STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195203	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on observation, interview, and record review, the facility failed to implement the facility's abuse policy to protect residents from potential neglect (S3LPN and S4LPN). Findings: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Funds Program, last revised in 01/2024, revealed, in part, all incidents or suspected incidents of neglect or mistreatment will be investigated immediately as directed by the Administration and/or the Director of Nursing. Further review revealed neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Further review revealed the facility's staff would immediately correct and intervene in reported or identified situations in which neglect is at risk for occurring. Further review revealed all allegations involving staff will necessitate immediate suspension without pay, pending completion of the investigation. Further reviewed revealed the administrator will take actions necessary to ensure that abuse, neglect or mistreatment does not continue. Review of the facility's Floor Nurse Job Description revealed, in part, the staff nurse assigned to each section was designated as the floor nurse and was responsible for supervision of the total nursing activities regarding their assigned section. Further review revealed the nurse's duties were to provide skilled nursing care according to the physician's orders, established standards and the facility's policies and procedures. Review also revealed the nurse's responsibility was to routinely make rounds to observe and evaluate residents' physical and emotional status. Review of Resident #1's August 2024 Physician's Orders revealed, in part, an order dated 07/19/2024 for Resident #1 to have a wander guard bracelet secondary to elopement risk, and census checks to be conducted on Resident #1 every two hours. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, S4LPN was assigned to the care of the residents in Room Assignment u from the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's time sheet report dated 08/28/2024 revealed, in part, S4LPN clocked in at 8:41 a.m., clocked out at 4:26 p.m., clocked in at 4:56 p.m., and clocked out at 9:55 p.m. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S3LPN was assigned to the care of residents in Room Assignment u for the 11:00 p.m. to 7:00 a.m. shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's 08/28/2024 time sheet reports, revealed, in part, S3LPN clocked in at 11:30 p.m. on 08/28/2024 and clocked out at 7:15 a.m. on 08/29/2024. Review of the facility's timeline from surveillance footage completed by S1Administrator on 08/29/2024 revealed, in part, Resident #1 was captured on footage exiting his room on 08/28/2024 5:16 p.m. Further review of the video footage documentation revealed Resident #1 entered his room again on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed the staff identified resident was not in his room [ROOM NUMBER]/29/2024 at 8:55 a.m. Further review revealed S4LPN went into Resident #1's room on 8/29/2024 at 5:29 p.m. Further review revealed S3LPN went into Resident #1's room on 08/29/2024 at approximately 12:03-12:04 a.m. Further review revealed S3LPN went into Resident #1's room [ROOM NUMBER] times on 08/29/2024 between 6:04 a.m. and 6:34 a.m. Further review revealed no other evidence that S3LPN and or S4LPN went into Resident #1's room at any other part of their assigned shifts. Review of the facility's surveillance footage from 08/28/2024 at 3:00 p.m. until 08/29/2024 at 8:41 a.m. revealed, in part, Resident #1 exited his room on 08/28/2024 at 5:16 p.m. and re-entered his room on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed S4LPN was seen entering Resident #1's room on 08/28/2024 at 5:31 p.m. and exiting Resident #1's room at 5:32 p.m. on 08/28/2024. Further review revealed S3LPN looked into Resident #1's room on 08/29/2024 at 12:04 a.m. and 6:15 a.m. Further review revealed S3LPN only entered Resident #1's room at 6:04 a.m., 6:14 a.m., and 6:35 a.m. on 08/29/2024. The facility was unable to provide any evidence S3LPN and/or S4LPN rounded (performed a visual inspection of Resident #1) on Resident #1 every 2 hours as per the physician's orders on 08/28/2024 and 08/29/2024. Observation on 08/30/3034 at 9:50 a.m., revealed S4LPN was working in the facility. In a telephone interview on 08/30/2024 at 11:56 a.m., S3LPN indicated she was unable to visualize Resident #1 on any of her rounds during her scheduled shift on 08/28/2024 through 08/29/2024. S3LPN further indicated had she looked into Resident #1's room, but did not see Resident #1 and assumed he was in the bathroom. S3LPN further indicated because she did not visually see Resident #1 during her shift, she had not completed the census check for Resident #1 every two hours as ordered. S3LPN further indicated when she could not locate Resident #1 during her 6:00 a.m. medication administration rounds, she checked the list of residents on facility pass, and did not locate Resident #1's name on the list. S3LPN indicated she was unaware of what to do when she was unable to locate Resident #1 throughout her shift and at 6:00 a.m. during medication administration rounds. S3LPN further indicated she did not report Resident #1's absence to the facility's Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), the oncoming nurse, and/ or Certified Nursing Assistant (CNA) she was working with. In an interview on 08/30/2024 at 2:40 p.m., S1Administrator indicated S3LPN had neglected Resident #1 by not visually checking him all night on 08/28/2024 during her 11:00 p.m. to 7:00 a.m. shift, nor notifying administration she was not able to locate him. In an interview on 08/30/2024 at 2:43 p.m., S1Administrator indicated that S3LPN worked last night on 8/29/2024 and was scheduled to work tonight on 08/30/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated due to Resident #1's wander guard/elopement status, the nurse should have completed a visual check of Resident #1 every 2 hours per the physician's orders. S1Administrator further indicated when she watched the facility's surveillance footage, she was preoccupied with seeing what time Resident #1 eloped, and had not noticed how often the staff monitored him. In an interview on 09/05/2024 at 3:18 p.m., S1Administrator indicated during the investigation, the facility's focus was on finding Resident #1. S1Administrator further indicated as soon as she would have identified the issues of the nurses not rounding on and/or locating Resident #1 during their shifts, she would have immediately suspended them, but because the focus was so much on finding Resident #1, their suspension was an oversite.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on interviews and record review, the facility failed to deliver care per professional standards by failing to ensure: 1. Licensed Practical Nurses (LPNs) (S3LPN and S4LPN) followed a physician's order for supervisory checks every 2 hours for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents and/or notified the facility's administration of a missing resident (Resident #1); and, 2. LPNs (S3LPN and/or S4LPN) did not falsify documentation of administering medications per a physician's orders and/or checking the placement of a resident's wander guard per a physician's order for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. This deficient practice resulted in an Immediate Jeopardy situation on 08/29/2024 at 8:55 a.m. for Resident #1, a resident identified by the facility as an elopement risk, when Resident #1 was unable to be located in the facility by the facility's staff. Resident #1 did not return to the facility until 08/30/2024 at 3:30 p.m. and was noted to have complaints of nausea and epigastric pain. Resident #1 was then transferred to the emergency room with police escort and was placed on a Physician's Emergency Certificate. S1Administrator was notified of the Immediate Jeopardy on 08/30/2024 at 5:26 p.m. The Immediate Jeopardy was removed on 09/04/2024 at 4:51 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimal harm to all 110 residents that were reported to reside in the facility on 08/30/2024. Findings: Review of Louisiana's R.S. 37:961, last amended in 2020, revealed, in part, the practice of practical nursing means the performance for compensation of any acts, in the care, treatment, or observation of persons who are ill, injured, or infirm and for the maintenance of the health of others and the promotion of health care, including the administration of medications. Review of the Louisiana State Board of Practical Nurse Examiners Scope of Practice revealed, in part, practical nursing is the performance, for pay, of acts in the care, treatment or observation of the ill and for the maintenance of the health of others and the promotion of health care. Review of the facility's undated Floor Nurse Job Description