

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Farmerville Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 813 N Main St Farmerville, LA 71241	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>Based on record review and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (#4) of 3 (#4, #5, and #6) residents investigated for pressure ulcers. The facility failed to 1) observe and report signs and symptoms of an unstageable pressure ulcer development on the sacrum area for resident #4 and 2) failed to treat a stage 4 pressure wound according to physician orders for resident #4.</p> <p>Findings:</p> <p>Review of the record revealed resident #4 was admitted to the facility on [DATE]. Resident #4's diagnoses included the following: quadriplegia, pressure ulcer of sacral region stage 4 (01/07/2025), pressure induced deep tissue damage of right heel (09/25/2024), and pressure induced deep tissue damage left ankle.</p> <p>Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #4 was dependent on staff for all activities of daily living. Resident #4 was at risk for pressure ulcers/injuries.</p> <p>Review of the pressure ulcer risk assessment with the last update on 01/07/2025 revealed resident #4 was at risk for pressure ulcers.</p> <p>Review of the care plan for resident #4 revealed documented pressure ulcer, stage 4 to sacrum. Interventions included to keep skin clean and well lubricated, evaluate skin for areas of blanching or redness, wound care specialist to follow and make recommendations.</p> <p>Review of the medical record revealed resident #4 was receiving weekly skin audits.</p> <p>Review of the weekly skin audit for resident #4 dated 12/30/2024 completed by S12Licensed Practical Nurse (LPN) revealed rectum area excoriated only.</p> <p>Review of weekly skin audit for resident #4 dated 01/07/2024 completed by S2Director of Nursing Services (DNS) revealed resident #4 had a Stage 4 sacrum pressure wound with following measurements: 6 centimeters (cm) x 2.6 cm x 1.5 cm.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195439
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #4's sacral wound measurements by S11Nurse Practitioner dated 01/07/2025 revealed following: 8 cm x 12 cm x 3 cm; stage 4 pressure wound sacral. Stage: unstageable pressure ulcer injury obscured full thickness skin and tissue loss. Review of the progress note revealed a new stage 4 pressure wound to sacrum. Surgical debridement completed. Culture obtained. Pack with 1/4 strength Dakin's cover with Abdominal (ABD) pad, tape. Change daily.</p> <p>Interview on 01/14/2025 at 12:10 p.m. with S2DNS revealed resident #4 tested positive for COVID-19 on 12/27/2024 and was placed on isolation and came off isolation of 01/07/2025.</p> <p>S2DNS reported she was not made aware of resident #4's sacral wound until the morning of 01/07/2025. S2DNS revealed she and S10RN Unit Manager assessed the wound and determined it to be a stage 4 pressure ulcer and obtained the following measurements: 6 cm x 2.5 cm x 1.5 cm. S2DNS reported that S11Nurse Practitioner (NP), wound care specialist, was at the facility and evaluated and treated the wound on 01/07/2025. S2DNS revealed S11NP provided debridement of the sacral wound and also determined it was a stage 4 pressure ulcer. S2DNS reported the sacral wound was re-measured post debridement so S11NP's measurements did not match S2DNS's measurements obtained prior to the debridement.</p> <p>Interview with S16Certified Nursing Assistant (CNA) on 01/28/2025 at 11:00 a.m. revealed that she took care of resident #4 on 01/06/2025. S16CNA stated that resident #4 had a small bowel movement and S16CNA noted very dry scaly skin but didn't see any open areas. S16CNA stated she applied cream to the sacral area of resident #4 which was requested by resident #4. S16CNA denied any changes in the skin and said other staff told her that resident #4 had excoriation already.</p> <p>Interview with S11NP on 01/28/2025 at 11:48 a.m. revealed that the sacrum pressure ulcer had to be noticeable several days before identified as an unstageable pressure ulcer then identified as stage 4 pressure ulcer. S11NP stated that the sacral area for resident #4 appeared to have a dark patch, eschar - dark slough appearance; like a leather patch covering the hole with slough around the edges.</p> <p>Interview with S3Clinical Operation Consultant on 01/28/2025 at 2:30 p.m. revealed the staff that provided care for resident #4 only report excoriation to the sacrum area prior to the finding of an unstageable pressure ulcer on 01/07/2025. At this time, S3Clinical Operation Consultant was notified that the sacrum's wound appearance should have been noticeable several days prior to being identified as an unstageable pressure ulcer.