STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373 Based on record review, observation, and interview the facility failed to ensure an allegation of physical abuse by staff was reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency for 1 (#59) of 1 Resident reviewed for abuse. Findings: Review of the facility's Abuse Prevention policy revealed, in part, the following: Reporting: . Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency, APS, and local law enforcement as required). Review of Resident #59's medical record revealed an admitted [DATE] with diagnoses that included Schizophrenia, Hypertension, Anxiety disorder, and Bipolar disorder. Review of Resident #59's MDS with an ARD date of 08/24/2022 revealed a BIMS score of 12, which indicated mildly impaired cognition. Further review of the MDS revealed the resident required extensive assistance by one person with bed mobility, transferring, and toilet use. In an observation and interview on 09/19/2022 at 02:47 p.m., Resident #59 pointed out two round bruises on his left upper arm above the elbow and reported the previous night at about 8:30 p.m. a CNA had done that to his arm. Resident #59 explained he asked to be put to bed and the CNA had an attitude and shoved him in the back in the bed. Resident #59 reported it hurt and he told her he was going to report her. Resident #59 explained the CNA then grabbed his arm where the bruises were and said, You can do what you want. I don't care. Resident #59 confirmed he reported it to a nurse this morning. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/2022 at 2:33 p.m., S2 DON reported Resident #59 did complain of abuse to her on the morning of 09/19/2022 and she was still investigating it. S2 DON reported his CNA at the time of the alleged abuse was S12 CNA. S2 DON confirmed she had not yet spoken with S12 CNA. In an interview on 09/20/22 at 3:35 p.m., S2 DON confirmed Resident #59 complained to her before noon on Monday, 09/19/2022, what had occurred on Sunday, 09/18/22, at bedtime. S2 DON explained Resident #59 reported to her on Sunday night an aide was rough with him during care and unprofessional. S2 DON further explained Resident #59 told her the CNA shoved him really hard while turning him over and grabbing his arm. S2 DON acknowledged visualizing the bruises to Resident #59's upper arm but said she thought the bruises were caused by blood draws or tourniquet pops. At this time, S1 Administrator joined the interview and reported she opened a grievance on this issue on Monday and took S12 CNA off of Resident #59's care. S1 Administrator confirmed S12 CNA did work again Monday night from 7 p.m.-7 a.m. on a different hall. S1 Administrator confirmed she did not open a SIMS report to the State Survey Agency until today, about 20 minutes ago, because they had originally thought it was a customer service issue and didn't think it was abuse. Numerous telephone calls placed to S12 CNA was unsuccessful.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22117 Based on observation, interview and record review, the facility failed to ensure a resident with a restraint (seatbelt) was released and monitored every two hours according to the care plan for 1 (#30) out of 2 (#30 and #27) residents reviewed for physical restraints. Findings: Review of Resident #30's Medical record revealed an admitted [DATE] with diagnoses that included: Dementia with behaviors, Major Depressive Disorder, Lower back pain, Hypertensive Heart Disease, Constipation and Chronic pain. Review of Resident #30's Physician's Orders for 09/2022 revealed no documentation of an order for a self-releasing seatbelt. Further review of the Physician's Orders revealed no documentation for monitoring of the use of the seatbelt. Review of Resident #30's Minimum Data Set, dated dated dated [DATE] revealed a BIMS (Brief Interview for Mental Status) Score of 99 out of 15 indicating the resident was unable to complete interview. Further review of the Quarterly assessment revealed resident required the use of seat belt dated 07/26/2022. Review of Resident #30's Care Plan revealed the resident was found to be at risk for falls and had an intervention for the seatbelt use to be monitored and released every two hours. Review of Resident #30's Restraint Evaluation Form dated 07/26/2022 due to self-releasing seatbelt was removed in an attempt to evaluate least restrictive which the resident attempted an unsafe transfer and it was placed back on. Review of the Self-releasing Seatbelt - Physical Restraint Consent revealed the following: Restraint Intervention Recommended. Restraint type - Self-releasing seat belt. Specific Target Behaviors - leans, general weakness and history of getting on floor. Observation of Resident #30 on 09/19/2022 at 11:15 a.m. revealed she was sitting in the day room in her wheelchair with a self-releasing seatbelt in place. The resident was non-verbal and was leaning forward with her head laying in her lap. Interview with S18 LPN on 9/20/2022 at 10:20 a.m. revealed she was the resident's nurse today. S18 LPN revealed the resident had a self-releasing seatbelt restraint due to her dementia and constant leaning forward. S18 LPN revealed the resident received toileting every two hours and that is when the resident is released for her seatbelt restraint. S18 LPN revealed there was no documentation done to show that the seatbelt was on and was being released every 2 hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with S22 CNA on 09/20/2022 at 10:50 a.m. revealed she had not checked or released Resident #30's seatbelt or changed the resident since her shift started at 6:00 a.m. Interview with S16 Corporate Nurse on 09/20/2022 at 03:00 p.m. confirmed Resident #30 should have had an order for the seatbelt and documentation of the use of the seatbelt every shift on the MARs and did not. S16 Corporate Nurse revealed she put in an order to monitor the seatbelt every shift as of today and interventions should have been included in Resident #30's Care Plan and was not done. Interview with S16 Corporate RN on 09/21/2022 at 09:47 a.m. revealed a resident that has a seatbelt (restraint) should have documentation on the MAR that indicated monitoring and release of the seatbelt every two hours and that the seatbelt is in place as ordered. S16 Corporate Nurse confirmed there was no documentation on Resident #30's MAR or in the current nurses' notes to indicate the resident was being released from the seatbelt every two hours. S16 Corporate Nurse further confirmed the S22 CNA should have checked and released the resident from the seatbelt every 2 hours and did not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41124 Based on record review and interview the facility failed to ensure a Resident's Person-Centered Plan of Care was reviewed and revised