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	08/20/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for 1 (Resident #27) of 40 sampled residents. The facility failed to monitor and document daily meal consumption for Resident #27, who had weight loss, as stated in the current plan of care. Findings: Review of an undated facility policy on 08/19/2025 at 2:14 p.m. titled, Comprehensive Resident Care Plans revealed the following in part.Purpose: The resident's comprehensive care plan will be developed utilizing the results of the comprehensive resident assessment instrument (RAI) plus information gained from resident and family interviews, care conferencing and health care professional data to determine daily care needs, ad to attain, or maintain, the resident's highest functional capacity. Review of Resident #27's medical record revealed an admission date of 10/02/2023, with diagnoses that included in part.Schizoaffective Disorder, Delusional Disorders, Moderate Protein-Calorie Malnutrition, and Generalized Anxiety Disorder. Review of Resident #27's active physician's orders revealed an order for high risk for malnutrition with a start date of 10/27/2023. Review of Resident #27's Annual MDS with an ARD of 07/21/2025 revealed a BIMS score of 14, which indicated intact cognition. Resident #27 was independent with eating and had weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. Review of Resident #27's current plan of care revealed the following in part.Initial Date: 10/30/2023-Focus: Potential for altered nutrition and dehydration related to Schizoaffective Disorder. Consumes less than 50% of meals. Has delusional thoughts of her food being poisoned. Interventions: Monitor percentage % of meal intake and offer alternate if 50% consumed. Review of Resident #27's medical record revealed the following Tasks for the CNAs to monitor/document meal consumption with each daily meal: Meal Intake-Breakfast 7:30 a.m., Meal Intake-Lunch 11:30 a.m., and Meal Intake-Dinner 5:00 p.m. Further review of the daily meal intake tasks from dates 08/01/2025- 08/19/2025 revealed the following: Breakfast: 16 days of no monitoring/documentation, Lunch: 15 days of no monitoring/documentation, and Dinner: 17 days of no monitoring/documentation. In an interview on 08/19/2025 at 4:29 p.m., Resident #27 revealed she did eat her meals, but had a poor appetite, and for today's lunch she ate less than 50% of her meal. Resident #27 stated she has had some weight loss lately. In an interview on 08/20/2025 at 9:47 a.m., S16 LPN revealed she was assigned to Resident #27 today and was familiar with her care. S16 LPN stated Resident #27's appetite varies and had declined due to recent delusional thoughts of people poisoning her food, in which she had a new diagnosis of Schizoaffective Disorder. S16 LPN stated that the CNAs were responsible for charting on all residents' daily meal consumption for each meal. In an interview and record review on 08/20/2025 at 12:34 p.m., S1 DON reviewed the 08/2025 meal intake tasks section for Resident #27 and confirmed the above findings. S1 DON confirmed that on several days in 08/2025 the CNAs did not monitor/document Resident #27's meal consumption as required with each meal, but should have. S1 DON confirmed Resident #27's plan of care was not implemented due to the CNAs failing to document meal consumption daily.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to:1. Ensure nurse staffing data was displayed daily in a prominent location readily accessible to all residents, staff, and visitors for viewing;2. Ensure nurse staffing data requirements for all shifts were documented on the daily posting; and 3. Ensure nurse staffing data included the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.This deficient practice had the potential to affect all 101 residents residing in the facility. Findings: Observation on 08/18/2025 at 2:06 p.m. of the facility entrance revealed no display of the nurse staffing posting. 1.Observation on 08/18/2025 at 2:08 p.m. revealed the facility nurse staffing posting was displayed at the end of 1 (Hall W) of 6 (Hall A, Hall B, Hall C, Hall D, Hall E, and Hall W) hallways at 1 (Nurse Station Y) of 2 (Nurse Station Y and Nurse Station Z) nurse's stations. Due to the staffing posting displayed only on Nurse Station Y's desk and at the end of Hall W, this made it difficult for all visitors, residents, and staff to access. 2. & 3.Review of the facility nurse staffing posting from dates 08/04/2025-08/17/2025 revealed no daily documentation of the nursing data for the evening shift (3:00 p.m.- 11:00 p.m.) or night shift (11:00 p.m.-7:00 a.m.) and no documentation of the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care for all shifts. In an interview and record review on 08/18/2025 at 3:20 p.m., S1 DON revealed she was responsible for overseeing the ward clerk's completion of the nurse staffing forms for the facility. S1 DON confirmed the above findings. S1 DON revealed she was unaware the nurse staffing posting should include all shifts (day, evening and night) and this portion was not completed daily. S1 DON confirmed that the nurse staffing data did not include the actual hours worked for each shift and was unaware of this requirement. S1 DON revealed she was unaware the staffing data should had been posted in an area for all visitors, residents, and staff to access upon entering the facility. S1 DON confirmed the staffing data was only displayed at Nurse Station Y located at the end of Hall W. S1 DON confirmed that due to the current placement of the nurse staffing data, only one half of the facility could easily access the data.