revealed, in part, the staff nurse assigned to each section was designated as the floor nurse and was responsible for supervision of the total nursing activities regarding their assigned section. Further review revealed the nurse's duties were to provide skilled nursing care according to the physician's orders, established standards, and the facility's policies and procedures. Review also revealed the nurse's responsibility was to routinely make rounds to observe and evaluate residents' physical and emotional status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	1. Review of Resident #1's electronic medical record (EMR) revealed, in part, Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] from a short term hospital stay with diagnoses, which included, unspecified dementia of an unspecified severity (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), major depressive disorder, and unspecified alcohol abuse. Review of Resident #1's Psychiatric Progress note dated 10/03/2023 revealed, in part, Resident #1 continued with intermittent confusion and continued to be fixated with leaving the facility. Further review revealed Resident #1 continued to appear anxious, restless, and wanted to leave the facility. Further review revealed Resident #1 had poor insight and was disoriented to time, place, and situation. Review of Resident #1's Psychiatric Progress note dated 03/20/2024 revealed, in part, Resident #1 continued with fixation about leaving the facility. Review of Resident #1's Psychiatric Progress note dated 05/22/2024 revealed, in part, Resident #1 was documented to have a bizarre affect with thought blocking, and refused medications and treatment over the previous few weeks. In addition, it was documented that Resident #1 reported he thought he should drink alcohol more to relax, had poor insight, and judgement with impaired memory. Review of Resident #1's August 2024 Physician's Orders revealed, in part, an order dated 07/19/2024 for Resident #1 to have a wander guard bracelet secondary to being an elopement risk, and census checks to be conducted on Resident #1 every two hours. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/2024 revealed, in part, Resident #1 had fluctuating disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) present. Review of Resident #1's most recent Care Plan revealed, in part, Resident #1 had impaired cognition. Further review revealed an intervention to observe Resident #1's whereabouts and document per the physician's orders initiated on 08/07/2024. Further review revealed a goal with a target date of 11/05/2024 that Resident #1 would not leave the facility unattended. Review of Resident #1's progress note dated 08/29/2024 at 8:33 a.m. revealed, in part, a Certified Nursing Assistant (CNA) alerted S24Licensed Practical Nurse (LPN) at 8:31 a.m. that Resident #1 was not in his room. Further review revealed S24LPN entered Resident #1's room and noted Resident #1's bed was empty and his bedding was neatly arranged. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, S4LPN was assigned to the care of the residents in Room Assignment u (where Resident #1 resided) from the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S3LPN was assigned to the care of residents in Room Assignment u (where Resident #1 resided) for the 11:00 p.m. to 7:00 a.m. shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility's timeline from surveillance footage completed by S1Administrator on 08/29/2024 revealed, in part, Resident #1 was captured on footage exiting his room on 08/28/2024 5:16 p.m. Further review of the video footage documentation revealed Resident #1 entered his room again on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed the staff identified resident was not in his room [ROOM NUMBER]/29/2024 at 8:55 a.m. Review of the facility's surveillance footage from 08/28/2024 at 3:00 p.m. until 08/29/2024 at 8:41 a.m. revealed, in part, Resident #1 exited his room on 08/28/2024 at 5:16 p.m. and re-entered his room on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed S4 LPN was seen entering Resident #1's room at 5:31 p.m. and exiting Resident #1's room at 5:32 p.m. on 08/28/2024. Further review revealed S3LPN looked into Resident #1's room on 08/29/2024 at 12:04 a.m. and 6:15 a.m. Further review revealed S3LPN entered Resident #1's room at 6:04 a.m., 6:14 a.m., and 6:35 a.m. on 08/29/2024. The facility was unable to provide any evidence S3LPN and/or S4LPN rounded (performed a visual inspection of Resident #1) on Resident #1 every 2 hours as per the physician's orders on 08/28/2024 and 08/29/2024. In a telephone interview on 08/30/2024 at 11:56 a.m., S3LPN indicated she was unable to visualize Resident #1 on any of her rounds during her scheduled shift from 11:00 p.m. on 08/28/2024 until 7:00 a.m. on 08/29/2024. S3LPN further indicated she had looked into Resident #1's room, but did not see Resident #1 and assumed he was in the bathroom. S3LPN further indicated because she did not visually see Resident #1 during her shift, she had not completed the census check for Resident #1 every two hours as ordered. S3LPN further indicated when she could not locate Resident #1 during her 6:00 a.m. medication administration rounds, she checked the list of residents on facility pass, and did not locate Resident #1's name on the list. S3LPN indicated she was unaware of what to do when she was unable to locate Resident #1 throughout her shift and at 6:00 a.m. during medication administration rounds. S3LPN further indicated she did not report Resident #1's absence to the facility's Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), the oncoming nurse, and / or Certified Nursing Assistant (CNA) she was working with. In an interview on 08/30/2024 at 12:18 p.m., S24LPN (the on-coming assigned shift nurse for Resident #1 on 08/29/2024) indicated S3LPN had not reported that she had not been able to visualize Resident #1 during her shift, nor that she was unable to locate Resident #1 at 6:00 a.m. for medication administration. S24LPN further indicated S3LPN should have reported Resident #1's absence. In an interview on 08/30/2024 at 12:20 p.m., S1Administrator indicated when S3LPN was unable to locate and visualize Resident #1 during rounds, S3LPN should have notified her and the DON, but failed to do so. In an interview on 08/30/2024 at 2:40 p.m., S1Administrator indicated S3LPN had neglected Resident #1 by not visually checking him throughout the night on 08/28/2024 during her 11:00 p.m. to 7:00 a.m. shift, nor notified administration when she was unable to locate Resident #1. In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated due to Resident #1's wander guard/elopement status, the nurse should have completed a visual check of Resident #1 every 2 hours as per the physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 09/05/2024 at 12:35 p.m., S2Director of Nursing (DON) indicated nurses should be rounding on residents identified as wanderers/elopement risk every 2 hours as per the physician's orders. 2. Review of Resident #1's August 2024 physician's orders revealed, in part, orders to administer Resident #1 Atorvastatin Calcium (a medication used to manage cholesterol) 10 mg tablet daily at bedtime, Quetiapine Fumarate (a medication used to treat depression) 25 mg tablet daily at bedtime, Mirtazapine Tartrate (a medication used to treat depression) 15 mg tablet daily, and to check for placement of Resident #1's wander guard bracelet every shift. Review of Resident #1's August 2024 electronic Medication Administration Record revealed, in part, S4LPN documented she administered Resident #1 one Atorvastatin Calcium 10 mg tablet at 8:00 p.m. on 08/28/2024, one Mirtazapine 15 mg tablet at 8:00 p.m. on 08/28/2024, and one Quetiapine Fumarate 25 mg tablet at 8:00 p.m. on 08/28/2024. Further review revealed, S3LPN documented she checked placement of Resident #1's wander guard bracelet on the night shift of 08/28/2024. Review of the facility's Medication Administration Audit Report from 08/27/2024 to 08/28/2024 for Resident #1 revealed, in part, S4LPN documented that she administered Resident #1 one Atorvastatin Calcium 10 mg tablet at 8:23 p.m. on 08/28/2024, one Mirtazapine 15 mg tablet at 8:23 p.m. on 08/28/2024, one Quetiapine Fumarate 25 mg tablet at 8:23 p.m. on 08/28/2024. Further review revealed S3LPN documented that she checked placement of Resident #1's wander guard bracelet on 08/29/2024 at 1:49 a.m. Review of the facility's surveillance footage from 08/28/2024 at 3:00 p.m. until 08/29/2024 at 8:41 a.m. revealed, in part, Resident #1 exited his room on 08/28/2024 at 5:16 p.m. and re-entered his room on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed S4 LPN was seen entering Resident #1's room at 5:31 p.m. and exiting Resident #1's room at 5:32 p.m. on 08/28/2024. Further review revealed no other evidence S4LPN entered Resident #1's room at any other time during her shift. In a telephone