</p> <p>Review of the current wound care physician orders for resident #4 dated 01/22/2025 revealed following: cleanse sacral wound with Dakin's wound cleanser, pat dry, apply Santyl and Dakins wet to dry dressing, cover with ABD pad, and secure with tape. Change dressing daily and as needed (PRN) soiled or dislodged.</p> <p>Interview with resident #4 on 01/27/2025 at 3:00 p.m. revealed she did not receive wound care treatment on Sunday, 01/26/2025. Resident #4 stated she was supposed to get treatment daily.</p> <p>Interview conducted with S3Clinical Operation Consultant on 01/27/2025 at 4:30 p.m. confirmed that resident #4 did not receive wound care on 01/26/2025. S3 Clinical Operation Nurse further confirmed that resident #4 was to receive wound care to the sacrum on a daily basis and as needed.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>I. Based on record reviews and interviews, the facility failed to ensure that 1 (#5) of 3 (#4, #5, #6) residents environment remained free of accident hazards by failing to ensure assistive devices (side rails) were in good repair.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 12/11/2024 at approximately 9:35 a.m. when resident #5 fell from his bed while using his right 1/4 side rail to assist with care. Resident #5's side rail was attached to a bed extender that flared approximately 45 degrees away from the bed which resulted in the fall. Resident #5 obtained a closed fracture of the left distal femur and had open reduction and internal fixation surgery (ORIF) with hardware on 12/12/2024.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 01/13/2025. It was determined to be a Past Noncompliance Citation.</p> <p>Findings:</p> <p>Review of the record for resident #5 revealed a [AGE] year old with an admitted [DATE]. Diagnoses included but not limited to the following: chronic respiratory failure, congestive heart failure, aphasia following cerebral infarction and fracture of left femur on 12/11/2024.</p> <p>Review of resident #5's annual Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderately impaired cognitive skills for daily decision making. He had no range of motion impairment to upper or lower extremities. Resident #5 was unable to walk and used a wheel chair for locomotion. Resident #5 was dependent on staff for toileting (one person physical assistance) and independent with rolling to the left, back and right side. Resident #5 always incontinent of bowel and bladder.</p> <p>Review of Morse Fall Scale Assessments dated 10/11/2024 revealed resident #5 to score a 55 which noted resident was a low risk. No history of falls in past year.</p> <p>Review of side rails evaluation revealed the evaluation was completed on 09/25/2024 and a consent from the responsible party noted. Resident #5 was assessed to have 1/4 side rails to grasp side rails and assist staff in turning and positioning.</p> <p>Review of an Accident Report for resident #5 dated 12/11/2024 at 9:35 a.m. for a fall during staff assist revealed the following:</p> <p>Incident location: resident #5's room</p> <p>Person preparing report: S13Licensed Practical Nurse (LPN)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Description: Resident noted lying on his right side on the floor between the bed and the wall. Resident alert and oriented to person, place, time, and situation. Resident didn't complain of pain, stated multiple times, Baby get me up. Resident stated I fell off the damn bed. Pulse 76, respirations 21, Blood pressure 138/76.</p> <p>Immediate action taken: Resident transferred to hospital per Emergency Medical Services. Intervention: Assist rails checked and old extensions on bed removed and assist rails connected to bed frame. Fracture of left femur reported from hospital.</p> <p>Injury: laceration right forearm</p> <p>Review of the facility's investigation summary form revealed the following:</p> <p>Review of local hospital physician documentation on 12/11/2024 revealed the following: [AGE] year old present to emergency room via emergency medical services with complaints of fall. Details of fall: The patient fell from supine position. Abrasion to right elbow. He was transferred to hospital emergency rodiagnom on [DATE] for distal left femur fracture, Long leg splint in place.