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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 record review, observation and interview, 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 ensure the resident was placed on contact precautions in a timely manner for 1 (#4) resident out of 2 (#4 and #87) residents investigated for infection control.Findings:A review of the facility's undated infection control precautions (isolation) policy, revealed under the title of Procedure: Placement In Isolation: 1) If there is reason to believe that a resident has a communicable disease, the attending physician or alternate shall be notified immediately of such condition and permission requested to initiate the appropriate isolation precautions.On 08/18/2025 at 8:55 a.m., Resident #4 was out of the facility at the mental health intensive outpatient program until his anticipated return at 3:00 p.m. the same day. There were no transmission-based precautions noted in his electronic health record.On 08/18/2025 at 3:35 p.m., Resident #4 was interviewed after returning to the facility from the mental health day program. Resident #4 was observed to have an intravenous access secured to the inside of his lower right arm.On 08/19/2025 at 8:55 a.m., Resident #4 was observed in his room under contact precautions. S4LPN confirmed Resident #4 is now in isolation and on contact precautions due to the culture results dated 08/13/2025, of his urinalysis collected on 08/11/2025.Review of Resident #4's urine culture collected on 08/11/2025 and reported on 08/13/2025 revealed in part.Urine culture results: E. coli.consistent with a probable ESBL.multi-drug resistant organism.Review of Resident #4's physician orders revealed an order dated 08/18/2025 that read:Contact isolation d/t e. coli/ESBL in urine.On 08/19/2025 at 3:17 p.m., S2 ADON/IP confirmed that Resident #4 should have been placed on contact precautions on 08/13/2025 when the physician ordered an intravenous antibiotic for the resident's urinary tract infection, as identified by the culture results dated 08/13/2025, but was not.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to ensure a quarterly assessment was completed timely for 1 (Resident #12) of 2 (Resident #12 and Resident # 97) Residents reviewed for Resident Assessments. The total sample size was 40. Findings:Review of an undated facility policy on 08/19/2025 at 2:14 p.m. titled Resident Assessment Instrument (RAI) read in part. Quarterly review assessments will be completed no less than once every 92 days. Review of Resident #12's medical record revealed an admission date of 12/10/2024. Resident #12 had the following diagnoses that included in part . Idiopathic Gout, Urinary Tract Infection, Repeated Falls, Chronic Pain Syndrome, Dementia, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #12's MDS assessments revealed a quarterly assessment was completed on 04/30/2025, with no MDS quarterly assessments completed and/or accepted since that time. Interview on 08/19/2025 at 2:50 p.m. with S3MDSLPN revealed a review of Resident #12's MDS assessments. S3MDSLPN confirmed that the last completed and/or accepted quarterly assessment for Resident #12 was on 04/30/2025, and a quarterly assessment had not been completed within 92 days since then, but should have.

