STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195539	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Nursing Center	1725 McArthur Drive Mansfield, LA 71052

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to accommodate the needs of 1(#8) of 20 sampled residents. The facility failed to ensure the resident was reassessed for the use assist rails.Review of Resident #8's medical record revealed Resident #8 was admitted [DATE], with a readmission date of 07/28/2025. Resident #8's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left-non dominate side and lack of coordination. Review of Resident #8's Quarterly MDS (Minimum Data Set) dated 06/08/2025 revealed Resident #8 had a BIMS (Brief Interview of Mental Status) score of 13/15, indicating intact cognition. Resident #8 had limited range of motion for both upper and lower extremities on one side. An observation on 08/11/2025 at 9:47 a.m. Resident #8's resting in bed, which did not have assist rails.During an interview on 08/11/2025 at 9:47 a.m. Resident #8 reported while she was away at the hospital, the facility removed her bed rails. Resident #8 reported she and her RP (Responsible Party) had requested to have Resident #8's assist rails back. During an interview on 08/13/2025 at 10:35 a.m. S5 CNA (Certified Nursing Assistant) reported Resident #8 used bed rails to turn and aid in mobility. S5 CNA further reported Resident #8 has requested bed rails to be placed placed back on. During an interview on 08/13/2025 at 10:40 a.m. S4 LPN (Licensed Practical Nurse) reported Resident #8 used bed rails for turning assistance during care and had requested bed rails to be returned. During an interview on 08/13/2025 at 10:45 a.m. S6 LPN/MDS nurse reported bed rail assessment should be completed quarterly, upon change in status, return from discharge, admission, or sooner if necessary. During an interview on 08/13/2025 at 10:50 a.m. S7 LPN/MDS reported residents have the right to have assist rails.

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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(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 - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to: provide to the resident and/or the resident's responsible party (RP) written notice which specified the reason for transfer, effective date, location and statement of the resident's appeal rights, and duration of the bed hold policy for 1 (#74) of 2 (#74, #76) residents reviewed for transfer/discharge, and notify the State's Long Term Care Ombudsman of discharges in writing for 2 (#74, #76) of 2 (#74, #76) residents reviewed for discharge requirements. Findings: Review of the facility's Bed Hold Prior to Transfer undated policy revealed in part: Policy:Prior to transferring a resident to the hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident and/or the resident representative regarding bed hold.Policy Explanation and Compliance Guidelines:Notice before Transfer1. The following information will be given to the resident and/or resident representative.a. The duration of the state bed-hold, if any, during which the resident is permitted to return and resume residence in the nursing facilityb. The reserve bed payment policy in the state plan, if anyc. The facility policy regarding behold periods to include permitting residents to return2. The facility will provide the receiving provider the following:a. Contact information of the practitioner responsible for the care of the residentb. Resident representative information including contact informationc. Advance Directive informationd. All special instructions or precautions for ongoing care, as appropriatee. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation to ensure a safe and effective transition of care.Resident #74 Review of Resident #74's medical record revealed an admit date of 03/11/2021 with diagnoses of, but not limited to Alzheimer's disease, major depressive disorder, and anxiety. Review of Resident #74's medical record revealed Resident #74 was sent to local ED (Emergency Department) on 06/20/2025 for evaluation. Further review of Resident #74's medical record failed to reveal a written notice of transfer/discharge had been provided at the time of transfer. The facility failed to provide documented evidence the State's Long-Term Care Ombudsman had been notified of Resident #74's discharge in writing as required. Resident #76Review of resident #76's medical record revealed an initial admit date of 06/17/2025, with diagnoses of, but not limited to chronic obstructive pulmonary disease major depressive disorder, chronic respiratory failure, and atrial fibrillation. Further review of Resident #76's medical record revealed Resident #76 was discharged home on [DATE].The facility failed to provide documented evidence the State's Long-Term Care Ombudsman had been notified of Resident #76's discharge in writing as required. During an interview on 08/13/2025 at 10:15 a.m., S2DON (Director of Nursing) reported nursing does not provide a written notice of bed hold to the resident or resident's RP at the time of discharge and or transfer and was not aware one needed to be sent with the resident. During an interview on 08/13/2025 at 10:30 a.m., S3Social Services reported a written notice of bed hold was not being provided to residents or residents' RPs at the time of transfer. During an interview on 08/13/2025 at 2:00 p.m. S1Administrator and S3Social Services confirmed the State's Long-Term Care Ombudsman had not been notified of Resident #74's transfer or Resident #76's discharge in writing as required.