for 1 Resident (#F5) of 7 sampled residents. The facility failed to revise Resident #F5's care plan to reflect the use of an additional restraint device. Findings: Review of the facility policy titled: Restraint Evaluation and Restraint Reduction revealed in part 1. The following devices are considered physical restraints and require evaluation. Category III: Seat belts, Wheelchair lap belts, Geri-chair with or without tray. Wheelchair with lap tray, Roll bar, Lap buddy 4. A specific physician's order is to be entered in the resident's Medical Record which details the medical reason, type of restraint and when to be used. 8. Care plan updates are to occur approximately every quarter and/or as a goal or approach direction changes. Review of Resident F5's clinical record revealed an admitted [DATE], with diagnoses that included: Schizophrenia, Unspecified Dementia without behaviors, Restlessness and Agitation, Essential Hypertension, and Terminal Alzheimer's. Review of Resident F5's Quarterly MDS with an ARD of 09/15/2022 revealed the BIMS section was left blank as resident was never/rarely understood. Further review revealed Resident #F5 had short and long-term memory problems, and required the extensive assistance of 1 person for transfers, dressing, eating, toileting, and hygiene. Resident #F5 was also assessed as having no upper or lower extremity ROM limitations. Review of Resident #F5's Person-Centered Plan of Care with a target date of 01/24/2023 revealed the resident was at risk for falls/injury. Approaches included Self-release seat belt while up in wheelchair as restraint due to poor safety awareness and unassisted transfers. Diagnosis of Dementia, Generalized Weakness and Muscle Wasting. Check q 30 minutes, release and reposition q 2hrs. Observation on 11/07/2022 at 10:48 a.m. revealed Resident #F5 asleep in bed. Resident #F5's bed was observed in lowest position with a fall mat at bedside. A wheelchair with a self-releasing belt was observed at the foot of the resident's bed. Further observation revealed a Geri-chair with lap tray positioned next to the wall, across from the residents' bed. Review of Resident #F5's 10/2022 and 11/2022 Physician's Orders revealed there were no orders for the use of a Geri-chair with lap tray. Review of Resident #F5's Person Centered Plan of Care revealed the resident was not care planned for the use of Geri-chair with lap tray. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/2022 at 12:54 p.m. with S5 CNA revealed the Geri-chair with lap tray in Resident F5's room was for use by Resident #F5. S5 CNA stated staff had been instructed to use the Geri- chair with the lap tray because the resident would move and squirm under the seat belt in his wheelchair to try and get up/out. S5 CNA stated Resident #F5 would slide down underneath the lap try in the Geri-chair so CNA's had been told to try and keep Resident #F5 in the bed until his cushion came in sometime this week. Further interview revealed Resident #F5 moved around constantly and was confused. S5 CNA confirmed the resident was unable to release the seat belt in his wheelchair and could not remove the tray when up in the Geri- chair. Interview on 11/07/2022 at 3:30 p.m. with S4 LPN revealed she was the nurse assigned to Resident #F5. S4 LPN stated the facility had tried several devices to keep the resident safe and upright while seated. S4 LPN stated an order was recently obtained for a Pommel cushion to prevent the resident from sliding out from underneath the tray while in the Geri-chair. S4 LPN confirmed the Geri-chair with lap tray was still in Resident #F5's room and had the potential to be used by staff. S4 LPN further confirmed the Pommel cushion would be used while the resident was in the Geri-chair with lap tray. Interview on 11/07/2022 at 3:55 p.m. with S2 DON revealed the self-releasing seat belt was a new order from last week. Further interview revealed the resident did not have an order for nor had Resident #F5 been care planned for the use of a Geri-chair with lap tray. Further interview revealed she was not sure the last time the resident was placed in the Geri-chair. She confirmed staff could still be using the Geri-chair with lap tray because the chair was in the resident's room. Interview on 11/07/2022 at 5:15 p.m. with S4 LPN revealed Resident #F5 transferred from the facility's secure unit to his current room a couple weeks ago. S4 LPN stated once the resident transferred out of the unit the use of the Geri-chair with lap tray was attempted for about a week and a half. S4 LPN stated the resident was able to sit up for about 1 and 1/2 hours at a time in the Geri-chair before sliding down under the tray. She confirmed the resident was unable to remove the lap tray. Review of a nurses' note dated 10/27/2022 at 4:40 p.m. and signed by S2 DON revealed in part per Physician's Order Resident #F5 was moved to Room A. Interview on 11/07/2022 at 5:21 p.m. with S2 DON confirmed the resident transferred out of the secure care unit on 10/27/2022. S2 DON confirmed the use of the Geri-chair with lap tray was an additional restraint device, had been in use longer than a week, and should have been added to Resident #F5's Person Centered Plan of Care with appropriate monitoring and had not been. Interview on 11/07/2022 at 5:30 p.m. with S1 Administrator revealed S3 LPN was responsible for updating resident care plans. S1 Administrator confirmed Resident #F5's care plan should have been updated to reflect the use/need for a Geri-chair with lap tray in addition to the self-release belt and had not been.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373 Based on record review, observation, and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (#59) resident in a total sample of 31 residents by failing to refer a resident with a fracture to an orthopedic specialist, as ordered. Findings: Review of Resident #59's medical record revealed an admitted [DATE] with diagnoses that included Schizophrenia, Hypertension, Anxiety disorder, and Bipolar disorder. Review of Resident #59's MDS with an ARD date of 08/24/2022 revealed a BIMS score of 12, which indicated mildly impaired cognition. Further review of the MDS revealed the resident required extensive assistance by one person with bed mobility, transferring, and toilet use. Review of Resident #59's nurses' notes revealed the following entries: 09/13/2022 at 6:47 p.m.- 10:45 a.m.-Upon making rounds this morning, resident noted to have bruising to right ankle with 1+ pitting edema to right foot. S4 NP notified with new orders received to have x-rays performed of right foot and ankle via _____ on premises. Report called to facility that resident has fracture of 5th metatarsal. S4 NP notified. S2 DON notified. By S3 LPN 09/13/2922 at 2:35 p.m.