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	10/02/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on observation, interview, and record review, the facility failed to ensure a resident received services in the facility with reasonable accommodation of resident needs for 1 (#30) of 1 (#30) resident reviewed for environment. The facility failed to ensure Resident #30 had a call light in reach in order to call for assistance. The total sample size was 23. Findings: Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses that included: Legal Blindness, Major Depressive Disorder, Schizoaffective Disorder, Major Depressive disorder, and Cognitive Communication Deficit. Review of Resident #30's Minimum Data Set (MDS) with an ARD of 08/15/2024 revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of Resident #30's Care Plan with review date of 04/25/2024 revealed in part . Sensory/Perception Altered: Vision related to legal blindness. Resident #30 is at risk for falls and injuries. Keep call light within reach while in room. Interview on 09/30/2024 at 10:50 a.m. with Resident #30 revealed she was blind and does not know how to find the call bell at night to ask for help. Observation on 10/01/2024 at 10:35 a.m. revealed Resident #30 lying in bed asleep with the call bell on a nightstand across the room, out of reach of the resident. Observation on 10/01/2024 at 2:10 p.m. of Resident #30 lying in bed asleep with no call bell nearby. Resident #30's call bell was plugged into a wall across the room, sitting on her roommate's nightstand. Interview on 10/01/2024 at 2:15 p.m. with S7 CNA revealed Resident #30 was not using a call bell at this time because of the position of the bed in to room would cause the call light cord to lay across her roommates bed and walkway path. S7 CNA revealed Resident #30 usually yelled out when she wanted to make her needs known. Interview on 10/02/2024 at 10:40 a.m. with S8 RN confirmed that Resident #30's call bell was not within reach because the facility was waiting on an extension cord, but should have been.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on interview and record review the facility failed to ensure a resident's right to be free from resident to resident physical abuse, for 1 (#76) of 2 (#68 and #76) residents reviewed for abuse. The facility failed to ensure Resident #76 was not physically abused by Resident #68. Findings: Review of the facility's policy titled Abuse Prevention, on 10/02/2024, with a review date of 10/2022, revealed in part .The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, friends, visitors, or any other individual. Abuse defined: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident to resident, staff to resident, family to resident, or visitor to resident. Physical Abuse: This includes but is not limited to hitting, slapping, pinching, and kicking. Resident #76 Review of Resident #76's medical records revealed an admitted [DATE], with diagnoses that included: Bipolar Disorder, Unspecified Psychosis, Unspecified Dementia, Major Depressive Disorder, Schizophrenia, and Anxiety Disorder. Review of Resident #76's Quarterly MDS with an ARD of 08/08/2024, revealed a BIMS score of 99, indicating the resident was unable to complete the interview. The MDS revealed Resident #76 required partial to moderate assistance with oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. Resident #76 was coded as independent with transfers. Review of Resident #76's care plan with a review date on 11/12/2024, revealed in part . Alterations in psychosocial well-being with interventions for behavior monitoring. Review of Resident #76's nurses' notes dated 08/11/2024 at 7:17 p.m., by S10 LPN, read as follows in part . S7 CNA reported that another resident pulled this resident down on the floor and started kicking her in the back. Residents separated at this time. Small red area noted to left mid back area, no other injuries noted at this time. Resident #68 Review of Resident #68's medical records revealed an admitted [DATE], with diagnoses that include: Traumatic Subarachnoid Hemorrhage, Persistent Mood Disorder, Cerebrovascular Disease, Paranoid Schizophrenia, Diffuse Traumatic brain injury with loss of consciousness, and Schizoaffective Disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #68's Annual MDS with an ARD of 07/26/2024, revealed a BIMS score of 9, indicating moderate cognitive impairment. The MDS revealed Resident #68 was coded as independent with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Review of Resident #68's Care Plan with a review date of 11/24/2024, read in part Resident #68 is at risk for psychosocial wellbeing and behavioral symptoms, altered mood state related to a diagnosis of Paranoid Schizophrenia