interview on 08/30/2024 at 11:56 a.m., S3LPN indicated she was did not visualize Resident #1 on any of her rounds during her scheduled shift from 11:00 p.m. on 08/28/2024 to 7:00 a.m. on 08/29/2024. The facility was unable to produce any evidence that S4LPN administered Resident #1's medications as documented above. In an interview on 09/05/2024 at 12:35 p.m., S2DON indicated S4LPN should not have documented she gave medication to Resident #1 at 8:23 p.m. on 08/28/2024 when she did not enter Resident #1's room at that time. S2DON further indicated that S3LPN should not have documented she checked the placement of Resident #1's wander guard when she had never visualized Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on observations, interviews, and record reviews, the facility failed to ensure staff provided supervision to prevent elopement for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for supervision. This deficient practice resulted in an Immediate Jeopardy situation on 08/29/2024 at 8:55 a.m. for Resident #1, a resident identified by the facility as an elopement risk, when Resident #1 was unable to be located in the facility by the facility's staff. Resident #1 did not return to the facility until 08/30/2024 at 3:30 p.m. and was noted to have complaints of nausea and epigastric pain. Resident #1 was then transferred to the emergency room with police escort and was placed on a Physician's Emergency Certificate. S1Administrator was notified of the Immediate Jeopardy on 08/30/2024 at 5:26 p.m. The Immediate Jeopardy was removed on 09/04/2024 at 4:51 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimal harm to the remaining 2 residents (#2, #3) who resided in the facility, were identified as a wandering/elopement risks, and were physically able to open and climb out of a window. Findings: Review of the facility's policy titled, Wandering and Elopements, last revised in 03/2019, revealed, in part, if a resident was missing, staff should initiate the missing resident emergency procedure. Further review revealed the staff should determine if the resident was out on an authorized leave or pass, and if the resident was not authorized to leave, staff would initiate a search of the building and premises. Further review revealed if resident was not located, staff should notify the Administrator, the Director of Nursing (DON), the resident's legal representative, the resident's attending physician, and law enforcement as necessary. Review of Resident #1's electronic medical record (EMR) revealed, in part, Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] from a short term hospital stay with diagnoses, which included, unspecified dementia of an unspecified severity (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), major depressive disorder, and unspecified alcohol abuse. Review of Resident #1's Psychiatric Progress note dated 10/03/2023 revealed, in part, Resident #1 continued with intermittent confusion and continued to be fixated with leaving the facility. Further review revealed Resident #1 continued to appear anxious, restless, and wanted to leave the facility. Further review revealed Resident #1 had poor insight and was disoriented to time, place, and situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #1's Psychiatric Progress note dated 03/20/2024 revealed, in part, Resident #1 continued with fixation about leaving the facility. Review of Resident #1's Psychiatric Progress note dated 05/22/2024 revealed, in part, Resident #1 was documented to have a bizarre affect with thought blocking, and refused medications and treatment over the previous few weeks. In addition, it was documented that Resident #1 reported he thought he should drink alcohol more to relax, had poor insight, and judgement with impaired memory. Review of Resident #1's August 2024 Physician's Orders revealed, in part, an order dated 07/19/2024 for Resident #1 to have a wander guard bracelet secondary to being an elopement risk, and census checks to be conducted on Resident #1 every two hours. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/2024 revealed, in part, Resident #1 had fluctuating disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) present. Review of Resident #1's most recent Care Plan revealed, in part, Resident #1 had impaired cognition. Further review revealed an intervention to observe Resident #1's whereabouts and document per the physician's orders initiated on 08/07/2024. Further review revealed a goal with a target date of 11/05/2024 that Resident #1 would not leave the facility unattended. Review of Resident #1's progress note dated 08/29/2024 at 8:33 a.m. revealed, in part, a Certified Nursing Assistant (CNA) alerted S24Licensed Practical Nurse (LPN) at 8:31 a.m. that Resident #1 was not in his room. Further review revealed S24LPN entered Resident #1's room and noted Resident #1's bed was empty and his bedding was neatly arranged. In an interview on 08/30/2024 at 8:28 a.m., S1Administrator indicated Resident #1 entered his room on 08/28/2024 at 5:17 p.m. and never exited his room per her review of the facility's surveillance footage. S1Administrator further indicated she believed Resident #1 exited through his bedroom window because of the missing window screen and dirty windowsill. S1Administrator further indicated by interviewing staff and review of the facility's surveillance footage, she was able to determine that resident was last seen by S6CNA at 4:41 a.m. on 08/29/2024. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S3LPN was assigned to the care of residents in Room Assignment u (where Resident #1 resided) for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 time sheet reports, revealed, in part, S3LPN clocked in at 11:30 p.m. on 08/28/2024 and clocked out at 7:15 a.m. on 08/29/2024. Review of the facility's timeline from surveillance footage completed by S1Administrator on 08/29/2024 revealed, in part, Resident #1 was captured on footage exiting his room on 08/28/2024 5:16 p.m. Further review of the video footage documentation revealed Resident #1 entered his room again on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. Further review revealed the staff identified resident was not in his room [ROOM NUMBER]/29/2024 at 8:55 a. m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility's surveillance footage from 08/28/2024 at 3:00 p.m. until 08/29/2024 at 8:41 a.m. revealed, in part, Resident #1 exited his room on 08/28/2024 at 5:16 p.m. and re-entered his room on 08/28/2024 at 5:17 p.m. Further review revealed Resident #1 did not exit his room again after 5:17 p.m. on 08/28/2024. In a telephone interview on 08/30/2024 at 11:56 a.m., S3LPN indicated she was unable to visualize Resident #1 on any of her rounds during her scheduled shift from 11:00 p.m. on 08/28/2024 until 7:00 a.m. on 08/29/2024. S3LPN further indicated she had looked into Resident #1's room, but did not see Resident #1 and assumed he was in the bathroom. S3LPN further indicated because she did not visually see Resident #1 during her shift, she had not completed the census check for Resident #1 every two hours as ordered. S3LPN further indicated when she could not locate Resident #1 during her 6:00 a.m. medication administration rounds, she checked the list of residents on facility pass, and did not locate Resident #1's name on the list. S3LPN indicated she was unaware of what to do when she was unable to locate Resident #1 throughout her shift and at 6:00 a.m. during medication administration rounds. S3LPN further indicated she did not report Resident #1's absence to the facility's Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), the oncoming nurse, and / or Certified Nursing Assistant (CNA) she was working with. In an interview on 08/30/2024 at 12:18 p.m., S24LPN (the on-coming assigned shift nurse for Resident #1 on 08/29/2024) indicated S3LPN had not reported to her that she had not been able to visualize Resident #1 during her shift, nor that she was unable to locate Resident #1 at 6:00 a.m. for medication administration. S24LPN further indicated S3LPN should have reported Resident #1's absence. In an interview on 08/30/2024 at 12:20 p.m., S1Administrator indicated when S3LPN was unable to locate and visualize Resident #1 during rounds, S3LPN should have notified her and the DON, but failed to do so. In a telephone interview on 08/30/2024 at 12:29 p.m., S6CNA (Resident #1`s CNA scheduled from 11:00 p. m. on 08/28/2024 to 7:00 a.m. on 08/29/2024) indicated Resident #1 was to have visual checks every 2 hours. S6CNA further indicated S3LPN did not notify her when she was unable to visualize Resident #1 during her rounds. S6CNA further indicated S3LPN should have notified staff when she was unable to locate Resident #1 so all staff could have been notified by an announcement overhead of a wandering resident being missing, and ensure S1Administrator was notified. In an interview on 08/30/2024 at 2:40 p.m., S1Administrator