STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195459	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Lake Skilled Nursing & Rehabilitation	1155 Sterlington Highway Farmerville, LA 71241

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interviews, the facility failed to act promptly upon the grievances voiced by residents during monthly Resident Council meetings and failed to demonstrate the facility's response for such grievances. Findings:Review of the facility's policy, Resident Council undated, revealed in part:6. All resident concerns will the addressed and revisited at the resident council meeting the following month. Review of the facility's policy, Filing Grievances/Complaints dated 1/22/2025 revealed in part: Policy Statement - Our facility will assist residents or his/her responsible party in filing grievances or complaints when such requests are made 3. Grievances and/or complaints may be submitted orally or in writing. 4. The administrator had delegated the responsibility of grievance and/or complaint investigation to the social services director. 7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Review of the facility's Resident Council Minutes Form for the time period of 10/23/2024 - 09/25/2025 revealed a section titled: Old Business (List follow-up on last month's minutes and identify staff person responsible). Further review revealed there was no documented response or follow up to issues concerning care and life at the facility. Review of the facility's Resident Council meeting held on 02/28/2025 revealed in part: Resident #60 looking for missing wheelchair (w/c) with no written response or follow up. Review of the facility's monthly grievance logs provided by S7SSD (Social Services Director) for November 2024 to September 2025 revealed one grievance dated 05/28/2025 for the 11 month period of grievance logs. During the resident council meeting held on 09/29/2025 at 2:30 p.m., residents reported not receiving any follow up on issues/complaints reported during resident council meetings. During the same meeting, Resident #60 revealed she made a verbal report that her personal wheelchair was missing during a past resident council meeting. During an interview on 10/01/2025 at 9:50 a.m., Resident #25 reported not receiving feedback or follow up for verbalized complaints in resident council. During an interview on 09/30/2025 at 10:48 a.m., S7SSD revealed she was the grievance official and had never seen the resident council meeting minutes during her tenure at the facility. During an interview on 09/30/2025 at 11:00 a.m., S6Administrative Assistant confirmed the identified issues in the resident council meeting notes should have been followed up on. During an interview on 10/01/2025 at 9:31 a.m., S1Administrator reported he received the minutes after each resident council meeting and followed up on them; however, was unable to provide any written documentation for follow up of individual or group issues reported in the monthly resident council meetings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents that received psychotropic drugs were not subjected to chemical restraints for 4 (#2, #11, #25, #37) of 5 (#2, #11, #25, #37, #65) residents reviewed for unnecessary medications. The facility failed to ensure:1). as needed (PRN) orders for psychotropic drugs were limited to 14 days (#2, #11, #37),2). a gradual dose reduction was attempted (#25, #37), and3). a physician addressed pharmacist recommendations (#25)Findings: Resident #11 Record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia with behaviors/agitation, major depressive disorder, and anxiety disorder. Record review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a brief mental status score (BIMS) of 3 which indicated severe cognitive impairment. Further review revealed she required substantial/maximal assistance for most activities of daily living (ADL). Review of Resident #11's September 2025 physician orders revealed an order dated 03/18/2024 for Lorazepam 0.5 milligrams (mg), give 1 tablet by mouth (po) every 6 hours PRN (as needed). Review of the Resident's September 2025 Medication Administration Record (MAR) revealed documentation the resident had received Lorazepam 0.5mg on 09/05/2025 and 09/29/2025. Review of the Pharmaceutical Consultant Report dated 07/24/2025 revealed the following recommendation for Lorazepam 0.5 mg, give 1 tablet po every 6 hours PRN. Psychotropic PRN medications are limited to an initial 14 days and requires prescriber