STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195446	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Nursing and Rehabilitation Center	400 Hospital Road New Roads, LA 70760

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to have a system in place to provide individualized behavioral health services, which met the individualized needs of a resident by preventing and treating their mental health disorder(s) for 1 (#17) of 7 residents reviewed for behavioral health in the sample Findings: Review of the facility's undated Provision of Quality Care Policy, as of 04/15/2026 at 3:45 p.m., revealed, in part, the following: Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 3. Qualified persons will provide the care and treatment in accordance with the resident's choices. 6. The facility will employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of the residents' care plans. Review of the facility's undated Behavioral Health Services Policy, as of 04/15/2026 at 3:45 p.m., revealed, in part, the following: Policy Explanation and Compliance Guidelines: 1. The facility will ensure each resident receives the necessary behavioral health care and services to attain or maintain highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 2. Behavioral health includes a resident's entire emotional and mental health, which includes the prevention and treatment of mental disorders. 3. The facility must have sufficient staff with the appropriate competencies and skill sets to provide services to assure resident safety and attain or maintain the highest practical, mental and psychosocial well-being of each resident determined by resident assessments and individual plans of care and considering the number, acuity, and diagnosis of the facility's resident population. 4. These competencies include, but are not limited to knowledge of and appropriate training and supervision for: B. Caring for residents with mental and psychosocial disorders identified in the facility assessment and; C. Implementing non-pharmacological interventions. 5. All residents who display or are diagnosed with mental disorders will receive appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. 6. Residents will receive care in accordance with professional standards of practice and accounting for residents' experiences and preferences.Review of Resident #17's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included, in part, Anxiety Disorder, Delusional Disorder, Depression, Psychotic Disorder; Insomnia; and Generalized Anxiety Disorder. Review of Resident #17's most recent Annual MDS, with an ARD of 04/09/2026, indicated she was assessed to be cognitively intact with a BIMS of 15. Further review revealed, in part, the following: Active Diagnoses: Anxiety Disorder, Depression, Psychotic Disorder, Delusional Disorders, Other Specified Anxiety Disorders, and Unspecified Depression.Special Treatments/Procedures/Programs: Psychological Therapy: 0 minutes; Recreational Therapy: 0 minutes; and Training and Skills Practice: 0 minutes. Medications Currently Taking:Antipsychotic, Antianxiety, and Antidepressant.Review of Resident #17's Physician Orders revealed, in part, the following active orders: 04/02/2025 - Alprazolam 0.25mg - 1 tablet twice daily as needed for Anxiety. (Stopped on 05/19/2025);04/29/2025 - Buspirone 10mg - 1 tablet three times daily for Sadness, Isolation, Depression.04/29/2025 - Fluoxetine 40mg - 1 capsule twice daily (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Loneliness, Isolation, Depression;05/16/2025 - Lorazepam 0.5mg - 1 tablet twice daily as needed for Anxiety. 06/04/2025 - Risperdal 0.5mg - 1 tablet daily for Mood Swings, Agitation, and Delusional Disorder. (Stopped on 06/03/2026);05/19/2025 - Alprazolam 0.5mg - 1 tablet twice daily as needed for Anxiety; 07/02/2025 - Lorazepam 0.5mg - 1 tablet twice daily for Anxiety (Stopped on 07/22/2025);07/22/2025 - Lorazepam 1mg - 1 tablet twice daily for Anxiety (Stopped on 01/29/2025); 01/06/2026 - Hydroxyzine 50mg. 1 tablet every 8 hours as needed for Picking/Itching; 01/08/2026 - Melatonin 5mg - 1 tablet at bedtime for Insomnia (Stopped 04/02/2026);01/16/2026 - Lorazepam 1mg. One time dose to be given for increased Anxiety;01/29/2026 - Lorazepam 1mg - 1 tablet three times daily for 7 days for Anxiety then resume Lorazepam 1mg twice daily on 02/06/2026. 