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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 2 (Resident #31 and Resident #48) 2 Residents reviewed for respiratory care. The facility failed to:1. Ensure Resident #31 received oxygen therapy as ordered;2. Provided Resident #48, who required continuous oxygen therapy, with portable oxygen while out of her room.Findings:Review of an undated facility policy on 08/19/2025 at 2:14 p.m. titled “Oxygen Administration (Concentrator or Tank) read in part… If a resident is ambulatory and requires oxygen, portable oxygen tanks should be considered to avoid restricting the resident to his/her room. Resident #31 Review of Resident #31’s medical record revealed an admission date of 02/24/2022. Resident #31 had diagnoses that included in part… Hemiplegia and Hemiparesis following Cerebral Vascular Accident- affecting Left Non Dominant Side, Cough, Shortness of Breath, and Dependence on Supplemental Oxygen. Review of Resident #31’s Significant Change MDS with an ARD of 07/11/2025 revealed Resident #31 had a BIMS score of 04, indicating severe cognitive impairment. Review of Resident #31’s 08/2025 physician orders read in part… Oxygen at 4 Liters per nasal cannula continuously related to diagnosis of Respiratory Failure and Chronic Obstructive Pulmonary Disease. Every Shift. Order date: 07/01/2024 Observation on 08/18/2025 at 9:35 a.m. of Resident #31 revealed her oxygen was set at 2 Liters per nasal cannula. Observation on 08/19/2025 at 9:02 a.m. of Resident #31 revealed she received oxygen therapy and her oxygen was set at 2 Liters per nasal cannula. Observation on 08/19/2025 at 11:40 a.m. of Resident #31 revealed her oxygen continued at 2 Liters per nasal cannula. Observation on 08/19/2025 at 12:24 p.m. of Resident #31 revealed her oxygen continued at 2 Liters per nasal cannula. Observation on 08/20/2025 at 9:25 a.m. of Resident #31 revealed she received oxygen therapy and her oxygen was set at 1.5 Liters per nasal cannula. Interview on 08/20/2025 at 9:35 a.m. with S6LPN revealed Resident #31 was ordered oxygen therapy at 4 Liters per nasal cannula continuously. S6LPN stated Resident #31 did not tolerate being off of oxygen therapy well, and required the oxygen therapy continuously. S6LPN revealed Resident #31 at times removed the oxygen, and would become symptomatic within a few hours, so staff had to closely monitor her to ensure she kept the oxygen on. S6LPN revealed Resident #31 was bedbound and not capable of changing her oxygen settings. S6LPN stated staff was to ensure that the oxygen settings are correct and as ordered for Resident #31 each shift. Observation of Resident #31’s oxygen settings with S6LPN confirmed Resident #31 was set at 1.5 Liters. S6LPN confirmed 1.5 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Liters was incorrect and the oxygen setting for Resident #31 should be at 4 Liters as ordered, but was not. Resident #48 Review of Resident #48’s medical record revealed an admit date of 03/29/2013 ….with diagnoses that included in part… …Chronic Obstructive Pulmonary Disease (Acute) Exacerbation, Vascular Dementia, mild, with agitation; Repeated Falls, Dependence on Supplemental Oxygen, Wheezing, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, Other Persistent Atrial Fibrillation, Schizoaffective Disorder, Depressive Type; Shortness of Breath, Other Specified Anxiety Disorders, Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, and Non-ST Elevation (NSTEMI) Myocardial Infarction. Review of Resident #48’s Quarterly Minimum Data Set with an Assessment Reference Date of 05/15/2025 revealed a Brief Interview Mental Status of 11, which indicated moderate cognition. Further review of MDS (Minimum Data Set) revealed Resident #48 required supervision or touching assistance with bathing and transfers, and was independent with toileting, bed mobility, and eating. Review of Resident #48’s Care Plan initiated on 07/17/2024 and a review date of 11/24/2025 revealed the resident was care planned for Potential for impaired gas exchange secondary to Chronic Obstructive Pulmonary Disease. Refuses to wear oxygen at times. Interventions included in part… Oxygen at 2 liters per minute per nasal cannula continuous due to shortness of breath related to Chronic Obstructive Pulmonary Disease Change Oxygen tubing/humidifier bottle, clean filter every week when in use Notify MD with increased shortness of breath or change in conditionPortable oxygen 2 liters per nasal cannula on excursions Review of Resident #48’s current physician’s orders revealed: 09/27/2021-Oxygen at 2 liters per minute per nasal cannula. Continuous due to shortness of breath 02/07/2025 - Change oxygen tubing/humidifier