STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195504	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Oaks Nursing & Rehabilitation Center	110 Maple Street Wisner, LA 71378

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 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 observation, record review, and interview, the facility failed to ensure that a resident remained free from chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility did not ensure that residents who are prescribed psychotropic drugs received a gradual dose reduction, unless clinically contraindicated, in an effort to discontinue these drugs for 1 (#7) of 5 (#2, #5, #7, #12, #23) residents reviewed for unnecessary medications.Findings: Review of the medical record for Resident #7 revealed diagnoses that included chronic respiratory failure, chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, cerebral infarction, type 2 diabetes mellitus with diabetic polyneuropathy, repeated falls, other schizoaffective disorder, and major depressive disorder, recurrent, severe without psychotic features.Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated that Resident #7 had moderate cognitive impairment for daily decision making. Review of the Electronic Order Summary Report as of 09/23/2025 revealed that Resident #7 was prescribed brexpiprazole tablet 2 milligrams (mg): 1 tablet orally at bedtime related to other schizoaffective disorders and sertraline hydrochloride tablet 100 mg: 1 tablet orally one time a day related to major depressive disorder, recurrent severe without psych features. Review of the Pharmaceutical Consultant Report/Psychoactive Gradual Dose Reduction dated 07/01/2025 revealed, in part:Please evaluate the routine use of the following psychoactive medications and consider a dose reduction. If a dose reduction is not desired, please indicate below a rationale for the continued use. The resident is prescribed the following psychoactive medications: Rexulti 2 mg every night, and Zoloft 100 mg daily.The document was signed by S2Director of Nursing (DON). It was noted that there was a handwritten notation which indicated that the report was sent to the provider for response on 07/06/2025. The portion of the document to be completed by the physician was blank which indicated that, as of 09/24/2025, the physician had not responded to the pharmacist's above recommendations. On 09/24/2025 at 3:30 p.m., S2DON was informed of the findings and agreed that the pharmacist's recommendations for gradual dose reductions had not been addressed timely.

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management for 1 (#24) of 1 (#24) sampled resident reviewed for pain management. Findings: Review of the Resident #24's record revealed diagnoses including Alzheimer's disease, vascular dementia, Type 2 diabetes with diabetic neuropathy, aftercare following joint replacement surgery of right knee, and pain in unspecified knee. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Further review revealed she required assistance for most activities of daily living. Review of Resident #24's Pain Risk assessment dated [DATE] revealed the facility had assessed the resident to be at a high risk for pain. Review of the resident's current care plan revealed she had chronic pain related to primary generalized osteoarthritis and right knee arthroplasty. Further review revealed to evaluate the effectiveness of pain medication if administered. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, and impact on functional ability and cognition. On 09/22/2025 at 8:55 a.m., an interview with Resident #24 revealed she had a total knee surgery on her right knee several months ago. The resident reported she takes Tramadol for pain but it does not always help her knee pain. Review of the September 2025 Physician's Orders revealed an order dated 06/26/2025 for Tramadol HCl oral tablet 50 milligrams (mg) give 1 tablet by mouth (po) every 6 hours as needed (prn) for knee pain. Review of Resident #24's September 2025 Medication Administration Record (MAR) revealed documentation she received Tramadol 14 times for September 2025 and her pain ranged from 5 to 9 on the pain scale. Review of the nurse's note dated 09/17/2025 at 11:48 a.m. revealed while providing wound care to Resident #24's right knee, she reported her Tramadol was not helping with her bilateral knee pain and asked if her doctor could be notified to see if he could order something stronger for her pain. S5Registered Nurse (RN)/Wound Care Nurse contacted the doctor's nurse concerning this matter and she was informed that the resident's doctor was out of town until next week. The doctor would make rounds at the facility on 09/23/2025 and would see her at that time and talk with her concerning her increased pain and about her pain medication. On 09/24/2025 at 1:00 p.m., an interview with S5RN/Wound Care Nurse confirmed Resident #24 had reported to her on 09/17/2025 that the Tramadol was not helping her pain. She revealed the doctor's nurse was notified on 09/17/2025 but her doctor was out of town and his nurse stated he would see her on 09/23/2025 during rounds. S5RN/Wound Care Nurse confirmed the order for Lortab was not received until 09/23/2025 and there was a delay in Resident #24 receiving a different pain medication. On 09/24/2025 at 1:50 p.m., S2Director of Nursing (DON) was informed that on 09/17/2025 Resident #24 complained Tramadol was not helping her right knee pain and she wanted something stronger for pain. S2DON confirmed on 09/23/2025, Resident #24's physician ordered Lortab 7.5-325mg 1 tablet po every 12 hours prn for pain, which was 6 days after the resident complained the Tramadol had not relieved her pain.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure that nursing staff had the appropriate competencies to care for resident needs. The facility staff failed to respond to call light assistance requests in a timely manner for 1 (#41) of 1 residents reviewed for sufficient and competent nurse staffing. Findings:On 09/22/2025 at 10:00 a.m., a meeting with regular attendees of the facility's resident council revealed complaints from Resident #51 and Resident #24 of excessive wait times for call light response from facility staff. Other attendees in the meeting concurred with Resident #51 and Resident #24's complaint. Resident #41Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, unspecified; weakness; other reduced mobility; and need for assistance with personal care. Review of Resident #41's Quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #41 required substantial/maximal assistance with personal hygiene. Review of Resident #41's active September 2025 plan of care revealed facility staff were to provide incontinence care as needed. On 09/01/2025 at 9:05 a.m., Resident #41 stated that the facility staff does not come to his room in a timely manner when he calls for assistance. Resident #41 informed the surveyor that his bed was wet with urine and needed to be changed. Surveyor observed Resident #41 press the call button and inform the nursing station that his bed was wet and needed to be changed. On 09/22/2025 at 9:44 a.m., observation and interview with Resident #41 revealed no facility staff member had come to his room to assist with incontinence care and linen change. On 09/22/2025 at 9:45 a.m., S3Assistant Director of Nursing (ADON) was informed of staff not responding to Resident #41's call for assistance. S3ADON confirmed that a facility staff member did not go to Resident #41's room and stated that a staff member should have went to his room to assist him. On 09/22/2025 at 10:45 a.m., S1Administrator was notified that staff did not respond to Resident #41's call light in a timely manner.