02/06/2026 - Lorazepam 1mg - 1 tablet three times daily for Anxiety Disorders; and04/02/2026 - Melatonin 10mg - 1 tablet at bedtime for Restlessness; and06/03/2026 - Risperdal 1mg - 1 tablet twice daily for Delusional Disorders, Agitation, Isolation.Review of Resident #17's Psychiatric Specialist Progress Notes, dated 08/13/2024 through 04/13/2026, revealed in part, she received the following 3 visits since her admission: [DATE]:Resident seen today due to staff reporting compulsive behaviors and excessive picking/scratching of her skin, which was causing sores. Has history of Delusional Disorder, Depression, and Generalized Anxiety Disorder; 05/06/2025:Resident seen today as follow up. Staff reported increased anxiety and agitation. Resident reported I'm not really great and endorsed anxiety, depression, sleep impairment and appetite impairment. Resident stated she was not adjusting well to living in the facility. New medication ordered; and 06/02/2025:Resident seen today as follow up. Resident reported I'm doing so-so and endorsed anxiety, depression and staying in her room all of the time. Resident reported increased difficulty with adjusting/coping with moving into the facility. Medication doses changed and new medications ordered. Review of Resident #17's General NP Progress Notes, dated 04/01/2025 through 04/13/2026, revealed in part, the following: 04/02/2025:Resident reported increased anxiety and having panic attacks. Xanax ordered. 04/28/2025:Resident reported anxiety was uncontrolled with current dose of Xanax and requested a dose increase or to be changed to Ativan. Will refer to Psychiatric Specialist to assume medication management. Resident intermittently compliant with attending therapy and has been progressing well when attending sessions. Reported attending sessions on Tuesdays, Wednesdays and Thursdays.05/01/2025:Resident remains intermittently compliant with attending therapy but has been progressing well when attending sessions. 05/07/2025:Resident seen by Psychiatric Specialist on 05/06/2025 who recommended increasing the dose of Xanax. Change made. 05/20/2025: Resident has now refused to leave the facility for her scheduled colonoscopy on 3 separate occasions. 06/04/2025:Resident seen by Psychiatric Specialist on 06/03/2025 who recommended discontinuing Xanax, adding Lorazepam, and increasing the dose of Risperidone. Changes made. 06/22/2025:Resident noted with multiple wounds present and reports picking at her skin. 07/22/2025:Increased anxiety during today's visit. Resident reported her anxiety was poorly controlled on her current dose of Lorazepam because she was taking a much higher dose prior to long term care admission. Lorazepam dose increased. 08/25/2025:Resident frequently lays in bed, refuses therapy and remains sedentary. 09/25/2025:Resident very anxious during visit today. 11/17/2025:Resident frequently lays in bed, refuses therapy and remains sedentary. Resident demonstrated increased anxiety during visit. 12/08/2025:Resident encouraged to get out of bed and up to wheelchair. Resident stated she may start therapy next month.01/06/2026:Resident has frequently refused therapy, to get out of bed and/or leave her room;01/09/2026:Resident reported increased difficulty sleeping. 01/12/2026:Resident lived alone in her own home and performed all ADLs independently prior to long term care admission. Currently sedentary, debilitated and has gained 14.8 pounds in 2 weeks. 01/16/2026:Resident reports increasing anxiety. Resident reports picking at skin. One time dose of anxiety medication ordered. 01/29/2026:Resident reported increasing anxiety. Appears anxious and apprehensive today. States she has been having panic attacks and reported having to breathe in a paper bag for 4 hours yesterday. Ativan dose increased x7 days to allow for (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	improvement then resume previous dose. 02/03/2026:Depression and Anxiety Assessment/Plan: Diphenhydramine; Lorazepam; Fluoxetine; Buspirone; and Risperidone. Discussed concerns regarding chronic opiate use through scheduled Ativan. Patient prioritizes anxiety control over receiving narcotics; 03/08/2026:Primary/secondary lesions on extremities, chest and abdomen;03/11/2026:Multiple scabs noted to skin. Frequently lays in bed and refuses therapy; 03/23/2026:Multiple scabs noted to skin; 04/04/2026:Longstanding history of mental health disorders which were managed by a Psychiatrist prior to admission to the long term care facility. Multiple scabs noted to skin. Review of Resident #17's Psychoactive GDRs revealed, in part, the following: 03/25/2025:Dose decrease in Risperdal, used to treat Delusional Disorder, contraindicated due to recent relapse in symptoms; and03/16/2026:Dose decrease to all psychoactive medications contraindicated due to symptoms remaining persistent enough