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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195605 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/18/2026 |
| NAME OF PROVIDER OR SUPPLIER Mary Anna Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 125 Turner 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) |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to protect the resident's right to be free from neglect for 1 (#26) of 1 sampled resident reviewed for neglect. S4CNA failed to provide and follow required safety procedures when transporting Resident #26 in the facility van. This deficient practice resulted in an Immediate Jeopardy situation on 01/06/2026 at approximately 1:30 p.m. when Resident #26 was returning from a physician appointment. S4CNA failed to properly secure Resident #26 with the restraining seatbelt in the facility van. Resident #26 verbalized to S4CNA during return transportation that she was sliding out of her wheelchair. S4CNA failed to stop the vehicle and assist Resident #26 with repositioning. S4CNA continued to drive to her personal residence and left Resident #26 alone in the van. Resident #26 slipped out of the wheelchair onto the floor of the van while alone in the van. S4CNA returned to the van, found resident on the floor of the van and continued to drive approximately 15.3 miles to the nursing home without notifying the facility of the fall. Upon arrival to the facility, S4CNA failed to notify the facility of when the fall occurred and how long Resident #26 had been on the floor. Although Resident #26 was assessed with no injuries upon return to the facility, the deficient practice had the likelihood of a serious injury, serious harm, serious impairment or death to occur. The facility implemented corrective actions which were completed prior to State Agency's investigation entry on 03/16/2026. It was determined to be a Past Noncompliance Citation. Findings:Review of the facility's Freedom from Abuse, Neglect, and Exploitation policy revised 07/31/2025 revealed in part:Purpose:Ensure each resident's right to be free from abuse, neglect, and corporal punishment of any type by anyone.Procedure:1. The resident has a right to be free from abuse, neglect, misappropriation of resident property, and exploitation.2. The facility does not tolerate abuse, neglect, or exploitation of any kind.3. Staff includes employees, the Medical Director, consultants, contractors, volunteers.Definitions: Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of S4CNA's annual training including the abuse and neglect policy revealed S4CNA completed her training on 10/01/2025. Review of the facility's Post - Fall Management and Transport policy dated 08/16/2023 revealed, in part: III. Procedure: 1. Safety and Assessment: do not move the resident until a comprehensive assessment is done, if the resident hit their head, is on anticoagulants, or the fall was unwitnessed, treat as a potential high risk injury and call 911 immediately. 2. Notification: notify the Charge Nurse/DON immediately. Review of the facility's Safe Procedures for Transporting People Who Use Wheelchairs policy (Transportation Policy) dated 03/24/2023 revealed, in part:It is the policy of the facility to ensure adequate training of all personnel responsible for transporting out residents. We are specifically addressing transporting those who use wheelchairs. Safety is our #1 goal.As part of our training, employees will be taught passenger assistive techniques. Each employee transporting residents will be required by management to attend this training course prior to transporting any resident in a wheelchair.An outline of the training will include what to do when: Entering the vehicle, Exiting the vehicle, Transporting the passenger, and Operating the lift.We will be using 2 online videos (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>which outline the proper way to safely secure the wheelchairs throughout the process. Both videos will be viewed by transporting employees. The videos are: Safe Transportation of people who use wheelchairs and Strapping Clients/Wheelchair in vans (YouTube) Our training will also include: Recommended guidelines for safe wheelchair transportation, Safe loading and unloading procedures, How to operate a vehicle lift, How to properly tie down a wheelchair, and what to do if someone falls. Review of the Transportation Training Checklist - Competency Checklist revealed the following: resident fall procedure, vehicle attendance with resident presence and facility transportation policy. S4CNA acknowledged the checklist and policy/procedure by signature and date of 07/16/2025. Review of the undated Passenger Assistive Techniques procedure revealed the following: always use a seat belt for you and your passengers, use passenger restraints and ensure the passenger restraint belts fit securely. S4CNA acknowledged the procedure by signature and date of 07/16/2025. Record review revealed Resident #26 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; hemiplegia, affecting left nondominant side; chronic systolic (congestive) heart failure; type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy; chronic pain due to trauma; spinal stenosis, cervical region; and chronic obstructive pulmonary disease. Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #26 was cognitively intact. Further review of the MDS revealed Resident #26 was dependent on a wheelchair for mobility and staff for transfers utilizing a lift. On 03/16/2026 at 9:35 a.m., an interview with Resident #26 revealed she sustained a fall from her wheelchair in the facility's transportation van when returning from an appointment. Resident #26 stated when she left her appointment on 01/06/2026, S4CNA failed to attach the van's restraining seatbelt across Resident #26's lap. Resident #26 stated while in route back to the facility, she informed S4CNA she felt like she was sliding down in her wheelchair. Resident #26 stated S4CNA did not stop the van to reposition her, but continued to drive until they reached S4CNA's personal residence. Resident #26 stated S4CNA went inside her personal residence and left her unattended without repositioning her in the wheelchair. Resident #26 stated she slid out of her wheelchair to the transportation van's floor while S4CNA was inside her personal residence. Resident #26 stated when S4CNA returned, she was not assisted off the floor and S4CNA did not call the facility for assistance. Resident #26 stated S4CNA drove her back to the facility while she was on sitting on the transportation van's floor. Resident #26 denied any other instances of not being secured in the transportation van without a seat belt. On 03/17/2026 at 3:05 p.m., an interview with S2DON revealed she was informed Resident #26 fell in the wheelchair van upon the resident's return to the facility, but assumed she sustained a fall when exiting the van at the facility. S2DON stated she was not made aware that Resident #26 fell at S4CNA's personal residence until the following morning when she interviewed Resident #26. On 03/17/2026 at 3:20 p.m., an interview with S4CNA confirmed she did not utilize the van's restraining lap belt when transporting Resident #26 back from her appointment. S4CNA confirmed she had received transportation safety training but did not provide an answer as to why she did not follow policy. S4CNA also confirmed she did not reposition Resident #26 in her wheelchair when Resident #26 informed her she was sliding down in her wheelchair. S4CNA stated she did stop at her personal residence to use the restroom and left Resident #26 unattended in the facility's transportation van. S4CNA confirmed Resident #26 was sitting on the floor of the transportation van when she returned and she did not call the facility for assistance to transfer Resident #26 off the floor. S4CNA confirmed she drove Resident #26 back to the facility from her personal residence while the resident was sitting on the floor of the van due to being unable to lift the resident off of the floor by herself. On 03/18/2026 at 7:45 a.m., an interview with S2DON confirmed S4CNA should have secured Resident #26 properly with the facility's van's restraining belt, S4CNA should have repositioned Resident #26 when she was notified by the resident, she was sliding down in her wheelchair, S4CNA should have not left Resident #26 unattended in the van while she went (continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>inside her personal residence, S4CNA should have notified the facility immediately when Resident #26 fell in the transportation van and S4CNA should not have driven the facility van to the nursing home with Resident #26 on the floor of the van. S2DON reported S4CNA had been previously trained prior to the 01/06/2026 incident on transportation safety, the fall policy and the abuse and neglect policy. On 03/18/2026 at 8:15 a.m., an interview with S1Administrator confirmed S4CNA should have properly secured Resident #26 by applying the facility's van's restraining belt, S4CNA should have assisted Resident #26 with repositioning when she was notified by the resident, she was sliding down in her wheelchair, S4CNA should have not left Resident #26 unattended in the van when she went inside her personal residence, S4CNA should have notified the facility immediately when Resident #26 fell in the transportation van and S4CNA should not have driven the facility van to the nursing home with Resident #26 on the floor of the van. S1Administrator reported S4CNA had been previously trained prior to the 01/06/2026 incident on transportation safety, the fall policy, and the abuse and neglect policy. A review of the facility investigation dated 01/07/2026 revealed the facility substantiated neglect in their findings. During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. The facility implemented the following actions to correct the deficient practice with a completion date of 01/08/2026: 1. Immediately assessed Resident #26 upon return to the facility on [DATE]. 2. Terminated the employment of S4CNA on 01/07/2026. 3. DON updated the facility's policy on transportation to notate change stating to call the facility in the event of a fall if non-emergent or to call 911 if it is an emergency on 01/08/2026. 