

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  Presbyterian Village of Homer		STREET ADDRESS, CITY, STATE, ZIP CODE  3700 Hwy. 79 South Homer, LA 71040	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Resident #39</p> <p>Observations on 05/27/2025 at 9:45 a.m., 05/28/2025 at 10:10 a.m. and at 1:45 p.m. of Resident #39's room revealed the air conditioner unit contained a black substance on the vents and needed to be cleaned.</p> <p>On 05/28/2025 at 3:45 p.m., an observation of Resident #39's room with S2 DON present revealed Resident #39's air conditioner had a black substance on the vents. S2 DON confirmed the air conditioner vents needed to be cleaned.</p> <p>Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 2 (#3 and #39) of 2 residents rooms observed. The failed practice was evidenced by 1) Resident #3 and #39's air conditioner vents needed cleaning, and 2) Resident #3's bed control needed cleaning, and 3) Resident #3's room had a bedrail stored under his bed.</p> <p>Findings:</p> <p>Resident # 3</p> <p>Observations on 05/27/2025 at 10:05 a.m. and 05/28/2025 at 12:10 p.m. of Resident #3's room revealed the air conditioner vent was dirty with a buildup of dust, the bed control was noted on the Resident's night stand and was dirty and had a brown sticky substance on it, and a bedrail was noted on the floor under the Resident's bed.</p> <p>On 05/28/2025 at 3:35 p.m. an observation of Resident #3's room with S2 DON (Director of Nursing) present revealed Resident #3's air conditioner vent had a builduip of dust, a bedrail was under the Resident's bed, and Resident's bed control was dirty with a brown, sticky substance. S2 DON confirmed that the air conditioner vent and bed control needed to be cleaned and the Resident should not have had a bedrail stored under his bed.</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interview the facility failed to ensure each resident/RP (Responsible Party) was notified in advance of care planning conferences to enable resident/RP participation for 1 (#27) of 28 sampled residents.</p> <p>Findings:</p> <p>Review of facility's undated Care Plan Policy revealed, in part:</p> <p>Application of Policy .</p> <p>4. Care plan conferences (meetings) are scheduled for each resident at admission and continuing at least quarterly by the MDS Coordinator. The resident and his/her legal guardian/family member is given at least seven (7) day notice of invitation to attend and participate in the resident's care planning conferences. The conference may be scheduled at an alternate date and time if more convenient for the resident and/or family member.</p> <p>5. The MDS Coordinator or designee will invite family members and maintain records of the invitation and whether the resident and/or family member participated in the care plan conference.</p> <p>6. Participation by the resident and/or family member is not limited to attending the scheduled conference but may be done by conversations in person or by telephone and by sending written letters addressed to the ID (Interdisciplinary) Team. Resident and/or family input can occur at any time.</p> <p>Review of Resident #27's medical revealed an initial admission date of 01/23/2024 with diagnoses that included, in part, other seizures, traumatic subarachnoid hemorrhage without loss of consciousness, attention-deficit hyperactivity disorder, anxiety disorder, hypertensive heart disease without heart failure, depression, and non-pressure chronic ulcer of other part of right foot.</p> <p>Review of MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/17/2025 revealed Resident #27 had a BIMS (Brief Interview Mental Status) score of 05, which indicated a severe cognitive impairment.</p> <p>During an interview on 05/27/2025 at 1:53 p.m. Resident #27's family member reported there had been no care plan meetings.</p> <p>During an interview on 05/28/2025 at 2:35 p.m. S6 SSD (Social Services Director) reported Resident #27's family/RP was not being notified of upcoming care plan meetings and she did not have care plan meeting announcements for the family/RP as they were not being done.</p> <p>During an interview on 05/29/2025 at 10:35 a.m. S3 LPN (Licensed Practical Nurse)/MDS Nurse confirmed S6 Social Services was responsible for notify family/RP regard the care plan meeting and would send the care plan meeting invitations to the family/RP.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Resident #47</p> <p>Review of Resident #47's record revealed an admission date of 12/16/2024 with diagnoses including hemiplegia and hemiparesis, muscle wasting, lack of coordination, dysphagia, cognitive communication deficit, aphasia, hyperlipidemia, reflux, depression, polyosteoarthritis, heart disease, and pseudobulbar affect.</p> <p>Review of Resident #47's Quarterly MDS assessment dated [DATE] revealed a Brief Interview of Mental Status score of 3 which indicated severe cognitive impairment for daily decision making. Further review of the MDS revealed Resident #47 was provided substantial/maximal assistance with bed mobility and dependent on staff for toileting. Resident #47 had limitation in range of motion on one side of upper and lower extremities.</p> <p>Review of Resident #47's May 2025 Physician's Orders revealed no documented evidence of an order for the use of bedrails/positioning bars/turn bars.</p> <p>Review of Resident #47's care plan dated 05/08/2025 revealed Resident 47's bed was equipped with turning bars for positioning purposes. Interventions included evaluation of the turning bar has been performed per policy and procedure; other options have been explored, but family and or Resident have chosen the option of having the turning bar put in place, and Resident knows how to utilize the turning bar.