to warrant continuation with all psychoactive medications managed by Psychiatric Specialist.An interview was conducted on 04/15/2026 at 9:55 a.m. with Resident #17. She confirmed she suffered from on-going issues with anxiety and depression, which were present long before she was admitted to the facility. She confirmed prior to admission, she lived alone, cared for herself independently and saw a psychiatrist who prescribed her medications and helped her manage her mental health issues. She confirmed she still experienced on-going issues with adjusting to not living independently anymore and all that comes with living in a long term care facility. She stated she also experienced extreme anxiety with having so many health issues and being fearful of what that will mean for her in the future. She stated she knew worrying won't change it, but she could not make herself stop all of the time. She confirmed she experienced panic attacks at times, which had become more frequent since the beginning of the year, and thought it may be because of some new health issues she'd developed. She stated when her anxiety was bad, she picked at her skin and either caused new sores or worsened ones she already had but she just couldn't make herself stop. She confirmed when she first entered the facility, she was comfortable leaving her room to participate in therapy sessions, activities, and to interact with other residents throughout the facility during meals or other events. She confirmed at some point after admission, she no longer left her room and no longer felt comfortable being around other people outside of her own space but could not express why. She confirmed in the past year, she'd missed multiple specialist appointments/testing/procedures, which would have required her to leave the facility. She stated none of the nursing staff or S6SSD had asked her why she no longer left her room and it was probably best because she wouldn't know how to answer. She confirmed a year or so back, S6SSD offered her an opportunity to participate in an intensive outpatient treatment program, but she declined due to having to leave her room and the facility in order to participate. She confirmed she used to see the facility's Psychiatric Specialist, but had not seen her in almost a year and was not sure why she quit coming. She confirmed the facility's nurse practitioners saw her and ordered her medications now. She confirmed she was never offered any sort of behavioral health counseling or therapy services to be provided in her room. She confirmed she never even realized that was a service a nursing home could provide or she would have requested it when she moved in. She confirmed if the facility provided a behavioral health counselor or therapist that came to her room, she would not only participate, she felt it would also greatly benefit her to talk through the things that were concerning her at the time.An interview was conducted on 04/15/2026 at 9:20 a.m. with S15LPN. S15LPN confirmed she was familiar with Resident #17 and provided her care frequently. S15LPN confirmed Resident #17 had on-going issues with uncontrolled anxiety and depression. S15LPN stated she could tell when Resident #17's anxiety was getting bad because she would pick at her skin and cause sores. S15LPN confirmed Resident #17 took medications several times a day to manage her signs and symptoms but some days it worked and other days weren't so good. S15LPN confirmed Resident #17 refused to leave her room but could not say why. S15LPN confirmed it had never crossed her mind it could be related to her anxiety and/or depression. S15LPN confirmed if the facility offered a counselor or therapist that saw residents in their rooms, she felt Resident #17 would (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	definitely participate. An interview was conducted on 04/15/2026 at 9:50 a.m. with S8CNA. S8CNA confirmed she was familiar with Resident #17 and provider her care frequently. S8CNA confirmed Resident #17 refused to leave her room but had never asked her why. S8CNA confirmed Resident #17 had on-going issues with anxiety and depression and some days were better than others. S8CNA stated she could tell when Resident #17's anxiety was getting bad because she would pick at her skin and cause sores. An interview was conducted on 04/15/2026 at 2:19 p.m. with S9CNA. S9CNA confirmed she was very familiar with Resident #17 and had worked with her since she was admitted to the facility. S9CNA confirmed Resident #17 had on-going issues with anxiety, depression and panic attacks since she was admitted to the