4. On 01/08/2026, in-service performed with transportation drivers at this time to make aware of policy changes and to perform competency checks on loading and unloading resident in wheelchair. In-service done by DON and Maintenance Supervisor. Transport drivers counseled on the importance of never leaving resident unsupervised. Counseled on notifying nursing immediately in the event of a fall. 5. On 01/08/2026, mandatory monitoring being done by DON or designee as follows 3x per week until 04/08/2026. This monitoring consists of checks upon arrival and departure to ensure resident is safely anchored in van and that resident is properly seated to ensure safety while being transported. Upon each assessment by DON, upon departure/arrival transport driver will be quizzed on who to call in the event of a fall while transporting. Will also speak with residents about their trip. 6. On 01/08/2026, monitoring compliance and situation weekly at our staff meetings. Will monitor and address at quarterly QAPI meetings and other intervals as needed to ensure compliance. Facility is in compliance as of 01/08/2026. Validation of plan of correction: The facility corrective actions were confirmed through onsite interviews, observations and record reviews. On 03/16/2026 at 10:00 a.m., record review revealed that Resident #26 was assessed by S2DON. On 03/17/2026 at 8:45 a.m., an interview with S8CNA revealed she was the main transportation driver for the facility. S8CNA stated she began transporting for the facility in January 2026 when S4CNA was terminated from employment. S8CNA confirmed she had received transportation safety training and proper restraining of residents in the van. S8CNA stated if a resident were to have a fall in the transportation van, she would stop the van and call 911 if the resident was injured or notify the facility immediately if no obvious injuries were sustained by the resident. On 03/17/2026 at 9:30 a.m., observation of S8CNA loading a wheelchair dependent resident in the facility's transportation van revealed the proper loading and securing of the resident without issues. On 03/17/2026 at 2:15 p.m., an interview with S2DON and review of employee files confirmed S4CNA's employment was terminated on 01/07/2026. On 03/18/2026 at 7:45 a.m., an interview with S2DON and review of facility's trainings confirmed CNA/Transport staff were in-serviced on updated transportation safety policies that included competency checks. The trainings included instruction to not leave residents unattended and properly securing residents in the transportation van. On 03/18/2026 at 10:34 a.m., an interview with S9CNA confirmed she is one of the facility's transportation drivers. S9CNA stated she was in-serviced in January on transportation safety and (continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>stated she would stop the van immediately and notify the facility if a resident were to fall. S9CNA stated she was in-serviced on not leaving residents unattended while in the transport van. On 03/18/2026 at 11:00 a.m., an interview with S2DON confirmed she had been conducting random checks 3 times weekly beginning the week of 01/11/2026 and randomly interviewing staff about transportation safety policy. On 03/18/2026 at 11:30 a.m., review of the facility's plan of correction revealed documentation of S2DON's audits of resident transports and monitoring of staff securing of residents. On 03/18/2026 at 11:45 a.m., review of the facility's QAPI revealed the interventions for transportation safety were added to the facility's QA. On 03/18/2026 at 3:20 p.m., an interview with S13Laundry employee confirmed she has received an in-service on fall protocol and stated if she discovered a resident had fallen, she would call the nurses station immediately to alert staff. On 03/18/2026 at 3:30 p.m. through 3:40 p.m., interviews conducted with S10CNA, S11CNA, and S12CNA confirmed they were in-serviced on fall protocol and stated they would notify a nurse immediately if a resident fell.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide adequate supervision and properly secure the resident with the facility van's restraining seatbelt to prevent accidents for 1 (Resident #26) of 5 sampled residents reviewed for accidents. This deficient practice resulted in an Immediate Jeopardy situation on 01/06/2026 at approximately 1:30 p.m. when S4CNA failed to properly secure Resident #26 (who was wheelchair dependent) with the transportation van's restraining seatbelt. S4CNA left Resident #26 in the transportation van unsupervised while S4CNA stopped at her personal residence. This resulted in Resident #26 slipping out of her wheelchair onto the van floor while she was unsupervised. Although Resident #26 was assessed with no injuries upon return to the facility, the deficient practice had the likelihood of a serious injury, serious harm, serious impairment or death to occur. The facility implemented corrective actions which were completed prior to State Agency's investigation entry on 03/16/2026. It was determined to be a Past Noncompliance Citation. Findings: Review of the facility's Safe Procedures