bottle, clean filter every week when in use. An observation on 08/19/2025 at 8:55a.m. revealed Resident #48 asleep in bed with continuous Oxygen in progress at 2 liters per minute per nasal cannula. An observation on 08/19/2025 at 10:53a.m. revealed Resident #48 sitting in wheelchair in day room of Hall X without oxygen. Oxygen noted in room on and in progress still at 2 liters per minute with nasal cannula underneath bed covers. In an interview on 08/19/2025 at 2:36p.m., S13LPN confirmed Resident #48 does have an order for continuous oxygen but takes it off at times. S13LPN stated when she visibly sees resident with shortness of breath or anxiousness, she will bring her to her room and put her oxygen on. S13LPN said she didn't know of any reason why she couldn't have portable oxygen. In an interview on 08/19/2025 at 2:47 p.m., S1DON confirmed Resident #48 did have an order for continuous oxygen but takes if off at times. S1DON voiced there was no rule Hall X residents could not have portable oxygen tanks.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview the facility failed to ensure a resident's food and drink were palatable, attractive, and at a safe and appetizing temperature for 1 (#70) of 40 sampled residents. The facility failed to ensure Resident #70 received a meal tray which was served at an appropriate, appetizing temperature. Findings:Review of Resident #70's medical record revealed an admit date of 07/12/2024 .with diagnoses that included in part. Restlessness and Agitation, Vascular Dementia, moderate, with Agitation, Pain-Unspecified, Major Depressive Disorder, Recurrent, Severe With Psychotic Symptoms, Other Specified Anxiety Disorders, Other Schizophrenia, and Other Insomnia.Review of Resident #70's Quarterly MDS with an ARD of 07/17/2025 revealed a BIMS was not completed because resident was rarely/never understood. Further review of MDS revealed Resident #70 was dependent on staff assistance with bathing, toileting, eating, and bed mobility, and required substantial/maximal assistance with transfers. Observation of Meal Cart (#X) right outside of kitchen area on 08/19/2025 at 11:53 a.m. revealed 2 disposable lunch trays with meal tickets on each plate on top of cart.Observation on 08/19/2025 at 12:10 p.m. revealed S12 CNA left out of Hall X to go get the lunch meal cart for the Hall X.In an interview on 08/19/2025 at 12:21 p.m., S12 CNA said the Hall X lunch meal cart (#X) was just finished being prepared when she got there to pick it up from the kitchen. She said she had to pass a few trays out to the rooms right outside of Hall X before entering Hall X. Observation of Meal Cart (#X) on hallway right in front of Hall X on 08/19/2025 at 12:22 p.m. revealed 2 disposable lunch trays with meal tickets on each plate remained on top of cart.Observation of Meal Cart (#X) entering into Hall X on 08/19/2025 at 12:24 p.m. revealed 2 disposable lunch trays with meal tickets on each plate remained on top of the cartObservation on 08/19/2025 at 1:07 p. m. revealed Resident #70's lunch meal tray that had been sitting on top of meal cart in a disposable tray was bought into Resident #70's room by a CNA for him to be fed per staff.In an interview on 08/19/2025 at 1:08 p.m., S13 LPN confirmed that Resident #70's lunch meal tray that had been sitting on top of the lunch meal cart (#X) for over an hour was cold, and the staff should have heated it in the microwave before giving it to the resident, but did not.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) received 12 hours of in-service training annually which included Dementia management and abuse prevention trainings for 1 (S11CNA) of 5 (S7CNA, S8CNA, S9CNA, S10CNA and S11CNA) CNAs' personnel files reviewed.Review of the facility assessment with review date of [DATE] revealed in part, Staff training/education and competencies: 3.3. Staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population will be completed on hire and annually. Required in-service training for nurse aides. In-service training must: be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. Include Dementia management training and resident abuse prevention training.Review of S11 CNA's personnel record revealed a hire date of [DATE] and no documentation that S11 CNA had received and/or completed the required yearly 12 hours of Dementia management training and abuse prevention training since upon hire.Interview on [DATE] at 3:25 p.m., with S5 HR for a review of S11 CNA's trainings revealed all required annual trainings had been expired and had a past due date. S5 HR confirmed that S11 CNA did not complete the required 12 hours of annual trainings to include dementia management and abuse prevention, but should have.