facility. S9CNA stated some days were better than others. S9CNA confirmed when Resident #17 was admitted , she attended therapy, activities and other events to interact with residents outside of her room; however, at some point she began refusing to leave her room for anything. An interview was conducted on 04/15/2026 at 2:45 p.m. with S7LPN. S7LPN confirmed when she was assigned to provide care for Resident #17, the resident typically experienced large amounts of increased anxiety. S7LPN confirmed she always documented Resident #17's anxiety in her chart so she would not inform S2DON, S3ADON or S6SSD because they reviewed documentation and discussed it then would ask questions if there were any. Review of Resident #17's Social Services Quarterly Assessment Notes revealed, in part, she was assessed quarterly by S6SSD to not have any changes or issues present regarding cognitive status, social interactions, mood status, behavioral status, and/or the presence of any rejection of care from August 2024 through April 2026. An interview was conducted on 04/15/2026 at 11:14 a.m. with S6SSD. S6SSD confirmed she was responsible for performing and documenting each resident's Quarterly SSD Assessment Note. S6SSD confirmed if a resident were capable of answering questions, she only asked them questions to complete the assessment. S6SSD confirmed if the resident couldn't answer her questions, she would check in with direct care staff. S6SSD confirmed the assessment included the entire quarter prior to the date of the assessment, not just a 7 day lookback period. S6SSD confirmed the assessment should include the presence of anything social services related that was observed by and/or reported to anyone in the facility, not just herself. S6SSD reviewed Resident #17's SSD Quarterly Assessments for 10/31/2024, 07/14/2025, 10/14/2025, 01/08/2026 and 04/09/2026 then confirmed she completed them. S6SSD confirmed each of the assessments indicated Resident #17 remained stable, did not have any changes and/or did not demonstrate any signs or symptoms related to her cognitive status, social interactions, mood status, behavioral status, and had not rejected any care from 08/2024 through 04/09/2026. S6SSD confirmed she was unaware Resident #17 experienced on-going issues with anxiety, depression and intermittent panic attacks since she was admitted to the facility and should have been. S6SSD confirmed she was unaware Resident #17 had been picking at her skin causing sores due to her anxiety and should have been. S6SSD confirmed she was unaware changes had been made to Resident #17's psychoactive medication regimen in order to better manage the onset of signs and symptoms and should have been so she could have followed up. S6SSD stated she attended a daily morning meeting with the directors of all the facility's departments and she would be notified of the presence of any behavioral and/or mental health signs and symptoms during that meeting so she could follow up with the resident. S6SSD confirmed she was not made aware of anything social services related involving Resident #17 during the daily morning meetings. S6SSD confirmed the direct care staff should also came to her if a resident was having any behavioral/mental health issues so she could follow up with the resident and see what was going on. S6SSD confirmed she was aware Resident #17 now refused to get out of bed and/or leave her room and she had been willing to do so when she was initially admitted to the facility. S6SSD confirmed Resident #17 was independent and lived at home alone prior to moving into the facility. S6SSD confirmed Resident #17 used to leave her room to participate in activities and interact with others but stopped doing so a while back. S6SSD stated she did not know when the change took place because she had not paid much attention to it and never thought it could have been related to her mental (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health. S6SSD confirmed she'd offered Resident #17 an opportunity to attend an intensive outpatient program in the past but confirmed she could not say when she had done so. S6SSD confirmed Resident #17 refused to participate due to not wanting to leave the facility and she did not offer or attempt to find additional options to accommodate for her unwillingness to leave her room. S6SSD confirmed she could not recall or provide documentation to indicate Resident #17 was offered any sort of counseling or therapy services to be provided in her room. S6SSD stated she only offered services to residents when there was an order present to do so or it was