-On skin assessment today resident noted to have bruising to right ankle with edema to right ankle and foot. Area painful when touched. Resident denies any fall or injury to area . .Bruising and edema to right ankle and foot reported to Resident's nurse, S3 LPN .By S5 RN/WCN. Review of Resident #59's right foot x-ray dated 09/13/2022 revealed an impression as follows: Fracture of the fifth metatarsal head of indeterminate age. Clinical correlation is necessary. Review of Resident #59's progress note dated 09/14/2022 revealed the resident was seen by S4 NP. Review of the history of present illness revealed S4 NP spoke with after-hours orthopedic specialist at _____ and they agreed to consult on patient. It further stated Will call in the morning and schedule an appointment. The diagnosis and plan revealed the NP ordered an orthopedic consult. Review of a progress note for Resident #59 dated 09/16/2022 revealed S4 NP documented Patient to see orthopedic doctor today. In an observation and interview on 09/20/2022 at 1:30 p.m., Resident #59's right foot was noted to be dark red in color and swollen. Resident #59 reported he had an x-ray done in the facility that showed he had a foot fracture. Resident #59 further reported he wanted to see an orthopedic specialist and was supposed to be sent out but he has not seen one yet. Resident #59 reported his right foot still hurts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/20/2022 at 2:33 p.m., S2 DON reported Resident #59 had seen an orthopedist the previous week on Friday and would provide documentation of that visit. In an interview on 09/20/2022 at 3:45 p.m., S2 DON reported she was wrong and stated Resident #59 had not been seen by an orthopedist yet. In an interview at 10:37 a.m. on 09/21/2022, S2 DON confirmed she could not provide any documentation of the facility attempting to make an orthopedic appointment for Resident #59.

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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** 38373 Based on record review, observation, and interview the facility failed to ensure residents received adequate supervision to prevent accidents for 1 (#186) of 2 (#19, #186) residents reviewed for elopement. The facility failed to provide adequate supervision for Resident #186 who was a known elopement risk. This deficient practice resulted in an immediate jeopardy situation for Resident #186 on 09/17/2022 sometimes after 1:40 p.m. when she wandered off the facility grounds unnoticed by staff. Resident #186 had a history of exit seeking behaviors, had been identified as an elopement risk, and wore a wanderguard ankle bracelet. Resident #186 was picked up by a family friend in a neighborhood behind the facility and returned, uninjured, to the facility at approximately 2:05 p.m. on 09/17/2022. The immediate jeopardy situation ended on 09/17/2022 at approximately 2:05 p.m. when the resident was placed on 1 to 1 supervision around the clock. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility's policy and procedure titled Missing Resident/Elopements revealed, in part, the following: Policy: The Unit Charge Nurse is responsible for knowing the location of their residents. When residents are participating in various programs, such as physical therapy, recreational activities, dining, etc., the staff in these programs will be responsible for the location of their participation. Procedure: 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical. Resident #186 Review of the medical record for Resident #186 revealed an admitted [DATE], with diagnoses that included, in part .unspecified psychosis, anxiety disorder, and unspecified dementia with behavioral disturbances. Review of Resident #186's admission orders dated 09/06/2022, revealed an order to admit Resident #186 to the Behavioral Unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Risk of Elopement Evaluation dated 09/06/2022 and signed by S20 LPN revealed: Resident #186 had a diagnosis of unspecified psychosis, was alert, and oriented to person only with hallucinations present. The Risk of Elopement Evaluation revealed Resident #186 ambulated independently, and was marked as-Yes, Resident is at risk for elopement. Resident Monitoring Bracelet applied and Door alarms were marked as an intervention. Review of the Admission MDS with an ARD date of 09/13/2022 revealed a BIMS score of 99, which indicated Resident #186 was unable to complete the interview. The MDS revealed Resident #186 required extensive assistance by one person physical assist with bed mobility, transferring, and toilet use. The MDS assessment revealed Resident #186's daily decision making was moderately impaired, and Resident #186 required supervision and cueing. Review of the baseline care plan (no date) revealed Resident #186 was care planned for elopement related to a history of exit seeking prior to admission to the nursing facility. Intervention listed: wanderguard. Review of Resident #186's physician's orders dated 09/2022 revealed there was no order for a wanderguard bracelet, or an order to monitor Resident #186's whereabouts prior to her elopement on 09/17/2022. Review of the nurses' notes for Resident #186 read as follows: 09/09/2022 at 9:00 a.m. documented by S21 LPN - Resident approached this nurse asking for a pair of scissors, this nurse stated to resident why do you need scissors and resident replied, I'm trying to cut this thing off my ankle. This nurse explained to resident that wanderguard could not be cut off and that it was there so we could monitor whereabouts. Resident stated but it's aggravating me, I got to get this off. Resident redirected to her room and is resting at this time. Call bell in reach. Will continue to monitor. 09/11/2022 at 7:36 p.m.: Resident is walking around hall way in a very confused state asking to cut the thing off her ankle .Will continue to document as needed. 09/12/2022 at 2:20 p.m. documented by S3 LPN - 9:00 a.m. - Resident states to this nurse I am going home tomorrow when my sister comes to get me. Can you please take this bracelet off of my ankle? This nurse explains to the resident that the bracelet will stay on until discharged , but will touch base with doctor and let him know that she doesn't want it. 09/13/2022 at 3:50 p.m. read in part BIMS and Pain Assessment: . Resident is confused. Daily decision making is moderately impaired. She requires supervision and cueing . Ambulates ad lib. Documented by S11 LPN. Review of progress note dated 09/14/2022 at 3:10 p.m. by S30 Nurse Practitioner, a private nurse practitioner who specializes in psychiatry, revealed an entry that read, Her nurse says she has an ankle monitor around the ankle-wander guard, which she would like removed. Her nurses say she repeats often during the day that she wants to go home. Further review revealed the resident had the following symptoms reported which are typical of moderately severe dementia: Poor judgment is creating safety issues when left alone. For example, Resident #186 may wander. Restless behaviors like pacing, and hallucinating. Diagnoses included anxiety disorder, mild cognitive impairment, and major depressive disorder, recurrent, with psychotic symptoms. This may be better if moved between 9/13 and 9/15, prior to the elopement . Supports culpability . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	09/15/2022 at 6:41 p.m. documented by S15 LPN - Resident appeared to have hallucinations throughout the day. Resident has voiced to staff that we need to call 911, her brother and sister are dead, and they are dying and needs assistance. She needs to go to the hospital to check on her dead siblings. Resident was walking down the hall way, stopped walking and layed in the middle of the hallway, staff helped her up and she walked back to her room. 09/16/2022 at 4:11 p.m. by S19 SSD - SSD observed resident having hallucinations, resident stated that the devil told her that if she walked in the room he was going to kill her, another conversation was that if she sat in the chair he would kill her. SSD was able to redirect. 09/17/2022 at 6:31 p.m. by S3LPN - At approximately 2:00 p.m., Resident was intercepted and brought to facility through the front door of the facility. The alarm went off, as resident has wander guard in place to left ankle. Resident ambulates back to her room with staff at side. Resident is awake, alert and oriented x 1 at this time and has MOF at side, 108/64, 82, 18, 97.6, 98% room air. Skin warm and dry to touch, Respirations even and unlabored, ambulatory per self without signs or symptoms of distress. Wanderguard in place to left ankle. Abdomen soft, non-tender. Continent of Bowel and bladder. Resident had managed to open a door and exit the facility and wander guard did not alarm, however upon re-entering facility, wander guard set alarm off. Resident is immediately placed on 1:1 observation with staff at doorway with eyes on resident 1:1 documentation started and will remain in effect until further notice. Resident is calm and responds to all questions from this nurse with no acute distress noted. Maintenance in building checking all exit and entrance doors. Family aware. Management aware. Will monitor. In an interview on 09/21/2022 at 8:05 a.m., S5 RN/WCN confirmed she was working in the facility on 09/17/2022 when Resident #186 eloped. S5 RN/WCN reported she answered the phone when the family called and said Resident #186 was out of the facility, and they were bringing her back. S5 RN/WCN stated she didn't know if Resident #186 was out on pass, or what the family meant. S5 RN/WCN said she went and talked with the resident's nurse, S3 LPN. S5 RN/WCN reported they checked the doors and were able to push the door open across from Resident #186's room. S5RN/WCN said it wasn't ajar, but just pushed open. S5 RN/WCN stated about the same time, Resident #186 was being brought back in the front door, and the door alarm sounded as Resident #186 came back in the facility. S5 RN/WCN stated the door alarm never went off when Resident #186 eloped. S5 RN/WCN reported S3 LPN examined Resident #186 when she returned. S5 RN/WCN reported she had last seen Resident #186 about lunch when the resident asked her to cut the wanderguard off her ankle, and she had to tell her she couldn't do that. S5RN/WCN confirmed upon Resident #186's return, the wanderguard was still in place on her ankle. S5 RN/WCN also reported Resident #186's information was located in the elopement binder located at the nurses' station with her picture in it. Review of the elopement binder at the nurses' station on 09/21/2022 on Resident #186's hall with S3 LPN and S5 RN/WCN revealed the resident's Face Sheet with Resident #186's picture on it. The binder also contained the facility's elopement policy as well as other residents at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/21/2022 at 9:15 a.m., S23 Admissions Director reported she was contacted by Resident #186's family and by the psychiatric hospital Resident #186 was in at the time, about being admitted to the facility. S23 Admissions Director reported the family had first tried to admit the resident to another facility who would not accept her due to her history of behaviors. S23 Admissions Director reported Resident #186 was admitted to the facility's locked behavioral unit on 09/06/2022 because it had been recommended by the psychiatric hospital upon referral, and due to her diagnoses and reported history of behaviors. S23 Admissions Director reported Resident #186 was moved to a regular room two days later because the family insisted, and Resident #186 had shown no behaviors on the unit. S23 Admissions Director further reported Resident #186's sister called her on 09/17/2022 to report the resident had eloped, and informed her that a family friend had picked Resident #186 up and was bringing her back to the facility. S23 Admissions Director stated she immediately called the Administrator to notify her, and confirmed no one at the facility was aware the resident was missing. In an interview on 09/21/2022 at 9:50 a.m., S3 LPN reported on 09/17/2022 at 2:05 p.m., S5 RN/WCN asked her where was Resident #186, and did her family check her out? S3 LPN said she told her no, Resident #186 was not out on a pass. S3 LPN said S5 RN/WCN told her Resident #186's family called and said someone picked Resident #186 up and was bringing her back. S3 LPN reported she started checking doors and discovered the door across the hall from Resident #186's room just opened up when she pushed on it, and the alarm did not go off. S3 LPN said it felt like the door wasn't catching. S3 LPN reported S25 Maintenance came in after the elopement that day and worked on it. S3 LPN reported Resident #186 had asked her several times to take her wanderguard off because it bothered her. However, S3 LPN reported she didn't think Resident #186 was an elopement risk. S3 LPN reported she last visualized Resident #186 some time that morning. S3 LPN stated she checks the resident's wanderguard by going to a door and opening it with the resident present to see if the alarm goes off. S3 LPN reported checking it every shift and said it was documented on the MAR. When asked to show the documentation, S3 LPN looked at the MAR and confirmed she could not find any documentation of the wanderguard being checked by staff prior to the elopement on 09/17/2022. S3 LPN stated CNAs were to check on residents every 2 hours. In an interview at 10:25 a.m. on 09/21/2022, Resident #38, who had a BIMS of 14 indicating he was cognitively intact, reported Resident #186 asked him three times on 09/17/2022, How do I get out of here? Resident #38 explained he told the