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of practice and followed facility's policies for 2 (# 60, #77) of 2 (#60, #77) residents reviewed for respiratory care. The facility failed to ensure: 1.) Oxygen cannula and tubing was changed per facility policy (Resident #60), 2.) Respiratory mask was stored per facility policy (Resident #77), and 3.) An oxygen in use sign was placed on the outside of the resident's room entrance door per facility policy (Resident #77). Findings:Review of the facility's Respiratory Equipment-Infection Control Guidelines policy procedures dated June 2024 revealed, in part: Oxygen Concentrators: 1. Oxygen cannula or mask and tubing should be dated when put in use and changed at least weekly or whenever contamination is suspected. Medication Nebulizers/Continuous Aerosol Machines/CPAP (Continuous Positive Airway Pressure) /BIPAP (Bilevel Positive Airway Pressure): 3. Equipment, administration sets, and tubing must be covered with plastic or clean towel when not in use. Review of the facility's undated Oxygen Administration procedure revealed, in part: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Steps: 2. Place an “Oxygen in Use” sign on the outside of the room entrance door. Resident #60 Review of Resident #60’s medical record revealed in part, Resident #60 was readmitted to the facility on [DATE] with diagnoses including, but not limited to chronic respiratory failure with hypoxia and shortness of breath. Review of Resident #60’s active physician orders revealed in part, an order dated 05/06/2025 oxygen at 2L (liters) via NC (nasal cannula) PRN (as needed) SOB (shortness of breath)/O2 (oxygen) saturation less than 95% and an order dated 06/11/2025 change and date O2 tubing every week on Friday during day shift. An observation on 08/11/2025 at 8:28 a.m. revealed Resident’s #60’s oxygen tubing dated 08/02/2025. During an interview on 08/11/2025 at 10:05 a.m. S4LPN (Licensed Practical Nurse) reported Resident’s #60’s oxygen tubing was dated 08/02/2025. S4LPN further reported oxygen tubing should be changed weekly and was not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 Review of Resident #77’s medical record revealed in part, Resident #77 was admitted to the facility on [DATE] with diagnoses including, but not limited to COPD (Chronic Obstructive Pulmonary Disease). Review of Resident #77’s active physician orders revealed in part, an order dated 07/23/2025 Ipratropium-albuterol solution 0.5-2.5 (3)mg (milligrams)/3ml (milliliter) inhale 1 vial orally 3 times a day and an order dated 07/28/2025 oxygen at 2L. An observation on 08/11/2025 at 8:50 a.m. revealed Resident #77 lying in bed with oxygen at 2L per nasal cannula in place. Observation on 08/11/2025 at 8:50 a.m. failed to reveal an oxygen in use sign on outside of Resident #77's room entrance door. An observation on 08/11/2025 at 11:00 a.m. revealed Resident #77's respiratory mask was stored uncontained on Resident #77’s bedside table. An observation on 08/11/2025 at 11:00 a.m. failed to reveal an oxygen in use sign on outside of Resident #77's room entrance door. During an interview on 08/11/2025 at 11:14 a.m. S9LPN confirmed nebulizer masks should been stored in a plastic bag when not in use and was not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews the facility failed to ensure the Controlled Drug Record was maintained and reconciled for 1 (Cart A) of 1 (Cart A) medication cart reviewed. Review of the facility's Medications - Controlled Substances Policy (undated) revealed in part:1. General Protocols:a. Controlled substances are stored in a separate compartment of an automated dispensing system or other locked storage unit with access limited to approved personnel. d. All controlled substances (Schedule II, III, IV, and V) are accounted for in one of the following ways:ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided.iii. All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy.h. The Controlled Drug Record/Narcotic Count form may serve the dual purpose of recording both narcotic disposition and patient administrationi. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR (Medication Administration Record) is the source for documenting any patient-specific narcotic dispensed from the pharmacy. Review of Resident #41's physician orders included an order dated 04/30/2025 Ativan (Lorazepam) oral tablet 0.5 mg (Milligram); give one-half tablet by mouth two times a day.During a review of Medication Cart A on 08/12/2025 at 3:50 p.m. with S4 LPN (Licensed Practical Nurse) an observation of Resident #41's Controlled Drug Record revealed an inaccurate remaining dose count for Lorazepam 0.5 mg oral tablet. Further review of Resident #41's Controlled Drug Record revealed the last dose of Resident #41's Lorazepam was administered 08/11/2025 at 8:00 p.m. with a remaining count of 48 doses. Review of Resident #41's Lorazepam blister pill packet revealed 47 doses remaining for administration. During an interview on 08/12/2025 at 3:50 p.m. S4 LPN reported she failed to complete the Controlled Drug Record for 08/12/2025 8:00 a.m. dose of Resident #41's Lorazepam. S4 LPN acknowledged there was a discrepancy in the dose count of Resident #41's Lorazepam blister pack.During an interview on 08/12/2025 at 3:55 p.m. S2 DON (Director of Nursing) reported narcotics should be documented with two different methods, the MAR and hard copy for [NAME] verification.