indicated S3LPN had neglected Resident #1 by not visually checking him throughout the night on 08/28/2024 during her 11:00 p.m. to 7:00 a.m. shift, nor notified administration when she was unable to locate Resident #1. In a telephone interview on 08/30/2023 at 7:14 p.m., S38LPN indicated on 08/29/2024 at 6:00 a.m., she was following S3LPN during medication administration rounds. S38LPN indicated she had not visualized Resident #1 during medication rounds. S38LPN indicated she was unaware S3LPN did not visualize Resident #1 during her shift. S38LPN further indicated, if she would have been aware Resident #1 was unable to be located she would have notified other facility staff to assist with attempts to locate Resident #1. In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated due to Resident #1's wander guard/elopement status, the nurse should have completed a visual check of Resident #1 every 2 hours as per the physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 09/05/2024 at 12:35 p.m., S2Director of Nursing (DON) indicated nurses should be rounding on residents identified as wanderers/elopement risk every 2 hours as per the physician's orders. Resident #2 Review of Resident #2's record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of, in part, dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, and syncope and collapse (condition where the resident loses consciousness briefly). Review of Resident #2's MDS with an ARD dated 06/25/2024 revealed, in part, Resident #2 was assessed with a Brief Interview for Mental Status (BIMS) score of 13 (score of 13-15 indicated Resident #2 was cognitively intact). Review of Resident #2's Elopement Risk Assessment completed on 03/23/2024 revealed, in part, Resident #2 was documented as cognitively impaired with poor decision making skills and had pertinent diagnoses. Further review revealed Resident #2 ambulated independently. Review of Resident #2's Elopement Risk Assessment summary/conclusions revealed wander guard placement. Review of Resident #2's nurse's note dated 06/25/2024 revealed, in part, Resident #2 had a wander guard on which was to be checked daily. Further review revealed Resident #2 was sometimes confused and was observed going to the exit doors. Review of Resident #2's most recent Care Plan revealed a focus of Resident #2 had exit seeking behaviors and was considered an elopement risk and had a wander guard with a focus onset date of 07/23/2021 and a target date of 09/2/2024. Further review revealed interventions included, in part, monitor Resident #2 every 2 hours and as needed; apply a wander guard to Resident #2; check Resident #2's wander guard placement every shift; photographic documentation of Resident #2 in the elopement binder; and alert staff of Resident #2's high risk for elopement. Review of Resident #2's August 2024 Physician's Orders revealed, in part, the following: check Resident #2's wander guard every day for proper operation; wander guard for safety with visual checks every 2 hours and as needed daily due to Resident #2's poor impulse control; and, visual checks every hour and as needed daily due to Resident #2 wandered in other residents rooms. Observation on 08/30/2024 at 9:36 a.m. revealed Resident #2's two windows in his room were able to be unlocked and fully opened. Observation further revealed Resident #2's window opened into the facility's outdoor courtyard. In an interview on 08/30/2024 at 9:40 a.m., S35Certified Nursing Assistant (CNA) Supervisor confirmed Resident #2 ambulated without assistance or assistive devices. In an interview on 08/30/2024 at 9:41 a.m., S9Licensed Practical Nurse (LPN) confirmed Resident #2 was able to walk independently. Observation on 08/30/2024 at 9:42 a.m. revealed Resident #2 ambulated in his room independently without staff assistance or mobility devices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 Idaho Street Kenner, LA 70062	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 08/30/2024 at 9:44 a.m., S15LPN indicated Resident #2 was independent with ambulation. S15LPN further confirmed Resident #2 had a wander guard bracelet present. In an interview on 08/30/204 at 11:32 a.m., S37CNA confirmed she was assigned to Resident #2. S37CNA failed to identify Resident #2 as an elopement risk and was unsure if Resident #2 wore a wander guard. S37CNA indicated if Resident #2 was an elopement risk, they would check on Resident #2 often and round at least every 2 hours. Resident #3 Review of Resident #3's record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses, in part, major depressive disorder; pseudobulbar affect (condition characterized by episodes of sudden uncontrollable inappropriate laughing or crying); bipolar disorder (condition characterized by unusual shifts in a person's mood); and traumatic brain injury (condition caused by injury to the brain). Review of Resident #3's MDS with an ARD dated 06/12/2024 revealed, in part, Resident #3 was assessed with a BIMS of 6 (a score of 00-07 indicated a severe cognitive impairment). Further review revealed Resident #3 required partial to moderate assistance with dressing the lower half of her body; and, Resident #3 required partial to moderate assistance with walking 10 feet in the room or corridor. Review revealed Resident #3 used a wander/elopement alarm daily. Review of Resident #3's Psychiatric Progress Note dated 02/21/2024 revealed, in part, Resident #3 was fixated on returning home. Review of Resident #3's Elopement Risk assessment dated [DATE] revealed, in part, Resident #3 was cognitively impaired due to traumatic brain injury. Further review revealed Resident #3 was an elopement risk due to unsuccessful attempts to enter codes on exit doors. Review of Resident #3's Elopement Risk Assessment further revealed interventions of wander guard personal safety alarm device applied; photo of Resident #3 on the wander list, and staff were aware of Resident #3's wander risk. Review of Resident #3's most recent Care Plan revealed a focus of Resident #3 was at risk for elopement with a target date of 09/10/2024. Further review revealed interventions of, in part, apply wander guard as ordered; notify staff Resident #3 was at risk for elopement; observe Resident #3's whereabouts and safety every shift and as needed; and obtain a physician order and written family consent for wander guard. Review of Resident #3's August 2024 and September 2024 Physician's Orders revealed, in part, Resident #3 was to have a wander guard bracelet to her left wrist with placement check every shift, Resident #3 was to have a census check every 2 hours, and wander guard check every day for proper operation. Observation on 08/30/2024 at 9:38 a.m. revealed Resident #3's bed was next to the window which was capable of being unlocked and fully opened to the outside. Further observation revealed Resident #3's windows exited to an unsecured location outside of the facility. In an interview on 08/30/2024 at 9:40 a.m., S35Certified Nursing Assistant (CNA) Supervisor confirmed Resident #3 ambulated without assistance or assistive devices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 08/30/2024 at 9:46 a.m., S15Licensed Practical Nurse (LPN) confirmed Resident #3 was independent with ambulation. S15LPN indicated she was not sure if Resident #3 wore a wander guard bracelet and would have to check the elopement risk binder. In an interview on 08/30/2024 at 11:11 a.m., Resident #3 indicated she did not want to be at the facility and if she could leave right now she would. Observation on 08/30/2024 at 11:19 a.m. revealed Resident #3 walked independently up and down the hall near her room with a steady gait. In an interview on 08/30/2024 at 12:14 p.m., S36CNA indicated Resident #3 was fully independent with ambulation. S36CNA further indicated she was unsure if Resident #3 was at risk for wandering but would have to check the elopement binder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41876 Based on record reviews and interviews, the facility failed to: 1. Ensure the facility had a sufficient number of licensed nurses to provide direct care to residents (08/08/2024, 08/13/2024, 08/14/2024, and 08/21/2024); and, 2. Ensure a nurse assigned to a group of residents did not leave the facility before the scheduled oncoming nurse arrived at the facility to assume the responsibility of the group of residents (08/21/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/25/2024, 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, and 08/30/2024). This deficient practice was identified for 13 (08/08/2024, 08/13/2024, 08/14/2024, 08/21/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/25/2024, 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, and 08/30/2024) of 30 (08/01/2024, 08/02/2024, 08/03/2024, 08/04/2024, 08/05/2024, 08/06/2024, 08/07/2024, 08/08/2024, 08/09/2024, 08/10/2024, 08/11/2024, 08/12/2024, 08/13/2024, 08/14/2024, 08/15/2024, 08/16/2024, 08/17/2024, 