to evaluate the resident prior to extending the order. If extending, document the rationale for the extended time period in the medical record. Further review revealed there was no documentation the resident's physician addressed the above recommendation. On 10/01/2025 at 3:18 p.m., S2Director of Nursing (DON) confirmed the above recommendation from the consultant pharmacist was not addressed by the physician in a timely manner and Resident #11 continued to receive the Lorazepam 0.5 mg 1 tablet po every 6 hours PRN. Resident #2 Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, dementia, and chronic pain. Record review of the quarterly MDS dated [DATE] revealed Resident #2 had a BIMS of 3 which indicated severe cognitive impairment. Further review revealed he required substantial/maximal assistance and was dependent for most ADLs. Review of Resident #2's September 2025 physician orders revealed an order dated 04/10/2025 for Lorazepam oral concentrate 2mg/milliliter (ml) give 1 ml by mouth every 4 hours as needed for agitation. Review of the Resident #2's September 2025 MAR revealed documentation the resident had received (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lorazepam 1 ml on 09/04/2025. Review of the Pharmaceutical Consultant Report dated 07/24/2025 revealed the following recommendation for Lorazepam 2mg/ml, give 1 ml by mouth every 4 hours as needed: Psychotropic PRN medications are limited to an initial 14 days and requires prescriber to evaluate the resident prior to extending the order. If extending, document the rationale for the extended time period in the medical record. Further review revealed there was no documentation the resident's physician addressed the above recommendation. On 10/01/2025 at 3:18 p.m., S2DON confirmed the physician did not provide a specific duration or stop date for the medication as recommended by the consultant pharmacist. Resident #25 Review of the medical record for Resident #25 revealed diagnoses that included major depressive disorder, hypertension, personal history of venous thrombosis, and chronic congestive heart failure. Review of the Quarterly MDS assessment dated [DATE] revealed, in part, a BIMS score of 10 which indicated that Resident #25 had moderate cognitive impairment. Further review revealed that the resident received high risk drugs which included antidepressant medication. Review of the September 2025 electronic physician's orders revealed an order for Zoloft oral tablet 50 mg: give 1 tablet by mouth one time a day and Doxepin Hydrochloride (HCl) oral tablet 10 mg: give 10 mg by mouth at bedtime. Review of the September 2025 MAR revealed that Resident #25 received Zoloft 50 mg and Doxepin HCl 10 mg as ordered. Review of the Pharmaceutical Consultant Report/Psychoactive Gradual Dose Reduction dated 07/24/2025 revealed that the pharmacist's recommendations for dose reduction of Zoloft 50 mg by mouth at bedtime and Doxepin HCl 10 mg by mouth at bedtime were not addressed by the physician. On 10/01/2025 at 3:18 p.m., S2DON confirmed that the recommendations from the consultant pharmacist were not addressed by the physician and Resident #25 continued to receive the Zoloft 50 mg and Doxepin HCl 10 mg as ordered. Resident #37 Review of the medical record for Resident #37 revealed diagnoses that included cerebral infarction, hemiplegia affective right dominant side, nicotine dependence, anxiety disorder, hypertension, dysphagia, and other depressive episodes. Review of the Annual MDS assessment dated [DATE] revealed a BIMS score of 10 which indicated that Resident #37 had moderate cognitive impairment. Further review revealed that Resident #37 received high risk drugs that included antipsychotic, anxiolytic, and antidepressant medications. Review of the September 2025 electronic physician's orders revealed an order for Ambien tablet 10 mg: give 10 mg by mouth every 24 hours as needed for sleeplessness, Buspirone HCl oral tablet 7.5 mg: give 1 tablet orally two times a day, Diazepam 2 mg tab: give 2 mg by mouth one time a day, Duloxetine HCl capsule delayed release sprinkle 30 mg: give 30 mg by mouth one time a day, and Seroquel oral tablet 25 mg: give 25 by mouth two times a day related to depression, unspecified. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2025 MAR revealed Resident #37 was administered Ambien 10 mg as ordered on 09/09/2025. Further review revealed that Buspirone HCl 7.5 mg, Diazepam 2 mg, Duloxetine HCl 30 mg, and Seroquel 25 mg were administered as ordered. Review of the Pharmaceutical Consultant Report/Psychoactive Gradual Dose Reduction dated 07/24/2025 revealed that the pharmacist requested dose reductions for Buspirone Hcl 7.5 mg, Diazepam 2 mg, and Duloxetine HCl 30 mg. Additionally, the pharmacist requested that the physician provide a specific duration with stop date for Ambien 10 mg as well as a Centers for Medicare and Medicaid Services (CMS) approved diagnosis for the use of Seroquel 25 mg. The recommendations and requests from the pharmacist were not addressed by the physician. On 10/01/2025 at 3:18 p.m., S2DON confirmed the above requests and recommendations from the consultant pharmacist were not addressed by the physician and Resident #37 received the medications as ordered.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (#40) of 1 residents reviewed for pressure ulcers. The facility failed to 1) have documented evidence of weekly body audits, 2) have documented evidence of wound treatments performed as ordered, and 3) failed to have an accurate pressure ulcer assessment. Findings: Review of the medical record for sampled resident #40 revealed an admission date of 03/05/2024 with diagnoses of somatoform disorder, hyperlipidemia, anxiety, major depression, transient ischemic attack, and pressure ulcer on the back. Review of the quarterly Minimum Data Set (MDS) dated [DATE] assessment revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognition for daily decision making and was dependent on staff for toileting, bathing and personal hygiene. Further review of the MDS revealed Resident #40 has one or more unhealed pressure injuries and was at risk for developing pressure ulcers. Review of the careplan revealed Resident #40 had the potential for impaired skin integrity. Resident #40 was total bowel and bladder incontinent and had a presence of feeding tube. Further review of the care plan revealed interventions were to administer medications as ordered for wound healing, apply barrier cream as needed, low air loss mattress to the bed, apply heel protectors to bilateral heels, and to turn/reposition every 2 hours. Review of the September 2025 physician orders revealed an order dated 09/17/2025 to clean left ankle with wound cleanser, apply collagen, alginate and cover with a foam dressing every other day and as needed. Review of the September 2025 Treatment Administration Record (TAR) revealed no documented evidence that the treatment was done on 09/21/2025, 09/23/2025, 09/25/2025, and 09/29/2025.Review of the September 2025 physician orders revealed an order dated 09/17/2025 to paint left back with betadine, apply alginate, and cover with silicone dressing every day and as needed. Review of the September 2025 TAR revealed no documented evidence that the treatment was done on 09/20/2025, 09/21/2025, 09/23/2025, 09/24/2025, 09/25/2025, 09/26/2025, 09/29/2025 and 09/30/2025.Review of the September 2025 physician orders dated 08/20/2025 to clean wound to back with skin prep, apply Santyl, Hydrofera Blue Foam, absorbent pad, abdominal pad, and secure with tape, change dressing every day, and as needed. Review of the September 2025 TAR revealed no documented evidence that the treatment was done on 09/20/2025, 09/21/2025, 09/23/2025, 09/24/2025, 09/25/2025, 09/26/2025, 09/29/2025 and 09/30/2025.Review of the record revealed no documented evidence of weekly body audits performed for Resident #40 who was at risk for developing pressure ulcers.On 09/30/2025 at 2:30 p.m. interview with S11Wound Care Nurse (WCN) confirmed she did not have documentation of weekly body audits for Resident #40. On 10/01/2025 at 9:30 a.m. interview with S4Assistant Director of Nursing (ADON) confirmed the pressure ulcer assessment dated [DATE] for Resident #40 was inaccurate. Further interview with S4ADON confirmed Resident #40 was at risk for pressure ulcers and weekly body audits should have been performed. On 10/01/2025 at 11:40 a.m. interview with S11WCN confirmed there was no documented evidence on the September 2025 TAR that wound care was performed for Resident #40 on the dates listed above.On 10/01/2025 at 3:15 p.m. interview with S2Director of Nursing (DON) confirmed the pressure ulcer assessment for Resident #40 was inaccurate and she was at risk for developing pressure ulcers. Further interview with S2DON confirmed there was missing documentation of treatments in September 2025 and confirmed weekly body audits should have been performed and documented for Resident #40.