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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) maintain oxygen concentrator filters as ordered for 1 (#7) of 1 (#7) residents reviewed for respiratory care, and 2) utilize disinfectant solution per manufacturer's instructions for use in the facility shower room where 40 of 52 residents are showered. Findings:Resident #7Review of the medical record for Resident #7 revealed diagnoses that included chronic respiratory failure, chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, cerebral infarction, type 2 diabetes mellitus with diabetic polyneuropathy, repeated falls, other schizoaffective disorder, and major depressive disorder, recurrent, severe without psychotic features.Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated that Resident #7 had moderate cognitive impairment for daily decision making. Review of the Electronic Order Summary Report as of 09/23/2025 revealed, in part, an order dated 05/22/2024 to change oxygen tubing/humidifier bottle and clean filter weekly on night shift every Thursday. On 09/23/2025 at 2:30 p.m., an observation of Resident #7's oxygen concentrator filter was performed with S5Licensed Practical Nurse (LPN) Charge Nurse. The oxygen concentrator did not have a filter in place on the right or left side. S5LPN Charge Nurse confirmed that the filters were not present. 09/23/2025 2:45 p.m., S2Director of Nursing was informed of findings. EnvironmentOn 09/23/2025 at 12:10 p.m., upon interview, S7Certified Nursing Assistant (CNA) reported that shower stalls are cleaned between residents. S7CNA explained that, after applying the disinfectant, she immediately rinses the area. S7CNA reported that she did not know if the solution required a wait time before rinsing. On 09/23/2025 at 12:36 p.m., an interview was conducted with S4Housekeeping Supervisor with S3Assistant Director of Nursing (ADON) present. S4Housekeeping Supervisor reported that the shower area is cleaned by housekeeping staff at the end of every day. S4Housekeeping Supervisor further reported that the wait time for the solution before rinsing was 5 to 10 minutes.On 09/23/2025 at 12:40 p.m., an interview was conducted with S5Licensed Practical Nurse (LPN) Charge Nurse who is also the facility's infection preventionist. S5LPN Charge Nurse reported that she was unaware if the cleaning solution required a wait time before rinsing. The manufacturer's documentation and cleaning solution label were reviewed; it was noted that the solution required a 10 minute sit time.On 09/23/2025 at 2:15 p.m., S5LPN Charge Nurse confirmed the facility failed to utilize the disinfectant solution per manufacturer's instructions for use.On 09/23/2025 at 2:20 p.m., S2Director of Nursing was informed and voiced understanding of findings.

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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 observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for a resident. The facility failed to ensure that interventions were implemented for an unsafe smoker as indicated in the plan of care for 1 (#45) of 3 (#7, #16, #45) residents reviewed for accidents.Findings:Review of the medical record for Resident #45 revealed diagnoses that included chronic obstructive pulmonary disease, other specified peripheral vascular diseases, acquired absence of left leg below knee, history of falling, and dysphagia.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9 which indicated that Resident #45 had moderate cognitive impairment for daily decision making. The MDS documented that Resident #45 had impairment to upper and lower extremities bilaterally with range of motion.Review of the active electronic Plan of Care as of 09/23/2025 revealed Resident #45 had a potential for injury related to smoking and classified the resident as an unsafe smoker. Interventions to address the unsafe smoker status included a smoking plan that specified, in part, Resident #45 required a smoking apron. Review of the Quarterly Safe Smoking Assessment, last reviewed 07/15/2025, revealed a current smoking plan that included the use of a smoking apron. On 09/23/2025 at 3:40 p.m., a smoking observation of Resident #45 was completed in the designated smoking area. It was noted that the resident was holding a lit cigarette in his right hand and no smoking apron was in place. On 09/23/2025 at 3:41 p.m., an interview was conducted with S6Certified Nursing Assistant (CNA) who reported Resident #45 did not require a smoking apron. On 09/23/2025 3:46 p.m., S3Assistant Director of Nursing (ADON) arrived to the designated smoking area per surveyor request. S3ADON observed Resident #45 smoking without a smoking apron. S3ADON then reviewed the smoking list with interventions and verbalized that Resident #45 did require a smoking apron. On 09/24/2025 at 10:21 a.m., S2Director of Nursing was informed of findings.