STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195412	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Leaves Nursing and Rehab Ctr, LLC	342 Country Club Road Winnfield, LA 71483

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844 Based on observation and interview 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 quality of life for 1 (Resident #59) out of a total sample of 26 Residents by failing to ensure a resident did not wear eyeglasses in disrepair. Findings: Review of Resident #59's medical record revealed an admitted [DATE] with diagnoses which included in part .Type II Diabetes Mellitus, Pain Unspecified, Aphasia, Cognitive Communication Deficit, and Need for Assistance with Personal Care. Review of Resident #59's Quarterly MDS with an ARD of 03/27/2024 revealed he had a BIMS score of 15 (indicating intact cognition). The MDS revealed Resident #59 was independent with: eating, personal hygiene, toileting and dressing; required partial/moderate assistance with bathing. Observation and interview on 05/06/2024 at 9:30 a.m. revealed Resident #59 sitting on the side of his bed with a pair of eyeglasses on, which were crooked on his face. The left template of the eyeglasses were made of elastic. Resident #59 revealed the handle (template) of the eyeglasses were gone but he had made a handle by using the elastic off of face masks; which he had tied together to make a handle. Observation on 05/07/2024 at 11:03 a.m. revealed Resident #59 ambulating in the hallway from playing Bingo. Resident #59's eyeglasses observed in his shirt pocket. Resident #59 revealed no one had asked him if he wanted new eyeglasses, and stated if he could get a new pair that would be great. Observation and interview on 05/07/2024 at 11:10 a.m. of Resident #59 with S8 Social Service Director in attendance revealed Resident #59 wore eyeglasses. Observation at this time revealed Resident #59's left eyeglasses temple were missing. Resident #59 revealed he had made a left template out of elastic strings of face masks; and tied them together to hold his eyeglasses in place. S8 Social Service Director confirmed Resident #59's eyeglasses were in disrepair and he should not have been wearing them.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844 Based on observation and interview, the facility failed to maintain a safe, clean, comfortable and homelike environment for 1 (Resident #251) of 26 sampled residents by failing to ensure the resident and her room was free of odor. Findings: Review of Resident #251's medical record revealed an admitted [DATE] with diagnoses which included in part .Disorientation, Vascular Dementia, Type II Diabetes Mellitus, Major Depressive Disorder and Functional Diarrhea. Review of Resident #251's Quarterly MDS with an ARD of 02/26/2024 revealed she had a BIMS score of 6 (indicating severe cognitive impairment). The MDS revealed Resident #251 required partial/moderate assistance with dressing; supervision or touching assistance with personal hygiene; and independent with toileting. Observation on 05/06/2024 at 9:43 a.m. of Resident #251's room revealed a malodorous scent of onion was detected. Resident #251 was lying in bed, there were no visible signs of being soiled. Resident stated she did not feel well enough to talk at this time. Observation revealed Resident #251's bathroom had dirty clothes in a basket, and her room was filled with clothes thrown on the bed and chair. Upon exiting Resident #251's room the malodorous scent of onion was detected in the hallway. Interview on 05/06/2024 at 9:47 a.m. with S1 DON outside of Resident #251's room revealed the facility was aware of the malodorous scent in Resident #251's room and had discussed it the prior week. S1 DON stated it smelled like onions in Resident #251's room. S1 DON stated the scent may have been dirty clothes in Resident #251's bathroom. Interview on 05/06/2024 at 11:54 a.m. with S11 housekeeper revealed Resident #251's room had a malodorous scent and stated it may have been the dirty clothes in her bathroom. Interview on 05/07/2024 at 10:30 a.m. with S9 CNA revealed she provided care for Resident #251. S9 CNA revealed she had smelled a malodorous scent in Resident #251's room, which smelled like onions. S9 CNA stated Resident #251 hoarded dirty clothes in her room and bathroom. Interview on 05/07/2024 at 11:00 a.m. with S10 CNA revealed she provided care for Resident #251 and had smelled a malodorous scent in resident #251's room which smelled like onions. S10 CNA stated this scent was in Resident #251's room all the time. Interview on 05/08/2024 at 12:15 p.m. with S1 DON revealed Resident #251's room had been discussed in a meeting last week by administrative nurses and department heads due to the her room having a bad odor like onions. S1 DON acknowledged this had been on on-going problem with Resident #251.