for Transporting People Who Use Wheelchairs policy (Transportation Policy) dated 03/24/2023 revealed, in part: It is the policy of the facility to ensure adequate training of all personnel responsible for transporting out residents. We are specifically addressing transporting those who use wheelchairs. Safety is our #1 goal. As part of our training, employees will be taught passenger assistive techniques. Each employee transporting residents will be required by management to attend this training course prior to transporting any resident in a wheelchair. An outline of the training will include what to do when: Entering the vehicle, Exiting the vehicle, Transporting the passenger, and Operating the lift. We will be using 2 online videos which outline the proper way to safely secure the wheelchairs throughout the process. Both videos will be viewed by transporting employees. The videos are: Safe Transportation of people who use wheelchairs and Strapping Clients/Wheelchair in vans (YouTube). Our training will also include: Recommended guidelines for safe wheelchair transportation, Safe loading and unloading procedures, How to operate a vehicle lift, How to properly tie down a wheelchair, and what to do if someone falls. Review of the Transportation Training Checklist - Competency Checklist revealed the following: resident fall procedure, vehicle attendance with resident presence and facility transportation policy. S4CNA acknowledged the checklist and policy/procedure by signature and date of 07/16/2025. Review of the undated Passenger Assistive Techniques procedure revealed the following: always use a seat belt for you and your passengers, use passenger restraints and ensure the passenger restraint belts fit securely. S4CNA acknowledged the procedure by signature and date of 07/16/2025. Record review revealed Resident #26 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; hemiplegia, affecting left nondominant side; chronic systolic (congestive) heart failure; type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy; chronic pain due to trauma; spinal stenosis, cervical region; and chronic obstructive pulmonary disease. Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #26 was cognitively intact. Further review of the MDS revealed Resident #26 was dependent on a wheelchair for mobility and staff for transfers utilizing a lift. On 03/16/2026 at 9:35 a.m., an interview with Resident #26 revealed she sustained a fall from her wheelchair in the facility's transportation van when returning from an appointment. Resident #26 stated when she left her appointment on 01/06/2026, S4CNA failed to attach the van's restraining seatbelt across Resident #26's lap. Resident #26 stated while in route back to the facility, she informed S4CNA she felt like she was sliding down in her wheelchair. Resident #26 stated S4CNA did not stop the van to reposition her but continued to drive until they reached S4CNA's personal residence. Resident #26 stated S4CNA went inside her personal residence and left her unattended (continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>without repositioning her in the wheelchair. Resident #26 stated she slid out of her wheelchair to the transportation van's floor while S4CNA was inside her personal residence. Resident #26 stated when S4CNA returned, she was not assisted off the floor and S4CNA did not call the facility for assistance. Resident #26 stated S4CNA drove her back to the facility while she was on sitting on the transportation van's floor. On 03/17/2026 at 3:20 p.m., an interview with S4CNA confirmed she did not utilize the van's restraining lap belt when transporting Resident #26 back from her appointment. S4CNA also confirmed she did not reposition Resident #26 in her wheelchair when Resident #26 informed her she was sliding down in her wheelchair. S4CNA stated she did stop at her personal residence to use the restroom and left Resident #26 unattended in the facility's transportation van. S4CNA confirmed Resident #26 was sitting on the floor of the transportation van when she returned and she did not call the facility for assistance to transfer Resident #26 off the floor. S4CNA confirmed she drove Resident #26 back to the facility from her personal residence while the resident was sitting on the floor of the van. S4CNA confirmed she had received transportation safety training. On 03/18/2026 at 7:45 a.m., an interview with S2DON confirmed S4CNA failed to properly secure Resident #26 into the transportation van with the restraining seatbelt and S4CNA left Resident #26 in the transportation van unsupervised while S4CNA stopped at her personal residence. Further interview confirmed Resident #26 slipped out of her wheelchair onto the van floor while the resident was not secure with a seatbelt and unsupervised in the facility van. S2DON reported S4CNA had been previously trained prior to the 01/06/2026 incident on transportation safety and the fall policy. On 03/18/2026 at 8:05 a.m., interview with S5LPN confirmed Resident #26 was sitting on the floor of the facility's transportation van upon return and assisted in assessing and lifting the resident off of the van's floor. On 03/18/2026 at 8:15 a.m., an interview with S1Administrator confirmed S4CNA failed to properly secure Resident #26 into the transportation van with the restraining seatbelt and S4CNA left Resident #26 in the transportation van unsupervised while S4CNA stopped at her personal residence. Further interview confirmed Resident #26 slipped out of her wheelchair onto the van floor while the resident was not secure with a seatbelt and unsupervised in the facility van. During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. The facility implemented the following actions to correct the deficient practice with a completion date of 01/08/2026: 1. Immediately assessed Resident #26 upon return to the facility on [DATE]. 