

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER The Care Center of Dequincy		STREET ADDRESS, CITY, STATE, ZIP CODE 602 North Division Dequincy, LA 70633	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to ensure the resident was treated with respect and dignity as evidenced by the facility failing to keep a resident's urine collection bag covered and private for 1 (Resident #113) out of 1 resident (#113) investigated for dignity. Findings: Review of Resident #113's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, acute kidney failure and retention of urine. Review of Resident #113's most recent admission Minimum Data Set (MDS) dated [DATE], revealed in part, Section H: Bladder and Bowel checked for indwelling catheter. Review of Resident #113's comprehensive care plan revealed in part, the resident has (foley) catheter with an intervention that read in part, catheter: the resident has 16 FR (French), 10 CC (cubic centimeter) foley. Position catheter bag and tubing below the level of the bladder and away from entrance room door. On 01/27/2025 at 9:30 a.m., an observation was made of Resident #113 from the hallway as his room door was open, he was resting in bed and his urine collection bag was observed hanging on the left side, at the foot of his bed without a privacy bag or covering. The urine collection bag was visible from the hallway. On 01/27/2025 at 9:45 a.m., an interview and observation was conducted with S7CNASup (Certified Nursing Assistant Supervisor). An observation was made of Resident #113 from the hallway with S7CNASup as his room door was open, he was resting in bed and his urine collection bag was observed hanging on the left side, at the foot of his bed without a privacy bag or covering. The urine collection bag was visible from the hallway. S7CNASup confirmed the resident's urinary collection bag was visible from the hallway, and did not have a privacy bag over it. S7CNASup further confirmed there should have been a privacy bag over the urine collection bag to ensure the resident's dignity. On 01/27/2025 at 2:04 p.m., an interview with S2DON (Director of Nursing) who confirmed that when a resident's urinary collection bag was visible from the hallway it should of had a privacy bag it to maintain the resident's dignity.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 195527	Facility ID: 195527 If continuation sheet Page 1 of 15

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F 0600 Level of Harm - Actual harm 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 interviews and record reviews, the facility failed to protect the residents' right to be free from physical abuse for 2 (#3 and #8) of 2 (#3 and #8) sampled residents investigated for abuse. The facility failed to protect: 1. Resident #8 from physical abuse by Resident #3 2. Resident #3 from physical abuse by Resident #63 This deficient practice resulted in physical harm for Resident #8 on 11/17/2024 at 4:22 p.m. when Resident #3 hit him multiple times. On 11/17/2024 at 4:22 p.m. when Resident #3 hit him multiple times, Resident #8 sustained skin tears to his left forearm and left lower leg. Findings: Review of the facility's undated policy titled Abuse Prevention and Investigation revealed, in part, the following: It is the policy of this facility to provide protections .that prohibit and prevent abuse. Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse includes hitting, slapping, punching . 1. Resident #8 Review of Resident #8's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Dementia with Behavior Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Severe Major Depressive Disorder with Psychotic Features, Schizoaffective Disorder, and Cognitive Communication Deficit. Review of Resident #8's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) Score of 12, indicating moderate cognitive impairment. Resident #8 had verbal behavioral symptoms directed toward others. Review of Resident #8's current comprehensive care plan revealed, in part, the resident has a behavior problem related to diagnosis of schizoaffective disorder initiated 09/01/2024, and the resident has the potential to be physically aggressive due to poor impulse control initiated on 09/29/2024. Review of the facility's Incidents by Incident Type record for the last 120 days revealed, in part, one incident of Physical Aggression Received for Resident #8 dated 11/17/2024. Review of the facility's incident report dated 11/17/2024 at 4:36 p.m. revealed, in part, the following: Incident Type: Physical Aggression Received Person Preparing Report: S9RN (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Incident Description: Resident #8 backed chair into Resident #3 while waiting to go outside to go smoke. Resident #8 was struck multiple times by Resident #3 resulting in a skin tear to Resident #8's left forearm. Residents separated. Immediate Action Taken: Residents were separated and placed on 1:1 monitoring Injuries Observed at the Time of Incident: Skin tear to left lower leg, and skin tear to left forearm Review of Resident #8's Nurse's Notes revealed, in part, the following: 11/17/2024 at 04:44 p.m. written by S9RN: Resident #8 was struck multiple times by Resident #3 resulting in a skin tear to left forearm. Skin tear to left forearm treated at this time. Review of Resident #8's Order Summary Report revealed, in part, the following: 11/17/2024 Telephone order: Cleanse skin tear to left lower leg with normal saline, apply antibiotic ointment and a dressing once daily until resolved. 