with interventions for behavior monitoring. Review of a facility's Incident Report documented by S1 Administrator, revealed on 08/11/2024 at 5:00 p.m., S9 CNA reported that while passing out snacks in the special care unit's common area, Resident #76 tapped Resident #68 on the shoulder. Resident #68 became frightened and made physical contact with Resident #76 by grabbing her hair. S9 CNA reported while on the way to separate the residents, Resident #76 fell on to the ground. Resident #68 and Resident #76 were immediately separated. Resident #68 was placed on 1:1 supervision until she was sent to a behavioral hospital on 08/12/2024. Interview on 10/01/2024 2:15 p.m. with S7 CNA, revealed she was on duty on the behavioral unit when the incident occurred. S7 CNA stated she heard S9 CNA yell out, so she ran into the behavioral unit's common area, and observed Resident #76 on the ground in front of Resident #68's wheelchair. S7 CNA denied seeing Resident #68 kicking Resident #76. S7 CNA revealed that Resident #68 was sent to her room with 1:1 supervision, and Resident #76 stayed in the common area. Interview on 10/02/2024 at 3:37 p.m. with S1 Administrator, revealed Resident #68 had a history of resident to resident altercations. S1 Administrator confirmed the Resident to Resident altercation between Resident #68 and Resident #76 occurred on 08/11/2024.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46773 Based on interview and record review, the facility failed to conduct a thorough investigation of an incident of abuse for 1 (#76) of 2 (Resident #68 and Resident #76) residents sampled for abuse in a total sample of 23. Findings: Review of the facility's policy dated 10/2022, and titled Abuse Prevention on 10/02/2024, read in part . Investigation: The facility will initiate at the time of any finding of potential abuse or neglect, an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. Review of a facility's Incident Report documented by S1 Administrator, revealed on 08/11/2024 at 5:00 p.m., S9 CNA reported that while she was passing out snacks in the special care unit's common area, Resident #76 tapped Resident #68 on the shoulder. Resident #68 became frightened and made physical contact with Resident #76 by grabbing her hair. S9 CNA reported while on the way to separate the residents, Resident #76 fell on to the ground. Resident #68 and Resident #76 were immediately separated. Resident #68 was placed on 1:1 supervision until she was sent to a behavioral hospital on 08/12/2024. Review of the Investigation revealed witness statements were not obtained from S9 CNA, S10 LPN, or the Registered Nurse on duty at the time of the incident. Interviews with S9 CNA, S10 LPN, and the RN that was on duty at the time of the incident, were not successful. Interview on 10/02/2024 at 3:37 p.m. with S1 Administrator, revealed Resident #68 had a history of resident to resident altercations. S1 Administrator confirmed the Resident to Resident altercation between Resident #68 and Resident #76 occurred on 08/11/2024. S1 Administrator confirmed the facility had not completed the investigation, and failed to complete body audits and safety rounds on all residents who resided on the behavioral unit. S1 Administrator confirmed that the facility failed to obtain witness statements for all staff that were on duty and witnessed the resident to resident abuse between Resident #68 and Resident #76 on 08/11/202, but should have.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373 Based on record review, observation, and interview, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, by failing to implement appropriate interventions for weight loss for 1 (#56) of 2 (#32 & #56) residents reviewed for nutrition. The facility failed to: 1. Ensure Resident #56's meal intake was documented for each meal, as care planned, and 2. Provide one on one assistance to Resident #56 with all meals, as care planned. Findings: Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses that included in part . Major Depressive Disorder, Unspecified Dementia, Cellulitis, and Hypertension. Review of Resident #56's Quarterly MDS with an ARD of 09/19/2024 revealed a BIMS could not be completed because the resident was rarely or never understood. Review of the MDS revealed Resident #56 required supervision or touching assistance with eating and was independent with sit to stand and chair/bed to chair transfers. Review of Resident #56's Care Plan with a target date of 01/01/2025 revealed the resident was care planned for Need to maintain adequate nutritional intake related to Dementia, Depression . Interventions included in part .1 on 1 Dependent Diner, Supplements as ordered, Encourage resident to allow staff to obtain weights, Dietician to evaluate and