STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195605	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Anna Nursing Home	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 01/07/2026On 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews, and record reviews, the facility failed to implement a person-centered care plan for each resident to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (#1) of 18 sampled residents. The facility failed to ensure care-planned interventions for falls were implemented. Findings:Resident # 1 Review of the record for Resident #1 revealed an admission date of 08/08/2024 with diagnoses that included type 2 diabetes mellitus with diabetic neuropathy, gastroesophageal reflux disease, vitamin D deficiency, osteoarthritis, dementia, hypertension, hyperlipidemia, and history of falling. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 7 which indicated Resident #1 had severe cognitive impairment with daily decision making. Further review revealed Resident #1 required supervision/touch assist with chair to chair and bed to chair transfers. Review of the quarterly fall risk assessment dated [DATE] revealed a score of 18 which indicated Resident #1 was a high fall risk. Review of the plan of care to address falls for Resident #1 revealed an intervention dated 02/09/2026 to encourage Resident #1's use of a reacher and ensure the device is within reach. On 03/17/2026 at 9:38 a.m., observation revealed Resident #1 did not have a reacher plainly visible.On 03/17/2026 at 12:53 p.m., Resident #1 was observed without a reacher. Interview with Resident #1 revealed she did not have the device and asked for surveyor to get her one.On 03/17/2026 at 12:56 p.m., S8CNA did not identify the reacher as a fall intervention for Resident #1.On 03/17/2026 at 1:53 p.m., S15LPN did not identify the reacher as a fall intervention for Resident #1. S15LPN reported being unaware of the reacher being a fall intervention.On 03/17/2026 at 12:27 p.m., S2DON was informed of the findings and confirmed there was no documentation to support a reacher was in place per the plan of care.

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Mary Anna Nursing Home	125 Turner Street Wisner, LA 71378

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure a resident maintained acceptable parameters of nutritional status by failing to follow their policy and procedure when a significant weight loss was identified for 1 (#2) of 3 residents reviewed for nutrition. Findings:Review of the facility undated Policy and Procedure: Weight Loss Management revealed the following, in part:III. Definitions:Significant Weight Loss: 1 month: >5% loss of body weightIV. ProcedureC. Identification of Weight Loss:1. If a significant weight loss is identified, nursing staff must notify the dietitian, attending physician, and the responsible party within 24 hours.2. Place the resident on the facility's High Risk /Weight Management List for closer monitoring.D. Evaluation and Intervention:2. IDT Meeting: Within 72 hours of identifying significant weight loss, the IDT (Dietician, Nurse, Physician, and Activity Director) will meet to review the plan of care.3. Interventions: Implement appropriate actions, which may include: Offering food substitutions, providing therapeutic diets as ordered, increasing protein/calorie density of meals, initiating nutritional supplements, assistance with feeding or adaptive feeding devices, and medication review by the pharmacist to identify drugs causing anorexia.E. Follow-up:1. Weekly weights will be taken until weight stabilizes for at least 3 months2. The IDT will review the effectiveness of interventions at least monthly.Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of pylorus, dysphagia following cerebral infarction, and Type 2 diabetes mellitus with chronic kidney disease.Review of the Significant Change 5 day MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 13, which indicated no cognitive impairment and he was independent with eating.Review of Resident #2's weights revealed:12/01/2026 - 180.801/05/2026 - 182.802/03/2026 - 169.803/02/2026 - 169.2Record review revealed Resident #2 was hospitalized from [DATE] - 02/03/2026 for diabetic ketoacidosis and a gastrointestinal bleed. His prehospitalization weight was 182.8 on 01/05/2026, and the resident's re-admit weight to the facility was 169.8 on 02/03/2026. This resulted in a 7.11% weight loss in 1 month. Review of S2DON's nurses' note dated 02/05/2026 at 6:34 p.m. revealed Resident #2 was in the hospital for 2 weeks and returned with a 13 pound weight loss. She noted before the resident was sent out to the hospital his weight was 182.8 pounds and since the resident returned, he had been eating 75-100% of all meals.Record review revealed after S2DON identified the resident's significant weight loss on 02/05/2026, there was no documentation of the following: notification of the dietician, physician, and responsible party within 24 hrs; IDT meeting within 72 hours; appropriate interventions for weight loss; weekly weights; and IDT follow-up on effectiveness of interventions at least monthly per the facility policy.Record review revealed there was no documentation the