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews the facility failed to ensure infection control measures were practiced to provide a safe, sanitary environment and help prevent the development and transmission of infection for 3 (#10, #13, #79) of 3 (#10, #13, #79) sampled residents requiring EBP (enhanced barrier precautions). The facility failed to:1. Post clear signage outside Resident #10, #13 and #79's room indicating the type of precautions, required personal protective equipment and high contact resident care activities that require the use of gown and gloves,2. Have gowns, gloves and alcohol-based hand rub available outside the room for Resident #10, #13 and #79 and 3. Obtain an order for EBP for Resident #79. Findings:Review of Enhanced Barrier Precautions policy dated January 2025, revealed in part: Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a multidrug-resistant organisms (MDRO) as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Policy Explanation and Compliance Guidelines:45. c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. 46. Enhanced Barrier Precautionsa. Nursing staff will place residents with any applicable conditions or devices on EBP. An order may be obtained. Applicable conditions and devices:i. Wounds and /or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes,.) even if the resident is not known to be infected or colonized with a MDRO. 47. Implementation of Enhanced Barrier Precautionsa. Gowns and gloves will be available outside of the resident's room. b. Alcohol-based hand rub will be available.c. A trash can will be positioned inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. 48. High-contact resident care activities include:a. Dressingb. Bathingc. Transferringd. Providing hygiene Resident #10Review of Resident #10's medical record revealed an admit date of 12/02/2024 with diagnoses which include in part acute kidney failure, benign prostatic hyperplasia, liver cell carcinoma, viral hepatitis C without hepatic coma, adult failure to thrive, and chronic obstructive pulmonary disease. Review of Resident #10's Physician orders revealed in part:07/31/2025 cleanse stage 2 to sacrum with wound cleanser and gauze, pat dry and apply foam dressing to area every 3 days and prn soiled or dislodged. 10/09/2024 Urinary Catheter care every shift12/02/2024 Enhanced Barrier Precautions related to Foley catheter. Review of Resident #10's quarterly Minimum Data Set report dated 06/09/2025 revealed in part Resident #10 had a Brief Interview for Mental Status score of 15 indicating intact cognition.Observation on 08/11/2025 at 8:30 a.m. of Resident #10's room failed to reveal EBP were in place. Observation on 08/11/2025 at 9:00 a.m. revealed Resident #10 lying in bed, Foley catheter in place. Further observation failed to reveal EBP signage posted and gowns, gloves and alcohol-based hand rub readily available outside Resident #10's room. Observation on 08/11/2025 at 9:30 a.m. revealed S10 CNA (Certified Nurse Aid) and S11 Student CNA using gloves as the only PPE while providing activities of daily living care for Resident #10. Observation on 08/12/2025 at 8:30 a.m. failed to reveal EBP in place.During an interview on 08/12/2025 at 9:15 a.m. Resident #10 reported staff have not been wearing a gown during baths or turning, only gloves. Resident #13Review of Resident #13's medical record revealed in part an admit date of 06/27/2025, a readmit date of 07/15/2025 with diagnosis which include in part: longstanding persistent atrial fibrillation, anxiety disorder, pain, acquired absence of right leg above knee, and burn of third degree of left lower leg. Review of Resident #13's physician orders revealed in part:08/05/2025 cleanse wound to left lower leg shin with wound cleanser, part dry, apply collagen to wound bed and cover every day07/31/2025 cleanse wound to left lower leg back with wound cleanser and gauze, pat dry, apply collagen to wound bed and cover with dry dressing every day and as needed dislodgement or soiled dressing.07/17/2025 clean stump daily with soap and water, pat dry, do not cover with dressings, leave open to air. Staples to be removed in one month with general surgery clinic.06/30/2025 Enhanced barrier precaution related to wounds Review of Resident #13's quarterly MDS dated [DATE] revealed in part Resident #13 had a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment. Observation on 08/11/2025 at 9:00 a.m. Resident #13 sitting up in his wheelchair, right above knee amputee noted. Further observation failed to reveal enhanced barrier precautions were in place. Observation on 08/12/2025 at 8:30 a.m. of Resident #13's room failed to reveal enhanced barrier precautions in place