STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure a resident's discharge was documented in the resident's medical record for 2 (Resident #1, Resident #R1) of 3 (Resident #1, Resident #R1, and Resident #R2) residents reviewed for discharge. The facility failed to:1. Ensure documentation in the medical record included the basis for discharge for Resident #1 and Resident #R1;2. Ensure documentation in the medical record included that written discharge instructions were given to and discussed with the Resident/Responsible Party for Resident #1 and Resident #R1; and3. Ensure documentation in the medical record included discharge planning that addressed caregiver support and referrals to local contact agencies for Resident #1.Findings:On 09/03/2025, a review of the facility's policy titled Discharge Plan/Summary last revised 04/2025 revealed in part.6. If the resident is discharging to a private home, social work should meet with the person accepting responsibility for the resident. Referrals needed should be made to home health, DHS, or others based upon the needs of the resident.11. Nursing should meet with the person responsible for the resident at home and provide instruction to that person as appropriate in regard to medication and treatments to be continued at home. Referrals should be ensured for home care as needed, and coordinate same with Social Services. Any unused medications that are currently ordered after discharge may be sent with the resident prior to discharge.17. There should be documentation in the Nurses Notes regarding resident status at the time of discharge.Resident #1Review of Resident #1's medical record revealed an admission date of 02/19/2025 with diagnoses including, in part.Other Fracture of Shaft of Right Tibia, Subsequent Encounter for Closed Fracture with Delayed Healing; Methicillin Resistant Staphylococcus Aureus Infection, Unspecified Site; Diabetes Mellitus due to Underlying Condition with Unspecified Complication; Personal History of Other Venous Thrombosis and Embolism.Review of Resident #1's Quarterly MDS with an ARD of 05/28/2025 revealed a BIMS Score of 15, indicating intact cognition. The resident was noted to be independent for ADLs and used assistive devices of a wheelchair and walker for mobility. Resident #1 was noted to be incontinent of bowel and bladder. Resident #1 participated in the assessment and goal setting. Resident #1 did not want to be a long-term resident and wanted to return to her home.Review of Resident #1's electronic and paper health record revealed that the resident did not have a documented discharge plan in place prior to her discharge. According to an interview on 09/03/2025 at 9:19 am with S6 SSD, on 08/01/2025, S4 BOM and S6 SSD went together to tell Resident #1 that her insurance had ended on 07/31/2025.In an interview with S6 BOM on 09/02/2025 at 10:57 a.m., she stated that she gave Resident #1 the fax confirmation of the resident's insurance coverage ending. S6 BOM stated the resident was given the choice to pay out of pocket to stay, but this amount and the resident's refusal were not documented by the facility in the resident's record. S4 BOM stated she gave the resident the amount she would be charged to stay, but couldn't verbalize the cost given to Resident #1.A review of Resident #1's closed record revealed that a discharge form was partially completed by S6 SSD and signed by Resident #1. No other discharge documentation, such as the basis for discharge, referrals, medication reconciliation, instructions for discharge, or coordination of care, was documented by the facility in Resident #1's record.An interview with S1 Administrator on 09/03/2025 at 9:25 a.m. confirmed that S6 SSD was responsible for discharge planning and documentation. In an interview on 09/03/2025 at 2:52 p.m., S2 DON stated Social Services was responsible for initiating the Discharge Summary and completing their part. S2 DON stated the nurse had a part to complete, also. S2 DON acknowledged Resident #1's medical record did not contain the reason for her discharge, nor any documentation that written instructions were given to or discussed with the resident regarding her medications at discharge. Resident #R1Review of Resident #R1's medical record revealed an admit date of 03/18/2025 and a discharge date of 06/10/2025. Resident #R1's diagnoses included Alzheimer's disease, Paroxysmal Atrial Fibrillation, Atherosclerotic Heart Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction.Review of Resident #R1's 5 day MDS with an ARD of 03/25/2025 revealed a BIMS score of 15, which indicated intact cognition.Review of Resident #R1's medical record revealed no documentation stating why the resident was discharged . Further review revealed no documentation of the medications provided to the resident at discharge or any instructions given to the resident.Review of Resident #R1's progress notes revealed the following:6/10/2025 at 12:23 p.m. Nurses Note by S8 LPN: Note Text: 12:20 p.m. Resident is discharged out of facility with medications.6/10/2025 at 10:54 a.m. Discharge Summary by S6 SSD: Resident sitting up in wheelchair waiting for family to arrive so that he can discharge home with fiancee. He is alert and oriented to