

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Wyatt Manor Nursing and Rehab Ctr, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4659 Highway 505 Jonesboro, LA 71251	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>18118</p> <p>Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 5 (#1, #6, #14, #19 and #33) of 5 residents rooms observed. The failed practice was evidenced by residents' air/heating units needed cleaning.</p> <p>Findings:</p> <p>Resident #1</p> <p>Observations of the air/heating unit on 01/06/2025 at 10:41 a.m., and on 01/07/2025 at 8:28 a.m. located in resident #1's room revealed a buildup of dust and a black substance was observed on the air/heating unit vents.</p> <p>Resident #6</p> <p>Observations of the air/heating unit on 01/06/2025 at 11:30 a.m., and on 01/07/2025 at 8:40 a.m. located in resident #6's room revealed dirt, dust and a black substance was observed on the air/heating unit vents.</p> <p>Resident #19</p> <p>Observations of the air/heating unit on 01/06/2025 at 10:29 a.m., and on 01/07/2025 at 8:20 a.m. located in resident #19's room revealed a black substance was observed on the air/heating unit vents.</p> <p>On 01/07/2025 at 8:55 a.m. observation/interview was conducted with S1Administrator. S1Administrator confirmed resident #1, #6, and #19's air/heating units needed to be cleaned.</p> <p>43405</p> <p>Resident #33</p> <p>Observation of the air/heating unit in resident #33's room on 01/06/2025 at 11:50 a.m.</p> <p>revealed a black substance inside the the vent and a dirt buildup surrounding the air conditioner vent.</p> <p>(continued on next page)</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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident # 14</p> <p>Observation of the air/heating unit in resident #14's room on 01/06/2025 at 9:30 a.m. revealed a buildup of dust inside and outside of the air conditioner vent.</p> <p>On 01/07/2025 at 8:55 a.m. observation/interview was conducted with S1Administrator. S1Administrator confirmed resident #33 and #14's air/heating units needed to be cleaned.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>13974</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints that were not required to treat a resident's medical symptoms for 1 (#32) of 2 (#5, and #32) residents reviewed for restraint use.</p> <p>Findings:</p> <p>Review of the medical record for resident #32 revealed he had diagnoses which included mood disorder, difficulty walking, muscle wasting and atrophy, seizures and severe intellectual disabilities.</p> <p>On 01/06/2025 at 9:30 a.m. and on 01/07/2025 at 10:10 a.m., resident #32 was observed in a geri-chair with a lap tray.</p> <p>Review of the Pre-Restraining assessment summary dated 11/19/2024 indicated resident #32 could remove the lap tray from the geri-chair.</p> <p>On 01/07/2025 at 12:40 p.m., interview with S4Minimum Data Set (MDS) Nurse revealed the facility did not consider the lap tray to be a restraint because resident #32 could remove the tray. On 01/07/2025 at 12:40 p.m., S4MDS prompted resident #32 to remove his lap tray. The resident was unable to remove the lap tray.</p> <p>On 01/07/2025 at 12:50 p.m., interview with S3Licensed Practical Nurse (LPN) revealed resident #32 was unable to remove the lap tray from the geri-chair</p> <p>On 01/07/2025 at 1:00 p.m., interviews with S5Certified Nursing Assistant (CNA) and S6CNA revealed resident #32 was unable to remove the lap tray from the geri-chair.</p> <p>On 01/08/2025 at 9:20 a.m., interview with S4MDS Nurse confirmed the geri-chair with a lap tray was a restraint for resident #32.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13974</p> <p>Based on interviews and record reviews, the facility failed to conduct a comprehensive and accurate assessment of each resident's functional capacity by failing to ensure the Minimum Data Set (MDS) Assessment was accurate for 1 (#32) of 2 (#5, and #32) residents reviewed for restraints.</p> <p>Findings:</p> <p>Review of the medical record of resident #32 revealed he had diagnoses which included mood disorder, difficulty walking, muscle wasting and atrophy, seizures and severe intellectual disabilities.</p> <p>On 01/06/2025 at 9:30 a.m., and on 01/07/2025 at 10:10 a.m., resident #32 was observed in a geri-chair with a lap tray.</p> <p>Review of the Pre-Restraining assessment summary dated 11/19/2024 indicated the resident could remove the lap tray from the geri-chair.</p> <p>On 01/07/2025 at 12:40 p.m., interview with S4MDS Nurse revealed the facility did not consider the lap tray to be a restraint because resident #32 could remove the lap tray. On 01/07/2025 at 12:40 p.m. S4MDS prompted resident #32 to remove his lap tray, but the resident was unable to remove the lap tray.</p> <p>Review of the Quarterly MDS assessment dated [DATE] revealed it was not coded accurately to indicate that a restraint was used for resident #32.</p> <p>On 01/07/2025 at 12:50 p.m., interview with S3Licensed Practical Nurse (LPN) revealed resident #32 was unable to remove the lap tray from the geri-chair.</p> <p>On 01/07/2025 at 1:00 p.m, interviews with S5Certified Nursing Assistant (CNA) and S6CNA revealed resident #32 was unable to remove the lap tray from the geri-chair.