</p> <p>Observations on 05/27/25 at 10:00 a.m., and 05/28/2025 at 2:51 p.m. revealed Resident #47 was lying in the bed with bilateral positioning bars in place in the up position on his bed.</p> <p>Review of Resident #47's record revealed no documentation of a quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p> <p>On 05/29/2025 at 2:00 p.m. interview with S4 Maintenance Director, S2 DON, S1 Administrator and S3 LPN/MDS confirmed no quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p> <p>Based on observations, interviews, and record reviews, the facility failed to 1) ensure residents had a physician's order for bed rails, 2) ensure residents or resident's responsible party were informed of the risks and benefits associated with the use of bed rails, 3) ensure a quarterly assessment was completed for the use of bed rails, and 4) assess residents for the risks of entrapment from bed rails prior to the installation of bed rails for 3 (#24, #46 and # 47) of 3 residents reviewed for bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings:</p> <p>Review of the Consent for Bed Rail Usage on Resident Bed revealed the following:</p> <ul style="list-style-type: none"> <li>-Facility must assess the resident for need of bed rails and must conduct a review of risks, which includes entrapment.</li> <li>-Types of bed rails which may be used at the facility for assistive turning devices, with physician's order and signed resident/RP (Responsible Party) consent, are: Turning Bars and Quarter Rails.</li> </ul> <p>Review of the facility's, undated, Policy for Bed Rails/Assist Bars/Turning Bars and Bed Safety revealed the following, in part:</p> <p>Application of Policy</p> <p>6. Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks and records such information in the Entrapment Prevention Program binder.</p> <p>12. Use of Bed Rails:</p> <ul style="list-style-type: none"> <li>a. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy bed rails shall include side rails, safety rails, and assist/grab/turning bars.</li> <li>c. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.</li> <li>f. The resident assessment to determine the risk of entrapment includes, but is not limited to: <ul style="list-style-type: none"> <li>-Medical diagnosis, conditions, symptoms, and/or behavioral symptoms</li> <li>-Sleep habits</li> <li>-Medications(s)</li> <li>-Acute medical or surgical interventions</li> <li>-Underlying medical conditions</li> <li>-Existence of delirium</li> <li>-Ability to toilet self safely</li> <li>-Cognition</li> </ul> </li> </ul> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Communication</p> <p>-Mobility in and out of bed, and</p> <p>-Risk of falling</p> <p>g. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following:</p> <p>-Accident hazards: (1) the resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or (2) the resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress</p> <p>-Restricted mobility: (1) hinders residents from independently getting out of bed thereby confining them to their beds; (2) creates a barrier to performing routine activities such as going to the bathroom or retrieving items in his/her room, eating, hydration and/or walking; (3) decline in resident unction, such as muscle functioning/balance; and/or (4) skin integrity issues</p> <p>-Psychosocial outcomes: (1) creates an undignified self-image and alters the resident's self-esteem; (2) contributes to feelings of isolation; and/or (3) induces agitation or anxiety.</p> <p>h. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The facility reviews this information with the resident/family upon admission and as necessary, after admission, with appropriate documentation/consents. The following information will be included in the consent:</p> <p>-The assessed medical needs that will be addressed with the use of bed rails;</p> <p>-The resident's risks from the use of bed rails and how these will be mitigated;</p> <p>-The alternatives that were attempted but failed to meet the resident's needs; and the alternatives that were considered but not attempted and the reasons.</p> <p>Resident #24</p> <p>Review of Resident #24's medical record revealed an initial admission date of 11/01/2016 with diagnoses that included, in part, muscle wasting and atrophy not elsewhere classified of multiple sites, other lack of coordination, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, hypertensive heart disease without heart failure, heart failure unspecified, and essential (primary) hypertension.</p> <p>Review of Resident #24's May 2025 Physician's Orders revealed no documented evidence of an order for the use of bilateral hand assist rails.</p> <p>Review of Resident #24's admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview Mental Status) should not have been conducted as Resident #24 was rarely/never understood and had a short and long term memory problem. Further review of the MDS revealed Resident #24 had impairment on both sides of upper and lower extremities and was dependent with roll left and</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>right, sit to lying, lying to sitting, and chair/bed-to-chair transfers.</p> <p>Review of Resident #24's care plan revealed Resident #24's bed was equipped with turning bars for positioning purposes with interventions that included, in part, evaluation of turning bar has been performed per policy and procedure, other options have been explored but family and/or resident have chosen the option of having the turning bar put in place.