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004 Based on observation, record review, and interview the facility failed to ensure that Resident's comprehensive care plan was reviewed and revised by the interdisciplinary team composed of individuals who have knowledge of the Resident's needs for 3 (#21, #49, and #51) of 26 sampled Residents. Findings: Review of the facility's undated policy titled Care Plans: Initial and Comprehensive on 05/07/2024 at 3:43 p. m. revealed in part . A comprehensive care plan will be developed for each resident, according to the OBRA mandated dates. The comprehensive care plan will be revised as often as necessary to provide the information necessary to provide appropriate care and services for the resident. Review/Revise: After a MDS is completed, the Resident's plan of care will be completed or revised, if necessary. The care plan is to be reviewed at least quarterly, and revised as necessary to address the current needs of the resident. Updates: Any change that would require an alteration in the normal, daily care routine of the resident should be added or deleted from the present plan of care when indicated. Resident #49 Review of Resident #49's medical record revealed she was admitted to the facility on [DATE] and had diagnoses that included in part .Retention of urine, Cognitive Communication Deficit, and Vascular Dementia. Review of Resident #49's 05/2024 physician's orders revealed in part . 05/02/2024 Clindamycin Hcl (Antibiotic) 300mg- Administer 1 capsule every 6 hours for 10 days for prophylactic measures. 04/17/2024 Macrobid (Antibiotic) 100mg- Administer 1 capsule one time a day every day prophylactically. Review of Resident #49's current Comprehensive Plan of Care plan revealed no entry for use of Antibiotics. Interview on 05/06/2024 at 11:08 a.m. with Resident #49 revealed she had a history of UTI's and received antibiotics. Resident #49 was observed with a Foley catheter hanging on bedframe within a privacy bag. Interview on 05/07/2024 at 9:04 a.m. with S3 LPN revealed Resident#49 currently did not have a diagnosed UTI, but was recently prescribed antibiotics prophylactically as Resident #49 had chronic UTI's. Interview on 05/07/2024 at 2:29 p.m. with S4 LPN revealed she was the Care Plan Coordinator and was responsible for updating resident's comprehensive plan of care. S4 LPN confirmed Resident #49's care plan was not revised to include the use of antibiotics, but should have been. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39317 Resident #21 Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Gastrostomy, GERD, and Vascular Dementia. Review of Resident #21's Physician's orders for the month of May 2024 revealed Continuous Jevity 1.2 at 25 ml per hour. Review of Resident #21's Comprehensive Care Plan with a target date of 07/19/2024 revealed in part . Potential for malnutrition and dehydration related to NPO status, receiving nutrition via peg tube. Goal: to maintain adequate nutritional status. Interventions included Jevity 1.2 at 30 ml/hr. Observation on 05/07/2024 at 1:16 p.m. revealed Resident #21 was resting in bed with the head elevated. She was receiving Jevity 1.2 at 25 ml/hr via pump. Interview on 05/08/2024 at 1:45 p.m. with S2 ADON revealed Resident #21 was previously receiving Jevity 1. 2 at 30 ml/hr, but was not tolerating the feeding well. S2 ADON stated the physician changed the order to decrease the amount of Jevity the resident was receiving in March of 2024, from 30ml/hr to 25ml/hr. Interview on 05/08/2024 at 1:44 p.m. with S2 DON confirmed the physician changed the orders for the tube feeding in March of 2024. S2 DON confirmed the care plan should have been updated to reflect the new orders. Resident #51 Interview on 05/08/2024 at 8:40 a.m. with S3 LPN revealed Resident #51 is currently receiving Keflex 500 mg BID for a diagnoses of pneumonia. She stated Resident #51 began receiving the antibiotic on 05/02/2024. Review of Resident #51's Physicians orders dated 05/01/2024 revealed Cefalexin (Keflex) 500 mg BID for diagnosis of bibasilar pneumonia. Review of Resident #51's Comprehensive Care Plan revealed no entry for pneumonia or treatment with Cefalexin. Interview on 05/08/2024 at 2:08 p.m. with S4 LPN revealed she is the Care Plan Coordinator. S4 LPN stated she does not update care plans to reflect new orders for antibiotics, or for the treatment of pneumonia. Interview on 05/08/2024 at 2:16 p.m. with S2 DON confirmed Resident #51's Comprehensive Care Plan should have been updated to reflect the diagnoses of Pneumonia and the treatment with Cefalexin.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004 Based on record review and interview the facility failed to ensure residents' drug regimens were free from unnecessary psychotropic medications for 3 (#71, #85, & #87) of 5 (#17, #71, #78, #85, & #87) residents reviewed for unnecessary medications. The facility failed to ensure: 1. A PRN order for a psychotropic drug was limited to 14 days for Resident #71. 