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to ensure laboratory tests were collected as ordered for 1 (#11) of 5 (#2, #11, #25, #37, #65) residents reviewed for unnecessary medications. Findings:Record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including hypothyroidism, dementia, major depressive disorder, and anxiety disorder. Record review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a brief mental status score (BIMS) of 3 which indicated severe cognitive impairment. Further review revealed Resident #11 required substantial/maximal assistance for most activities of daily living (ADL). Review of Resident #11's September 2025 physician orders revealed an order dated 04/22/2025 for Levothyroxine Sodium 125 micrograms (mcg) 1 by mouth (po) one time a day. Further review revealed an ordered dated 07/12/2023 for Ferrous Sulfate 325 milligrams (mg) 1 po one time a day. There was also an order dated 04/30/2025 to obtain Thyroid Stimulating Hormone (TSH) and Iron laboratory levels every 6 months. Review of Resident #11's September 2025 Medication Administration Record (MAR) revealed documentation she received Levothyroxine Sodium 125 mcg 1 po one time a day from 09/01/2025 - 09/30/2025. Further review revealed documentation she received Ferrous Sulfate 325mg 1 po one time a day from 09/01/2025 - 09/30/2025. Review of the medical record for Resident #11 revealed no documented evidence that the TSH and Iron levels were obtained as ordered. On 10/01/2025 at 1:15 p.m., an interview with S3Assistant Director of Nursing (ADON) confirmed the facility failed to obtain Resident #11's TSH and Iron levels as ordered. On 10/01/2025 at 3:18 p.m., an interview with S2Director of Nursing (DON) confirmed the facility had not obtained TSH and Iron levels for Resident #11 as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. The facility failed to 1) disinfect whirlpool A and whirlpool B per Manufacturer's Instructions for Use, and 2) implement standard precautions for proper storage of a non-invasive urine collection system, and administration of medications. Findings: Review of the facility's undated Whirlpool/Shower Cleaning and Disinfecting policy revealed the following: Purpose: To ensure that whirlpool/showers are cleaned and disinfected according to disinfectant manufacturer guidelines. General Guidelines: Whirlpool/shower shall be cleaned and disinfected between each use. Remove any visible soil before disinfecting. Apply Non-Acid Disinfectant Bathroom Cleaner (NABC) with a cloth, mop, sponge, or coarse sprayer. All surface areas and each individual jet shall be treated with disinfectant. Treated surfaces shall remain wet for 10 minutes then rinse thoroughly with water. On 09/30/2025 at 11:05 a.m., an interview was conducted with S18Certified Nursing Assistant (CNA) related to the process for cleaning and disinfecting the whirlpool. S18CNA reported that she cleans the whirlpool at the beginning of the day by spraying down the whirlpool with tile and grout cleaner and lets the solution sit for 5 minutes and rinses the whirlpool. S18CNA further reported that she then presses the disinfectant button for approximately 10 seconds, allows the disinfectant to sit for about 30 seconds, and finally rinses the whirlpool thoroughly. S18CNA also reported that, between residents, she sprays down the whirlpool with tile and grout cleaner and allows it to sit for about 30 seconds followed by a rinse. After this, the disinfectant button is pressed for 10-15 seconds and allowed to sit for about 1-2 minutes followed by a thorough rinse. On follow-up inquiry, S18CNA reported that the maintenance department refills the disinfectant and she did not know who cleaned the whirlpool jets. On 09/30/2025 at 11:16 a.m., an interview with S10CNA reported that, prior to beginning baths, she sprays the whirlpool down with tile and grout cleaner, lets the solution sit for about 5 minutes, then rinses the whirlpool thoroughly. S10CNA reported that between residents the whirlpool is sprayed down with tile and grout cleaner with is allowed to sit for 2 minutes followed by a thorough rinse. S10CNA reported that she did not use the disinfectant button because there is no disinfectant in the whirlpool. S10CNA further stated that there had not been disinfectant in the whirlpool since May of 2025. S10CNA reported that she did not know who cleaned the whirlpool jets. On 09/30/2025 at 11:18 a.m., an interview was conducted with S19Maintenance who reported that neither the housekeeping or maintenance departments replace the disinfectant