STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195439	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmerville Nursing and Rehabilitation Center, LLC	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829 Based on observations, interviews, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene for 1 (#15) of 1 (#15) residents sampled for activities of daily living. Findings: Record review revealed resident #15 was admitted to the facility on [DATE]. Resident #15's diagnoses include quadriplegia, chronic respiratory failure, tracheostomy status, anxiety, hypertensive heart disease without heart failure, chronic pain syndrome, colostomy status, gastrostomy status, dysphagia, type 2 diabetes mellitus with diabetic neuropathy, and stage 4 pressure ulcer of sacral region. Review of quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview Mental Status) score of 15 which indicated resident #15 was cognitively intact. Further review reveal resident #15 was dependent on staff for all ADLs (Activities of Daily Living). Resident #15 required substantial/maximal assistance with personal hygiene. Review of active care plans revealed resident #15 had an ADL self-care deficit. Resident #15 required assistance from staff with mobility, transfers, dressing, bathing, and personal hygiene. On 05/20/2024 at 09:05 a.m. an observation of resident #15 revealed his fingernails on both hands were long and jagged with a brown grime substance under fingernails. An interview with resident #15 revealed they trimmed and cleaned his fingernails a couple months ago. Resident #15 reported his fingernails were long and needed to be cleaned and trimmed. On 05/21/2024 at 11:51 a.m. an observation of resident #15 revealed his fingernails on both hands were long and jagged with a light brown grime substance under fingernails on both hands. On 05/22/2024 at 07:35 a.m. an interview with S3DON (Director of Nursing) was conducted in resident #15's room. S3DON confirmed resident #15's fingernails were long and needed to be trimmed and cleaned.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on interviews and record reviews, the facility failed to ensure residents remain as free of accident hazards as possible for 1 (#31) of 4 (#31, #32, #39, and #276) residents reviewed for accidents. The facility failed to ensure staff provided proper transfer using a mechanical lift for resident #31 on 04/01/2024 and 04/10/2024. The facility also failed to ensure a thorough investigation was completed by the facility on 04/01/2024 by failing to identify the 2 Certified Nurse Aids (CNAs), who were involved in the improper transfer of resident #31 using a mechanical lift. Findings: Review of the User Manual for the Invacare Reliant 450 and Invacare Reliant 600 dated 10/01/2018 revealed Section 8 Transferring Patient to a Wheelchair revealed: 5. Use the straps or handles on the side and the back of the sling to guide the patient's hips as far back as possible into the seat for proper positioning; 6. Position the patient over the seat with their back against the back of the chair; 8. Two assistants are recommended for this step- one assistant stands behind the chair and the other operates the patient lift. The assistant behind the chair pulls back on the grab handle (on select models) or sides of the sling to seat the patient well into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward. Further review of the User [NAME] revealed illustrations on the page (31) indicating the lift being in front of the wheelchair with the lift legs on the outside of the wheelchair wheels. Review of the record revealed resident #31 was admitted to the facility on [DATE] with diagnoses including necrotizing fasciitis, morbid obesity, type 2 diabetes mellitus, end stage renal disease, hypertension, and functional quadriplegia. Review of resident #31's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. Further review of the MDS revealed the resident was totally dependent on staff for all transfers. Review of the incident log revealed resident #31 had an incident involving physical contact with an object on 04/01/2024 and 04/10/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/20/2024 at 1:10 p.m. with resident #31 revealed she was being transferred from the bed to her wheelchair using the lift by staff on 04/01/2024 and 04/10/2024, and she was hit in the head by the lift during both incidents. Resident reported the staff did not lock the lift during the transfers. Resident reported that the incident on 04/01/2024 resulted in a bump to the left side of her forehead, and the incident that occurred on 04/10/2024 resulted in a laceration to the right side of her forehead, and she was sent to the hospital. Review of the incident report for resident #31 dated 04/10/2024 at 5:53 a.m. revealed the nurse was alerted by a CNA that during a lift transfer, resident #31 leaned forward and hit her head on the side of the rail. Nurse entered room and observed resident sitting up in the wheelchair with a towel to right side of her head. The nurse documented a small round, raised round area was noted with a laceration to the right side of the resident's head. Review of the facility's investigation of resident #31's incident on 04/10/2024 revealed resident was being transferred from the bed to the wheelchair with the lift by 2 CNAs, and during the transfer resident #31 was hit in the head by the lift when they were adjusting the resident in her wheelchair. The 2 CNAs identified in the investigation were S6CNA and S7CNA. Review of S6CNA's statement dated 04/10/2024 revealed she was assisting S7CNA with transferring resident #31 from the bed to the wheelchair via the mechanical lift, the resident was rushing the staff so she would not be late for her dialysis. S6CNA reported that while S7 CNA pulled resident #31 back in the lift to position the resident in the wheelchair, the lift hit the resident in the head. Review of S7CNA's statement dated 04/10/2024 revealed she was transferring resident #31 from the bed to the wheelchair via the mechanical lift, and the resident was rushing staff to hurry up so she would not be late for dialysis. S7CNA reported that while they had resident #31 up in the lift, she told them to place the lift to the side of the wheelchair to place the resident in the wheelchair. S7CNA told the resident that she had never transferred residents in the lift this particular way, and when she pulled the resident while in the lift, the lift tilted over and resident was hit in the head with the lift. An interview on 05/20/2024 at 3:50 p.m. with S7CNA revealed on 04/10/2024 she and another CNA got resident #31 dressed and used the lift to transfer the resident from the bed into the wheelchair. S7CNA reported the resident was rushing them so she could get to dialysis on time. S7CNA reported that resident #31 wanted the CNAs to place the lift to the side of the resident's wheelchair, and the CNAs placed the lift to the side of the wheelchair. S7CNA reported she started pulling on the resident to place her in the correct position in the wheelchair, but the lift tilted and the top hanging part hit the resident in the head. S7CNA reported that she noticed resident's forehead was bleeding so she applied pressure and the other CNA went to notify the nurse on the hall. S7CNA reported she had not been trained by the facility on the lift prior to the incident on 04/10/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone call interview on 05/21/2024 at 12:45 p.m. with S6CNA revealed she was in resident #31's room with S7CNA on 04/10/2024 assisting with transferring resident from the bed to the wheelchair using the mechanical lift. S6CNA revealed when they had resident up in the lift about to place her in the wheelchair, S7CNA started to pull resident #31 into the wheelchair and the lift started to tilt, and the lift hit the resident in the head. S6CNA confirmed after they had gotten resident up in the lift, they positioned the lift to the side of the wheelchair per the request of resident #31. S6CNA confirmed she had not been trained on lifts by the facility prior to the incident on 04/10/2024 with resident #31. An interview on 05/22/2024 at 9:20 a.m. with S2Previous Executive Director confirmed S6CNA and S7CNAs statements and interviews regarding the 04/10/2024 incident corroborated. They both reported the lift was placed improperly to the side of the wheelchair which caused the front of the lift to become unbalanced during the transfer and resulted in the lift hitting resident #31 in the head. S2Previous Executive Director confirmed that S6CNA and S7CNA did not transfer resident #31 properly using the mechanical lift on 04/10/2024 based on review of the manufacture's user manual for Invacare Reliant 450 and Reliant 600. Review of the incident report for resident #31 dated 04/01/2024 at 5:01 a.m. revealed 2 certified nurse aids (CNAs) and S4Licensed Practical Nurse (LPN) were transferring resident from the bed to the wheelchair via the lift, and while trying to get the resident situated in the wheelchair, the lift tilted and bumped resident #31 above the left eye causing a small bump above the left eye. Review of the facility's Supervisor Investigation Summary Form for resident #31's incident on 04/01/2024 revealed the resident was a two person assist with lift for all transfers with a bariatric full body lift pad. Investigation completed by the facility revealed statements were obtained from S4LPN and resident #31; however there was no documented evidence of the identity of the 2 CNAs involved in the incident for 04/01/2024. Further review revealed the facility failed to ensure a thorough investigation was completed for the incident that occurred on 04/01/2024 involving resident #31. An interview on 05/22/2024 at 3:15 p.m. with S3DON confirmed there was no documented evidence of the identity of the 2 CNAs involved with the incident with resident #31 on 04/01/2024 and confirmed a thorough investigation was not conducted by the facility on the incident that occurred on 04/01/2024. A phone call on 05/22/2024 at 11:17 a.m. with S4LPN revealed she was in the room on 04/01/2024 when the incident occurred involving resident #31 being transferred using the lift from the bed to the wheelchair. S4LPN reported that while the 2 CNAs were transferring resident #31 into the wheelchair the mechanical lift tilted causing the resident to be struck in the head with the lift. S4LPN confirmed the lift was improperly positioned during the transfer. S4LPN reported she was unsure of the names of the 2 CNAs that were working when the incident occurred on resident #31 on 04/01/2024.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on record review and interview the facility failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure a resident's (#44) medications were not left unattended at his bedside. Findings: Review of the facility's Medication Administration - General Guidelines Policy dated 08/2016 revealed in part: Subject: Medication Administration- General Guidelines Responsibility: All Licensed Nursing Personnel Procedure: 4. Medications are administered at the time they are prepared for each resident. Medications are not pre-poured. Review of the medical record for resident #44 revealed diagnoses of specified sequelae of cerebral infarction and major depressive disorder. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed resident #44 had a Brief Interview for Mental Status score of 9 which indicated severe cognitive impairment and he required partial to moderate assistance with most activities of daily living. On 05/20/2024 at 9:43 a.m. an observation revealed a medication cup with 3 unidentified pills were on resident #44's overbed table near his bed. An interview with resident #44 revealed he was unsure who left the medication at his bedside. At 9:50 a.m., S12Licensed Practical Nurse (LPN)/Treatment Nurse entered the resident's room and saw the pills that were left at his bedside and stated S13LPN must have left them there. S12LPN/Treatment Nurse confirmed S13LPN was assigned to resident #44's hall this morning and she saw her passing medications to the residents on his hall. On 05/20/2024 9:55 a.m. an observation revealed S12LPN/Treatment Nurse accompanied S13LPN to resident # 44's room and asked her if she left the pills at resident #44's bedside. S13LPN confirmed she was assigned to resident #44's hall but did not remember leaving the pills on resident # 44's overbed table. On 05/22/2024 at 5:45 p.m. an interview with S3Director of Nursing confirmed S13LPN should not have left resident #44's pills at the bedside.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 22575 Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) provided services of 8 consecutive hours a day on 11/05/2023, 02/03/2024, 02/10/2024, and 05/12/2024. Findings: Review of the facility's Payroll Based Journal (PBJ) staffing data report revealed the time frame of 10/01/2023 - 12/31/2023 triggered for excessively low weekend staffing. Review of the Nursing/Ancillary Personnel Staffing Pattern Reporting Forms for the weekends of October 2023 - May 2024 completed by S2Previous Executive Director revealed there were no staffing hours for the RN (Registered Nurse) for the following dates: 11/05/2023, 02/03/2024, 02/10/2024, and 5/12/2024. There was no documented evidence the RN worked 8 consecutive hours on those dates. On 05/08/2024 at 8:20 a.m., an interview with S1Executive Director and S2Previous Executive Director revealed they were unable to find the documentation or time sheets to prove a RN worked for 8 hours on the dates listed above.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 22575 Based on record reviews and interview, the facility failed to ensure the State Adverse Actions Website checks were completed for Certified Nursing Assistants (CNA) initially upon hire and monthly thereafter for 1(S7CNA) of 6 (S6CNA, S7CNA, S14CNA, S15CNA, S16CNA and S17CNA) personnel files reviewed. Findings: Review of S7CNA's personnel file revealed a hire date of 10/04/2023. Further review of S7CNA's personnel file revealed there was no documented evidence of a State Adverse Actions check for S7CNA upon hire or monthly thereafter. An interview with S11Corporate Human Resource Coordinator on 05/22/2024 at 3:30 p.m. confirmed there was no documentation of a State Adverse Action check for S7CNA upon hire or monthly thereafter.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 19121 Based on record review and interview the facility failed to ensure resident's drug regimens were free from unnecessary psychotropic medications for 1 (#323) of 5 (#39,#47,#48,#276,#323) residents reviewed for unnecessary medications. The facility failed to ensure a psychotropic medication was used only when there was an acceptable diagnosis documented in the medical record for resident #323. Findings: 43405 Resident #323 Review of the record for resident #323 revealed an admitted [DATE] with diagnosis including cerebral infarction, unspecified dementia, senile degeneration of the brain, and palliative care. Review of resident #323's May 2024 Physician's Orders revealed the following orders: 04/30/2024- Seroquel 100 mg tablet, give 100 mg orally every 12 hrs q day (unspecified dementia) 05/06/2024- Ativan 0.5 mg, give 0.5 mg orally once every day (unspecified dementia) 04/30/2024- Doxepin 10 mg capsule, give 10 mg orally once every day (unspecified dementia) Review of the record revealed no documentation of an appropriate diagnosis for the use of Seroquel (antipsychotic medication), Doxepin (antidepressant medication), and Ativan (antianxiety medication). Further review revealed all 3 of these medications have an associated diagnosis of unspecified dementia unspecified severity without behavior, psych, mood, or anxiety. An interview on 05/22/2024 at 1:30 p.m. with S3DON confirmed resident #323 was taking Seroquel, Ativan, and Doxepin with a diagnosis of dementia with behaviors and did not have any other diagnosis for the use of antipsychotic, antidepressant, and antianxiety medications. Review of resident #323's Consultant Pharmacist Communication to Physician dated 05/08/2024 revealed a request for a diagnosis for justification of use of Seroquel (antipsychotic medication) signed by nurse practitioner on 05/22/2024. Further review revealed the nurse practitioner documented resident #323 has dementing illnesses with associated behavioral symptoms, but this diagnosis does not provide an acceptable diagnosis for the use of antipsychotics, antianxiety, and antidepressant medications. An interview on 05/22/2024 at 6:20 p.m. with S3DON confirmed the only associated diagnosis of unspecified dementia with unspecified severity, without behaviors/psych/mood/anxiety listed for the use of Seroquel (antipsychotic medication), Doxepin (antidepressant medication), and Ativan (antianxiety medication).