STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195555	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sabine Retirement and Rehab Center	965 Fisher Road Many, LA 71449

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. This deficient practice had the potential to affect all 106 residents who resided in the facility. The facility failed to:Ensure expired and unlabeled medications were not available for administration to residents in 1 (Med Room B) of 2 medication rooms; andEnsure expired medications and supplies were not available for administration to residents in 2 (Med Cart B and Med Cart E) of 5 medication carts. Findings:Review of a facility policy on 01/13/2026 at 10:40 a.m. titled, Pharmacy Services with a revision date of 01/05/2025 revealed the following in part .It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Review of an undated facility policy on 01/13/2026 at 10:10 a.m. titled, Medications-Storage revealed the following in part .The facility shall store all drugs and biological in a safe, secure, and orderly manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. Review of an undated facility policy on 01/13/2026 at 10:10 a.m. titled, Medications-Administering revealed the following in part .9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. 1.Observation on 01/13/2026 at 8:15 a.m. of Med Room B with S7 ADON, revealed the following expired and/or undated items:One opened and undated bottle of 1% Lidocaine 100mg/10ml; andSix 3ml prefilled Normal Saline syringes with an expiration date of 05/02/2025.In an interview on 01/13/2026 at 8:45 a.m., S7 ADON confirmed the above findings and stated that all the nurses were responsible for disposing of expired medications and labelling multi-use medications once opened. S7 ADON confirmed all of the above medications should have been disposed of and not been available for resident use, but were not. 2.Observation on 01/13/2026 at 11:15 a.m. of Med Cart B with S8 LPN, revealed the following expired items:Four packages of five individual prefilled 3ml vials (20 total items) of Ipratropium/Albuterol Sulfate 3mg with an expiration date of 05/2025.In an interview on 01/13/2026 at 11:35 a.m., S8 LPN confirmed the above medications were expired and stated she administered these expired medications to a resident this morning. S8 LPN stated she was unware the medication was expired prior to administration. S8 LPN confirmed the above medications should have been disposed of, not available for resident use, and expired medications should not have been administered to a resident. Observation on 01/13/2026 at 12:00 p.m. of Med Cart E with S9 Treatment Nurse, revealed the following expired items:Eleven individual packets of Iodine with an expiration date of 10/2023;One bottle of Desenex 2% powder with an expiration date of 10/09/2025; Three Adaptive non-adherent dressings with an expiration of 07/31/2025; andGreater than 100 individually packaged 3g Lubricating Jelly with an expiration date of 03/03/2025. In an interview on 01/13/2026 at 12:18 p.m., S9 Treatment Nurse confirmed all of the above findings and stated no expired medications or supplies should have been available for resident use. S9 Treatment Nurse confirmed that all expired treatment supplies, medicated ointments, and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	powders should have been disposed of after the expiration date, but were not. In an interview on 01/13/2026 at 12:58 p.m., S2 DON revealed she expected all nurses to dispose of expired medications and treatment supplies from the medication/treatment carts and storage rooms. S2 DON stated that no expired medications or medical supplies should have been available for resident use in the medication/treatment carts or in the medication storage rooms.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to make a prompt effort to resolve grievances filed by a resident's representative, for 1 (Resident #3) of 27 sampled residents.Findings: Review of the facility's policy titled Grievances/Complaints, with no review date, revealed in part.1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint to the facility.3. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. 4. Upon receipt of a grievance and/or complaint, the grievance official will ensure prompt investigation and resolution of the allegations; and ensure that immediate action is taken if necessary to prevent further potential violations of any resident rights while the allegation is under investigation.5. The administrator will review the grievance.6. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.7. The resident, or person filing the grievance and/or complaint in 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. Such report will be made orally by the administrator, or his or her designee, within 3 working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident which includes date grievance was received, summary of the grievance, a statement of whether or not the grievance was confirmed, any corrective action to be taken by the facility and the date the decision was issued. The summaries will be maintained in the facility for a period of no less than 3 years from issuance of the decision.Review of Resident #3's medical record revealed she was admitted to the facility on [DATE] with diagnoses which included in part.Hemiplegia and Hemiparesis following Infarction affecting Left Non-Dominant Side, Pain Unspecified, and Contracture of Left Hand.Review of Resident #3's Quarterly MDS with an ARD of 11/14/2025 revealed she had a BIMS score of 14 indicating intact cognition. The MDS revealed Resident #3 was dependent for transfers and