</p> <p>On 01/08/2025 at 9:20 a.m., interview with S4MDS Nurse confirmed the MDS assessment did not accurately identify the use of a lap tray as a restraint for resident #32.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on record review, observations, and interview the facility failed to implement a comprehensive person-centered care plan for 1 (#15) of 2 (#13, and #15) residents reviewed for falls. The facility failed to ensure resident #15 had a fall mat in place beside his bed per the physician orders and in accordance with his plan of care.</p> <p>Record review revealed resident #15 was admitted to the facility on [DATE]. Resident #15's diagnoses included muscle wasting and atrophy multiple sites, other abnormalities of gait and mobility, unsteadiness on feet, paranoid schizophrenia, delusional disorders, manic episode severe with psychotic symptoms, generalized anxiety disorder, insomnia, and major depressive disorder.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score 9 which indicated moderate cognitive impairment. Resident #15 was unable to ambulate and used manual wheelchair for locomotion. Further review revealed resident#15 required partial/moderate assistance with toileting, showers/bathing, dressing, and transfers. Resident #15 was frequently incontinent of bladder, and always incontinent of bowel.</p> <p>Review of active January 2025 physician orders revealed an order for a fall mat to open side of bed every shift (order start date 07/24/2024) and high risk for falls: resident is on the falling star program.</p> <p>Review of active care plans revealed resident #15 was at high risk for falls. An intervention included for a mat placed to open side of bed.</p> <p>On 01/06/2025 at 1:02 p.m., an observation of resident #15 revealed he was asleep lying in bed. The bed was in the lowest position. The right side of the bed was positioned against the wall. There was no fall mat noted on the floor on the left side of his bed.</p> <p>On 01/07/2025 at 11:40 a.m. an observation of resident #15 revealed he was asleep lying in bed. The bed was in the lowest position. The right side of the bed was positioned against the wall. There was no fall mat noted on the left side of his bed. Further observation revealed there was a blue fall mat lying on the floor underneath resident #15's bed.</p> <p>On 01/07/2025 at 11:56 a.m., an observation of resident #15 with S2Director of Nursing (DON) revealed resident #15 was asleep lying in bed. There was no fall mat on the left side of his bed. There was a blue fall mat lying on the floor underneath resident #15's bed. S2DON confirmed the fall mat should be positioned on the left side of resident # 15's bed according to the physician order and care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>18118</p> <p>Based on observations and interview, the facility failed to ensure the resident's environment remained as free of accident hazards as possible by failing to ensure resident rooms maintained a water temperature of less than 120 degrees Fahrenheit for 1 (#6) of 1 residents reviewed for accident hazards.</p> <p>Findings:</p> <p>On 01/06/2025 at 11:20 a.m. an observation of the water temperature in resident #6's bathroom sink revealed the hot water temperature was 127.6 degrees Fahrenheit.</p> <p>On 01/06/2024 at 12:17 p.m. observation of the water temperature in resident #6's bathroom sink with S1Administrator and S7Maintenance Supervisor, using the facility's thermometer, revealed the water temperature was 127.7 degrees Fahrenheit. S1Administrator confirmed the hot water temperature was too hot and should not be greater than 120 degrees Fahrenheit.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405</p> <p>Based on record reviews and interviews, the facility failed to ensure resident's drug regimens were free from unnecessary psychotropic medications for 5 (#2, #11, #14, #15, and #33) of 5 residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Resident #2</p> <p>Review of resident #2's record revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, major depressive disorder, acute respiratory failure, other specified extrapyramidal and movement disorders, other psychotic disorder not due to a substance or known physiological condition.</p> <p>Review of resident #2's January 2025 Physician's Orders revealed an order dated 03/15/2024 for Escitalopram Oxalate tab 10 milligrams (mg) give 1 tablet by mouth 1 time a day and Olanzapine tab 10 mg give 1 tablet by mouth 2 times a day (bid).</p> <p>Review of the Pharmaceutical Consultant Report dated 06/13/2024 for resident #2 revealed the pharmacist recommended a gradual dose reduction for Zyprexa (Olanzapine)10 mg bid and Lexapro (Escitalopram Oxalate) 10 mg every day. Further review revealed the physician documented a dose reduction was not appropriate and resident was on the minimal effective dose, but the physician did not provide a handwritten rationale to justify for not reducing the psychoactive medications.</p> <p>On 01/08/2025 at 1:50 p.m., an interview with S2Director of Nursing (DON) confirmed the physician did not document a handwritten rationale as to why resident #2 's psychotropic medications were not reduced on the gradual dose reduction letter.</p> <p>Resident #14</p> <p>Review of resident #14's record revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, dementia in other disease classified elsewhere with behavioral disturbance, pseudobulbar affect, bipolar disorder, major depressive disorder, and generalized anxiety disorder.