resident, You can't get out of here. Resident #38 reported he had seen Resident #186 pushing the doors at the end of the hall earlier in the day on 09/17/2022 but she was unable to open them. Resident #38 denied reporting it to anyone. In an interview at 12:51 p.m. on 09/21/2022, S26 CNA confirmed she was working when Resident #186 eloped. S26 CNA reported she saw Resident #186 in the hall talking with Resident #38 between 1:30 p.m. - 1:40 p.m. S26 CNA reported Resident #186 was always asking everyone to take her to see her mom. S26 CNA stated she did not know that Resident #186 was an elopement risk, and stated she never saw Resident #186 push doors. S26 CNA stated rounds were completed every 2 hours on all residents who resided in general population, regardless of whether they wore a wanderguard bracelet. In an interview on 09/20/2022 at 08:53 a.m., S28 CNA who said she had been sitting with Resident #186 for 12 hours shifts since Sunday, 09/18/2022, yesterday, and today. S28 CNA acknowledged Resident #186 was an elopement risk and reported Resident #186 walked around the facility yesterday and tried to open doors unsuccessfully. S28 CNA reported Resident #186 was very confused. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/20/22 at 2:19 p.m., S27 CNA, confirmed she was an agency CNA caring for Resident #186 after the elopement on 09/17/2022, and stated she receives a Pocket Care Guide when she comes in the facility each shift that tells her information on the residents to guide her care. Review of the Daily Care Guide (pocket guide used by CNAs) dated 09/15/2022 for Resident #186 revealed no documentation or interventions listed to alert the CNA that Resident #186 was an elopement risk or that Resident #186 had a wanderguard in place. Interventions listed were: Family will do laundry, full code status, new admit to facility-approach in calm manner, regular diet-encourage to eat in dining room, requires minimal assistance with ADLS, and shower every other day and as needed and shave if needed. In an interview on 09/20/22 at 2:00 p.m., S1 Administrator confirmed the facility did not have a Wanderguard policy. When asked how staff knew who had a wanderguard on, when to check it, and what to do with it, S1 Administrator stated it would be on the MAR for the nurses to check, and the CNAs would know what resident had one because it would be on their pocket guide. When asked how agency staff would know who had a wanderguard on, when to check it, and what to do with it, S1 Administrator stated They just know. S1 Administrator confirmed Resident #186 was being cared for by an agency CNA (S29 CNA) at the time of elopement. #186's care on 09/17/202 at the time of elopement. Review of Resident #186's MAR for 09/2022 revealed no documentation of Resident #186's wanderguard being checked prior to the elopement on 09/17/2022. In an interview on 09/20/2022 at 12:46 p.m., S1 Administrator reported Resident #186 was admitted to the facility's locked, behavioral unit on 09/06/2022 from an inpatient psychiatric stay, and was transferred two days later to a regular room because the family insisted on it. S1 Administrator reported staff had not really had enough time to evaluate the resident on the behavioral unit, and said they discouraged the family from moving Resident #186 to the regular floor, but the family insisted. S1 Administrator acknowledged a wanderguard was placed on Resident #186 when she was moved off the locked unit because she was an elopement risk. S1 Administrator confirmed Resident #186 eloped from the facility on 09/17/2022 without staff becoming aware the resident was missing until the family called the facility to report it. Review of Resident #186's medical record revealed the intervention of the wanderguard bracelet was put in place when Resident #186 was moved from the locked behavioral unit to general population on 09/08/2022. There was no documentation to increase supervision of Resident #186 prior to her elopement on 09/17/2022. The surveyor was unable to interview the S29 CNA who was assigned to Resident #186's care on 09/17/202 at the time of elopement. Through observation, interview and record review, surveyors were able to verify that the facility has implemented the following actions to correct the deficient practice: 1. Resident was assessed immediately upon return to the facility. Resident was placed one to one immediately upon returning to facility at 2:05 p.m. on 09/17/2022. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. 100% head count for all other Residents to ensure they were accounted for. 3. Staff interviewed on 09/17/2022. All staff denied that any door alarm sounding. 4. 100% elopement assessment was performed on all 87 residents on 09/17/2022. 5. Resident to be left 1:1 until an additional key pad is added that would separate the doors from being controlled by the wander guard panel. Frequency of monitoring will be determined by resident behavior after the additional locking system is added to the door. This effort will allow the doors to be controlled independent and doors will remain secure even if wander guard panel becomes malfunctioning. 6. Exit door by nurses' station was immediately assessed by Maintenance Director on 09/17/2022. Door was found to malfunction; alarm bracelets did not sound when exiting door, but did alarm when entering door. Door was placed out of commission immediately on 09/17/2022. Representative from _____Medical Company came to facility to check door by nurses' station and stated the door contacts were broken on the panel causing the door to not lock and alarm not to sound. New orders received for 1:1 until all doors checked by Medical Company to ensure working appropriately. 7. Additional alarms were added to both exit doors on hall #A until additional key pads are added. 8. 100% of all other exit doors with alarms were assessed on 09/17/2022 by Maintenance Director. No other issues noted. 9. 100% of all windows was assessed by Maintenance Director on 09/17/2022. No concerns were noted. 10. Reviewed TELS for weekly door functioning. Door functioning was completed on Friday, September 16, 2022. No issues identified. Facility initiated daily door functioning on 09/17/2022. Maintenance Director will check daily functions Monday-Friday and weekend Managers will check them on Saturday and Sunday. Executive Director will be responsible for ensuring daily checks are being performed. 11. In-service initiated 09/17/2022 for staff on Wandering/Elopement Policy and Abuse. 12. _____ Company repaired door contacts and wires between two mag locks on 09/18/2022. 13. New hires are oriented on wandering policy and Dementia training upon hire. As of 09/17/2022 at 2:05 p.m. and once the above interventions were all implemented, the past noncompliance was considered to be corrected.