2. Terminated the employment of S4CNA on 01/07/2026. 3. DON updated the facility's policy on transportation to notate change stating to call the facility in the event of a fall if non-emergent or to call 911 if it is an emergency on 01/08/2026. 4. On 01/08/2026, in-service performed with transportation drivers at this time to make aware of policy changes and to perform competency checks on loading and unloading resident in wheelchair. In-service done by DON and Maintenance Supervisor. Transport drivers counseled on the importance of never leaving resident unsupervised. Counseled on notifying nursing immediately in the event of a fall. 5. On 01/08/2026, mandatory monitoring being done by DON or designee as follows 3x per week until 04/08/2026. This monitoring consists of checks upon arrival and departure to ensure resident is safely anchored in van and that resident is properly seated to ensure safety while being transported. Upon each assessment by DON, upon departure/arrival transport driver will be quizzed on who to call in the event of a fall while transporting. Counseled on notifying nursing immediately in the event of a fall. 6. On 01/08/2026, monitoring compliance and situation weekly at our staff meetings. Will monitor and address at quarterly QAPI meetings and other intervals as needed to ensure compliance. Facility is in compliance as of 01/08/2026. Validation of plan of correction: The facility corrective actions were confirmed through onsite interviews, observations and record reviews. On 03/16/2026 at 10:00 p.m., record review revealed that Resident #26 was assessed by S2DON with no injuries documented. On 03/17/2026 at 8:45 a.m., interview with S8CNA revealed she was the main transportation driver for the facility. S8CNA stated she began transporting for the facility in January 2026 when S4CNA was (continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>terminated from employment. S8CNA confirmed she had received transportation safety training and proper restraining of residents in the van. S8CNA stated if a resident were to have a fall in the transportation van, she would stop the van and call 911 if the resident was injured or notify the facility immediately if no obvious injuries were sustained by the resident. On 03/17/2026 at 9:30 a.m., an observation was conducted of S8CNA loading a resident into the transportation van in a wheelchair. S8CNA was observed to properly secure the wheelchair and place the restraining seatbelt on the resident. On 03/17/2026 at 2:15 p.m., an interview with S2DON and review of employee files confirmed S4CNA's employment was terminated on 01/07/2026. On 03/18/2026 at 7:45 a.m., an interview with S2DON and review of facility's trainings confirmed CNA/Transport staff were in-serviced on updated transportation safety policies that included competency checks. The trainings included instruction to not leave residents unattended and properly securing residents in the transportation van. On 03/18/2026 at 10:34 a.m., an interview with S9CNA confirmed she is one of the facility's transportation drivers. S9CNA stated she was in-serviced in January on transportation safety and stated she would stop the van immediately and notify the facility if a resident were to fall. S9CNA stated she was in-serviced on not leaving residents unattended while in the transport van. On 03/18/2026 at 11:00 a.m., an interview with S2DON confirmed she has been conducting random checks 3 times weekly beginning the week of 01/11/2026 and randomly interviewing staff about transportation safety policy. On 03/18/2026 at 11:30 a.m., review of the facility's plan of correction revealed documentation of S2DON's audits of resident transports and monitoring of staff securing of residents. On 03/18/2026 at 11:45 a.m., review of the facility's QAPI revealed the interventions for transportation safety were added to the facility's QA. On 03/18/2026 at 3:20 p.m., an interview with S13 Laundry employee confirmed she has received an in-service on fall protocol and stated if she discovered a resident had fallen, she would call the nurses station immediately to alert staff and remain with the resident. On 03/18/2026 at 3:30 p.m. through 3:40 p.m., interviews conducted with S10CNA, S11CNA, and S12CNA confirmed they were in-serviced on fall protocol and stated they would notify a nurse immediately if a resident fell and not leave resident unattended.</p> | | |