</p> <p>Resident #5 admitted to another hospital with a closed fracture of the left distal femur and had open reduction and internal fixation surgery (ORIF) with hardware on 12/12/2024.</p> <p>Interview on 01/13/2024 at 12:15 p.m. with S14Certified Nursing Assistant (CNA) revealed she had worked at the facility for a little over 6 months. S14CNA reported on 12/11/2024 around 9:35 a.m. she was assisting resident #5 who had a bowel movement and needed to be changed. S14CNA revealed she asked resident #5 to turn to his right side like he normally would do and he grabbed and pulled himself to his right side in the bed using the 1/4 assistive rail on the right side of the bed. S14CNA reported she asked him to remain still while she cleaned him up. S14CNA reported within 15-20 seconds resident #5 said, It's breaking loose, I am falling. S14CNA reported she immediately went to try to prevent him from falling. S14CNA reported she had made it to the foot of the bed when resident #5 had fallen on the floor between the bed and the wall. S14CNA reported the right side 1/4 assistive rail broke way and leaned at about a 45 degree angle. S14CNA reported the right side of the bed was approximately 2 feet from the wall. S14 CNA reported she hollered out for help and stayed with resident #5 until S13Licensed Practical Nurse (LPN) arrived. S14CNA reported that resident #5 had a skin tear to his right forearm. S14CNA reported resident #5 was sent out to the hospital via ambulance.</p> <p>Interview on 01/14/2025 at 10:32 a.m. with S13LPN revealed that on 12/11/2024 around 9:35 a.m. she was in another resident's room next door to resident #5's room when she heard S14CNA holler out for help. S13LPN reported she immediately went to resident #5's room and observed resident #5 lying on the floor on his right side between the bed and the wall. S13LPN reported that resident #5's left leg was lying across his right leg. S13LPN reported resident #5 had a laceration to his right foreman. S13LPN reported resident #5 did not complain of any pain. S13LPN reported resident #5's right side rail was angled out in a 45 degree angle toward the wall. S13LPN revealed she asked S14CNA what happened. S14CNA reported to S13LPN that she was providing resident #5's incontinent care and she had asked him to turn to his right side like he normally does when she provides his incontinent care. S13LPN reported S14CNA then stated that within 20 seconds of the resident turning to his right side, resident #5 told her he was falling and the rail was letting go. S13LPN reported that S14CNA stated she could not get to the right side of the bed in time to prevent him from falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>S13LPN reported she called the ambulance service for resident #5 to be evaluated at the local hospital. S13LPN reported she provided wound care for laceration and placed a dressing on his right forearm. S13LPN revealed she contacted S10Registered Nurse (RN) unit manager.</p> <p>Interview on 1/13/2025 at 11:30 a.m. with S10RN Unit Manager revealed she was notified by S13LPN that resident #5 was on floor and was being sent to the local emergency room for evaluation. Upon entering the room, resident #5 was on the floor between the bed and wall. S10RN Unit Manager stated that resident #5 was on his stomach leaning toward the right side with his right arm down beside him and his left arm had a small skin tear noted. S10RN Unit Manager stated resident #5 yelled, Get me off of the floor, help me up! S10RN Unit Manager reported that S14CNA stated resident #5 fell from the bed while holding onto the right side rail. S10RN Unit Manager reported that the right side rail was down when she entered the room.</p> <p>Interview on 01/13/2025 at 12:30 p.m. with S9Maintenance Director revealed he was notified on the morning of 12/11/2024 after resident #5 had fallen to check his bed and his side rails. S9Maintenance Director reported the right upper side rail was still in place but it was angled about 45 degrees away from bed toward the wall. S9Maintenance Director reported that the upper extender at the top of the bed had the side rails still attached properly, but the upper extender bracket that rested on top of the bedframe was flared out which allowed the right upper side rail not to function properly.</p> <p>Interview on 01/27/2025 at 8:00 a.m. with S1Executive Director(ED) revealed that he was aware of incident involving resident #5 falling and fracturing his left femur on 12/11/2024. S1ED reported it was determined that there was a problem with the bed extender. The side rail was connected to the bed extender and as a result caused resident #5 to fall.