 RT confirmed that he did not implement EBP practices while suctioning Resident #7, Resident #34, and Resident #73, but should have. Interview on 06/02/2026 at 3:45 p.m. with S2 DON confirmed S7 RT should have worn a gown and gloves for Resident #7, Resident #34, and Resident #73 that required EBP. Resident #17 Review of Resident #17's medical record revealed an admission date of 04/20/2023 with diagnoses, which included Iron Deficiency Anemia; Hypotension; Diffuse Traumatic Brain Injury with loss of Consciousness; and Major Depressive Disorder. Review of Resident #17's Quarterly MDS with an ARD of 03/03/2026 revealed a Brief Interview Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. Review of Resident #17's current care plan revealed the following in part . (Date Initiated: 11/04/2024) Focus: Requires enhanced barrier precautions per CDC (Center for Disease Control) regulations related to presence of peg tube, etc. Interventions: Continue EBP for duration of stay or until reason for EBP to be resolved. Review of Resident #17's current physician's orders revealed the following in part . -Flush feeding tube with 30 milliliters of water before and after meds/feedings; -Bolus 237 milliliter of Fibersource PPT (per peg tube) every 4 hours; and -Initiate Enhanced Barrier Precautions due to presence of Peg/Cath to remain in effect until devices removed. Observation on 06/01/2026 at 11:59 a.m. revealed S8 LPN administered Resident #17's peg tube feeding without using PPE (gown and gloves). In an interview on 06/02/2026 at 10:24 a.m., S2 DON confirmed all staff who provided direct care for residents with EBP should wear PPE (gown and gloves). S2 DON acknowledged S8 LPN should have worn PPE while administering a bolus peg feeding for Resident #17. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 06/01/2026 at 12:00 p.m., S8 LPN revealed she did not know what EBP meant. S8 LPN stated she was unaware she needed to wear PPE (gown and gloves) when administering a bolus feeding via peg tube for Resident #17. Resident #31 Review of Resident #31's medical record revealed an admission date of 04/20/2023 with diagnoses, which included Seizures; Major Depressive Disorder; Insomnia; and Diffuse Traumatic Brain Injury with loss of Consciousness. Review on 06/03/2026 at 2:36 p.m. of Resident #31's Annual MDS with an ARD of 05/05/2026 revealed a Brief Interview Mental Status (BIMS) was unable to be performed because Resident #31 was rarely/never understood. Further review of the MDS revealed Resident #31 had a peg tube. Review of Resident #31's current care plan revealed the following in part . (Date Initiated: 11/18/2024) Focus: Requires enhanced barrier precautions per CDC (Center for Disease Control) regulations related to presence of peg tube, etc. Interventions: Continue EBP for duration of stay or until reason for EBP to be resolved. In an interview on 06/02/2026 at 10:32 a.m., S9 CNA revealed she and S10 CNA gave Resident #31 a complete bed bath this morning. S9 CNA revealed EBP meant enhanced barrier precautions, which required them to wear gloves and gowns during direct care for residents who had a peg tubes. S9 CNA revealed she did not wear EBP PPE (gown and gloves) when she performed the bed bath for Resident #31 this morning. In an interview on 06/02/2026 at 10:39 a.m., S10 CNA revealed she and S9 CNA gave Resident #31 a complete bed bath this morning without wearing PPE (gown and gloves). In an interview on 06/02/2026 at 10:24 a.m., S2 DON confirmed all staff who provided direct care for residents with EBP should wear PPE (gown and gloves). S2 DON acknowledged S9 CNA and S10 CNA should have worn PPE while performing direct care/bed bath for Resident #31.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to ensure that each Resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, by failing to honor 1(Resident #10) of 1 sampled resident's choices. Findings: Review of a Facility Policy titled Resident Rights-Exercise of Rights with a review date of 01/17/2024, revealed in part .Intent: All residents have rights guaranteed to them under Federal and State laws and Regulations. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. Procedure: The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.The facility will protect and promote the rights of the resident. Review of Resident #10's medical record revealed an admit date of 12/24/2024, with diagnoses which included in part. Hemiparesis following Cerebral Infarction affecting left non-dominant side, Type 2 Diabetes Mellitus, Bipolar Disorder, Unspecified Dementia, Post Traumatic Stress Disorder, General Anxiety, and Schizophrenia. Review of Resident #10's Quarterly MDS with an ARD of 04/28/2026, revealed a BIMS score of 15 indicating intact cognition. The MDS revealed Resident #10 had no behaviors and required set-up assistance with eating, personal hygiene, and oral hygiene, and required substantial/maximal assistance with toileting hygiene, dressing and bathing.Review of Resident #27's medical record revealed an admit date of 01/20/2023, with Diagnoses that included in part.Alzheimer's Disease with Late Onset, Major Depressive Disorder, Recurrent, sever with Psychotic Symptoms, Restlessness and Agitation. During an interview on 06/01/2026 at 9:48 a.m., Resident #10 revealed Resident # 27 who resided across the hall, had been coming in his room. Resident #10 stated he had complained about it to staff (didn't know the names of the staff), but nothing had been done about it. Resident #10 stated when he complained to staff they would say Oh, he's old and confused, or He has Dementia and is confused. During the interview with Resident #10, Resident #27 came inside the doorway of Resident #10's room. During an interview on 06/02/2026 at 8:51 a.m. S14 LPN revealed Resident #27 had a history of wandering in other residents' rooms. During an interview on 06/02/2026 at 8:55 a.m., S15 Housekeeper revealed he had seen Resident #27 in Resident #10's room several times, and had also seen him in several other residents' rooms. During an interview on 06/02/2026 at 9:00 a.m., S10 CNA stated Resident #27 did wander into Resident #10's room. S10CNA stated she had seen Resident #27 in Resident #10's room the previous day. During an interview on 06/02/2026 at 10:47 a.m., S1 Administrator revealed she was aware that Resident #27 propelled himself throughout the facility and was confused. S1 Administrator confirmed if staff were aware of Resident #27 wandering into Resident #10's room, they should have reported it. S1 Administrator confirmed Resident #27 should not have been wandering into Resident #10's room.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care that met professional standards of quality care for 1 (Resident #78) of 1 sampled residents.Findings: Review of Resident #78's medical record revealed an admission date of 05/29/2026 with diagnoses including, in part.Schizoaffective Disorder, Unspecified; Asymptomatic Human Immunodeficiency Virus, Bipolar Disorder, and Insomnia Review of Resident #78's medical record revealed Resident #78 did not have a baseline care plan. Interview on 06/01/2026 at 10:39 a.m., Resident #78 stated he was new to the facility and was recently admitted on [DATE]. Interview on 06/02/2026 at 12:52 p.m., S3 Unit Manager stated she was responsible for completing the baseline care plans and a floor nurse would complete it if a resident was admitted on the weekend or late at night. S3 Unit Manager stated she was responsible for following up on the completion of the baseline care plans to ensure they were developed and completed within the required 48-hour timeframe. S3 Unit Manager stated if a baseline care plan was not developed or completed it would flash in red on her computer's dashboard. S3 Unit Manager reviewed Resident #78's medical record and confirmed Resident #78's baseline care plan was not developed or completed within 48-hours, but should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews the facility failed to ensure the Comprehensive Resident Centered Plan of Care was revised to include behaviors for 1 (Resident #31) of 41 sampled residents. Findings:Review of the facility's policy with a review date of 01/08/2026 titled Comprehensive Care Plans read in part.Policy Statement: To meet the resident's physical, psychosocial and functional needs, the facility will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and target goals. Procedure: Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Review of Resident #31's medical record revealed an admission date of 04/20/2023 with diagnoses, which included Other Seizures; Essential Hypertension; Major Depressive Disorder; Insomnia; and Constipation. Review of Resident #31's Annual MDS with an ARD date of 05/05/2026 revealed a BIMS was unable to be performed. Further review of the MDS revealed Resident #31 was short tempered and easily annoyed. Observation of Resident #31 on 06/01/2026 at 2:35 p.m. revealed he was seated in the day room in his Geri chair hitting the side of chair constantly. In an interview on 06/02/2026 at 10:32 a.m., S10 CNA revealed she had worked at the facility for about a