

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Winnfield Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, record review, and interviews, the facility failed to implement a comprehensive person-centered care plan for 1 (Resident #2) out of 3 (Resident #1, Resident #2, Resident #3) sampled residents. Findings: Review of Resident #2's EMR (Electronic Medical Record) revealed an initial admission date of 12/23/2024 and diagnoses that included in part, Schizoaffective Disorder, Bipolar type, Type 2 Diabetes, Hypertensive Heart Disease without heart failure, Anxiety, History of falling, and Dementia in other diseases classified elsewhere, unspecified severity, with agitation. Review of Resident #2's Quarterly MDS (Minimum Data Set) dated 09/22/2025 indicated Resident #2 was dependent on staff for assistance with eating, mobility, transfers, and personal hygiene. Resident #2 has a BIMS (Brief Interview for Mental Status) score of 4, which indicates severe cognitive impairment. Review of Resident #2's Care Plan dated as initiated 09/19/2025 included but is not limited to, At risk for falls. resident to be up in dining room for all meals. On 12/01/2025 at 12:15 p.m., Resident #2 was observed in her room with a lunch tray on the over-the-bed table drinking milk, with all other food remaining untouched on her tray. On 12/01/2025 at 12:20 p.m., S3 CNA revealed in an interview she had not assisted Resident #2 to the dining room today for breakfast or lunch. S3CNA confirmed she should have assisted the resident to the dining room for all meals as instructed by the resident's care plan but did not. On 12/01/2025 at 12:25 p.m., in an interview S2LPN confirmed that Resident #2 was not assisted to the day room or dining room on 12/01/2025 for breakfast or lunch but should have been. On 12/01/2025 at 1:40 p.m., an interview with S1Administrator confirmed Resident #2 should have been up in the dining room for all meals according to the resident's fall care plan but was not. On 12/01/2025 at 2:42 p.m., an interview with S4CNA revealed should be up in the dining hall for all meals to prevent falls.</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
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