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>On 12/11/2024, the facility implemented the following actions to correct the deficient practice with a completion date of 12/24/2024.</p> <p>12/11/2024- S9Maintenance Director examined the side rail for resident #5. It was determined that the bed extensions that held the hand rails were flared out and rotated around the head of the frame. The left side rail was up right and the right side rail was at a 45 degree angle. S9Maintenance Director removed all six bed extensions from the bed of resident #5.</p> <p>12/11/2024- There are no other bed extensions in use at the facility. The facility will no longer use bed extensions.</p> <p>12/11/2024- S9Maintenance Director completed an audit of 100% side rails used in the facility.</p> <p>12/24/2024- S9Maintenance Director completed bed and mattress audit on all beds in the facility.</p> <p>II. Based on observations, record reviews and interviews, the facility failed to ensure 1 (#1) of 3 (#1, #2, #3) residents who were assessed at risk for wandering and elopement, was adequately supervised to prevent him from eloping from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This deficient practice resulted in an Immediate Jeopardy situation on 01/05/2025 at approximately 6:40 a.m. when resident #1 (a moderately impaired resident who was placed on 1 to 1 supervision on 01/04/2025 at approximately 11:00 p.m. for wandering in other residents' rooms) was found approximately 2.4 miles from the facility by the local police department. Resident #1 was located approximately 1 hour and 40 minutes after last being seen by assigned staff at the facility.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 01/13/2025. It was determined to be a Past Noncompliance Citation.</p> <p>Findings:</p> <p>Review of policy with the latest revision date of 05/2022 revealed the following: Subject: Missing Resident/Eloperments. Policy: the Unit Charge Nurse is responsible for knowing the location of their residents. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. At any time in which a resident is determined missing, the following procedure will be strictly followed: A) Alert: The supervisor/charge nurse will alert all other personnel by all-paging Dr. Wander' and Location: B) Search: a search of the immediate area will be initiated under the Director of Nursing (DON) shift supervisor/charge nurse; all rooms will be searched (including locked rooms).</p> <p>The Nursing shift supervisor/charge nurse will designate staff to search the area surrounding the building, as appropriate (patio, parking area) C) Contacts: If the search of the immediate area is unsuccessful, the nursing shift supervisor will immediately contact the: Executive director and DON; local police department; family/responsible party; vice president of operations; attending Physician/medical director; department of health notification as required; D) Missing resident guidelines: The resident: 1. Determine time and location when last seen.</p> <p>Review of the medical record revealed resident #1 was admitted to the facility on [DATE] with diagnoses of unspecified intracranial injury without loss of consciousness, generalized anxiety disorder, hypertension, non-traumatic subarachnoid hemorrhage, other non-traumatic intracerebral hemorrhage, fracture of condylar process of left mandible subsequent encounter for fracture with routine healing, and diffuse traumatic brain injury w/o loss of consciousness.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had a brief interview for mental status (BIMS) of 10 which indicated that resident #1 had moderately impaired cognitive skills for daily decision making. The assessment also indicated the resident was independent with transfers and did not require mobility devices.</p> <p>Review of the Elopement Risk assessment dated [DATE] at 2:45 p.m. by S9Registered Nurse (RN) revealed resident #1 was oriented to person, place, time and situation upon assessment. Noted episodes of confusion and history of psychoactive meds (Zyprexa); mobility independent. Resident #1 was not deemed an elopement risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an Incident Report dated 01/05/2025 at 6:40 a.m. completed by S6Licensed Practical Nurse (LPN) revealed that she received a phone call from the local police department asking if we had a resident by the name of resident #1. This nurse stated yes. Officer stated that resident #1 was out by the local apartments wandering (approximately 2.4 miles from facility). S6LPN instructed officer to bring resident #1 back to facility. Resident #1 unable to give clear description of events. Immediate action taken: Local police department returned resident to facility at approximately 6:50 a.m.