</p> <p>Observations on 05/27/2025 at 10:07 a.m. and 05/28/2025 at 10:59 a.m. revealed hand assist rails were in place on each side of Resident #24's upper bed.</p> <p>Review of Resident #24's record revealed no documentation of a quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p> <p>On 05/29/2025 at 2:00 p.m. interview with S4 Maintenance Director, S2 DON (Director of Nursing), S1 Administrator and S3 LPN (Licensed Practical Nurse)/MDS confirmed no quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p> <p>Resident #46</p> <p>Review of Resident #46's record revealed an admission date of 10/17/2024 with diagnoses including quadriplegia, polyneuropathy, pressure ulcer of sacral region stage 4, neuromuscular dysfunction of bladder, unspecified injury at C1 level of cervical spinal cord, hypotension, and muscle spasm.</p> <p>Review of Resident #46's Quarterly MDS assessment dated [DATE] revealed a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. Further review of the MDS revealed Resident #46 was provided substantial/maximal assistance with bed mobility and transfers and dependent on staff for eating, toileting, and sit to stand/bed to chair transfers. MDS revealed Resident #46 had functional limitation in range of motion on both upper and lower extremities.</p> <p>Review of Resident #46's May 2025 Physician's Orders revealed no documented evidence of an order for the use of bedrails/positioning bars/turn bars.</p> <p>Review of Resident #46's care plan dated 04/10/2025 revealed Resident 46's bed was equipped with turning bars for positioning purposes. Interventions included evaluation of the turning bar has been performed per policy and procedure; other options have been explored, but family and or Resident have chosen the option of having the turning bar put in place, and resident knows how to utilize the turning bar.</p> <p>Observations on 05/27/2025 at 2:10 p.m. and 05/28/2025 at 10:00 a.m. of Resident #46 revealed the Resident had bilateral positioning bars in place in the up position on his bed.</p> <p>Review of Resident #46's record revealed no documentation of a quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p> <p>On 05/29/2025 at 2:00 p.m. interview with S4 Maintenance Director, S2 DON, S1 Administrator and S3 LPN/MDS confirmed no quarterly assessment for bed rails, no assessment for the risk of entrapment prior to installation of bed rails, the consent did not include risk and benefits, no routine inspection of the bed rails, the resident assessment did not contain the components as addressed on the facility's bed rail policy, and there was no documented evidence of the medical need for the use of bed rails.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record reviews and interview, the facility failed to ensure an RN (Registered Nurse) was on duty for 8 consecutive hours per day, 7 days a week, for 4 days within FY (Fiscal Year) Quarter 1 2025 (October 1- December 31).</p> <p>Findings:</p> <p>Review of the facility's PBJ (Payroll Based Journal) Staffing Data Report for FY Quarter 1 2025 (October 1- December 31) revealed there were no RN hours for four or more days within the quarter. Further review revealed no RN hours for the dates of 10/27/2024, 11/30/2024, 12/01/2024, and 12/28/2024.</p> <p>During an interview on 05/28/2025 at 1:00 p.m. S1 Administrator reported he was responsible for completing the PBJ staffing report. S1 Administrator reviewed the PBJ for FY Quarter 1 2025 (October 1-December 31) and reported during that time period the facility only had one full time RN and 4 part time RNs. S1 Administrator confirmed there was not RN coverage for at least 8 consecutive hours a day for 10/27/2024, 11/30/2024, 12/01/2024, and 12/28/2024 and there should have been.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure the physician documented a rationale for denying a gradual dose reduction for 1 (#36) of 5 (#17, #24, #35, #36 and #47) Residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Resident #36 had diagnoses including restlessness and agitation, pseudobulbar affect, depression, muscle wasting, Alzheimer's disease, dementia, and bipolar disorder.</p> <p>Review of Resident #36's May 2025 physician orders revealed an order dated 02/26/2025 for Abilify 5 mg (milligrams) every morning and evening.</p> <p>Review of the consultant Pharmacist report revealed a dose reduction letter dated 03/18/2025 recommended a gradual dose reduction for Abilify 5 mg bid (two times a day) for Resident #36. Further review of the report revealed the physician chose not to attempt a gradual dose reduction, and failed to give a written clinical rationale.</p> <p>On 05/28/2025 at 3:50 p.m. interview with S2 DON (Director of Nursing) confirmed the letter from the pharmacist to the physician, requesting a gradual dose reduction, regarding Abilify 5 mg did not have a handwritten rationale for the reason the physician did not want to decrease the medication.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation and interview, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in the kitchen as evidenced by the deep fryer's internal compartment having a heavy grease buildup.</p> <p>Findings:</p> <p>Initial observation of the kitchen on 05/27/2025 at 8:50 a.m. revealed the deep fryer internal compartment had a heavy grease buildup and needed to be cleaned.</p> <p>On 05/27/2025 at 2:27 p.m. S5 DM (Dietary Manager) confirmed the deep fryer's internal compartment had a grease buildup and needed to be cleaned.</p>		