follow up as needed, and Monitor food intake at each meal and record. Report any decline to physician and dietician. Review of Resident #56's medical record revealed the following weights which indicated a 17.15% weight loss over the past six months: 09/10/2024-97.6 pounds 08/09/2024-106.3 pounds 06/07/2024-112.8 pounds 03/08/2024-117.8 pounds Review of Resident #56's current physician's orders revealed the following: 03/31/2021-Regular diet 03/21/2023-House supplement-offer if resident eats less than 50% of meals and monitor percentage taken (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 10/01/2024 at 12:21 p.m., Resident #56 was observed in her room standing at the table, eating spaghetti and vegetables with her hands. No staff was observed in her room during meal. At 12:25 p.m., S5 CNA went in the resident's room and took the tray out of her room while Resident #56 was still standing near it. When S5 CNA exited the room, this surveyor entered and found Resident #56 stuffing a wad of plastic wrap in her mouth. This surveyor called S6 LPN who came and took the plastic wrap away from the resident. S6 LPN asked Resident #56 if she was still hungry and the resident nodded yes. S6 LPN left and returned shortly with a fudge round, took it out of the wrapper, and gave it to the resident who began eating it. When S5 CNA returned, she stated Resident #56 had eaten about 50% of her tray. Review of the Meal Report (documentation of meal intake) on 10/02/2024 revealed the following: 09/30/24-no documentation of intake at breakfast or lunch 09/29/24-no documentation of intake at breakfast or lunch 09/28/24-no documentation of intake at breakfast or lunch 09/27/24-no documentation of intake at breakfast, lunch, or dinner 09/26/24-no documentation of intake at breakfast or lunch 09/25/24-no documentation of intake at breakfast or lunch 09/24/24-no documentation of intake at breakfast or lunch 09/23/24-no documentation of intake at breakfast or lunch 09/22/24-no meal intake documented for breakfast, lunch, or dinner 09/21/24-no meal intake documented for breakfast, lunch, or dinner 09/19/24-no meal intake documented for breakfast or lunch 09/18/24-no meal intake documented for breakfast, lunch, or dinner 09/17/24-no documentation of intake at breakfast or lunch 09/16/24-no documentation of intake at dinner In an interview on 10/02/2024 at 2:21 p.m., S2 DON acknowledged staff were not documenting Resident #56's food intake at each meal and should have been. S2 DON acknowledged Resident #56 was observed eating lunch on 10/01/2024 without staff assistance. S2 DON confirmed Resident #56 was care planned for one on one assistance with dining.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51096 Based on observation and interview the facility failed to meet the nutritional needs of residents in accordance with established national guidelines. The facility failed to follow the menu in regard to portion size to ensure the nutritional adequacy of the meal for all residents who received a regular diet prepared by the facility kitchen. Findings: Review of Production Sheet Main Menu S/S 2024 provided by the facility revealed Baked Chicken portion size was 3 oz. Observation of lunch preparation on 09/30/2024 at 11:40 a.m. revealed improper serving sizes for six residents. Plates were served to 5 residents on a regular diet with one small chicken leg and two small chicken legs served as a double portion for 1 resident. Interview with S3 Dietary Manager and S4 Regional Director of Nutritional Services on 09/30/2024 at 12:43 p. m. confirmed one chicken leg without the bone was only approximately 2 oz. and that residents should have been served two chicken legs to meet the 3 oz. portion size on the menu and that two small chicken legs were not considered a double portion.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096 Based on observation and interview the facility failed to store food in accordance with Professional standards for food safety. The facility failed to properly store dry food items in the kitchen as evidenced by one loaf of bread with mold present; two packages of hot dog buns that expired on [DATE]; one opened box of cornstarch that was undated and one used pad of butter in the refrigerator, unsealed and undated. This deficient practice had the potential to affect any resident who consumed meals served from the facility's kitchen. Findings: Kitchen observation of the dry food storage area with S3 Dietary Manager on [DATE] at 09:04 a.m. revealed one loaf of bread with mold present; two packages of hot dog buns that expired on [DATE] and one box of cornstarch opened and undated. Observation of the walk-in refrigerator with the S3 Dietary Manager revealed one used pad of butter, unsealed and undated.