year. S10 CNA stated Resident #31's does have a lot of behaviors such as hitting, punching, and kicking at staff while performing direct care. S10 CNA stated Resident #31 had thrown feces all over the room last week twice. S10 CNA stated she has reported Resident 31's behaviors to S1 Adm and S2 DON. Review on 06/02/2026 at 11:25 a.m. of Resident #31's care plan with a target date of 08/06/2026 revealed there was no plan of care for behaviors. Review of May EMARs (electronic medication administration records) revealed on May 4, 9, 23, 28, and 29 nurses had documented Resident #31 had behaviors. Review of May 2026 Nurses notes revealed Resident #31 had documented behaviors on 04/18/2026, 04/22/2026, 04/26/2026, and 05/29/2026. In an interview on 06/02/2026 at 4:17 p.m. with S13 MDS Nurse revealed Resident #31's care plan had not been updated to reflect his behaviors and should have been. In an interview on 06/02/2026 at 2:42 p.m., S2 DON confirmed the plan of care had not been revised with Resident #31's behaviors and should have been. Observation and interview with S13 MDS on 06/03/2026 at 3:30 p.m. of the plan of care for Resident #31 revealed it was updated on 06/02/2026 to reflect his behaviors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure that residents who were unable to carry out ADLs (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene for 2 (Resident #8 and Resident #26) sampled residents. The facility failed to: provide nail care for Resident #8; andprovide hair care for Resident #26. Findings: Review of the facility policy titled, Supporting Activities of Daily Living (ADL) with a reviewed date of 01/26/2026 revealed in part, Residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). 5. Functional decline or improvement will be evaluated in reference to the ARD and the following MDS definitions: Total Dependence-Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. 1. Resident #8 Review of Resident #8's clinical record revealed an admit date of 02/10/2026 with diagnoses that included in part: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side; Pressure Ulcer of Right Ankle, Unstageable; Dementia, Unspecified; and Anxiety. Review of Resident #8's Quarterly MDS with an ARD of 05/21/2026 revealed a BIMS Score of 03, which indicated severe cognitive impairment. Resident #8 was dependent for all ADLs. Review of Resident #8's Care Plan with a next review date of 08/21/2026 revealed in part.focus: the resident requires assistance with ADLs. Interventions: Bathing/Showering: check nail length and trim and clean on bath day and as necessary, with an initiated date of 02/27/2026. Review of Resident #8's facility task log revealed he required a daily bed bath on the day shift. The last documented bed bath was completed on 06/01/2026. Observation on 06/01/2026 at 11:48 a.m. revealed Resident #8 lying in bed asleep with untrimmed, jagged nails, and a black unknown substance underneath his fingernails. Observation on 06/02/2026 at 8:51 a.m., revealed Resident #8 lying in bed awake and alert to his self only. Observed Resident #8 with untrimmed, jagged nails, and a black unknown substance underneath his fingernails. Observation on 06/02/2026 at 11:43 a.m., revealed Resident #8 lying in bed awake and alert to his self only. Observed Resident #8 with untrimmed, jagged nails, and a black unknown substance underneath his fingernails. Observation on 06/03/2026 at 8:56 a.m., revealed Resident #8 lying in bed awake and alert to his self (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only. Observed Resident #8 with untrimmed, jagged nails, and a black unknown substance underneath his fingernails. Interview on 06/03/2026 at 9:09 a.m., S6 CNA revealed Resident #8 required total care assistance with all ADLs. S6 CNA stated Resident #8 required a daily bed bath and rarely refused care. She stated the daily bed bath consisted of cleaning Resident #8's fingernails. During observation at this time, accompanied by S6 CNA, of Resident #8's fingernails S6 CNA stated she gave him a bath on 06/01/2026 and there was no reason his fingernails should have looked like this. S6 CNA confirmed Resident #8's fingernails were untrimmed, jagged, and had a black unknown substance underneath. Interview on 06/03/2026 at 9:58 a.m., S3 Unit Manager accompanied surveyor to Resident #8's bedroom and stated Resident #8 required a daily bed bath. S3 Unit Manager confirmed that Resident #8's fingernails were untrimmed, jagged, and had a black unknown substance underneath his fingernails, but should not have been. 2. Resident #26 Review