</p> <p>On 01/13/2025 at 2:00 p.m. interview with S1Executive Director (ED) confirmed resident #1 was currently at an inpatient psychiatric hospital due to aggression toward staff. S1ED confirmed that on 01/05/2025 sometime after 5:00 a.m., resident #1 eloped from the building and it was undetermined as to what door the resident exited out of. S1ED revealed he was contacted by S2Director of Nursing Services (DNS) on 01/05/2025 at around 7:00 a.m. S1ED reported that an immediate investigation was initiated.</p> <p>On 01/14/2025 at 10:00 a.m. interview with S2DNS confirmed resident #1 eloped from the building on 01/05/2025 after being placed on 1 to 1 monitoring for supervision on 01/04/2025 at approximately 11:00 p.m. S2DNS stated that on 01/04/2025 at approximately 9:52 p.m., S1ED called to inform her that resident #10's family member called him and was upset about resident #1 entering into the room of resident #10 and upsetting the resident. Further interview revealed on 01/04/2025 at 10:20 p.m. S2DNS came to the facility to meet with the family member who was upset due to resident #1 attempting to enter the room and bathroom of resident #10. S2DNS stated she then addressed the issue with nursing staff and informed them that resident #1 was disoriented as to where his bathroom and room were. She stated at this time she placed resident #1 on 1 to 1 monitoring supervision and to change out with other workers when they do rounds on other residents. S2DNS stated that she told all the nurses and aides on duty to make sure someone was with resident #1 at all times and that the nurses could switch out with the aides as needed. S2DNS further stated she told them to report to the day shift to continue the 1 to 1 monitoring. S2DNS stated that S5Certified Nursing Assistant (CNA) was assigned the 1 to 1 monitoring for resident #1 and was stationed outside resident #1's room when she left building at approximately 11:00 p.m.</p> <p>S2DNS further confirmed on 01/05/2025 at 6:44 a.m., she received a phone call from S6LPN stating they just received a phone call from the local police department stating that they picked up resident #1 at a local apartment complex and were bringing him back to facility. S2DNS stated she instructed S6LPN to do a head to toe assessment on resident #1's return and to restart a strict 1 to 1 monitoring. She stated that the Administrator was notified and staff placed a Wanderguard monitoring device on resident #1 upon his return. S2DNS stated that she contacted S5CNA who stated she monitored resident #1 until around 5:00 a.m. S2DNS reported that S5CNA then said that S4LPN said she would watch out for resident #1 and that she could go make her rounds on other residents. S2DNS stated she talked with S4LPN on 01/05/2025 at 8:00 a.m. S4LPN stated that she last saw resident #1 around 4:50 a.m. when she administered medication to him. S4LPN stated resident #1 was sitting up in a chair in his room and that S5CNA was outside the door. S2DNS stated she asked S4LPN if S5CNA asked if she would monitor resident #1 while she finished her rounds and S4LPN denied that this was said. S2DNS confirmed that resident #1 was able to elope out of building on 01/05/2025 after 5:00 a.m. due to staff not properly monitoring resident #1 on a 1 on 1 observation status. S2DNS confirmed that the facility did not have a policy on 1 to 1 monitoring supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 01/15/2025 at 7:05 a.m. an interview with S6LPN revealed that on 01/05/2025 at 6:40 a.m. she received a call from the local police department stating that they found resident #1 wandering outside an apartment complex approximately 3 miles from facility. S6LPN asked the police to return resident #1 to facility. S6LPN stated after she got off phone with police, S5CNA came up to nursing station and asked if anyone had seen resident #1. S6LPN told S5CNA that the police found resident #1 wandering around an apartment complex some 3 miles from the facility. S6LPN stated that S5CNA told her that resident #1 was placed on 1 to 1 monitoring last night by S2DNS for wandering behavior. S6LPN said she contacted S2DNS immediately after becoming aware of incident. S6LPN stated that she was not made aware by the night nurses that resident #1 was on a 1 to 1 monitoring for supervision.