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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** 44844 Based on record review and interview the facility failed to ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range for 3 (#9, #13 and #67) out of 32 sampled Residents. Findings: Resident #9 Review of Resident #9's clinical record revealed an admitted [DATE] with diagnoses which included: Schizophrenia, Unspecified Dementia without Behavioral Disturbance, Cognitive Communication Deficit and Abnormal Weight Loss. Review of Resident #9's Care Plan with a Target Date of 10/2022 revealed a Potential for Weight Loss with approaches for the dietician to evaluate and follow up as needed and to weigh Resident every month unless otherwise deemed necessary by staff. Review of Resident #9's Quarterly MDS with an ARD of 06/23/2022 revealed a BIMS score of 99 (indicating severe cognitive impairment). Further review of Resident #9's MDS revealed he required extensive physical assistance of one person for: bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. Resident's weight was assessed at 186 pounds on this MDS. Record review of Resident #9's Weight Change History revealed the following weights: 03/23/2022-195# 04/05/2022-184# 06/01/2022-186#'s 07/07/2022-212# 08/03/2022-229# 09/14/2022-241.4 Record review of Departmental notes dated 04/05/2022 at 1:35 p.m. by Registered Dietician read in part . Nutrition Weight Loss Note: weight on 04/05/2022 184#'s, weight on 03/23/2022 195.2#'s. Weight down 11. 2#'s (5.7%) X past 2 weeks. Interview on 09/20/2022 at 11:33 a.m. with S2 DON revealed she was aware of Resident #9's weight fluctuating. Stated the facility's scales were inaccurate and they recently had them calibrated. S2 DON stated the restorative CNA's are responsible for obtaining residents' weights and she oversees the facility's weight program and inputs all weights into the computer. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/20/2022 at 12:22 p.m. with S2 DON revealed Resident #9's weight for today was 199#'s. S2 DON stated she did not re-weigh Resident #9 on 07/07/2022 (212#), 08/03/2022 (229#) or on 09/14/2022 (241.4) when she documented a significant weight gain. Telephone interview on 09/20/2022 at 1:10 p.m. with S17 Registered Dietician revealed she was new to the facility but was aware of some weights being inaccurate due to staff not subtracting wheelchair weights correctly. Interview on 09/20/2022 at 3:05 p.m. with S2 DON confirmed she should have re-weighed Resident #9 on 07/07/2022, 08/03/2022 and 09/14/2022 due to a significant weight gain and to ensure weight accuracy for MD notification and she had not. Resident #13 Facility's policy on Nutrition/Hydration/Skin Monitoring Committee read in part . Weekly Weight List-Minimum Criteria: Significant weight loss/gain (1, 3, 6 month). Gradual weight loss/gain (unplanned, that is not significant). Meeting Format: Residents with significant weight loss: Placed on weekly weights for minimum of 4 weeks-Discontinue only by the weight committee. Review of Resident #13's clinical record revealed an admitted [DATE] with diagnoses which included: Schizoaffective Disorder, Bipolar type, Major Depressive Disorder, Vitamin Deficiency, Hypotension, Anxiety Disorder, and COVID-19. Review of Resident #13's Care Plan with a Target Date of 10/2022 revealed a Potential for Weight Loss with approaches for the dietician to evaluate and follow up as needed and to weigh Resident every month unless otherwise deemed necessary by staff. Review of Resident #13's MDS with a ARD date of 08/09/2022 revealed a BIMS score of 99 (indicating severe cognitive impairment). Further review of Resident #13's MDS revealed he required extensive physical assistance of one person for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. Resident's weight was assessed at 137 pounds on this MDS. Record review of Weight Change History revealed: 4/4/22-146.6lbs 5/2/22-166.4lbs 6/1/22-137.2lbs 7/7/22-140.6lbs 8/11/22-132.4lbs 9/1/22-144.2lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Physician's Orders dated 09/2022 revealed an order for weekly weights. No weekly weight was noted for the week of 09/05/2022. Interview with S13 CNA on 09/20/2022 at 3:04 p.m. revealed she weighs Residents that are on weekly weights on Wednesday. S13 CNA further stated she did not weigh Resident #13 on the week of 09/05/2022 because the scales were on hold to be calibrated. Interview with S2 DON on 09/20/2022 at 12:30 p.m. revealed weekly weights were ordered for Resident #13 on 9/1/2022. S2 DON further stated that weights were not obtained the week of 09/05/2022 due to the scales being calibrated that week. Interview with S14 RD LDN on 9/21/2022 at 10:45 a.m. confirmed a weight loss of 6% (May 2022-June 2022) on Resident #13 on 06/01/2022 was not followed up on and it should have been. S14 RD LDN further stated the high risk team which included the DON and the RD should have met the week of 06/01/2022 to develop a plan of action and they did not. Interview with S2 DON on 09/21/2022 at 3:05 p.m. confirmed there was no order to hold weekly weights the week of 09/21/2022 and the MD was not notified of weekly weights not being obtained on Resident #13 and it should have been. S2 DON further confirmed Resident #13's significant weight loss in 06/2022 had not been followed up on and it should have been. 44315 Resident #67 Review of Resident #67's medical record revealed an admitted [DATE] with diagnoses that included Type 2 DM with Hyperglycemia and Diabetic Neuropathy, Constipation, GERD, Hypokalemia, Hyperlipidemia, Magnesium Deficiency, COPD, Essential Primary Hypertension, Iron Deficiency Anemia, Nausea and Vomiting. Review of Resident #67's Physician's orders for 09/2022 revealed an order dated 10/19/2018 for NAS diet with diabetic precautions, no fried foods and add milk to breakfast and supper meals for extra protein. Review of Resident #67's Quarterly MDS with ARD 08/25/2022 revealed a BIMS of 15 indicative of intact cognition. Resident required supervision with oversight, encouragement or cueing for eating with no setup or physical help from staff. Resident's nutritional status revealed a weight loss of 5% or more in last month or loss of 10% in last 6 months and not on a physician-prescribed weight-loss regimen. Resident's height 67 and weight 220#. Resident with risk of pressure ulcer and one unhealed stage 3 pressure ulcer). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's Care Plan with a target date of 11/25/2022 revealed a problem onset on 8/25/2022 of resident needs to maintain adequate nutritional intake related to hyperlipidemia, vitamin deficiency and receives therapeutic diet with diabetic precautions with goal to maintain adequate nutritional status as evidenced by no significant +/-5% weight changes x 90 days. Approaches in part included for ST to screen per protocol, nutritional services to evaluate resident's nutritional status per protocol and prn, monitor weights, assess for and address any significant weight changes +/-5%, document and report to MD and RD, offer substitute if less than 50% consumed, provide diet as ordered: NAS with diabetic precautions, no fried foods and maintain accurate and current likes and dislikes. Review of Resident #67's weights revealed the following: 03/01/2022 - 249.00 lbs. 05/18/2022 - 237.00 lbs. 06/01/2022 - 229.60 lbs. 07/07/2022 - 238.40 lbs. 08/03/2022 - 220.00 lbs. 09/01/2022 - 240.00 lbs. 09/20/2022 - 245.00 lbs. On 08/03/2022, the resident weighed 220 lbs. On 09/01/2022, the resident weighed 240 pounds which is a 9. 09 % Gain. On 07/07/2022, the resident weighed 238.4 lbs. On 08/03/2022, the resident weighed 220 pounds which is a -7.72 % Loss. Review of the Facility's Weekly Weights log revealed Resident #67 was to receive weekly weights. Further review of Resident's weights revealed weekly weights were not done. Review of Resident #67's Departmental Notes dated 09/07/2022 at 2:17 p.m. by S17 RD revealed RDN follow up related to skin treatment as noted; CBW; 240# with 9% increase from previous months weight although IBW 230-249# last 6 months and remain above IBW with BMI 37.6; Record reflects resident with pressure wound with treatment provided as ordered. He continues on a NAS diet with diabetic precautions, no fried foods and milk with breakfast and supper meals for additional protein to promote wound healing: Consuming average of 75-100% of meals with no problems voiced with no recommended changes to nutritional POC at this time. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #67's Departmental Notes dated 08/02/2022 at 3:27 p.m. by the former S24 RD revealed record reflects resident with pressure wound with TX provided as ordered and NAS diet with diabetic precautions, no fried foods and milk with breakfast and supper meals for additional protein to promote wound healing, is reported to have a good appetite /intake of meals. Weight noted #220 reflects 7.5% loss in past 30 days, 7% loss after 90 days and 8% loss after 180 days. BMI remains elevated. Diet as ordered is adequate to meet est healing needs. Will recommend weekly weight monitoring related to weight loss, questionable weight accuracy for this month. RDN to monitor as indicated related to weight, lab, healing and intake records. Review of the facility's Nutrition/ Hydration/ Skin Monitoring Committee policy in part revealed members included the DON, DM and/or RD and designated licensed nurses and will meet one time per week on same set day and time. The DM and /or designee will maintain a roster of those residents reviewed. Weekly Weight list - Minimum criteria: Significant weight loss/ gain (1, 3, 6 month), Gradual weight loss/ gain (unplanned, that is not significant), tube fed residents with a change in Enteral orders and new orders x 4 weeks, New admissions x 4 weeks, RD, MD Weight Team recommendations, PU - Stage III, IV or multiple wounds or other. Interview on 09/20/2022 at 11:35 a.m. with S13 CNA stated she is responsible for Resident's weights and reports to S2 DON. S13 CNA stated she weighed Resident #67 monthly and did not weigh him weekly. She stated Resident #67's family brings food to resident and resident orders take out food frequently to be delivered to him. Interview on 09/21/2022 at 11:20 a.m. with S14 RD LDN revealed Resident #67's weight loss of 7.72% on 08/03/2022 from 07/07/2022 would have triggered for monitoring weekly weights for a least 30 days and had not been done. S14 RD LDN further revealed the 20 pound weight gain of 9.09% on 09/01/2022 from 08/03/2022 would have triggered for monitoring weight weekly for 180 days if the weight loss or gain would have been 10% or greater. S14 RD LDN further confirmed Resident #67 should have been receiving weekly weights and had not been done. Interview on 09/21/2022 at 11:25 a.m. with S2 DON confirmed Resident #67's weight loss of 7.72% noted 08/03/2022 and 9.09% weight gain noted on 09/01/2022 in one month were significant weight changes. S2 DON stated she did not re-weigh Resident #67 on 08/08/2022 (#220) and 09/01/2022 (#240) when the noted significant weight changes were report to her. S2 DON further confirmed Resident #67's significant changes in weight indicated an increase in monitoring his weights from monthly to weekly should have been done and was not done. 46773