shower/bath and required substantial/maximal assistance with personal hygiene. Resident #3's MDS coded with no behaviors/refusals of care.Review of Resident #3's care plan revealed in part. at risk for Self-Care Deficit related to Left Hemiplegia/Hemiparesis following a Cerebrovascular Accident, Contracture of Left Hand, withTelephone interview on 01/13/2026 at 10:35 a.m. with Resident #3's Responsible Party, revealed he had complained to staff numerous times about his wife not receiving a shower and about her hair being dirty. Responsible Party stated he had called the Corporate Administration to complain about a month ago and was told it would be looked into. Responsible Party stated Resident #3 had called him in the past to say she had not received her shower.Interview on 01/14/2026 at 8:10 a.m. with S1 Administrator revealed Resident #3's Responsible Party had complained to Corporate Administration about Resident #3's hair being dirty and needed washing. S1 Administrator confirmed Corporate had notified her of the complaint. S1 Administrator had no documented evidence of follow-up regarding the complaint.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of resident to resident physical abuse was reported to the State Survey Agency immediately, but not later than 2 hours after the resident to resident physical abuse was discovered for Resident #55. Total sample size 27. Findings:Review of the facility's undated policy titled Abuse Prevention and Investigation read in part.Residents have the right to be free from verbal, sexual, physical, and mental abuse. Policy Interpretation and Implementation:1. The facility defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Examples of physical abuse include: hitting, slapping, pinching, and kicking. 16. Reporting:a. All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately, but no later than 2 hours after the allegation is made if the alleged violation involves abuse. Resident # 55 Review of Resident #55 's medical record revealed an initial admit date of 08/16/2022 with a re-entry date of 05/19/2025 with diagnoses that included in part: Transient Cerebral Ischemic Attack, Major Depressive Disorder, Unspecified Mood Disorder, Cerebral Infarction without Residual Deficits, Hypertension, and Presence of Other Specified Devices. Review of Resident #55's Minimum Data Set (MDS) with an ARD of 12/17/2025 revealed Resident #55 had a BIMS score of 14, indicating intact cognition. Resident #55 was independent with ADLs. Review of Resident #55's care plan, with a revision date of 12/17/2025, revealed in part.On 05/13/2025, Resident #55 received physical aggression from another resident. The residents were immediately separated and neurological checks initiated at that time. Resident #55 was sent to the emergency room for further evaluation. Resident # 110 Review of Resident #110 's medical record revealed an initial admit date of 07/30/2024 with a re-entry date of 09/15/2025 with diagnoses that included in part: Autistic Disorder, Anxiety Disorder, Extrapyramidal and Movement Disorder, Restlessness and Agitation, Moderate Intellectual Disabilities, Dementia, and Major Depressive Disorder. Review of Resident #110's Minimum Data Set (MDS) with an ARD of 06/27/2025 revealed Resident #110 had a BIMS score of 2, indicating severe cognitive impairment. Resident #110 was independent/ required minimal assistance with ADLs. Review of Resident 110's care plan read in part.Resident #110 was at risk for altered mood and behaviors related to diagnosis of Depression, Anxiety, Autism, and Dementia with Mood Disturbance. An intervention was initiated on 05/13/2025, which included: Administer Depakote as ordered. Review of an incident report dated 05/13/2025 at 4:30 p.m. read in part.Another resident struck Resident #55 on the head and back. Resident #55 reported a headache following the incident and was transferred to the emergency room for further evaluation. Resident #55 stated, He just started hitting me for no reason. The incident occurred in the dining room. Review of the facility's investigation dated 05/13/2025 read in part.at 4:30 p.m., staff reported Resident #110 became physically aggressive in the dining room toward Resident #55. Resident #110 became upset after another resident moved his walker and subsequently struck Resident #55 on the back of the head twice, making contact. On 01/13/2026 at 4:00 p.m., an interview with Resident #55 revealed that on the evening of 05/13/2025, she was seated in the dining room when Resident #110 approached her from behind and struck her on the head multiple times. Resident #55 stated she believed Resident #110 appeared angry. Resident #55 experienced a headache following the incident and was transported to the hospital for evaluation due to a previously placed cranial shunt. On 01/14/2026 at 8:36 a.m., an interview with S3CNA Supervisor confirmed that on 05/13/2025 she witnessed Resident #110 become upset in the dining room and strike Resident #55 on the head. On 01/14/2026 at 8:42 a.m., an interview with S6LPN revealed she witnessed Resident #110 strike Resident #55 on the head twice with a closed fist while in the dining room on 05/13/2025. S6LPN reported she escorted Resident #110 back to his room, where he stated he was upset with Resident #55.S6LPN confirmed that Resident #110 had a history (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of aggressive behaviors. On 1/14/2026 at 10:15 a.m., Interview with S1Admin revealed she was aware of the resident-to-resident abuse. S1Admin confirmed she did not report the incident to the State Agency because she did not believe the incident warranted reporting to the state.