specifically listed on their recommended services. S6SSD confirmed she was responsible for arranging behavioral health services for the facility's residents and working with all the members of the interdisciplinary team to create an individualized plan of care which met the resident's specific needs. S6SSD confirmed this had not occurred for Resident #17 and should have. An interview was conducted on 04/15/2026 at 10:05 a.m. with S2DON. S2DON confirmed the facility's interdisciplinary team was responsible for identifying the behavioral health needs of their residents, educating the resident on what services were available, making arrangements for the services to be provided then ensuring the services were being provided as they should. S2DON confirmed the team met every morning to review what was going on with all of the resident's in the facility. S2DON confirmed they reviewed a 24 hour report to see if any of the residents had any changes or anything new since the previous meeting, such as the presence of behavioral health signs and symptoms. S2DON confirmed in addition to reviewing the report, she also expected her direct care staff to keep not only the NP's but also her informed of what was going on with the residents; if any new behaviors presented or if current ones were not resolving. S2DON confirmed she utilized all of this information to ensure she had the most up to date information during their daily morning meetings. S2DON confirmed the facility offered a Psychiatric Specialist who made monthly rounds in the facility to assess and treat resident's on their list. S2DON confirmed she was responsible for maintaining the Psychiatric Specialist's list of residents to be seen during their next rounding day. S2DON confirmed the Psychiatric Specialist should see any resident experiencing current, on-going behavioral health signs and symptoms along with residents who required psychoactive medication dose changes and/or psychoactive medication changes and/or residents who were identified as needing to be seen by a Psychiatric Specialist on their Level II PASRR. S2DON confirmed if a resident was seen for uncontrolled signs and symptoms and/or had a medication dose change/new medication addition, the resident should be added to the Psychiatric Specialist's list of residents to be seen the following month so she could follow up and ensure everything resolved since the previous visit. S2DON confirmed it was her responsibility to know which residents should be added to the list for follow up the following month. S2DON confirmed the only reason the Psychiatric Nurse practitioner would see a resident less frequently than every month was if they were stable on their medication doses and were not experiencing any signs or symptoms and at that point they would be seen annually. S2DON confirmed it was her responsibility to be aware of what was going on with the residents so she could ensure everyone who needed to be seen were seen when the Psychiatric Specialist was at the facility. S2DON confirmed if one of the facility's general NP's were making changes to a resident's psychoactive medication(s), the resident should be seen by the Psychiatric Specialist the next time they round in the facility to ensure they are in agreement with the changes that were made. S2DON confirmed Resident #17's Progress Note from the Psychiatric Specialist on 06/02/2025 indicated she was seen for unresolved signs and symptoms and received medication order changes during the visit. S2DON confirmed Resident #17 should have been seen again the following month and she was not. S2DON confirmed it was her responsibility to add Resident #17 to the list and to ensure she was seen but she did not know what happened or why she was left off. S2DON confirmed in addition to providing residents with a mental health diagnosis the opportunity to see the Psychiatric Specialist, the facility also offered residents the opportunity to participate in an intensive outpatient program which was provided at another facility in a nearby town. S2DON confirmed the facility did not currently provide any in-house options for behavioral health therapy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety by failing to ensure: 1. Food was labeled and / or dated with a preparation date; and 2. Left over food was discarded in a timely manner.This deficient practice had the potential to affect any of the 91 residents who received nourishment from the facility's kitchen.Findings: Review of the undated facility policy titled Storage: Freezer revealed the following, in part:3. Label and date all items Review