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844 810 Based on observation, interview and record review, the facility failed to provide an assistive device at meal times for 1 (#16) of 32 sampled residents. Findings: Review of Resident #16's clinical record revealed an admitted [DATE] with diagnoses which included: Hemiplegia following Cerebral Infarction Affecting Left Dominant Side, Gastrostomy Status, Vascular Dementia with Behavioral Disturbance, Dysphagia, and Aphasia. Review of Resident #16's Quarterly MDS with an ARD of 06/30/2022 revealed he had a BIMS score of 10 (indicating moderately impaired cognition). The MDS further revealed the Resident required two person physical assistance for bed mobility, transfers, toilet use; and one person physical assistance for dressing, eating and personal hygiene. Observation of Resident #16 on 09/19/2022 at 12:10 p.m. revealed Resident in the dining room eating his noon meal. Resident was feeding himself spaghetti off a regular plate and was noted to have difficulty scooping the food from his plate. Resident had food spilled down the front of his shirt and on his lap. Review of Resident #16's diet card read adaptive equipment: Deep Divided Plate/ High Wall Plate Every Meal. Observation and interview of Resident #16 on 09/20/2022 at 12:13 p.m. revealed Resident in the dining room eating his lunch off a regular plate. Resident stated he did have difficulty at times scooping his food from his plate. Interview on 09/20/2022 at 12:17 p.m. with S10 Dietary Manager confirmed Resident #16 did not have a Deep Divide Plate/High Wall Plate Every Meal as indicated on his diet card and he should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnfield Nursing and Rehabilitation Center, LLC	915 1st Street Winnfield, LA 71483

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44844 Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings: Observation of the facility's kitchen on 09/19/2022 at 9:00 AM accompanied by S10 Dietary Manager revealed: 1. 1 bag of lima beans open and undated in the walk in freezer. 2. 1 box of biscuits open and undated in the walk in freezer. 3. 1 box of pork sausage links open and undated in the walk in freezer. 4. The microwave setting on the tea table was unsanitary with dried food splattered on the top and bottom. 5. Cooking pans stacked on top of each other wet. Interview at the time of observation with S10 Dietary Manager revealed the cook is responsible for sealing and labeling food items. S10 Dietary Manager confirmed the above listed items were open and undated and they should have been. S10 Dietary Manager further confirmed the microwave setting on the tea table should not have dried food particles splattered on the top and bottom of it, and the cooking pans should not be stacked on top of each other wet.

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22117 Based on interview and record review the facility failed to provide PT services according to a resident's comprehensive plan of care for 1 resident (#5) identified for Rehab and Restorative Services out of a total sample of 30 residents. Findings: Review of Resident #5's record revealed an admitted [DATE] with medical diagnoses that included: Degenerative Joint Disease, Chronic Pain, Constipation, and Lower back pain. Review Resident #5's admission MDS with an ARD dated 03/23/2022 revealed the resident required supervision/setup for bed mobility, walking in room, locomotion on and off unit, dressing, eating, and personal hygiene. The resident required limited assist of one person with transfers and for toileting and for walking in corridor he required supervision only. Review Resident #5's Quarterly MDS with an ARD dated 06/16/2022 revealed the resident had several changes in his functional status. The resident required extensive assistance with bed mobility, dressing, toileting and personal hygiene. Interview with Resident #5 on 09/19/2022 at 11:18 a.m. revealed that he wanted to receive therapy services to help him walk again, as he did when he was first admitted . Interview with S15 LPN at 9:37 a.m. revealed the resident was not currently receiving therapy services. S15 LPN stated each time he has been placed on restorative services he refuses to participate. S15 LPN stated resident #5 will ask for therapy, but when it is provided, he refuses to continue with it. Review of the resident's physician orders dated 08/22/2022, revealed an order for PT evaluation. Interview on 09/20/2022 at 11:05 a.m. with S7 COTA/Rehab Director revealed the therapy department had not received an order to evaluate Resident #3 for Physical Therapy since 03/2022. S7 COTA/Rehab Director stated that they never received the order to evaluate the resident for PT as written on 08/22/2022. S7 COTA/Rehab Director also revealed the therapy department did not have a full time Physical Therapist, but PRN Physical Therapist were filling in several day a week to meet the needs of the residents. Interview 09/20/22 11:20 AM with S8 and S9 LPN/Case Coordinator were primarily responsible for taking off the Physician Orders for the whole building. S8 LPN/Case Coordinator confirmed the 08/22/2022 for a PT evaluation must have been missed but the other part of the order to set up with pain management was done. Interview 09/20/22 12:10 PM with S11 LPN/MDS revealed resident #5's current care plan revealed the resident had a problem with consistent refusal of medical treatment but there was no date of when this problem started, what the goal date was and the approaches were not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195454	A. Building B. Wing	09/21/2022

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with resident #5 on 09/20/22 12:27 PM revealed he was walking when he came in to the nursing home and now he can't walk. Resident #5 stated he has Osteoarthritis and he has been depressed. Resident #5 stated that he may have in the past refused restorative at times, especially if he was hurting, but had told the nurses recently that he felt that he could began therapy. Interview on 09/21/2022 at 2:00 p.m. with S16 Corporate RN confirmed that the PT order for resident #5 dated 08/22/2022 was missed, resulting in the resident not being evaluated for physical therapy services. S16 Corporate RN confirmed the resident should have received a PT evaluation, but did not.