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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. F656Based on interview and record review the facility failed to develop/implement a Person-Centered Care plan for 1 (Resident #78) of 27 sampled residents to include a Percutaneous Endoscopic Gastrostomy (PEG tube) and appropriate nursing interventions.Findings: Review of Resident #78's medical record revealed an admit date of 10/07/2025 with diagnoses that included in part.Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Mild Protein-Calorie Malnutrition, Type II Diabetes Mellitus, Dysphagia following Cerebral Infarction, and Cognitive Communication Deficit.Review of Resident #78's Significant Change MDS with and ARD of 11/21/2025 revealed a BIMS score of 4 which indicated severe cognitive impairment. The MDS revealed Resident #1 was dependent for all ADL's. The MDS revealed Resident #78 was coded for holding food in mouth/cheeks or residual food in mouth after meals.Observation on 01/12/2026 at 9:50 a.m. revealed Resident #78 lying in bed. Enteral feeding and water infusing via pump.Review of Resident #78's 01/2026 physician orders revealed in part.Enteral Feed Order every shift Diabetisource per PEG tube @ 80/HR/Pump with water auto flush 45ML/HR x 22 hours-Turn feeding off at 2PM and restart at 4PM. Start date 12/11/2025.Review of Resident #78's care plan revealed no documentation of Resident #1's PEG tube with appropriate nursing interventions.Interview on 01/13/2026 at 3:45 p.m. with S12 LPN/MDS confirmed Resident #78 did not have a PEG tube care plan with appropriate interventions and should have.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident who were unable to carry out ADL's (Activities of Daily Living) received necessary services to maintain good grooming and personal hygiene. The facility failed to provide a shower/bath to dependent residents for 1 (Resident #3) of 27 sampled resident.Findings:Review of the facility's policy titled Activities of Daily Living (ADLs) with no review date, revealed in part.Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable.Care and services will be provided for the following activities of daily living:1. Bathing, dressing, grooming and oral care.Policy Explanation and Compliance Guidelines:3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Review of Resident #3's medical record revealed she was admitted to the facility on [DATE] with diagnoses which included in part.Hemiplegia and Hemiparesis following Infarction affecting Left Non-Dominant Side, Pain Unspecified, and Contracture of Left Hand.Review of Resident #3's Quarterly MDS with an ARD of 11/14/2025 revealed she had a BIMS score of 14 indicating intact cognition. The MDS revealed Resident #3 was dependent for transfers and shower/bath and required substantial/maximal assistance with personal hygiene. Resident #3's MDS coded with no behaviors/refusals of care.Review of Resident #3's care plan revealed in part. at risk for Self-Care Deficit related to Left Hemiplegia/Hemiparesis following a Cerebrovascular Accident, Contracture of Left Hand, with interventions that included to provide extensive assistance with bed baths.Observation and interview on 01/12/2026 at 10:14 a.m. revealed Resident #3 sitting in her room in a wheelchair. Resident #3 stated she had not received her shower as scheduled. Resident #3 stated staff had told her it was because she wiggled on the shower chair. Resident #3 revealed she received her baths in the evenings.Interview on 01/13/2026 at 9:15 a.m. with Resident #3 stated she did not receive a shower or bed bath the previous evening. Resident #3 stated her preference was a shower and she had told staff in the past that was her preference, but staff continued to bed bathe her.Interview on 01/13/2026 at 9:15 a.m. with S10 CNA revealed Resident #3 had complained in the past of not receiving a shower in the evenings.Interview on 01/13/2026 at 9:50 a.m. with S11 LPN/MDS revealed Resident #3 had no behaviors or refusal of care. S11 LPN/MDS revealed the care plan did not reflect when Resident #3 received a bath or what type of bath (bed bath or shower).Interview on 01/13/2026 at 10:35 a.m. with Resident #3's Responsible Party, revealed he had complained to staff numerous times about Resident #3 not receiving a shower and her hair being dirty. Resident #3's Responsible Party stated he had called the Corporate Administration to complain about a month ago and was told it would be looked into. Responsible Party stated Resident #3 had called him in the past to say she had not received her shower.Interview on 01/14/2026 