of the undated facility policy titled Storage: Refrigerator revealed the following, in part:6. If raw foods must be kept in the same refrigerator keep cooked foods above raw foods. If cooked foods are kept below raw foods, they can become contaminated by drips and spills. Then, if they are not to be cooked again before serving, they may be hazardous.7. Keep refrigerated foods wrapped or covered in sanitary containers. On 04/14/2026 at 2:24 p.m., an interview was conducted with S4DM. S4DM confirmed 91 residents received food from the kitchen. On 04/13/2026 at 8:23 a.m., a tour of the kitchen was conducted with S4DM. The following observations were made and confirmed: Freezer a 1 personal cup with a lid and straw containing liquid sitting on top of the freezer;1 large Styrofoam cup with a lid containing ice with no label and no date; and1 small Styrofoam cup with a lid containing a dessert with no label and no date. Cooler a1 container of cut tomatoes with a preparation date of 04/06/2026 and a use by date of 04/12/2026;1 container labeled of mixed peanut butter jelly with no preparation date and no use by date; 3 cartons of pork chops stored on a wire shelf over a covered bowl of diced pears; and1 container of tuna salad with no label and no preparation date. On 04/13/2026 at 8:36 a.m., an interview was conducted with S4DM. S4DM confirmed the Styrofoam cups in Freezer a belonged to an employee and should not have been stored in the freezer. S4DM confirmed the personal cup with a lid and straw should not have stored on top of Freezer a. S4DM confirmed the cut tomatoes and container of beets should have been used within a week's time. S4DM confirmed the 3 cartons of pork chops should not be stored over the bowl of diced pears. S4DM confirmed all foods should be labeled and have a preparation date. On 04/14/2026 at 2:38 p.m., an interview was conducted with S1ADM. S1ADM confirmed employees should not store personal items in the freezer of the kitchen. S1ADM confirmed pork chops and meats should be stored on lower levels below other food items. S1ADM confirmed opened foods and left over food should be labeled with a preparation date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195446	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Nursing and Rehabilitation Center	400 Hospital Road New Roads, LA 70760

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure nursing staff notified the provider when staff heard Resident #89 state she did not want to live anymore for 1 (#89) of 3 residents reviewed for Dementia Care.Findings:Review of Resident #89's Clinical Record revealed she was admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia, Mood Disturbance, Anxiety, and Schizoaffective Disorder.Review of Resident #89's Quarterly MDS with an ARD of 03/03/2026 revealed the resident had a BIMS of 12, indicating the resident was moderate cognitively impaired.Review of Resident #89's Nursing Notes, dated 02/23/2026 at 5:53 a.m., revealed the following: Resident #89 was heard in her room stating I just want to die already. S16LPN asked Resident #89 why she felt that way and Resident #89 stated because people are talking about her. S16LPN asked what people and Resident #89 pointed to the empty bed in her room. S16LPN assured her no one was in the room with her. Resident #89 continued to state that she no longer wanted to live. NP and DON made aware. Review of Resident #89's NP Progress notes, dated 02/23/2026 to 03/27/2026, revealed no documentation Resident #89 stated she did not want to live anymore. An interview was conducted with S16LPN on 04/15/2026 at 10:38 a.m. She stated during the night shift of 02/23/2026, she heard Resident #89 state she just wanted to die and did not want to live any longer. She stated she left a message for the on call provider via voice message and wrote the information in the green NP communication binder found at the nurse's station. An interview was conducted with S2DON on 04/15/2026 at 10:48 a.m. She stated she was aware Resident #89 had a diagnosis of Dementia and Schizoaffective Disorder. She stated she was not aware of a green communication binder at the nurse's station and she would expect staff to contact her and the NP immediately if the resident was heard saying she did not want to live any longer. She confirmed she was not made aware of Resident #89's change of condition and should have been. An interview was conducted with S10NP on 04/15/2026 at 1:05 p.m. She stated there was a NP on call 24 hours a day 7 days a week. She stated if Resident #89 stated, I just want to die already, the on call provider should have been notified immediately and the on call provider would have sent the resident out to the hospital for an evaluation. She confirmed she rounded on Resident #89 on 02/23/2026 and was not made aware of Resident #89's statement. She stated if she was made aware it would have been in her encounter note on 02/23/2026 and she would have sent Resident #89 out to the hospital for an evaluation.