</p> <p>Review of resident #14's January 2025 Physician's Orders revealed the following:</p> <p>04/25/2022- Trazodone Hydrochloride 100 mg give 1 tablet orally at bedtime (hs),</p> <p>03/11/2012- Geodon Oral Capsule 80 mg give 2 tablet by mouth one time a day,</p> <p>04/09/2019- Lorazepam Oral Tablet 1 mg give 1 tablet by mouth two times a day; and</p> <p>09/27/2012- Zolofl Oral Tablet 100 mg give 1 tablet by mouth one time a day.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Pharmaceutical Consultant Report dated 06/13/2024 for resident #14 revealed the pharmacist recommended a gradual dose reduction for Geodon 160 mg every night, Zoloft 100 mg every day, Ativan (Lorazepam) 1 mg bid, and Trazadone 100 mg at hs. Further review revealed the physician documented a dose reduction was not appropriate and the resident was on the minimal effective dose, but the physician did not provide a handwritten rationale to justify for not reducing the psychoactive medications.</p> <p>On 01/08/2025 at 1:50 p.m., an interview with S2DON confirmed the physician did not document a handwritten rationale as to why resident #14 's psychotropic medications were not reduced on the gradual dose reduction letter.</p> <p>Resident #33</p> <p>Review of resident #33's record revealed an admitted [DATE] with diagnoses including dementia in other diseases classified elsewhere mild with other behavioral disturbance, dementia in other disease unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, psychotic disorder with delusions due to known physiological condition, schizophrenia, Alzheimer's disease, and delusional disorders.</p> <p>Review of resident #33's January 2025 Physician's Orders revealed an order dated 07/01/2024 for Olanzapine oral tablet 10 mg give 1 tablet by mouth at bedtime related to delusional disorders.</p> <p>Review of resident #33's Pharmaceutical Consultant Report letter dated 06/13/2024 revealed the pharmacist recommended a gradual dose reduction for Zyprexa (Olanzapine) 10 mg at hs. Further review revealed the physician documented a dose reduction was not appropriate and the resident was on the minimal effective dose, but the physician did not provide a handwritten rationale to justify for not reducing the psychoactive medication.</p> <p>On 01/08/2025 at 1:50 p.m., an interview with S2DON confirmed the physician did not document a handwritten rationale as to why resident #33's psychotropic medications were not reduced on the gradual dose reduction letter.</p> <p>41829</p> <p>Resident #11</p> <p>Record review revealed resident #11 was admitted to the facility 03/18/2011. Resident #11 diagnoses included paranoid schizophrenia, delusional disorders, manic episode severe with psychotic symptoms, generalized anxiety disorder, insomnia, and major depressive disorder.</p> <p>Review of the January 2025 Physician's Orders included the following psychotropic medications: Abilify 30 mg tablet give one tablet orally at bedtime, Citalopram Hydrobromide 10 mg tablet give 1 tablet orally one time a day, Quetiapine Fumarate 400 mg give 1 tablet orally bid, Lorazepam 0.5 mg tablet give 1 tablet orally three times a day (tid).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction letter dated 06/13/2024 revealed a gradual dose reduction was requested for the following medications: Seroquel (Quetiapine Fumarate) 400 mg bid, Abilify 30 mg hs, Celexa (Citalopram Hydrobromide) 10 mg daily, and Ativan (Lorazepam) 0.5 mg tid. The physician documented a dose reduction was not appropriate and minimal effective dose. Further review revealed the physician failed to provide a handwritten valid clinical rationale as justification for not reducing the psychotropic medications.</p> <p>On 01/08/2025 at 1:50 p.m., an interview with S2DON confirmed the physician did not document a handwritten rationale as to why resident #11 's psychotropic medications were not reduced on the gradual dose reduction letter.</p> <p>Resident #15</p> <p>Record review revealed resident #15 was admitted to the facility 07/25/2016. Resident #15's diagnoses included paranoid schizophrenia, insomnia, restlessness and agitation, and generalized anxiety disorder.</p> <p>Review of the January 2025 Physician's Orders included the following psychotropic medications: Risperidone 2 mg tablet give 1 tablet orally one time a day, Risperidone 3 mg tablet give 1 tablet orally at bedtime, and Lorazepam 0.5 mg tablet give 1 tablet orally bid.</p> <p>Review of the Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction letter dated 06/13/2024 revealed a gradual dose reduction was requested for the following medications: Risperdal (Risperidone) 2 mg every day and 3 mg every hs, and Ativan (Lorazepam) 0.5 mg bid. The physician documented a dose reduction was not appropriate and minimal effective dose. Further review revealed the physician failed to provide a handwritten valid clinical rationale as justification for not reducing a psychotropic medication.</p> <p>On 01/08/2025 at 1:50 p.m., an interview with S2DON confirmed the physician did not document a handwritten rationale as to why resident #15 's psychotropic medications were not reduced on the gradual dose reduction letter.</p>		