2. A psychotropic medication was used only when there was an acceptable diagnosis documented in the clinical record for Residents #85 and #87. Findings: Review of the facility's undated policy titled Drug Regimen Review on 05/07/2024 at 3:43 p.m. revealed in part . Drug Regimen Review consists of a review and analysis of prescribed medication therapy and medication use review, using the Federal indicators. The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director or Nursing, and the responsible physician. Procedure: The Consultant Pharmacist documents potential or actual medication therapy problems and communicates them to the responsible physician and the Director of Nursing. The Consultant Pharmacist drug regimen review is processed as follows: Drug Regimen Review recommendations to physician: 1.The notification/letter is provided by the Consultant Pharmacist and sent by facility to the responsible physician. 2. The notification/letter is filed in the residents' medical record for the responsible physician's review on his next visit to the facility if the irregularity/recommendation is not of a life-threatening nature. 3. The physician is asked to provide a written response to the irregularity/ recommendation. 4. A copy of the notification/ letter is kept in the facility until the physician's signed response is returned. 5. The DON or her designee takes action on the physician's signed response prior to being filed in the residents' medical record. Resident #71 Review of Resident #71's Medical Record revealed an admitted [DATE] with diagnoses that included in part . Neurocognitive Disorder with Lewy Bodies, Unspecified Dementia without Behavioral Disturbance, Aphasia, Cognitive Communication Deficit, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #71's care plan with a start date of 03/28/2024 and a review date of 07/12/2024 revealed she had potential for adverse effects due to use of psychotropic medications. The care plan revealed Resident #71 Takes Lorazepam (Ativan) for Anxiety Disorder Interventions included administer medication as ordered and drug regimen review monthly and as needed. Review of Resident #71's current physician's orders revealed the following order: 04/16/2024: Ativan 2mg tablet- Administer 1 tablet orally as needed every 8 hours as needed for restlessness/agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #71's 04/2024 and 05/2024 EMARs revealed Resident #71 received Ativan 2mg tablet as needed on 04/18/2024, 05/04/2024, and 05/06/2024. Review of the Psychoactive Gradual Dose Reduction letter sent to Resident #71's physician by the pharmacist on 04/01/2024 revealed the pharmacist asked the physician to evaluate the resident prior to extending the order for psychotropic medication as PRN is limited to 14 days. The physician responded on 04/11/2024 to continue the current use of the listed medications with his rationale as In locked memory unit. No reduction. It was signed by S1 DON, also. Interview on 05/07/2024 at 2:17 p.m. with S5 LPN revealed psychotropic PRN's are ordered for 14 days unless the physician wants to order the medication for 30days with a valid reason. S5 LPN stated she was unsure why Ativan 2mg tablet- Administer 1 tablet orally as needed every 8 hours as needed for restlessness/agitation was ordered for longer than 14 days for Resident #71. Interview on 05/07/2024 at 2:25 p.m. with S1 DON revealed a review Resident #71's GDR dated 04/01/2024. S1 DON confirmed the PRN order for Ativan should have been discontinued after 14days, or the physician should have assessed Resident #71 and provided a rationale to continue the use, but had failed to do so. 38373 Resident #85 Review of Resident #85's medical record revealed an admitted [DATE] with diagnoses that included in part . Pneumonia, Cerebral Infarction, Aphasia, Type 2 Diabetes Mellitus, Dysphagia, Vascular Dementia, Major Depressive Disorder, and Shortness of Breath. Review of Resident #85's current physician's orders revealed the following order: 11/22/2023: Risperidone (Risperdal-an antipsychotic medication) 0.25 mg tablet-administer 1 tablet oral one time a day every day. Review of Resident #85's April 2024 and May 2024 MARs revealed Resident #85 received Risperidone 0.25 mg tablet by mouth every day with the diagnosis listed as Vascular Dementia. Review of Resident #85's care plan with a start date of 11/22/2023 and a review date of 07/25/2024 revealed the resident was care planned for potential for adverse effects due to use of psychotropic medications. The care plan revealed Resident #85 takes Lexapro for Depression and Risperidone for diagnosis of Dementia. Interventions included administer medication as ordered and drug regimen review monthly and as needed. Review of the Psychoactive Gradual Dose Reduction letter sent to Resident #85's physician by the pharmacist on 02/23/2024 revealed the pharmacist asked the physician to consider a GDR of Risperdal 0. 25mg every day and to Please evaluate the use of Risperdal for the treatment of dementia as this is considered inappropriate according to the CMS interpretive guidelines. Please consider an alternative therapy. The physician responded on 04/29/2024 to continue the current use of the medication with his rationale as Hospice patient, well controlled on current regimen. It was signed by S1 DON, also. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/2024 at 3:20 p.m., S1 DON and S2 ADON acknowledged Resident #85 was prescribed Risperdal for Dementia and did not have an appropriate diagnosis for an antipsychotic medication documented in Resident #85's medical record. In an interview on 05/08/2024 at 9:23 a.m., S1 DON acknowledged she reviewed the GDR letter after the doctor completed it and did not follow up with the doctor when he did not follow the recommendations of the pharmacist for an alternative therapy for Risperdal. S2 DON stated she usually just goes along with whatever orders the doctor documents on the form. Resident #87 Review of Resident #87's medical record revealed an admitted [DATE] with diagnoses that included in part . Vitamin Deficiency, Hypothyroidism, Hyperlipidemia, Vascular Dementia, unspecified severity, with Agitation, Osteoarthritis, Repeated Falls, CKD, Alzheimer's disease with late onset, and Malignant Neoplasm of Prostate. Review of Resident #87's current physician's orders revealed the following: 12/14/2023: Seroquel (an antipsychotic medication) 50mg po daily at bedtime 11/29/2023: Abilify (an antipsychotic medication) 10mg po every day at bedtime 10/04/2023: Cymbalta (an antidepressant medication) 30mg po daily at bedtime Review of Resident #87's current care plan revealed the resident was care planned for the potential for adverse effects due to the use of psychotropic medication; Takes Abilify, Seroquel, and Cymbalta for diagnosis of Dementia with behaviors. Interventions listed included administer medications as ordered and drug regimen review monthly and prn. Review of April and May 2024 MARs for Resident #87 revealed the resident received Cymbalta for the diagnosis of Myalgia and received Seroquel and Abilify for the diagnosis of Vascular Dementia. Review of the Psychoactive Gradual Dose Reduction letter sent to Resident #87's physician by the pharmacist on 02/23/2024 revealed the pharmacist asked the physician to consider a gradual dose reduction of Abilify 10 mg po daily at bedtime, Seroquel 50 mg po daily at bedtime, and Cymbalta 30 mg po daily at bedtime. The pharmacist also requested the physician to please evaluate the use of Seroquel and Abilify for the treatment of Dementia as this is considered inappropriate according to the CMS interpretive guidelines. Please consider an alternative therapy. Resident #87's physician responded a dose reduction was not appropriate and to continue current use of above stated medication. The physician's rationale for continuance was documented as Hospice patient easily agitated-meds are effective. The form was signed by S1 DON and Resident #87's physician on 04/29/2024. In an interview on 05/07/2024 at 3:21 p.m., S2 ADON and S1 DON [NAME] acknowledged there were no appropriate diagnoses documented in Resident #87's medical record for the use of antipsychotics and Abilify and Seroquel were prescribed for the diagnoses of Dementia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/2024 at 9:23 a.m., S1 DON who confirmed she does receive the pharmacist's GDR letter back for review after the physician signs it. S1 DON stated she did not follow up with the physician when he didn't consider an alternative therapy for the antipsychotic medications, as recommended by the pharmacist. S1 DON stated she usually just goes along with whatever the doctor documents on the form.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46773 Based on observation, interview, and record review the facility failed to meet the nutritional needs of residents in accordance with established national guidelines. The facility failed to follow the menu in regard to portion size to ensure nutritional adequacy of the meal for 9 residents that received mechanically altered diets prepared by the facility kitchen. Findings: Review of the facility's policy titled: Preparation and Service of Pureed Diets read in part Procedure: 8. Pureed foods should be served with correct utensils. Serving sizes will depend upon the recipe used and are indicated on menu modifications when different from the regular portion. Review of the facility's approved 2023 Fall/Winter Menu revised on 10/2018 revealed on 05/06/2024 the facility was on week 2, day 2. Pureed lunch menu, in part, consisted of: Pureed Red beans and sausage 3/4 cup, pureed rice 1/2 cup, pureed mixed green 1/3 cup, pureed cornbread 1/4 cup, pureed bread pudding 1/2 cup, beverage of choice and water. Observation on 05/06/2024 at 11:45 a.m. revealed S7 Dietary Aide serving a pureed lunch tray with 4 oz scoop of rice, 4 oz scoop of greens and 4 oz scoop of pureed meat and beans. S7 Dietary Aide revealed she does not typically serve food and had not been trained on portion sizes. Interview on 05/06/2024 11:50 a.m. with S6 Dietary manager revealed the correct serving size for pureed beans and meat is 3/4 cup and the tray was only served 1/2 cup . S6 Dietary Manager stated she typically ensured the proper size scoops were being used but had not checked them prior to serving food today. S6 Dietary Manager confirmed residents being served mechanically altered diets were not given the proper portion sizes because the wrong scoop size was used and should not have been.