of Resident #26's medical record revealed an admission date of 02/06/2023 with diagnoses that included in part. Osteomyelitis, Anxiety Disorder, Major Depressive Disorder, Pain Unspecified, Unspecified Dementia, and Rash and other nonspecific skin eruptions. Review of Resident #26's Quarterly MDS with an ARD of 04/21/2026 revealed Resident #26 had a BIMS score of 99 which indicated resident was unable to complete interview. The MDS revealed Resident #26 was dependent for oral hygiene, toileting hygiene, shower/bathe, and personal hygiene. Resident #26 required set-up or clean-up assistance with eating. Review of Resident #26's care plan revealed in part.Resident #26 required assist with ADL's with interventions that included in part.Bathing/Showering-The resident require 1 person assist with daily bed bath; personal hygiene/oral hygiene-The resident require 1 person assist an ADL self-care. Review of Resident #26's bath roster for 05/2026 and 06/2026 read in part. Bed bath daily on day shift. No documented evidence of when Resident #26's hair was washed. During an observation on 06/01/2026 at 9:33 a.m. revealed Resident #26 in bed. Resident #26's hair was dirty, dry/flaky, and matted to her head. Resident #26 was unable to say when her hair had been washed. During an interview on 06/01/2026 at 12:19 a.m. with Resident #26's sister revealed she visited Resident #26 daily at the facility. Resident #26's sister stated My sister's hair is not being washed regularly. Resident #26's sister stated she had complained numerous times to staff (didn't know the staff's names) about Resident #26's hair being extremely dry/flaky and dirty, but the complaints had been ignored. During an observation on 06/02/2026 at 10:53 a.m. S12 LPN revealed Resident was bed bound and received hospice for palliative care. During observation of Resident #26's hair at that time, S12 LPN confirmed Resident #26's hair was dirty and needed to be washed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/02/2026 at 10:59 a.m., S14 LPN confirmed Resident #26's hair was dry/flaky, dirty, and needed to be washed. During a telephone interview on 06/02/2026 at 11:03 a.m., S17 Hospice Nurse revealed she had been providing care for Resident #26 for 2 to 3 months and her hair had been dry and flaky the whole time. During an observation and interview with S2 DON on 06/02/2026 at 2:20 p.m., S2 DON stated her hair (Resident #26) should not be looking like this, ideally it should be clean. S2 DON confirmed Resident #26's hair was not clean and it should be. S2 DON confirmed Resident #26's bath roster did not indicate when Resident #26's hair had been washed.

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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, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 1 (Resident #17) of 1 resident reviewed for respiratory care in a total sample of 41 residents. The facility failed to ensure respiratory equipment was properly changed, labeled, and stored. Findings:Review of the facility policy with a review date of 03/06/2026 titled Care and Cleaning of Respiratory Equipment revealed in part .Purpose: To maintain equipment in proper working order and to reduce the risk of nosocomial infection. XII. Additional Equipment. Respiratory tubing, catheters, masks, and cleaning kits will be secured or placed in a container, original package or bag. Review of Resident #17's medical record revealed an admission date of 04/20/2023 with diagnoses, which included Iron Deficiency Anemia; Morbid Obesity; Diffuse Traumatic Brain Injury with loss of Consciousness; and Unspecified Convulsions. Observation on 06/01/2026 at 12:44 p.m. revealed an undated Aerosol mask attached to a Nebulizer machine on Resident #17's nightstand, open to air. Review of Resident #17's May 2026 EMAR (electronic medication administration record) on 06/01/2026 at 3:35 p.m. revealed Resident #17 had a medication order of Ipratropium-Albuterol Solution-1 vial inhale orally four times a day for wheezing, cough for 5 days with a start date of 05/28/2026. Observation on 06/02/2026 at 8:49 a.m. revealed the undated Aerosol mask attached to a Nebulizer machine remained on Resident #17's nightstand, open to air. In an interview on 06/02/2026 at 10:03 a.m., S8 LPN confirmed the Aerosol mask attached to the Nebulizer machine on Resident #17's nightstand was open to air and not labeled or stored properly. In an interview on 06/02/2026 at 10:24 a.m., S2 DON confirmed Resident #17's Aerosol mask and tubing had not been dated or stored properly but should have been.