solution in the whirlpools. Interview with S25Housekeeping Supervisor at this time revealed their department has never been instructed to clean and disinfect the whirlpool. On 09/30/2025 at 11:20 a.m., S20CNA Supervisor reported that residents received whirlpool baths on 09/30/2025. The surveyor and S20CNA observed the whirlpool and the hose labeled disinfectant was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not connected to a supply bottle. On 09/30/2025 at 11:25 a.m., S1Administrator was notified of findings in the whirlpool. S1Administrator was unable to confirm that the instructions posted near the whirlpool were the manufacturer's instructions for use. Review of the whirlpool's manufacturer's instructions for use, after every bath, the whirlpool should be cleaned and disinfected. The steps included: heating the disinfectant solution via the temperature control knob, removing visible tissue, residue or fluids with the shower sprayer, draining/plugging the tub, and holding the disinfectant button until the solution is coming out of the air jets and there is 1 to 1 1/2 gallons of disinfectant solution in the tub. This is to be followed by a thorough scrub of all interior surfaces of the tub and allowing the disinfectant to stay on the surface for 10 minutes, or, as recommended by the instructions on the disinfectant concentrate container. Per manufacturer's instructions for use, the whirlpool is then to be rinsed thoroughly and the air blower run to push the rinse water out of the air injection system. On 10/01/2025 at 11:20 a.m., an interview with S21CNA revealed the whirlpool tub is sprayed down after each use, including the jets. The solution sits for 5-10 minutes and is then rinsed thoroughly. S21CNA confirmed that the whirlpool jets and bubbles are used for residents. On 10/01/2025 at 2:35 p.m., S2Director of Nursing (DON) confirmed that 58 residents received whirlpool baths. S2DON was informed of whirlpool findings and agreed that the whirlpool was not disinfected per manufacturer's instructions for use. Resident #90 Review of the medical record for Resident #90 revealed diagnoses that included personal history of urinary tract infections, and overactive bladder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. On 09/29/2025 at 9:15 a.m. and 10/01/2025 at 8:22 a.m., observations revealed Resident #90 was in her recliner in her room. Further observations revealed her non-invasive urine collection system tubing was not covered and was clipped to the upper drawer of her plastic storage bin. The resident's snacks, chocolate candy and cheese nips) were stored in the top drawer near the uncovered tubing. On 10/01/2025 at 1:15 p.m., the surveyor and S3Assistant Director of Nursing (ADON) made an observation in Resident #90's room. The resident was in her recliner and the urine collection system tubing was uncovered and was clipped to the upper drawer of her plastic storage bin. The resident's snacks (chocolate candy and cheese nips) were stored in the top drawer near the uncovered tubing. S3ADON confirmed the tubing should be in a bag and not kept near food items. On 10/01/2025 at 2:30 p.m., an interview with S23Certified Nursing Assistant (CNA) revealed the tubing (urine collection system) should be stored in a bag and kept in the bathroom. She stated the resident wanted it by her bedside. S23CNA confirmed the tubing should not be kept near the resident's food. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/2025 at 2:35 p.m., an interview with S24LPN confirmed the tubing should not be kept near the resident's snacks. On 10/01/2025 at 3:18 p.m., an interview with S2Director of Nursing (DON) confirmed the urine collection system tubing should be stored in a bag and not near food items. Resident #4 On 09/30/2025 at 10:10 a.m., during medication pass S26Licensed Practical Nurse (LPN) dropped 2 pills on top of the medication cart. The pills were Neurontin 600mg and Zyrtec 10mg, S26LPN picked them up with her ungloved hand and put them back into the medication cup with the other pills and administered them to Resident #4. On 09/30/2025 at 2:40 p.m., S26LPN confirmed she picked up Resident #4's Neurontin and Zyrtec pills and placed them in the medication cup and administered them to the resident after dropping them on the medication cart. On 10/01/2025 at 3:18 p.m., S2Director of Nursing (DON) confirmed S26LPN should not have picked up the dropped pills and administered them to Resident #4.