dietician assessed Resident #2 in February 2026. Review of Resident #2's February 2026 orders revealed there was no order for nutritional supplements or an appetite stimulant.Review of Resident #2's current care plan revealed he had a possible nutritional deficit related to diabetes mellitus and he was non-compliant with his diet. Further review revealed there were no new interventions for the resident's significant weight loss that was identified by S2DON on 02/05/2026.Review of S6Registered Dietician notes' dated 03/12/2026 at 4:48 p.m. revealed Resident #2's current weight was 169.2 pounds (03/02/2026) and he had a weight loss of 13.6 pounds in the past 2 months. S6Registerd Dietician recommended sugar free health shakes with meals for weight maintenance.Observations of Resident #2 on 03/16/2026 at 12:00 p.m., and 03/17/2026 at 12:05 p.m. revealed he was eating lunch in the dining room. Further observation revealed the resident did not receive any sugar free health shakes on his lunch trays.Interview with S7Cook on 03/18/2026 at 10:35 a.m. confirmed Resident #2 had not received sugar free health shakes with his meals on 03/16/2026 or 03/17/2026. S7Cook reported they do not keep sugar free health shakes on hand, and they had not received any for Resident #2.An interview with S2DON on 03/18/2026 at 1:45 p.m., revealed she was responsible for following up on the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietician's recommendations. She confirmed Resident #2 had not received any health shakes since the 03/12/2026 dietician's recommendation.Interviews with S1Administrator and S2DON on 03/18/2026 at 2:40 p.m., confirmed the facility failed to comply with the following areas of the facility weight loss management policy regarding Resident #2: notify the dietician, physician, and responsible party within 24 hours of identifying a significant weight loss; IDT meeting within 72 hours of identifying significant weight loss; implement appropriate interventions for weight loss; follow-up with weekly weights until weight stabilizes; and IDT will review the effectiveness of interventions at least monthly.

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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 observations, interviews, and record reviews, the facility failed to ensure that nurses have specific competencies and skill sets necessary to care for residents' needs by not: 1) clarifying the correct dosage of a medication for 2 (#1, #16) of 5 residents observed for medication administration and 2) notifying the physician with changes in condition for 1 (#37) of 2 residents reviewed for hospitalization. Findings:Resident #1Review of the record for Resident #1 revealed an admission date of 08/08/2024 with diagnoses that included type 2 diabetes mellitus with diabetic neuropathy, gastroesophageal reflux disease, vitamin D deficiency, osteoarthritis, dementia, hypertension, hyperlipidemia, and history of falling. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 7 which indicated Resident #1 had severe cognitive impairment with daily decision makingReview of the record for Resident #1 revealed a physician's order dated 12/11/2025 for Voltaren 1% external gel topical apply to bilateral hands topically two times a day related to osteoarthritis. On 03/18/2026 at 8:15 a.m. S5LPN confirmed Resident #1 received Voltaren 1% gel without the dosage ordered by the physician. Further review of the record revealed Resident #1 received Voltaren 1% external gel topically twice daily from 01/01/2026-03/17/2026, except for the morning dose 01/09/2026 which was refused. On 03/18/2026 at 5:47 p.m., S1Administrator was informed of findings. Resident #16Review of the record for Resident #16 revealed an admission date of 01/30/2023 with diagnoses that included coronary artery disease, heart failure, hypertension, gastroesophageal reflux disease, renal insufficiency, and arthritis.Review of the comprehensive MDS dated [DATE] revealed a BIMS score of 11 which indicated Resident #16 had moderate cognitive impairment with daily decision making.Review of the record for Resident #16 revealed a physician's order dated 04/03/2025 for Voltaren 1% external gel topical apply to bilateral lower extremities topically two times a day related to pain.On 03/18/2026 at 8:01 a.m. S5LPN prepared to administer Voltaren 1% external gel topically to Resident #16. Upon interview, S5LPN confirmed Resident #16 received Voltaren 1% gel topically without the dosage ordered by the physician.Further review of the record revealed Resident #16 received Voltaren 1% external gel topically twice daily from 01/01/2026-03/17/2026, except for the morning doses on: 01/02/2026, 01/03/2026, 01/08/2026, 01/09/2026, 01/15/2026, and 01/20/2026.On 03/18/2026 at 5:47 p.m., S1Administrator was informed of findings. Resident #37Review of the record for Resident #37 revealed an admission date of 02/11/2026 with diagnoses that included occlusion and stenosis of unspecified carotid artery, heart failure, hypertension, cardiomegaly, cerebral ischemia, stage 3 chronic kidney disease, dysuria, wedge compression fracture of first lumbar vertebra, history of falling, traumatic hemorrhage of right cerebrum without