self. His speech is clear. His hearing is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to have a discharge summary that included the required information for 2 (Resident #1 and Resident #R1) of 3 (Resident #1, Resident #R1, and Resident #R2) residents reviewed for discharge. The discharge summaries for Resident #1 and Resident #R1 failed to include:1. A recapitulation of the residents' stay that included diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results;2. A final summary of the residents' status at the time of the discharge; and3. Reconciliation of all pre-discharge medications with the residents' post-discharge medications (both prescribed and over-the-counter).Findings:On 09/03/2025, a review of the facility's policy titled, Discharge Plan/Summary last revised 04/2025 revealed in part.12. The Discharge Summary form should be completed with care needs identified and documented as appropriate.14. Guidelines for completion of the Discharge Summary: Nursing: Identifies continuing nursing needs. Specifies level of nursing care needed. Verifies resident/family understanding of orders including all medications prescribed by physician. Detailed nursing care plan, special problems, teaching steps and level of progress and further teaching as appropriate. Social Services: May identify resident's personal, financial and social needs in relation to medical and psychological problems.15. A copy of the summary is given to resident/family upon discharge when resident is going home. 16. The original is placed in the resident Medical Record. 17. There should be documentation in the Nurses Notes regarding resident status at the time of discharge.Resident #1Review of Resident #1's medical record revealed an admit date of 02/19/2025 with diagnoses that included in part Other Fracture of Shaft of Right Tibia, Subsequent Encounter for Closed Fracture with Delayed Healing; Methicillin Resistant Staphylococcus Aureus Infection, Unspecified Site; Diabetes Mellitus due to Underlying Condition with Unspecified Complication; Personal History of Other Venous Thrombosis and Embolism. Further review revealed a discharge date of 08/01/2025.Review of Resident #1's Quarterly MDS with an ARD of 05/28/2025 revealed a BIMS Score of 15, which indicated intact cognition. Resident #1 was noted to be independent for ADLs and used assistive devices of a wheelchair and walker for mobility. Review of Resident #1's electronic record revealed there was no documented discharge summary, which should have included a recapitulation of Resident #1's stay, a final summary of the Resident #1's status, and a reconciliation of Resident #1's medications.Review of Resident #1's paper medical record revealed a partially completed document titled, Discharge Summary/Instructions, dated 08/01/2025 signed by S6 SSD and Resident #1.Interview with S6 SSD on 09/03/2025 at 9:19 a.m. confirmed the partially completed document titled, Discharge Summary/Instructions, dated 08/01/2025 was provided to Resident #1 at the time of discharge.Interview with S1 Administrator on 09/03/2025 at 9:25 a.m. revealed she did not provide any documentation to Resident #1 upon discharge and S6 SSD was responsible for discharge documentation.Interview with S2 DON on 09/03/2025 at 2:52 p.m. confirmed Resident #1's medical record did not contain a completed discharge summary and should have.Resident #R1Review of Resident #R1's medical record revealed an admit date of 03/18/2025 and a discharge date of 06/10/2025. Resident #R1's diagnoses included Alzheimer's disease, Paroxysmal Atrial Fibrillation, Atherosclerotic Heart Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction.Review of Resident #R1's progress notes revealed the following:06/10/2025 at 10:54 a.m.: Discharge Summary by S6 SSD: Resident sitting up in wheelchair waiting for family to arrive so that he can discharge home with fiance. He is alert and oriented to self. His speech is clear. His hearing is adequate. He understands and is understood. No behaviors noted nor observed. He has a diagnosis of Alzheimer's disease, cerebral infarction, HTN, and type 2 diabetes. He is incontinent of bowel and bladder. He is aware of activities and will attend those that interest him. Resident's main mode of transportation is wheelchair. Resident has to be encouraged to socialize with other residents. He prefers to stay in room and isolate to his room. His family is active in his care and attentive to his needs. He is capable of voicing his preference regarding his care. He is a full code, no living will, no POA, non-smoker, and not at risk for elopement. Resident discharges home 6/10/25. LTPCS will evaluate resident on 6/23/25 to see what services that he can receive at home. 06/10/2025 at 12:23 p.m.: Nurses Note by S8 LPN: Note Text: 12:20 p.m. Resident is discharged out of facility with medications.Review of Resident #R1's medical record revealed no documentation stating why Resident #R1 was discharged , no documentation of the medications provided to Resident #R1 at discharge, or any instructions given to the resident. Review of Resident #R1's Discharge Summary/Instructions form dated 06/10/2025 revealed no documentation of Resident #R1's diagnoses, course of illness/treatment, or