STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195407	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ringgold Nursing and Rehabilitation Center, LLC	2501 Kenneth Street Ringgold, LA 71068

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015 Based on record review and interview, the facility failed to ensure MDS (Minimum Data Set) assessment was accurate for 1 (#2) of 3 (#1, #2, #3) sampled residents. The facility failed to include Resident #2's wheelchair alarm on MDS assessment. Findings: Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] and had diagnoses that included, in part, history of falling, schizoaffective disorder, unspecified dementia, unspecified psychosis, psychotic disorder with delusions due to known physiological condition, other encephalopathy, and type 2 diabetes mellitus. Review of Resident #2's physician orders revealed an order dated 01/30/2024 for wheelchair clip alarm to wheelchair. Observations conducted at the following dates/times revealed a wheelchair alarm was in place for Resident #2. 05/06/2024 at 1:26 p.m. 05/06/2024 at 2:25 p.m. 05/06/2024 at 4:10 p.m. 05/07/2024 at 10:38 a.m. 05/07/2024 at 12:20 p.m. 05/07/2024 at 3:15 p.m. 05/08/2024 at 1:35 p.m. Review of Resident #2's Quarterly MDS dated [DATE], Section P Restraints revealed Chair Alarm was marked as not used. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/2024 at 12:59 p.m. S1 DON (Director of Nursing) confirmed Resident #2's chair alarm had been placed on 1/30/2024 after Resident #2 had a fall. During an interview on 05/07/2024 at 5:00 p.m. S2 MDS Coordinator confirmed Resident #2 had a chair alarm in place. After review of Resident #2's 04/09/2024 quarterly MDS S2 MDS Coordinator further confirmed the restraints section did not have a check by chair alarm and should have.