11/17/2024 Telephone order: Cleanse skin tear to left forearm with normal saline, apply antibiotic ointment and a dressing once daily until resolved. On 01/29/2025 at 1:45 p.m. an interview was conducted with S1ADM. He confirmed the Incident of Physical Aggression Received reported on 11/17/2024 at 4:36 p.m. was an incident of resident to resident abuse. 2. Resident #3 Review of Resident #3's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Mild Cognitive Impairment, Generalized Anxiety Disorder, Major Depressive Disorder, Unspecified Intracranial Injury, Bipolar Disorder, and Schizoaffective Disorder. Review of Resident #3's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) Score of 14, indicating intact cognition. Review of Resident #3's current Comprehensive Care Plan revealed, in part, the resident has the potential to be physically aggressive due to anger and poor impulse control initiated on 09/12/2024. Review of the facility's Incidents by Incident Type record for the last 120 days revealed, in part, one incident of Physical Aggression Received for Resident #3 dated 09/12/2024. Review of the facility's Incident Report dated 09/12/2024 at 6:46 p.m. revealed, in part, the following: Incident Type: Physical Aggression Received Person Preparing Report: S8LPN (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Incident Description: Resident #3 and Resident #63 were both going outside to smoke. Resident #3 backed his wheelchair into Resident #63 three times. Resident #63 hit Resident #3 in the face 3 times with his closed fist. The nursing aide separated the residents. Resident #3 stated he backed up on Resident #63 three times. Resident #3 stated he was hit three times in the face by Resident #63. Immediate Action Taken: Resident #3 was sent to the emergency room for psychiatric evaluation Injuries: No injuries observed at the time of the incident. Review of the facility's investigation record for the incident which occurred on 09/12/2024 revealed, in part: 1. An Incident Communication form dated 09/12/2024 revealed, in part, Resident #63 then hit Resident #3 in the face. 2. An undated, handwritten note prepared by Resident #63, revealed in part, ,after he turned to me I punched him in the face. On 01/29/2025 at 1:45 p.m., an interview was conducted with S1ADM. He confirmed the Incident of Physical Aggression Received reported on 09/12/2024 at 6:46 p.m. was an incident of resident to resident abuse.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record reviews and interviews, the facility failed to ensure alleged violations of abuse were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency for 2 (Resident #3, Resident #8) of 2 (Resident #3, Resident #8) residents reviewed for Abuse. Findings: Review of the facility's policy titled Abuse Prevention and Investigation revealed, in part, the following: It is the policy of this facility to provide protections .that prohibit and prevent abuse. Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse includes hitting, slapping, punching . The facility will report all alleged violations to the Administrator, state agency .immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. The Administrator will follow up . to report the results of the investigation when final within 5 working days of the incident as required by state agencies. Resident #3 Review of Resident #3's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Mild Cognitive Impairment, Generalized Anxiety Disorder, Major Depressive Disorder, Unspecified Intracranial Injury, Bipolar Disorder, and Schizoaffective Disorder. Review of Resident #3's most recent Quarterly MDS assessment dated [DATE] revealed a BIMS Score of 14, indicating intact cognition. Review of Resident #3's current Comprehensive Care Plan revealed, in part, the resident has the potential to be physically aggressive due to anger and poor impulse control initiated on 09/12/2024. Review of the facility's Incidents by Incident Type record for the last 120 days revealed, in part, one incident of Physical Aggression Received for Resident #3 dated 09/12/2024. The facility denied reporting any Critical Incident Reports to the Statewide Incident Management System during the last six months. Review of the facility's Incident Report dated 09/12/2024 at 6:46 p.m. revealed, in part, the following: Incident Type: Physical Aggression Received Person Preparing Report: S8LPN Incident Description: Resident #3 and Resident #63 were both going outside to smoke. Resident #3 backed his wheelchair into Resident #63 three times. Resident #63 hit Resident #3 in the face 3 times with his closed fist. The nursing aide separated the residents. Resident #3 stated he backed up on (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63 three times. Resident #3 stated he was hit three times in the face by Resident #63. Immediate Action Taken: Resident #3 was sent to the emergency room for psychiatric evaluation Injuries: No injuries observed at the time of the incident Review of the facility's investigation record for the incident which occurred on 09/12/2024 revealed, in part: 1. An Incident Communication form dated 09/12/2024 revealed, in part, Resident #63 then hit Resident #3 in the face. 2. An undated, handwritten note prepared by Resident #63, revealed in part, .after he turned to me I punched him in the face On 01/29/2025 at 1:45 p.m. an interview was conducted with