loss of consciousness, sequela, dyspnea, fracture of nasal bones and anxiety.Review of the comprehensive MDS dated [DATE] revealed Resident #37 had severely impaired cognitive skills for daily decision making skills. Resident #37 was noted to have an unplanned discharge to a short-term general hospital on [DATE].Review of the plan of care to address Resident #37's stage 3 chronic kidney disease, revealed an intervention to monitor, document, and report as needed signs and symptoms that included edema, weight gain of over 2 lbs a day, difficulty breathing, level of consciousness, and breath sounds. Review of the nurses note dated 02/26/2026 at 6:43 a.m. revealed, in part, Resident #37 had 4+ edema in lower extremities. Further review revealed no documentation to support the physician was notified of the edema per the interventions in the plan of care.Review of the nurses note dated 03/03/2026 at 10:18 p.m. revealed, in part, medication held per family due to resident is incoherent. Further review revealed no documentation to support the physician was notified of Resident #37's level of consciousness per the interventions in the plan of care. Review of the nurses note dated 03/03/2026 at 10:31 p.m., revealed Resident #37 was administered ipratropium-albuterol inhalation solution via nebulizer due to wheezing (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and congestion noted to lung sounds. Further review revealed an order to perform a post nebulizer assessment. There was no documentation to support the post-nebulizer assessment was completed as ordered or breath sounds monitored per the plan of care. Review of Resident #37's weights revealed weight of 202.6 lbs on 02/16/2026 and 212 lbs on 03/03/2026. Interview with S2DON revealed no other weights were obtained, and Resident #37 was being weighed weekly instead of daily per the plan of care. S2DON confirmed being responsible for weights.During an interview on 03/18/2026 at 12:32 p.m., S2DON was unable to provide documentation to support the physician was notified of Resident #37's edema and weight gain and S2DON was unable to provide documentation to support a post nebulizer assessment was performed on 03/03/2026. Further interview revealed S2DON confirmed the physician should have been notified of Resident #37's level of consciousness on 03/03/2026 per the interventions in the plan of care.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews the facility failed to ensure residents received mail on Saturdays. This deficient practice had the potential to affect 35 residents residing in the facility. Findings,During a resident council interview on 03/16/2026 at 12:45 p.m., Resident #19 reported they receive mail Monday through Friday. Resident #19 reported they do not receive mail on Saturdays. On 03/16/2026 at 1:10 p.m. an interview with S14Office Manager revealed she goes to the post office Monday through Friday and picks up all of the facility's mail and the residents' mail from the post office box. S14Office Manager reported she passes out the residents' mail to them Monday through Friday after she returns from the post office. S14Office Manager reported she does not go to the post office to pick up mail on Saturdays. On 03/16/2026 at 1:15 p.m. an interview with S1Administrator reported the facility's mail and the residents' mail are both delivered to the provider's post office box at the post office. S1Administrator reported S14Office Manager has the key to the post office box and goes to the post office and collects the mail Monday through Friday. S1Administrator reported they do not have a dedicated staff member that checked the post office box on Saturdays. S1Administrator confirmed residents were not able to receive mail on Saturdays.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and observations, the facility failed to provide the care and services that is in accordance with professional standards of practice for 1 (#5) of 1 resident reviewed for respiratory care. The facility failed to date nebulizer tubing and properly store nebulizer tubing and face mask in a plastic bag when not in use. Findings:Review of the provider's nursing procedure for compliance with changing oxygen/nebulizer tubing/humidifier policy, undated policy, revealed in part: Policy: to aid in the prevention of the spread of infection and the buildup of bacteria on the tubing over time. Oxygen and nebulizer tubing will be changed two times per month on the 1st and 15th. Tubing will be dated at this time. LPN will check upon each shift that tubing is still in designated bag and labeled properly and document it on EMAR for that shift. If tubing is not properly stored it should be replaced and dated at this time.Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic systolic congestive heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, type 2 diabetes mellitus without complications, aftercare following joint hip replacement surgery, presence of right artificial hip joint, presence of coronary artery angioplasty implant and graft, ischemic cardiomyopathy, acute embolism and thrombosis of deep vein of right upper extremity, anxiety disorder, and fracture of the neck of right femur sequela.Review of current March 2026 physician orders revealed the following orders: 1) 03/12/2026: Ipratropium-albuterol solution (0.5-2.5 (3) mg/3ml. 1 vial inhale orally every 6 hours x 3 days; 2) 02/27/2026 albuterol sulfate inhalation solution (2.5 mg/3ml) 0.083%. 