</p> <p>On 01/15/2025 at 7:50 a.m. an interview with S4LPN revealed that she worked at facility on 01/04/2025 from 6 p.m. to 01/05/2025 to 6 a.m. S4LPN revealed that she was made aware that resident #1 was placed on 1 to 1 monitoring supervision for wandering type behavior on 01/04/2025 around 11:00 p.m. by another nurse. S4LPN stated that S5CNA was assigned 1 to 1 monitoring and was stationed outside the door of resident #1's room. S4LPN stated that she last time she saw resident #1 was around 4:30 a.m. at which time she administered a medication for anxiety. S4LPN stated she was never asked by S5CNA to monitor resident #1 due to her needing to make rounds on other residents. S4LPN stated she was never aware that resident #1 had eloped out of the facility.</p> <p>On 01/15/2025 at 9:15 a.m. an interview with S5CNA revealed that she worked at facility on 01/04/2025 from 7:00 p.m. to 01/05/2025 at 7:00 a.m. S5CNA said she was assigned the hall that resident #1 resided. S5CNA observed resident #1 wandering around facility and into other residents' rooms during her shift. S5CNA reported that S2DNS came to facility on 01/04/2025 around 10:00 p.m. and met with a family member of resident #10. S5CNA stated that S2DNS placed resident #1 on 1 to 1 monitoring supervision and made all staff aware. S5CNA stated that she was assigned the 1 to 1 for resident #1 but it was expected for her to also round and assist other residents she was assigned to. S5CNA stated that around 5:00 a.m. she had to assist another CNA and also do her rounds on other residents. S5CNA asked S4LPN if she could provide the 1 to 1 monitoring for resident #1 and S4LPN stated that she would. S5CNA stated that she returned to check on resident #1 around 6:20 a.m. and realized he was not in his room. S5CNA stated that she attempted to search for resident #1 and looked in other residents' rooms but could not find him. She stated that she asked other CNAs if they had seen him but they denied seeing him. S5CNA stated she asked the day nurse around 6:40 a.m. if she had seen resident #1. S4CNA confirmed that from 5:00 a.m. to 6:20 a.m. she did not perform 1 to 1 monitoring supervision on resident #1. S5CNA confirmed that when she observed that resident #1 was missing, she did not alert a nurse until approximately 20 minutes after noting him missing.</p> <p>On 01/15/2025 at 10:00 a.m. interview with S3Clinical Operation Consultant confirmed the staff did not perform 1 to 1 monitoring supervision for resident #1 as ordered and as a result resident #1 was able to elope from the facility. S3Clinical Operations Consultant confirmed that nursing was not immediately notified when it was determined that resident #1 was missing and that night staff did not communicate with day staff that resident #1 was on 1 to 1 monitoring. S3Clinical Operations Consultant confirmed that the facility did not have a policy for 1 to 1 monitoring supervision.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Farmerville Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 813 N Main St Farmerville, LA 71241	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 01/05/2025 the facility implemented the following actions to correct the deficient practice with a completion of 01/09/2025:</p> <p>Actions: Upon return to the facility on [DATE] at 6:50 a.m., resident #1 was placed on 1:1 monitoring and a wander guard was placed on resident #1.</p> <p>01/05/2025- 100% census count was completed by Unit Manager, all residents were accounted for.</p> <p>01/05/2025- Resident #1 Elopement risk evaluation reviewed, re-evaluated and updated to reflect his current elopement risk status.</p> <p>01/05/2025- 100% Elopement assessments re-evaluated and updated to reflect current elopement status.</p> <p>Facility found that 3 other residents were at risk for elopement status. Elopement evaluation updated to reflect current status.</p> <p>01/05/2025- 100% audit of all residents with wanderguards was initiated, no resident with wander guards identified. After re-evaluation, facility identified 3 residents who were at risk, received wanderguard after evaluation, all wanderguards were tested and working properly by Unit Manager.</p> <p>01/05/2025- Executive Director examined exit doors and windows for malfunction, windows and doors are functioning and in proper working order.</p> <p>Doors and windows last checked on 01/01/2025 with resident monitoring system reviewed and Mag lock system checked. All were in proper working order.