S1ADM. He confirmed no Critical Incident Reports have been created during the last six months. He confirmed the Incident of Physical Aggression Received reported on 09/12/2024 at 6:46 p.m. was an incident of resident to resident abuse. He confirmed the incident of abuse was not reported immediately, or within 2 hours after the allegation was made to the State Survey Agency, but should have been. Resident #8 Review of Resident #8's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Dementia with Behavior Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Severe Major Depressive Disorder with Psychotic Features, Schizoaffective Disorder, and Cognitive Communication Deficit Review of Resident #8's most recent Quarterly MDS assessment dated [DATE] revealed a BIMS Score of 12, indicating moderate cognitive impairment. Review of Resident #8's current Comprehensive Care Plan revealed, in part, the resident has a behavior problem related to schizoaffective disorder initiated 09/01/2024, and the resident has the potential to be physically aggressive due to poor impulse control initiated on 09/29/2024. Review of the facility's Incidents by Incident Type record for the last 120 days revealed, in part, one incident of Physical Aggression Received for Resident #8 dated 11/17/2024. Review of the facility's Incident Report dated 11/17/2024 at 4:36 p.m. revealed, in part, the following: Incident Type: Physical Aggression Received Person Preparing Report: S9RN (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Incident Description: Resident #8 backed chair into Resident #3 while waiting to go outside to go smoke. Resident #8 was struck multiple times by Resident #3 resulting in a skin tear to left forearm. Residents separated. Immediate Action Taken: Residents were separated and placed on 1:1 monitoring Injuries Observed at the Time of Incident: Resident #8 had a skin tear to left lower leg and left forearm Review of Resident #8's Nurse's Notes revealed, in part, the following: 11/17/2024 at 4:44 p.m. written by S9RN: Resident #8 was struck multiple times by another resident resulting in a skin tear to left forearm. On 01/29/2025 at 1:45 p.m. an interview was conducted with S1ADM. He confirmed no Critical Incident Reports have been created during the last six months. He confirmed the Incident of Physical Aggression Received reported on 11/17/2024 at 4:36 p.m. was an incident of resident to resident abuse. He confirmed the incident of abuse was not reported immediately, or within 2 hours after the allegation was made to the State Survey Agency, but should have been.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interviews, the facility failed to initiate an investigation of an alleged violation of abuse for 1 (Resident #8) of 2 (Resident #3, Resident #8) sampled residents. Findings: Review of the facility's undated policy titled Abuse Prevention and Investigation revealed, in part, the following: It is the policy of this facility to provide protections .that prohibit and prevent abuse. Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse includes hitting, slapping, punching . An immediate investigation is warranted when suspicion of abuse or reports of abuse occur. Investigations include identifying and interviewing all involved persons, determining if abuse occurred, determining the extent and cause of the abuse, and providing complete and thorough documentation of the investigation. Review of the facility's Incidents by Incident Type record for the last 120 days revealed, in part, one incident of Physical Aggression Received for Resident #8 dated 11/17/2024. Review of Resident #8's Nurse's Notes revealed, in part, the following: 11/17/2024 at 4:44 p.m. written by S9RN: Resident #8 was struck multiple times by Resident #3 resulting in a skin tear to left forearm. Skin tear to left forearm treated at this time. On 01/28/2025 at 10:08 a.m. S1ADM stated he was responsible for investigation of all incidents. S1ADM stated he was responsible for creating Critical Incident Reports. S1ADM was asked to provide a copy of the incident report involving Resident #8 which occurred on 11/17/2024. On 01/28/2025 at 10:37 a.m. S1ADM was asked to also provide documentation of the investigation of the 11/17/2024 incident. On 01/28/2025 at 10:41 a.m. S2DON provided copy of incident report. No documentation of investigation was provided. Review of the facility's incident report dated 11/17/2024 at 4:36 p.m. revealed, in part, the following: Incident Type: Physical Aggression Received Person Preparing Report: S9RN Incident Description: Resident #8 backed chair into Resident #3 while waiting to go outside to go smoke. Resident #8 was struck multiple times by Resident #3 resulting in a skin tear to Resident #8's left forearm. Residents separated. Immediate Action Taken: Residents were separated and placed on 1:1 monitoring Injuries Observed at the Time of Incident: Skin tear to left lower leg, and skin tear to left (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	forearm On 01/28/2025 at 12:33 p.m. S1ADM stated he had no documentation of investigation of the incident involving Resident #8 which occurred on 11/17/2024. On 01/29/2025 at 1:45 p.m. an interview was conducted with S1ADM. He confirmed the Incident of Physical Aggression Received reported on 11/17/2024 at 4:36 p.m. was an incident of resident to resident abuse. S1ADM confirmed an investigation of the abuse was not conducted or documented, but should have been.		