at 8:05 a.m. with S2 DON stated it was not reported to her that staff was not showering Resident #3 due to positioning. S2 DON stated S3 CNA Supervisor had spoken with Resident #3 and said she wanted a shower but did not want the water in her face. Review of Resident #3's bath roster provided by S2 DON revealed 19 days of 31 days in 12/2025 with no documented evidence of a shower or bath.Interview on 01/14/2026 at 8:10 a.m. with S1 Administrator revealed Resident #3's Responsible Party had complained to Corporate Administration about Resident #3's hair being dirty and needed washing. S1 Administrator confirmed Corporate Administration had notified her of the complaint. S1 Administrator had no documented evidence of follow-up regarding the complaint.Interview on 01/14/2026 at 9:14 a.m. with S3 CNA Supervisor revealed she had received complaints from Resident #3 about not receiving her shower.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring and administration of a prescribed medication (Amiodarone) to meet the needs of Resident #37. Total Sample size 27. Findings:Review of the facility's undated policy titled Medications-Administering read in part.Medications shall be administered in a safe and timely manner, and as prescribed. Review of Resident #37 's medical record revealed an admit date of 06/27/2025 with diagnoses that included in part: Chronic Atrial Fibrillation, Chronic Combined Systolic and Diastolic Heart Failure, Hyperlipidemia, Hypertension, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Hypertensive Heart Disease. Review of Resident #37's Minimum Data Set (MDS) with an ARD of 10/30/2025 revealed Resident #37 had a BIMS score of 13, indicating intact cognition. Resident #37 was independent/ required minimal assistance with activities of daily living. Review of Resident #37's Physician Orders for January 2026 revealed in part. Amiodarone HCl oral tablet 200mg- Administer 1 tablet by mouth two times a day related to Chronic Atrial Fibrillation with an ordered date of 07/31/2025. Review of Resident #37's Care Plan, with a revision date of 10/03/2025, revealed in part.Resident #37 was at risk for altered cardiovascular status related to Atrial Fibrillation, Congestive Heart Failure and Hypertension. Interventions to manage this risk included administration of Amiodarone as ordered. Review of Resident #37's Medication Administration Record (MAR) revealed the following documentation related to the administration of Amiodarone 200mg tablet:On 01/10/2026 at 10:00 a.m. and 01/11/2026 at 10:48 a.m., the MAR reflected code 9, indicating the medication was not administered with a directive to refer to the progress notes. Review of the corresponding progress note revealed the medication was unavailable and the facility was awaiting delivery from pharmacy. There was no documentation indicating the pharmacy or the prescribing provider was contacted regarding the missed doses. On 01/12/2026 at 10:15 a.m. Interview with Resident #37 revealed that the facility was unable to provide her prescribed cardiac medications for several days due to awaiting delivery from pharmacy. Resident #37 expressed concern regarding the missed medication. On 01/13/2026 at 9:11 a.m., an interview with S2DON revealed the facility's process when a medication is not administered due to unavailability requires the nurse to contact the pharmacy to determine whether the medication can be obtained. If the medication cannot be obtained, the nurse is responsible for documenting in the resident's progress notes the reason the medication was missed and notification of the prescribing provider. On 01/13/2026 at 12:55 p.m., a telephone interview with S4LPN confirmed she did not administer Resident #37's Amiodarone on the mornings of 01/10/2026 and 01/11/2026 due to medication being unavailable at the facility. S4LPN confirmed she did not contact the pharmacy or the prescribing provider regarding the medication unavailability or missed doses. On 01/14/2026 at 1:57 p.m., a telephone interview with S5LPN confirmed she did not administer Resident #37's Amiodarone on the evening of 01/10/2026 due to the medication being unavailable at the facility. S5LPN acknowledged an error in documentation indicating the medication had been administered when it had not. S5LPN confirmed she did not contact the pharmacy or the prescribing provider regarding the medication unavailability or missed doses. On 01/14/2026 at 2:33 p.m. An interview with S2DON confirmed review of Resident #37's MAR and acknowledged the nursing staff should have contacted both the pharmacy and prescribing provider, but had not.