</p> <p>01/05/2025- Elopement drill initiated on day shift By Staff Development Coordinator and night shift</p> <p>Facility staff are 12 hours with in-servicing on Policy on wandering and elopements</p> <p>01/05/2025- Elopement policy reviewed by Clinical Operations Nurse with no changes made at this time.</p> <p>01/05/2025- Resident #1 BIMS was assessed by Director of Nursing BIMS score was 10</p> <p>01/05/2025- Social Services Director reviewed and updated elopement binder with current residents at risk.</p> <p>01/05/2025- Door sign posted by Executive Director to alert staff and visitors to be aware of their surroundings as you enter and exit the building stating please do not let anyone out.</p> <p>01/05/2025- resident #1 was moved to another room closer to the nurses' station for increased supervision.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Farmerville Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 813 N Main St Farmerville, LA 71241	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>01/05/2025 - 01/09/2025 In-servicing of Executive Director and DNS via phone by [NAME] President of Operations regarding any resident who elopes or attempts to elope, displays exit seeking behavior, or Demands to go home, must be placed on 1 to 1 supervision. Supervision to be tapered based on behavior as deemed appropriate. In-service will be on going.</p> <p>01/05/2025 - 01/09/2025 In-service initiated by Staff Development Coordinator on current staff/agency staff on Incident/accidents, elopement policy, residents who demands wanting to go home, have exit seeking behavior, and wanders the facility must place resident 1 on 1 supervision and must notify the Executive Director and Director of Nursing immediately. Post-test on wandering and elopements. In service will be ongoing.</p> <p>01/05/2025- In-service initiated by Staff Developed Coordinator with CNA's and Nurses, when putting someone on 1 on 1 this means the resident is in your vision at all times. 1 on 1 is a nursing intervention put into place when close monitoring is warranted, for a certain length of time, until the person behavior/condition/ is re-evaluated by the staff and deemed appropriate to be taken off.</p> <p>This means, when you have to care for another resident, or attend to personal issues, or for any reason you have to step away, you have to ensure you coworker is aware and is actively monitoring the resident, while you are away. At no point is the resident to be left alone while 1 on 1 is in progress. In-service will be ongoing.</p> <p>Director of Nursing and or designee to monitor 24 hours report sheets, nurses notes and incident/accident 2 x daily x 5 days a week x 4 weeks to ensure that residents who exhibit exit seeking behaviors, demands to go home and wanders through out the facility are assessed for the safety of the resident. Any concerns will be immediately addressed. The Executive Director will forward results to the monthly Quality Assurance Committee. The Quality Assurance Committee will recommend the frequency or discontinuation based on results achieved.</p> <p>Director of Nursing and or designee to monitor new interventions that are put in place with observation 2 x daily x 5 days a week x 4 weeks to ensure interventions are in place. Any concerns will be immediately addressed. The Executive Director will forward results to the monthly Quality Assurance Committee. The Quality Assurance Committee will recommend the frequency or discontinuation based on results achieved.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>17835</p> <p>Based on record reviews and interview, the facility failed to ensure the agency Certified Nursing Assistant (CNA) and agency Licensed Practical Nurse (LPN) had documented training and competency demonstrations for all skills related to their expected roles for 2 (S5CNA and S4LPN) out of 5 (S4LPN, S5CNA, S8CNA,S14,CNA,S15CNA) personnel files reviewed.</p> <p>Findings:</p> <p>Review of S4LPN's personnel file revealed S4LPN's first date to work at the facility was 01/04/2025. Further review revealed no documented evidence of any facility training and policy reviews prior to working.</p> <p>Review of S5CNA's personnel file revealed C5CNA's first date to work at the facility was 12/26/2024. Further review revealed no documented evidence of any competencies or trainings were completed prior to working.</p> <p>During an interview on 01/15/2025 at 2:15 p.m., S3Clinical Operations Consultant acknowledged skill competencies, training, and policy reviews had not been completed by employees, S4LPN and S5CNA, prior to providing patient care and should have been.</p>