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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. Based on record review and interview, the facility failed to ensure the resident's Minimum Data Set (MDS) assessment accurately reflected the discharge status for 1 (Resident # 60) out of 31 sampled residents. Findings: Review of Resident #60's discharge transfer summary on 11/29/2024 revealed he was transferred to another nursing home. Review of Resident #60's Discharge MDS assessment, with an ARD (Assessment Reference Date) of 11/29/2024 revealed: Section A .Discharge assessment, return not anticipated, planned A2105. Discharge Status. Code 04. Short-Term General Hospital. On 01/29/2025 at 12:21 p.m., an interview and record review was conducted with S4MDS. She confirmed Resident #60 was discharged from the facility on 11/29/2024 to another nursing home. She reviewed the Discharge MDS, and confirmed the discharge status indicated he was discharged to a short term general hospital, which was coded inaccurately.		

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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. Based on observations, interview, and record review, the facility failed to provide necessary care and services that is in accordance with professional standards of practice for 2 (Resident #34, Resident #58) out of 5 (Resident #11, Resident #17, Resident #19, Resident # 34, Resident #58) residents reviewed for respiratory care, with the potential to effect 23 residents receiving oxygen therapy. Findings: The facility did not provide a policy for storing of oxygen/nebulizer equipment by survey exit. Resident #34 Review of Resident #34's EMR (Electronic Medical Record) revealed the resident was admitted to facility on 01/02/2024 with diagnosis not limited to Dyspnea, COPD (Chronic Obstructive Pulmonary Disease) and CHF (Congestive Heart Failure). Review of the physician's orders for Resident #34 revealed an order dated 09/03/2024 - apply O2 (oxygen) 2-4 liters (L) via N/C (nasal cannula) PRN (as needed) to keep oxygen saturation above 90% (percent). On 01/27/2025 at 9:53 a.m., an observation of Resident #34's O2 concentrator was done. The oxygen storage bag with a date of 01/27/2025 was on floor, with oxygen tubing running through the bag. On 01/27/2025 at 1:53 p.m., during an observation and interview with S5LPN (Licensed Practical Nurse), she observed and confirmed the oxygen storage bag was on the floor. She confirmed the oxygen tubing storage bag should not be on the floor. Resident #58 Review of Resident #58's EMR revealed the resident was admitted to facility on 09/24/2024 with diagnosis not limited to Acute and Chronic Respiratory Failure with Hypoxia, COPD and Pneumonia. Review of the physician's orders for Resident #58 revealed an order dated 10/09/2024 - Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligrams)/3ML (milliliters) give 1 vial inhale orally every 6 hours as needed for wheezing and 09/24/2024 - Pulmicort Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation) give 1 blister inhale orally two times a day On 01/27/2025 at 10:00 a.m., an observation of Resident #58's nebulizer machine and nebulizer tubing in a storage bag were on the floor at the head of the resident's bed. On 01/27/2025 at 11:13 a.m., an interview was conducted with Resident #58. Resident #58 stated that his respiratory equipment should be clean and did not understand why it was stored on the floor and not on a shelf. On 01/27/2025 at 1:48 p.m., an observation and interview with S5LPN of Resident #58's nebulizer machine and nebulizer tubing. She confirmed the nebulizer machine and nebulizer tubing were on the floor and should not be stored on the floor.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles. The facility failed to ensure schedule IV controlled medications were stored in a locked, permanently affixed compartment and/or a single unit package drug distribution system for 1 (Room A) of 1 medication storage room reviewed. Findings: On 01/27/2025, a review of the facility's policy titled, Medications - Controlled Substances with a last review date of 01/2025, read in part, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use or controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The policy also indicated how controlled medications are to be stored: Patient-specific controlled substances (e.g. narcotic/epidural infusions, tablets, etc.) are stored under double lock until administered to the patient. On 01/27/2025 at 12:54 p.m., an observation was conducted of medication storage in Room A with S2DON (Director of Nursing). Upon entering into Room A, a black refrigerator was noted and was unlocked. S2DON stated medications were stored in the black refrigerator. A black safe box was noted inside the refrigerator and was unlocked. Medications observed inside of the unlocked black safe box were: 1. Valium suppository 10 mg (milligram) PR (per rectum) - Quantity was 2 2. diazePAM Rectal Gel 10 mg PR - Quantity was 3 An interview was conducted with S2DON at this time. S2DON confirmed the black medication refrigerator and black safe box were unlocked. S2DON further confirmed the medications stored in the black safe box were schedule IV controlled medications that should have been double locked and were not.