1 vial inhale orally every 6 hours as needed for wheezing or shortness of breath. Review of the March 2026 EMAR revealed documentation Resident #5 received Ipratropium-albuterol solution (0.5-2.5 (3) mg/3ml 1 vial inhale orally every 6 hours x 3 days as ordered.Observations of Resident #5's room on 03/16/2026 at 9:00 a.m. and 03/17/2026 at 8:20 a.m. revealed a nebulizer machine sitting on dresser beside Resident #5's bed. The nebulizer tubing and face mask were connected to the side of the nebulizer machine. The nebulizer tubing and face mask were not dated and were not properly stored in a plastic bag. On 03/17/2026 at 8:27 a.m. an observation of Resident #5's room with S2DON revealed a nebulizer machine sitting on dresser beside bed. The nebulizer tubing and face mask were connected to the side of the nebulizer machine. The nebulizer tubing and face mask were not dated. The nebulizer tubing and face mask were not properly stored in a plastic bag. S2DON confirmed the nebulizer tubing should be dated and the nebulizer tubing and face mask should be stored in a plastic bag when not in use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. The facility failed to implement the EBP policy for 2 (#14, #5) of 2 residents reviewed for EBP. Findings: Resident #5 Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus without complications, pain in right hip, aftercare following joint hip replacement surgery, presence of right artificial hip joint, fracture of the neck of right femur sequela, and chronic venous hypertension (idiopathic) with ulcer and inflammation of unspecified lower extremity. Review of current March 2026 Physician Orders included the following: 1) 02/11/2026: Cleanse incision to right hip daily with hydrogen peroxide, apply thin layer of bactroban, cover with 4x4 and tape daily and as need for soilage/dislodgement; 2) 02/12/2026: Cleanse unstageable pressure ulcer to left great toe with wound cleanser, pat dry with gauze, apply iodine, cover with dressing daily until healed; and 3) 02/12/2026: Cleanse DTI to right heel with wound cleanser, pat dry with gauze, apply iodine, cover with dressing daily until healed. Review of admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated Resident #5 was cognitively intact for activities of daily decision making. Further review revealed Resident #5 had a surgical wound and unstageable wounds present on admission. On 03/16/2026 at 9:00 a.m. an interview with Resident #5 reported she has a surgical wound to her right hip area that still has a slight drainage. Resident #5 reported she also has a wound on her left great toe and right heel. Observation revealed there was no signage posted outside Resident #5's door indicating she was on EBP. On 03/17/2026 at 8:20 a.m. an observation revealed there was no signage posted outside Resident #5's door that indicated EBP were in place. On 03/17/2026 at 8:25 a.m. observation and interview with S2DON revealed there was no signage posted outside Resident #5's door indicting she was on EBP. S2DON revealed Resident #5 should be on EBP related to her wounds. S2DON confirmed there should have been a sign posted outside Resident #5's door indicating EBP were in place. Resident #14 Review of the facility's, undated, Enhanced Barrier Precautions in Nursing Homes Policy revealed the following, in part: EBP will be used when performing high-contact resident care activities for the below list: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Review of the record for Resident #14 revealed an admission date of 10/01/2029 with diagnoses that included traumatic brain injury, aphasia, post-traumatic seizures, hemiplegia, and gastrostomy status. Review of the quarterly MDS dated [DATE] revealed Resident #14 was severely impaired with daily decision making. Further review revealed Resident #14 had a feeding tube. Review of Resident #14's physician's orders revealed an order dated 11/18/2024 for EBP: use hand sanitizer when entering and before leaving room, must wear gown and gloves while performing the following with resident: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: feeding tube. On 03/16/2026 at 1:30 p.m., S3LPN administered medications per PEG tube without donning a gown. S3LPN was unable to confirm donning a gown prior to PEG use was required. On 03/16/2026 at 1:30 p.m., an observation of S3LPN revealed she administered medications per peg tube to Resident #14 and failed to don a gown. S3LPN was unable to confirm if she should have donned a gown prior to administering medications per peg tube to Resident #14. On 03/16/2026 at 1:45 p.m., S3LPN reviewed Resident #14's physician's order for EBP and confirmed she should have donned a gown prior to administering medications to Resident #14 per her peg tube. On 03/16/2026 at 2:03 p.m., S2DON was informed EBP was not implemented as ordered for Resident #14. S2DON confirmed S3LPN should have donned a gown while administering medications via PEG tube for Resident #14.