STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195464	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellington	308 Amelia Street Rayne, LA 70578

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews and interviews, the facility failed to notify the state's Long-Term Care Ombudsman in writing of a discharge for 1 (#123) of 1 (#123) residents reviewed for discharge requirements out of a total sample of 41 residents.Findings:Review of Resident #123's electronic medical record (EMR) revealed an admission date of 06/12/2025, with diagnoses that included cerebral infarction, type 2 diabetes mellitus, and chronic atrial fibrillation. Further review of Resident #123's EMR revealed a discharge summary with a discharge date of 06/23/2025. Continued review of Resident #123's EMR revealed no evidence the State's Long-Term Care Ombudsman had been notified in writing of Resident #123's discharge from the facility on 06/23/2025.On 08/05/2025 at 4:22 p.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated the Ombudsman had not been notified of the resident's discharge as this is something they do not do.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the minimum data set (MDS) assessment accurately reflected the status of 2 (Resident #5 and #55) of 41 sampled residents.Resident #5Review of Resident #5's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included but were not limited to hypertensive heart disease without heart failure, major depressive disorder, shortness of breath, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #5's current physician's orders revealed an order dated 03/08/2025 that read in part, Hydrochlorothiazide (diuretic) oral tablet 25 mg (milligrams) Give 25 by mouth one time a day.Review of Resident #5's MAR (medication administration record) for June 2025 revealed she had been administered Hydrochlorothiazide 25mg for the entire month as ordered.Review of Resident #5's Annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 06/19/2025 revealed in Section N (Medications) that she was not coded for diuretic use.On 08/06/2025 at 3:07 p.m., an interview and record review was conducted with S2MDS (Minimum Data Set). She confirmed Resident #5 received Hydrochlorothiazide, which was a diuretic, for the entire month of June 2025 and should have been coded for diuretic use on her annual MDS and was not. Resident #55Review of Resident #55's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecified sequelae of cerebral infarction, hypertensive heart disease without heart failure, anxiety disorder, unspecified and dermatitis. Review of Resident #55's nurse's notes dated 01/08/2025 at 10:46 a.m., revealed a stage 2 pressure wound was noted to her sacrum by the treatment nurse. Further review of the nurse's notes dated 01/08/2025 at 3:00 p.m., revealed a DTI (deep tissue injury) was noted to Resident #55's left heel by the treatment nurse.Review of Resident #55's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/30/2025 in Section M (Skin Conditions) revealed she was coded for 2 Stage 3 pressure ulcers that were present upon admission/entry or reentry. On 08/05/2025 at 10:30 a.m., an interview and record review was conducted with S1DON (Director of Nursing). She confirmed the two pressure ulcers identified on 01/08/2025, one to the left heel and one to the sacrum, were both acquired while Resident #55 was in the facility and had been inaccurately coded. On 08/05/2025 at 10:41 a.m., an interview and record review of Resident #55's MDS was conducted with S2MDS (Minimum Data Set). She confirmed Resident #55's MDS had been inaccurately coded for two pressure ulcers as present upon admission and should have been coded as acquired in the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to implement a person centered care plan by failing to ensure physician orders were followed for heel protectors for 1 (Resident #55) of 41 sampled residents. Review of Resident #55's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecified sequelae of cerebral infarction, hypertensive heart disease without heart failure, anxiety disorder, unspecified and dermatitis.Review of Resident #55's current physician's orders revealed an order dated 01/09/2025 that read in part, Apply heel protectors every morning while patient is in bed every day shift.Review of Resident #55's care plan with a focus that read in part, Resident has potential for alteration in skin integrity related to impaired mobility and history of pressure ulcers. Heel protectors when in bed was listed as an intervention for this focus with a date initiated on 05/07/2025.On 08/05/2025 at 09:16 a.m., an observation was made of Resident #55 during wound care in bed with no heel protectors in place.On 08/05/2025 at 10:50 a.m., a second observation was conducted of Resident #55. She was lying in bed with no heel protectors in place.On 08/06/2025 at 9:12 a.m., an interview and observation was conducted with S4ACNA (Agency Certified Nursing Assistant). She stated that she was responsible for caring for Resident #55. Resident #55 was observed lying in bed and not wearing heel protectors. S4CNA stated that she was not sure if Resident #55 should have heel protectors.On 08/06/2025 at 9:51 a.m., an interview, observation, and record review was conducted with S3LPN (Licensed Practical Nurse). S3LPN observed Resident #55 lying in bed and confirmed that she was not wearing any heel protectors. A review of Resident #55's physician's orders and care plan was also conducted with S3LPN and she confirmed that Resident #55 should have had heel protectors on while in bed.

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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** Based on record review and interviews, the facility failed to review and revise the care plan for 1 (#80) of 2 (#9, #80) residents investigated for dialysis out of a sample of 41 residents. Finding: Record review revealed Resident #80 was admitted to the facility on [DATE] with diagnosis not limited to end stage renal disease, hemodialysis, obstructive sleep apnea, type 2 diabetes mellitus, and peripheral vascular disease. Record review of Resident #80 physician orders dated 02/01/2025 read in part, provide foley (urinary catheter) care every shift and change bag and tubing every month. Record output and the end of every shift. Start date of order read 01/02/2025and was discontinued on 02/02/2025. Record review of Resident #80's care plan read in part, C.N.A. (Certified Nursing Asistant) and LPN (Licensed Practical Nurse) monitor intake and output for Resident #80. Start date was listed as 12/31/2024. On 08/06/2025 at 12:30 p.m., S7LPN confirmed during an interview that she does not monitor intake and output on Resident #80. On 08/06/2025 1:30 p.m., S8CNA confirmed during an interview that she does not monitor intake and output on Resident #80. On 08/06/2025 1:45 p.m., S2MDS (Minimum Data Set) Coordinator was interviewed. During the interview, she reviewed Resident #80's physician orders and care plan and confirmed Resident #80's care plan should not include the intervention for LPN and CNA to monitor the resident intake and output. She stated Resident #80's catheter was discontinued on 02/02/2025. On 08/06/2025 at 2:20 p.m., S9QAN (Quality Assurance Nurse) was interviewed. During the interview, she reviewed Resident #80's Care Plan and confirmed the resident's catheter was discontinued and her care plan should not include that the C.N.A. and LPN are to monitor the resident's intake and output.