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	06/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interviews, the facility failed to provide pharmaceutical services that ensure accurate acquiring, receiving, dispensing and administration of medications to meet the needs of each resident. The facility failed to provide medications and/or biologicals to meet the needs of residents for 1 (Resident #59) of 1 resident reviewed for pharmaceutical services in a total sample of 41 residents.Findings:Review of the facility's policy with a review date of 03/01/2026 titled, Medication Administration revealed in part .Intent: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. 24. If medication is ordered but not present check to see if it was misplaced and then call the pharmacy to obtain the medication.Review of Resident #59's medical record revealed an admission date of 07/27/2025 with diagnoses, which included ESRD (End Stage Renal Disease); Type 2 Diabetes Mellitus with unspecified complications; Depression; Anxiety; Bipolar Disorder; and Parkinsonism. Review of Resident #59's Annual MDS with an ARD date of 04/28/2026 revealed a BIMS score of 15, which indicated intact cognition.Review on 06/03/2026 at 3:16 p.m. of Resident #59's April 2026 EMAR (electronic medication administration record) revealed Resident #59 had an order for Sevelamer Carbonate (Renvela) 800mg-1 tablet by mouth before meals for Other Disorders of Phosphorus Metabolism with a start date of 04/17/2026. Further review of the EMAR revealed Resident #59 had not received the above medication from 04/18/2026 to 04/30/2026.Review on 06/03/2026 at 3:16 p.m. of Resident #59's May 2026 EMAR(electronic medication administration record) revealed Resident #59 had a medication order of Renvela 800mg-1 tablet by mouth before meals for Other Disorders of Phosphorus Metabolism with a start date of 04/17/2026 and a hold date from 05/01/2026 to 05/04/2026; a hold date from 05/05/2026 to 05/19/2026; and another hold date from 05/22/2026 to 06/01/2026. Further review of EMAR revealed Resident #59 did not receive any doses of the above medication for the month of May 2026.Review on 06/03/2026 at 3:16 p.m. of Resident #59's June 2026 EMAR(electronic medication administration record) revealed Resident #59 had a medication order of Renvela 800mg-1 tablet by mouth before meals for Other Disorders of Phosphorus Metabolism. Further review of EMAR revealed Resident #59's had not received the above medication from 06/01/2026 to current. The EMAR revealed H in the boxes from the dates of 06/01/2026 to 06/12/2026 indicating the medication had been put on hold.In a telephone interview on 06/03/2026 at 10:52 a.m., S11 RD revealed she was the Registered Dietitian at the dialysis center for Resident #59. S11 RD stated Resident #59 is on a 1200 milliliter fluid restriction with monitoring of urine outputs. S11 RD also stated Resident #59 is on Sevelamer Carbonate 800mg- 2 tabs with meals and 1 with snacks because of his abnormal lab of an elevated phosphorus in 04/2026. S11 RD stated dialysis and herself communicate via communication forms and faxing over orders to the facility. Further interview with S11 RD revealed the dialysis center orders the Sevelamer Carbonate and sends it with the resident back to the facility. S11 RD stated the above medication was filled last on 03/27/2026 and 04/20/2026 and Resident #59 should not have been out of his medication. S11 RD stated the facility knows that they need to call dialysis for Sevelamer Carbonate refills. On 06/03/2026 at 3:16 p.m., a review of the dialysis communication sheets from April 2026 to June 2026 (current) revealed no new orders. In an interview on 06/03/2026 at 3:22 p.m. S12 LPN revealed she called the facility's pharmacy about getting the medication refilled and they told her they normally don't fill the Sevelamer Carbonate because dialysis refills it, but they could fill it if needed.In an interview on 06/03/2026 at 3:23 p.m., S2 DON stated she did not know Resident #59 had did not have any Sevelamer Carbonate doses from 04/18/2026 to 06/03/2026. S2 DON also stated she was under the impression the above medication could only be refilled through dialysis but confirmed they should have ordered it using the facility's pharmacy when they could not get it from dialysis. S2 DON confirmed the facility did not have the Sevelamer Carbonate for Resident #59 readily available, but should have.