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations and interviews the facility failed to ensure all mechanical equipment was maintained in safe operating condition by having a pipe leaking water under the 3-compartment sink and the deep fryer with grease buildup on the internal compartment. This deficient practice had the potential to affect 93 residents that received meals from the kitchen. Findings:On 09/29/2025 at 8:30 a.m. observation of the kitchen revealed a polyvinyl chloride (PVC) pipe under the 3 - compartment sink was leaking water. The water was being captured in a large tin can and when the can was full the dietary workers would discard the water in the sink. Further observation of the kitchen revealed the deep fryer contained a buildup of grease on the internal compartment. On 09/29/2025 at 8:45 a.m. an interview with S8Dietary Manager confirmed the PVC pipe was in need of repair and the deep fryer needed to be cleaned. On 09/30/2025 at 1:30 p.m. S1Administator was notified of the above issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195459	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Lake Skilled Nursing & Rehabilitation	1155 Sterlington Highway 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure each resident was treated with dignity and respect in an environment that promotes maintenance and enhancement of his or her quality of life for 1 (#77) of 1 resident reviewed for dignity. Findings: Review of facility's policy Assistance with Meals dated 07/2017 revealed in part: 3.a. not standing over residents while assisting with meals. Review of facility's policy Quality of Life-Dignity dated 01/10/2025 revealed in part: 1. Residents shall be treated with dignity and respect at all times. Review of Resident #77's clinical record revealed an admit date of 02/14/2025 with diagnoses that included: Parkinson's disease, dysphagia following cerebral infarction and gastro-esophageal reflux disease without esophagitis.Review of Resident #77's Quarterly Minimum Data Set (MDS) dated [DATE] indicated substantial/maximal assistance while eating. Observation on 09/30/2025 at 7:48 a.m. revealed Resident #77 seated in a geri chair with a lap tray in the dining room. Further observation revealed S10Certified Nursing Assistant (CNA) was standing up while assisting the resident with the meal. During an interview on 09/30/2025 at 7:53 a.m. with S10CNA in the dining room, S10CNA confirmed she was standing over Resident #77 while assisting him with his meal. During an interview on 10/01/2025 at 3:00 p.m., S3Assistant Director of Nursing (ADON) confirmed staff should not stand over residents while assisting them with their meals. During an interview on 10/01/2025 at 3:12 p.m., S2Director of Nursing confirmed staff should not stand over the residents while assisting them with meals.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to develop and implement a comprehensive care plan for 1 (#90) of 1 (#90) resident reviewed for care of a urinary collection system.FindingsReview of the medical record for Resident #90 revealed diagnoses that included personal history of urinary tract infections, and overactive bladder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. On 09/29/2025 at 9:15 a.m. and 10/01/2025 at 8:22 a.m., observations revealed Resident #90 was in her recliner in her room. Further observations revealed her urine collection system tubing was not covered and was clipped to the upper drawer of her plastic storage bin. The resident's snacks, chocolate candy and cheese nips) were stored in the top drawer near the uncovered tubing. On 10/01/2025 at 1:15 p.m., the surveyor and S3Assistant Director of Nursing (ADON) made an observation in Resident #90's room. The resident was in her recliner and the urine collection system tubing was uncovered and was clipped to the upper drawer of her plastic storage bin. The resident's snacks (chocolate candy and cheese nips) were stored in the top drawer near the uncovered tubing. Review of Resident #90's current care plan revealed the facility failed to identify the urine collection system and the proper storage of supplies in Resident #90's plan of care. On 10/01/2025 at 1:00 p.m., an interview with S3ADON confirmed Resident #90's urine collection system was not identified on her careplan and there were no approaches regarding how to store and care for the supplies. On 10/01/2025 at 3:18 p.m., an interview with S2Director of Nursing (DON) confirmed Resident #90's urine collection system should have been identified on her current care plan.