08/18/2024, 08/19/2024, 08/20/2024, 08/21/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/25/2024, 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, and 08/30/2024) days reviewed for sufficient staffing. Findings: Review of the facility's Facility Assessment Tool completed on 07/24/2023 revealed, in part, the facility's average daily census was 90-120. Review of the facility's Major RUG-IV Categories (a Centers for Medicare and Medicaid classification system used to determine payment based on the average resources needed to care for someone with similar needs) revealed a number/average of 10 residents for Rehabilitation services, a number/average of 2 residents for Extensive Services, a number/average of 2 residents for Special Care High services, a number/average of 3 residents for Special Care Low services, a number/average of 17 residents for Clinically Complex services, a number/average of 5 residents for Behavioral Symptoms and Cognitive Performance services, and a number/average of 23 residents for Reduced Physical Function services. Further review revealed the facility's staffing plan was to have 2 to 4 licensed nurses providing direct care during the day shift (7:00 a.m. to 3:00 p.m.), 2 to 4 licensed nurses providing direct care during the evening shift (3:00 p.m. to 11:00 p.m.) and 2 to 3 licensed nurses providing direct care during the night shift (11:00 p.m. to 7:00 a.m.). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's Census and Conditions of Residents dated 09/05/2024 revealed, in part, the facility had a total of 98 residents. Further review revealed 2 residents had an indwelling or external catheter, 90 residents were occasionally or frequently incontinent of bladder, and 77 residents were occasionally or frequently incontinent of bowel. Review revealed 71 residents were in a chair all or most of the time and 5 residents ambulated with assistance or assistive devices. Review revealed 31 residents had a psychiatric diagnosis, 19 residents had dementia, and 11 residents had behavioral healthcare needs. Further review revealed 2 residents had pressure ulcers, 5 residents received hospice care, 4 residents received dialysis treatments, 1 resident required the administration of intravenous (into the vein) medication, 10 residents required respiratory treatments, and 2 residents required ostomy (a surgical opening in the abdomen that changed the way waste exited the body) care. Further review revealed 21 residents required medication injections, 3 residents required tube feedings, and 33 residents required rehabilitative services. Review of the facility's 2024 Floor Nurse Job Description revealed, in part, the staff nurse assigned to each section was designated as the floor nurse and was responsible for supervision of the total nursing activities regarding their assigned section. Further review revealed it was unacceptable to clock out of the facility and leave their assigned residents without changeover of care. Review also revealed a proper shift report must be given to the nurse that would hold responsibility for the assigned residents until the next oncoming nurse arrived. 1. Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form revealed, in part, on 08/08/2024 the facility's census was documented as 108 residents. Review of the facility's 08/08/2024 time sheet reports revealed, in part, from 7:00 a.m. until 7:05 a.m., S3Licensed Practical Nurse (LPN) was the only documented nurse assigned to direct resident care present in the facility. Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form revealed, in part, on 08/13/2024 the facility's census was documented as 112 residents. Review of the facility's 08/13/2024 time sheet reports revealed, in part, from 7:00 a.m. until 7:07 a.m., S3LPN was the only documented nurse assigned to direct resident care present in the facility. Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form revealed, in part, on 08/14/2024 the facility's census was documented as 113 residents. Review of the facility's 08/14/2024 time sheet reports revealed, in part, from 7:03 a.m. until 7:10 a.m., S3LPN was the only documented nurse assigned to direct resident care present in the facility. Further review revealed from 7:10 a.m. until 7:18 a.m., there was no documented nurse assigned to direct resident care present in the facility. Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form revealed, in part, on 08/21/2024 the facility's census was 109 residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/21/2024 time sheet reports revealed, in part, from 11:31 p.m. until 12:00 a.m. on 08/22/2024, S14LPN was the only documented nurse assigned to direct resident care present in the facility. There was no documented evidence, and the facility did not present any documented evidence that sufficient direct care nursing staff was provided to residents during the above mentioned time periods. In a telephone interview on 09/01/2024 at 3:11 p.m., S14LPN indicated it was not safe for her to have 50 to 60 or more residents assigned to her. In an interview on 09/04/2024 at 11:52 a.m., S20Assistant Director of Nursing (ADON) indicated that when she arrived to the facility on the morning shifts, she did not accept the responsibility of residents' direct care. S20ADON further indicated that more than 1 direct care nurse was needed for 109 to 110 residents. S20ADON confirmed she assigned 3 direct care nurses for a night shift with 109 to 110 residents. In an interview on 09/04/2024 at 12:04 p.m., S29Agency LPN indicated that the facility had a problem with nurses arriving to their assigned shift late or leaving their assigned shift early. 2. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to the residents in Room Assignment w for the 7:00 a.m. to 3:00 p.m. shift and S10LPN was the nurse assigned to the residents in Room Assignment w for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S9LPN clocked out of the facility at 3:17 p.m. and S10LPN did not clock in at the facility until 3:30 p.m., leaving the residents in Room Assignment w without an assigned nurse for 13 minutes. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S11LPN and S12LPN were the nurses assigned to the residents in Room Assignment z for the 3:00 p.m. to 11:00 p.m. shift and S13LPN was the nurse assigned to the residents in Room Assignment z for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S11LPN clocked out of the facility at 10:47 p.m. and S12LPN clocked out of the facility at 11:03 p.m. Further review revealed S13LPN did not clock into the facility until 12:00 a.m. on 08/22/2024, leaving the residents in Room Assignment z without an assigned nurse for 57 minutes. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S10LPN was the nurse assigned to the residents in Room Assignment s for the 3:00 p.m. to 11:00 p.m. shift and S13LPN was the nurse assigned to the residents in Room Assignment s for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S10LPN clocked out of the facility at 11:30 p.m., and S13LPN did not clock into the facility until 12:00 a.m. on 08/22/2024, leaving the residents in Room Assignment s without an assigned nurse for 30 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S10LPN was the nurse assigned to the residents in Room Assignment t on the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment t on the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S10LPN clocked out of the facility at 11:30 p.m. Further review revealed no documented evidence S3LPN worked at the facility on 08/21/2024 from 11:00 p.m. to 7:00 a.m. on 08/22/2024. There was no documented evidence, and the facility was unable to present any documented evidence a nurse was assigned to the residents in Room Assignment t on 08/21/2024 from 11:30 p.m. until 7:00 a.m. on 08/22/2024. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S4LPN was the nurse assigned to the residents in Room Assignment u for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment u for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S4LPN clocked out of the facility at 9:13 p.m. Further review revealed no documented evidence S3LPN worked at the facility on 08/21/2024 from 11:00 p.m. to 7:00 a.m. on 08/22/2024. There was no documented evidence, and the facility was unable to present any documented evidence a nurse was assigned to the residents in Room Assignment u on 08/21/2024 from 11:30 p.m. until 7:00 a.m. on 08/22/2024. In an interview on 09/04/2024 at 12:00 p.m., S20ADON confirmed there was no documented evidence S3LPN worked on 08/21/2024 as scheduled. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S13LPN was the nurse assigned to residents in Room Assignment i for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to the residents in Room Assignment i on the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S13LPN clocked out of the facility at 5:50 a.m. on 08/22/2024. Review of the facility's 08/22/2024 time sheet reports revealed, in part, S9LPN did not clock into the facility until 7:16 a.m., leaving residents in Room Assignment i without an assigned nurse for 1 hour and 26 minutes. Review of the facility's 08/21/2024 Daily Nursing Assignment revealed, in part, S13LPN was the nurse assigned to residents in Room Assignment ee for the 11:00 p.m. until 7:00 a.m. shift. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S15LPN was the nurse assigned to the residents in Room Assignment ee on the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/21/2024 time sheet reports revealed, in part, S13LPN clocked out of the facility at 5:50 a.m. on 08/22/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/22/2024 time sheet reports revealed, in part, S15LPN did not clock into the facility until 7:03 a.m., leaving the residents in Room Assignment ee without an assigned nurse for 1 hour and 13 minutes. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to residents in Room Assignment o for the 7:00 a.m. to 3:00 p.m. shift and S10LPN was the nurse assigned to residents in Room Assignment o for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/22/2024 time sheet reports revealed, in part, S9LPN clocked out of the facility at 3:04 p.m. and S10LPN did not clock into the facility until 3:09 p.m., leaving the residents in Room Assignment o without a nurse for 5 minutes. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S10LPN was the nurse assigned to the residents in Room Assignment l on the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the assigned nurse to the residents in Room Assignment l on the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/22/2024 time sheet reports revealed, in part, S10LPN clocked out of the facility at 10:58 p.m. and S3LPN did not clock into the facility until 12:00 a.m. on 08/23/2024, leaving the residents in Room Assignment l without an assigned nurse for 1 hour and 2 minutes. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S4LPN was the nurse assigned to the residents in Room Assignment m on the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the assigned nurse to the residents in Room Assignment m on the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/22/2024 time sheet reports revealed, in part, S4LPN clocked out of the facility at 9:21 p.m. and S3LPN did not clock into the facility until 12:00 a.m. on 08/23/2024, leaving the residents in Room Assignment m without an assigned nurse for 2 hours and 39 minutes. Review of the facility's 08/22/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment ff for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S11LPN was the nurse assigned to the residents in Room Assignment ff for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/22/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 7:12 a.m. on 08/23/2024. Review of the facility's 08/23/2024 time sheet reports revealed, in part, S11LPN did not clock into the facility until 7:49 a.m., leaving the residents in Room Assignment ff without an assigned nurse for 37 minutes. Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S11LPN was the nurse assigned to the residents in Room Assignment g for the 7:00 a.m. to 3:00 p.m. shift, and S16LPN was the nurse assigned to the residents in Room Assignment g for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/23/2024 time sheet reports revealed, in part, S11LPN clocked out of the facility at 3:03 p.m. and S16LPN did not clock into the facility until 3:42 p.m., leaving the residents in Room Assignment g without an assigned nurse for 39 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S10LPN was the nurse assigned to the residents in Room Assignment l for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment l for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/23/2024 time sheet reports revealed, in part, S10LPN clocked out of the facility at 11:00 p.m. and S3LPN did not clock into the facility until 12:15 a.m. on 08/24/2024, leaving the residents in Room Assignment l without an assigned nurse for 1 hour and 15 minutes. Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S4LPN was the nurse assigned to the residents in Room Assignment m for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment m for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/23/2024 time sheets revealed, in part, S4LPN clocked out of the facility at 9:11 p.m. and S3LPN did not clock into the facility until 12:15 a.m. on 08/24/2024, leaving the residents in Room Assignment m without an assigned nurse for 3 hour and 4 minutes. Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment f for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/24/2024 Daily Nursing Assignment revealed, in part, S11LPN was the nurse assigned to the residents in Room Assignment f for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/23/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:55 a.m. on 08/24/2024. Review of the facility's 08/24/2024 time sheet reports revealed, in part, S11LPN clocked into the facility at 7:05 a.m., leaving the residents in Room Assignment f without an assigned nurse for 10 minutes. Review of the facility's 08/23/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment g for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/24/2024 Daily Nursing Assignment revealed, in part, S17LPN was the nurse assigned to the residents in Room Assignment g for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/23/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:55 a.m. on 08/24/2024. Review of the facility's 08/24/2024 time sheet reports revealed, in part, S17LPN clocked into the facility at 7:15 a.m., leaving the residents in Room Assignment g without an assigned nurse for 20 minutes. Review of the facility's 08/24/2024 Daily Nursing Assignment revealed, in part, S11LPN was the nurse assigned to the residents in Room Assignment n for the 7:00 a.m. to 3:00 p.m. shift and S22LPN was the nurse assigned to the residents in rooms Room Assignment n for the 3:00 p.m. to 11:00 p.m. shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/24/2024 time sheet reports revealed, in part, S11LPN clocked out of the facility at 2:56 p.m. and S22LPN did not clock into the facility until 3:43 p.m., leaving the residents in Room Assignment n without an assigned nurse for 47 minutes. Review of the facility's 08/25/2024 Daily Nursing Assignment revealed, in part, S17LPN was the nurse assigned to the residents in Room Assignment g for the 3:00 p.m. to 11:00 p.m. shift and S14LPN was the nurse assigned to the residents in Room Assignment g for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/25/2024 time sheet reports revealed, in part, S17LPN clocked out of the facility at 10:09 p.m. and S14LPN did not clock into the facility until 10:45 p.m., leaving the residents in Room Assignment g without an assigned nurse for 36 minutes. Review of the facility's 08/25/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment f for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S15LPN was nurse assigned to the residents in Room Assignment f for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/25/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:45 a.m. on 08/26/2024. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S15LPN did not clock into the facility until 7:11 a.m., leaving the residents in rooms Assignment f without an assigned nurse for 26 minutes. Review of the facility's 08/25/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment g for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment g for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/25/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:45 a.m. on 08/26/2024. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S25LPN did not clock into the facility until 8:30 a.m., leaving the residents in Room Assignment g without an assigned nurse for 1 hour and 45 minutes. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S4LPN was the nurse assigned to the residents in Room Assignment g for the 3:00 p.m. to 11:00 p.m. and S14LPN was the nurse assigned to the residents in Room Assignment g for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S4LPN clocked out of the facility at 9:09 p.m. and S14LPN did not clock into the facility until 10:46 p.m., leaving the residents in Room Assignment g without an assigned nurse for 1 hour and 37 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S26Minimum Data Set Licensed Practical Nurse (MDSLPN) was the nurse assigned to the residents in Room Assignment l for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment l for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S26MDSLPN clocked out of the facility at 11:15 p.m. and S3LPN did not clock into the facility until 12:00 a.m. on 08/27/2024, leaving the residents in Room Assignment l without an assigned nurse for 45 minutes. Review of the facility's Daily Nursing Assignment revealed, in part, S15LPN was the nurse assigned to the residents in Room Assignment m for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment m for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S15LPN clocked out of the facility at 11:23 p.m. and S3LPN did not clock into the facility until 12:00 a.m. on 08/27/2024, leaving the residents in Room Assignment m without an assigned nurse for 37 minutes. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment f for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S15LPN was the nurse assigned to the residents in Room Assignment f for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:48 a.m. on 08/27/2024. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S15LPN did not clock into the facility until 7:03 a.m., leaving the residents in Room Assignment f without an assigned nurse for 15 minutes. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment g for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment g for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 6:48 a.m. on 08/27/2024. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S25LPN did not clock into the facility until 8:19 a.m., leaving the residents in Room Assignment g without an assigned nurse for 1 hour and 31 minutes. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S3LPN was the nurse assigned to the residents in Room Assignment l for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility 08/27/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to the residents in Room Assignment l for the 7:00 a.m. to 3:00 p.m. shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/26/2024 time sheet reports revealed, in part, S3LPN clocked out of the facility at 7:11 a.m. on 08/27/2024. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S9LPN did not clock into the facility until 7:15 a.m., leaving the residents in Room Assignment l without an assigned nurse for 4 minutes. Review of the facility's 08/26/2024 Daily Nursing Assignment revealed, in part, S3LPN was the nurse assigned to the residents in Room Assignment m for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S24LPN was the nurse assigned to the residents in Room Assignment m for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/26/2024 time sheet reports revealed, in part, S3LPN clocked out of the facility at 7:11 a.m. on 08/27/2024. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S24LPN did not clock into the facility until 7:18 a.m., leaving the residents in Room Assignment m without an assigned nurse for 7 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment g for the 7:00 a.m. to 3:00 p.m. shift and S16LPN was the nurse assigned to the residents in Room Assignment g for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S25LPN clocked out of the facility at 3:18 p.m. and S16LPN did not clock into the facility until 3:52 p.m., leaving the residents in Room Assignment g without an assigned nurse for 34 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to the residents in Room Assignment o for the 7:00 a.m. to 3:00 p.m. shift and S27LPN was the nurse assigned to the residents in Room Assignment o for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S9LPN clocked out of the facility at 3:47 p.m. and S27LPN did not clock into the facility until 5:01 p.m., leaving the residents in Room Assignment o without an assigned nurse for 1 hour and 14 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S4LPN was the nurse assigned to the residents in Room Assignment m for the 3:00 p.m. to 11:00 p.m. shift and S3LPN was the nurse assigned to the residents in Room Assignment m for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S4LPN clocked out of the facility at 8:07 p.m. and S3LPN did not clock into the facility until 11:30 p.m., leaving the residents in Room Assignment m without an assigned nurse for 3 hours and 23 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment p for the 11:00 p.m. to 7:00 a.m. shift. (continued on next page)

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

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 Idaho Street, Kenner, LA 70062	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S15LPN was the nurse assigned to the residents in Room Assignment p for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 7:06 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S15LPN did not clock into the facility until 7:09 a.m., leaving the residents in Room Assignment p without an assigned nurse for 3 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment q for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment q for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 7:06 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S25LPN did not clock into the facility until 8:25 a.m., leaving the residents in Room Assignment q without an assigned nurse for 1 hour and 19 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment p for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S15LPN was the nurse assigned to the residents in Room Assignment p for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 7:06 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S15LPN did not clock into the facility until 7:09 a.m., leaving the residents in Room Assignment p without an assigned nurse for 3 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S14LPN was the nurse assigned to the residents in Room Assignment q for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment q for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S14LPN clocked out of the facility at 7:06 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S25LPN did not clock into the facility until 8:25 a.m., leaving the residents in Room Assignment q without an assigned nurse for 1 hour and 19 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 Idaho Street Kenner, LA 70062	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S3LPN was the nurse assigned to the residents in Room Assignment t for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S9LPN was the nurse assigned to the residents in Room Assignment t for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S3LPN clocked out of the facility at 7:15 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S9LPN did not clock into the facility until 7:20 a.m., leaving the residents in Room Assignment t without an assigned nurse for 5 minutes. Review of the facility's 08/27/2024 Daily Nursing Assignment revealed, in part, S3LPN was the nurse assigned to the residents in Room Assignment u for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S24LPN was the nurse assigned to the residents in Room Assignment u for the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's 08/27/2024 time sheet reports revealed, in part, S3LPN clocked out of the facility at 7:15 a.m. on 08/28/2024. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S24LPN did not clock into the facility until 7:21 a.m., leaving the residents in Room Assignment u without an assigned nurse for 6 minutes. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S25LPN was the nurse assigned to the residents in Room Assignment q for the 7:00 a.m. to 3:00 p.m. shift and S16LPN was the nurse assigned to the residents in Room Assignment q for the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S25LPN clocked out of the facility at 3:06 p.m. and S16LPN did not clock into the facility until 3:39 p.m., leaving the residents in Room Assignment q without an assigned nurse for 33 minutes. Review of the facility's 08/28/2024 Daily Nursing Assignment revealed, in part, S29Agency LPN was the nurse assigned to the residents in Room Assignment s for the 3:00 p.m. to 11:00 p.m. shift and S22LPN was the nurse assigned to the residents in Room Assignment s for the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's 08/28/2024 time sheet reports revealed, in part, S29Agency LPN clocked out of the facility at 11:15 p.m. and S22LP[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Post nurse staffing information every day. 41876 Based on observations and interviews, the facility failed to ensure the daily nurse staffing information was posted daily as required. Findings: Observation on 09/01/2024 at 10:14 a.m. revealed the facility's daily nurse staffing information was dated 08/30/2024. Observation on 09/04/2024 at 9:05 a.m. revealed the facility's daily nurse staffing information was dated 09/03/2024. Observation on 09/05/2024 at 8:40 a.m. revealed the facility's daily nurse staffing information was dated 09/04/2024. In an interview on 09/05/2024 at 10:45 a.m., S8Ward Clerk confirmed she was responsible for updating the nurse staffing information daily on weekdays. In an interview on 09/05/2024 at 11:10 a.m., S2Director of Nursing indicated S9Certified Nursing Assistant was responsible for posting the nurse staffing information on the weekend. S2Director of Nursing confirmed the daily nurse staffing information should be posted