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER The Care Center of Dequincy		STREET ADDRESS, CITY, STATE, ZIP CODE 602 North Division Dequincy, LA 70633	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to ensure that the recipes for pureed foods were followed by the S6DC (Dietary Cook) failing to follow the recipes when preparing pureed foods. This deficient practice had the potential to affect the six residents in the facility who received a pureed diet. Findings: On 01/28/2025, a review of the facility's policy titled, Use of Recipes with no revision date, read in part, .Policy: Recipes are to be used when preparing menu items. Procedure: #3) Cooks are expected to use and follow the recipes provided. On 01/27/2025 at 10:20 a.m., an observation was conducted of S6DC as she prepared pureed white beans with ham. S6DC placed an undetermined amount of white beans with ham using a large scoop with no marked measurements. S3DM (Dietary Manager) stopped S6DC from beginning the puree process and poured the white beans with ham back in the original large pot. S3DM then measured out 7 servings of white beans with ham using a 6oz (ounce) spoodle into the blender. S6DC then began the puree process adding 4 scoops of powdered food thickener. S6DC transferred the puree white beans with ham to a pan on the steam table and washed the blender. S6DC then began the puree process for cornbread muffins. S6DC placed 7 cornbread muffins into the blender, added an 8oz carton of thickened milk and pureed until smooth. S6DC was observed preparing both items without using a recipe. S6DC subsequently interviewed. S6DC confirmed she does not follow recipes; stated she just adds water, juice, milk, or thickener as needed. On 01/27/2025 at 12:45 a.m., an interview was conducted with the S3DM. S3DM confirmed that the dietary staff had not been following recipes when preparing puree foods since the rotation of the menu's and could not recall when that was. She provided the recipes for this day's noon meal and stated; I'm not going to lie, I just printed these and made this binder. S3DM confirmed the dietary staff should be following recipes when preparing puree foods.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER The Care Center of Dequincy		STREET ADDRESS, CITY, STATE, ZIP CODE 602 North Division Dequincy, LA 70633	
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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to obtain the most recent recertification of terminal illness and most recent POC (plan of care) for 1 (Resident #26) out of 1 resident (#26) sampled residents reviewed for hospice. Review of Resident #26's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, senile degeneration of brain, personal history of colon polyps and vascular dementia. Review of Resident #26's Quarterly MDS (Minimum Data Set) dated 01/07/2025 revealed in part, Section O: Special Treatments, Procedures, and Programs checked for Hospice Care. Review of Resident #26's physician's orders revealed an order entry with a start date of 10/07/2024 read in part, Admit to contracted hospice under the care of physician with Terminal dx (diagnosis) of senile degeneration of brain. Review of Resident #26's hospice documents in the contracted hospice binder revealed, in part, the most recent certification of terminal illness by the contracted hospice agency's physician was signed on 10/27/2024 for the certification period dated 10/07/2024 to 01/04/2025. Review of Resident #26's hospice documents in the contracted hospice binder revealed, in part, the most recent POC by the contracted hospice agency's physician was signed on 10/27/2024 for the period dated 10/07/2024 to 01/04/2025. On 01/29/2025 at 9:34 a.m. a record review and interview was conducted with S2DON (Director of Nursing). Review of Resident #26's hospice documents in the contracted hospice binder was conducted with S2DON who confirmed the most recent certification of terminal illness and POC was for the period dated 10/07/2024 to 01/04/2025. She confirmed there was not an updated recertification of terminal illness and POC in Resident #26's contracted hospice binder and should have been.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER The Care Center of Dequincy		STREET ADDRESS, CITY, STATE, ZIP CODE 602 North Division Dequincy, LA 70633	
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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's Quality Assurance and Performance Improvement (QAPI) Program and interview, the facility failed to take actions aimed at performance improvement and after implementing those actions, measure its success and track performance. This was evidenced by lack of evidence of: 1. Measuring or tracking success of actions implemented; and 2. collection and analysis of data; This deficient practice had the potential to affect a census of 61 residents. Findings: On 01/29/2025, a review of the facility's undated policy titled, Quality Assurance and Performance Improvement (QAPI) Program, with a review date of 01/2025, revealed the following in part: Each facility must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. 2. c. Develop and implement appropriate plans of action to correct identified quality deficiencies. On 01/29/2025 at 2:30 p.m., a review of the QAPI program and an interview was conducted with S2DON (Director of Nursing). There was no documented evidence that the actions implemented were measured or performance of the action plans were tracked from July 01, 2024 through January 12, 2025. There was also no evidence of data collection and analysis. S2DON confirmed there was no documented evidence of data collection, analysis of data, monitoring, or performance tracking being conducted from July 01, 2024 to January 12, 2025.		