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews, and record reviews, the facility failed to respect the resident's right to personal privacy for 2 (#8 and #63) of the 25 residents reviewed for privacy in the initial pool. The facility failed to ensure Residents #8 and #63 had privacy curtains around their beds.Findings: Resident #8Review of Resident #8's Clinical Record revealed an admission date of 07/03/2025. Review of Resident #8's Quarterly MDS with an ARD of 03/26/2026 revealed that the resident had a BIMS of 15, indicating the resident was cognitively intact. Resident #63Review of Resident # 63's Clinical Record revealed an admission date of 04/28/2025. Review of Resident #63's Quarterly MDS with an ARD of 02/02/2026 revealed that the resident had a BIMS of 14, indicating the resident was cognitively intact. Review of facility Census revealed Resident #8 and Resident #63 were roommates. On 04/13/2026 at 9:01 a.m., an observation was conducted of Resident #8 sitting in her room next to the window. Further observation revealed there was no privacy curtain attached to the track on the ceiling. Resident #8 stated she would like to have a curtain for privacy in her room. On 04/14/2026 at 4:20 p.m., an observation was conducted of Resident #8's and Resident #63's room which revealed there was no privacy curtain attached to the track on the ceiling. On 04/15/2026 at 7:50 a.m., an observation was conducted of Resident #8's and Resident #63's room which revealed there was no privacy curtain attached to the track on the ceiling.An interview was conducted with Resident #63 on 04/14/2026 at 4:25 p.m. Resident # 63 stated she would like a privacy curtain in her room to separate her space from Resident #8. An interview with observation was conducted with S18CNA on 04/15/2026 at 7:56 a.m. Observation of Resident #8 and Resident #63's room revealed no privacy curtain was attached to the ceiling track. S18CNA confirmed Resident #8 and Resident #63 should have a privacy curtain between the beds to ensure they each had personal space. An interview was conducted with S17CNAS on 04/15/2026 at 8:04 a.m. She confirmed all rooms should have a privacy curtain. She stated she was not aware the room did not have a privacy curtain and should have. An interview was conducted with the S2DON on 04/15/2026 at 3:35 p.m. She confirmed all resident's had the right to privacy and a privacy curtain should be in all resident's rooms.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure a resident with a newly identified psychiatric diagnosis was referred for a Preadmission Screening and Resident Review (PASRR) Level II evaluation as required for 1 (#51) of 4 sampled residents reviewed for PASRR. Review of the facility's undated Policy titled Resident Assessment- Coordination with PASRR Program revealed the following, in part: Policy: The facility coordinates assessments with preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. U9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: aa. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASRR. Review of Resident #51's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #51 acquired a new psychiatric diagnosis of Schizophrenia on 03/20/2025. Review of Resident # 51's most recent PASRR Level 1 Form dated 08/08/2022 revealed no psychiatric diagnoses. Review of Resident #51's Care Plan with a revised date of 10/02/2025 revealed, in part the following: The resident had a behavioral problem related to Schizophrenia.On 04/14/2026 at 1:30 p.m., an interview was conducted with S6SSD. She confirmed she did not have a Level II PASRR for Resident #51. S6SSD confirmed Resident #51 had acquired a diagnosis of Schizophrenia on 03/20/2025. 6SSD stated she was unaware a Resident Review Form should have been submitted after acquiring diagnosis of Schizophrenia. S6SSD confirmed there was no process in place for identifying residents with any newly acquired psychiatric diagnoses. On 04/15/2026 at 2:45 p.m., an interview was conducted with S1ADM. S1ADM confirmed if a resident received a new mental health or psychiatric diagnosis the facility should submit a Resident Review Form for evaluation and determination for Level II services.