STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195156	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Wood at Woldenberg Village	3701 Behrman Place New Orleans, LA 70114

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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was not required to supply a personal sitter (a caregiver who provides bedside assistance and supervision for safety) as a condition of continued stay for 1 (Resident #2) of 1 (Resident #2) sampled residents reviewed for resident rights. Findings: Review of the facility's Resident Rights policy statement, amended on 09/2016, revealed, in part, non-covered special care services such as privately hired nurses or aides may be charged to residents' funds if the services are requested by a resident. Further review revealed the facility must not require a resident to request services as a condition of admission or continued stay. Review of Resident #2's clinical record revealed, in part, Resident #2 was admitted to the facility's dementia unit on 04/07/2025 and was discharged from the facility on 04/08/2024. Further review revealed Resident #2 had a diagnosis of unspecified dementia. Review of Resident #2's progress notes dated 04/07/2025 revealed, in part, Resident #2 became verbally and physically aggressive towards staff. Review of Resident #2's progress notes dated 04/08/2025 revealed, in part, Resident #2 continued to be verbally and physically aggressive towards staff. Further review revealed Resident #2 was issued a Psychiatric Emergency Certificate (a legal document that authorizes a healthcare professional to detain and treat a patient in a psychiatric emergency) and was transferred to a behavioral health hospital for treatment. In an interview on 04/30/2025 at 2:28PM, Resident #2's daughter/Resident Representative (RR) indicated she was contacted by the facility on 04/08/2025 and notified Resident #2 had been combative with the staff and was transferred to a behavioral health hospital. Resident #2's daughter/RR further indicated she was informed by a nurse, who she could not name, that Resident #2 could not return to the facility without a personal sitter supplied by Resident #2. Resident #2's daughter/RR further indicated she had to bring Resident #2 home because she could not afford to pay for a personal sitter. (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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/2025 at 11:15AM, S4Social Worker indicated she was responsible to coordinate all planned resident transfers and discharges from the facility. S4Social Worker indicated S3Assistant Director of Nursing (ADON) emailed her and requested S4Social Worker reach out to Resident #2's daughter/RR to inform her Resident #2 required a personal sitter when Resident #2 returned to the facility from the behavioral health hospital. Review of S4Social Worker's email correspondence with S3ADON dated 04/09/2025 revealed, in part, S3ADON indicated she spoke to Resident #2's daughter/RR regarding Resident #2's daughter/RR having to obtain a personal sitter for Resident #2 when Resident #2 returned to the facility from the behavioral health hospital. Further review revealed S3ADON indicated she was not sure if Resident #2's daughter/RR would be able to afford the personal sitter services. Review of Resident #2's behavioral health hospital's multidisciplinary note dated 04/09/2025 revealed, in part, the facility would allow Resident #2 to return to the facility provided Resident #2's family supplied a personal sitter. In an interview on 05/05/2025 at 11:23AM, the behavioral healthcare hospital Clinical Director indicated the behavior health hospital nurse who made rounds at the facility told her Resident #2's family would have to supply a personal sitter if Resident #2 returned to the facility. The behavioral health hospital Clinical Director further indicated Resident #2 discharged to home from the behavioral health hospital on [DATE] with Resident #2's daughter/RR. In an interview on 05/05/2025 at 11:48AM, the behavioral health hospital nurse indicated S2Director of Nursing informed her that she contacted Resident #2's daughter/RR and informed her Resident #2 could return to the facility, but Resident #2's family would have to supply a personal sitter until Resident #2 adjusted to the nursing home setting. In an interview on 05/05/2025 at 12:04PM, S2DON indicated she spoke to Resident #2's daughter/RR days after Resident #2 transferred to the behavioral health hospital to inform Resident #2's daughter/RR that Resident #2 required a personal sitter when she returned to the facility to monitor Resident #2's behaviors until she adjusted. In an interview on 05/06/2025 at 1:23PM, S1Administrator confirmed the facility had notified Resident #2's daughter/RR Resident #2 required a personal sitter if Resident #2 returned to the facility to monitor Resident #2's behaviors. In an interview on 05/06/2025 at 2:57PM, S5Admissions Coordinator indicated on 04/16/2025 Resident #2's daughter/RR had informed her she was in the facility to pick up Resident #2's belongings and indicated she could not afford to pay for a personal sitter for Resident #2. S5Admissions Coordinator further indicated she then notified S2DON that Resident #2's daughter/RR was taking Resident #2 home because Resident #2's daughter/RR could not afford to pay for a personal sitter. S5Admissions Coordinator indicated S2DON responded that it was Resident #2's daughter/RR's, right to do so.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify a resident's representative and the State's Long-Term Care Ombudsman in writing of a resident transfer for 1 (Resident #2) of 1 (Resident #2) sampled residents reviewed for transfer and discharge requirements. Findings: Review of Resident #2's electronic medical record (EMR) revealed, in part, Resident #2 was admitted to the facility on [DATE] and was discharged from the facility on 04/08/2025. Review of Resident #2's nurse's note dated 04/08/2025 at 5:06PM revealed, in part, Resident #2 was transferred on 04/08/2025 at 2:30PM to a behavioral health hospital for treatment. Review of Resident #2's clinical record revealed no documented evidence, and the facility did not present any documented evidence, Resident #2's representative and the State's Long-Term Care Ombudsman were notified in writing of Resident # 2's transfer to a behavioral health hospital on [DATE], as required. In an interview on 05/06/2025 at 10:35AM, the facility's assigned Ombudsman indicated she had not received a written transfer notice from the facility when Resident #2 was transferred from the facility to a behavioral health hospital on [DATE]. In an interview on 05/06/2025 at 11:48AM, Resident #2's daughter/Resident Representative indicated she had not received a written transfer notice from the facility when Resident #2 was transferred from the facility to a behavioral health hospital on [DATE]. In an interview on 05/06/2025 at 2:48PM, S1Administrator indicated the facility had not issued a written notice to Resident's #2's representative or the facility's assigned Ombudsman when Resident #2 transferred to a local behavioral health hospital on [DATE], as required.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interviews, the facility failed to ensure the daily nurse staffing information was posted daily in a prominent place readily accessible as required. Findings: Observations on 04/30/2025 at 12:00PM of the facility hallways and public areas revealed the facility's daily nurse staffing information was not posted in a prominent place and readily accessible. There was no documented evidence, and the facility was unable to provide any documented evidence, the daily nurse staffing information was posted daily in a prominent place readily accessible as required. In an interview on 04/30/2025 at 12:00PM, S1Administrator indicated he had no knowledge the daily nurse staffing information was to be posted daily and available to the public for review. In an interview on 05/01/2025 at 7:55AM, S2Director of Nursing indicated the facility had not posted the daily nurse staffing information because the administrative staff was not aware of the above requirement.