as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41876 Based on record reviews and interviews, the facility failed to: 1. Maintain a system to periodically reconcile controlled drugs for 4 (Medication Cart a, Medication Cart b, Medication Cart c, and Medication Cart d) of 4 (Medication Cart a, Medication Cart b, Medication Cart c, and Medication Cart d) medication carts reviewed for the reconciliation documentation of controlled substances; and 2. Administer a resident's medication per a physician's order for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: 1. Review of the facility's undated Storage of Medications Policy and Procedure revealed, in part, controlled medications must be counted at the end of each shift. Further review revealed the nurse coming on duty and the nurse going off duty determine the count together. Review of the facility's 2024 Floor Nurse Job Description/Responsibility revealed, in part, a narcotic (controlled substance) count must be performed at ongoing and off going of the shift, and the nurse must sign in the appropriate spot on the Controlled Drugs-Count Record. Review of the facility's August 2024 Medication Cart a Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs: -08/09/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/09/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/12/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/30/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/31/2024 on the 7:00 a.m. to 3:00 p.m. shift; and -08/31/2024 on the 11:00 p.m. to 7:00 a.m. shift. Review of the facility's August 2024 Medication Cart b Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs: -08/09/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/09/2024 on the 11:00 p.m. to 7:00 a.m. shift; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-08/14/2024 on the 7:00 a.m. to 3:00 p.m. shift; -08/14/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/15/2024 on the 7:00 a.m. to 3:00 p.m. shift; -08/15/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/16/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/17/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/18/2024 on the 7:00 a.m. to 3:00 p.m. shift; -08/30/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/31/2024 on the 7:00 a.m. to 3:00 p.m. shift; and, -08/31/2024 on the 3:00 p.m. to 11:00 p.m. shift. Review of the facility's August 2024 Medication Cart c Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs: -08/01/2024 on the 7:00 a.m. to 3:00 p.m. shift; -08/10/2024 on the 7:00 a.m. to 3:00 p.m. shift; -08/14/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/16/2024 on the 11:00 p .m. to 7:00 a.m. shift; and, -08/17/2024 on the 7:00 a.m. to 3:00 p.m. shift. Review of the facility's August 2024 Medication Cart d Controlled Drugs-Count Record revealed, in part, the following shifts had an incomplete reconciliation of controlled drugs: -08/05/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/05/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/12/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/12/2024 on the 11:00 p.m. to 7:00 a.m. shift; -08/19/2024 on the 3:00 p.m. to 11:00 p.m. shift; -08/19/2024 on the 11:00 p.m. to 7:00 a.m. shift; and, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-08/26/2024 on the 11:00 p.m. to 7:00 a.m. shift. In an interview on 09/04/2024 at 1:51 p.m., S9Licensed Practical Nurse (LPN) indicated nurses were required to reconcile controlled substances with the off-going nurse at the beginning of their shift and reconcile control substances with the on-coming nurse at the end of their shift. S9LPN confirmed she has had occurrences where the assigned nurse she was relieving left the facility without reconciling controlled substances with her as required. In an interview on 09/05/2024 at 9:55 a.m., S2Director of Nursing (DON) indicated whenever there was a change in nurses from shift to shift, the off-going nurse was supposed to verify the controlled substance count with the oncoming nurse. S2DON indicated the narcotic count sheet should be filled out in its entirety to ensure the reconciliation of controlled drugs was completed as required. 2. Review of the facility's undated Floor Nurse Job Description revealed, in part, the nurse's duties were to provide skilled nursing care according to the physician's orders, established standards, and the facility's policies and procedures. Review of Resident #1's August 2024 physician's orders revealed, in part, orders to administer Resident #1 Atorvastatin Calcium (a medication used to manage cholesterol) 10 mg tablet daily at bedtime, Quetiapine Fumarate (a medication used to treat depression) 25 mg tablet daily at bedtime, Mirtazapine Tartrate (a medication used to treat depression) 15 mg tablet daily. Review of Resident #1's August 2024 electronic Medication Administration Record revealed, in part, S4LPN documented she administered Resident #1 one Atorvastatin Calcium 10 mg tablet at 8:00 p.m. on 08/28/2024, one Mirtazapine 15 mg tablet at 8:00 p.m. on 08/28/2024, and one Quetiapine Fumarate 25 mg tablet at 8:00 p.m. on 08/28/2024. Review of the facility's Medication Administration Audit Report from 08/27/2024 to 08/28/2024 for Resident #1 revealed, in part, S4LPN documented that she administered Resident #1 one Atorvastatin Calcium 10 mg tablet at 8:23 p.m. on 08/28/2024, one Mirtazapine 15 mg tablet at 8:23 p.m. on 08/28/2024, one Quetiapine Fumarate 25 mg tablet at 8:23 p.m. on 08/28/2024. Review of the facility's surveillance footage from 08/28/2024 at 3:00 p.m. until 08/29/2024 at 8:41 a.m. revealed, in part, Resident #1 exited his room on 08/28/2024 at 5:16 p.m. and re-entered his room on 08/28/2024 at 5:17 p.m. Further review revealed S4LPN was seen entering Resident #1's room at 5:31 p.m. and exiting Resident #1's room at 5:32 p.m. on 08/28/2024. Further review revealed no other evidence S4LPN entered Resident #1's room at any other time during her shift. The facility was unable to produce any evidence that S4LPN administered Resident #1's medications as documented above. In an interview on 09/05/2024 at 12:35 p.m., S2DON indicated S4LPN should not have documented she gave medication to Resident #1 at 8:23 p.m. on 08/28/2024 when she did not enter Resident #1's room at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 47487 Based on observations, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to have an adequate system in place to ensure: 1. Licensed Practical Nurses (LPNs) (S3LPN and S4LPN) followed a physician's order for supervisory checks every 2 hours for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents and/or notified the facility's administration of a missing resident (Resident #1); 2. LPNs (S3LPN and/or S4LPN) did not falsify documentation of administering medications per a physician's orders and/or checking the placement of a resident's wander guard per a physician's order for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents; and, 3. Staff provided supervision to prevent elopement for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for supervision; 4. The facility had a sufficient number of licensed nurses to provide direct care to residents (08/08/2024, 08/13/2024, 08/14/2024, and 08/21/2024): and, 5. A nurse assigned to a group of residents did not leave the facility before the scheduled oncoming nurse arrived at the facility to assume the responsibility of a group of residents (08/21/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/25/2024, 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, and 08/30/2024). This lack of administrative oversight resulted in an Immediate Jeopardy situation on 08/29/2024 at 8:55 a.m. for Resident #1, a resident identified by the facility as an elopement risk, when Resident #1 was unable to be located in the facility by the facility's staff. Resident #1 did not return to the facility until 08/30/2024 at 3:30 p. m. and was noted to have complaints of nausea and epigastric pain. Resident #1 was then transferred to the emergency room with police escort and was placed on a Physician's Emergency Certificate. S1Administrator was notified of the Immediate Jeopardy on 08/30/2024 at 5:26 p.m. The Immediate Jeopardy was removed on 09/04/2024 at 4:51 p.m., after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. This deficient practice had the likelihood to cause more than minimal harm to all 110 residents that were reported to reside in the facility on 08/30/2024. 1. Cross Reference F658 (continued on next page)

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 08/30/2024 at 12:20 p.m., S1Administrator indicated when S3LPN was unable to locate and visualize Resident #1 during rounds, S3LPN should have notified her and the DON, but failed to do so. In an interview on 08/30/2024 at 2:40 p.m., S1Administrator indicated S3LPN had neglected Resident #1 by not visually checking him throughout the night on 08/28/2024 during her 11:00 p.m. to 7:00 a.m. shift, nor notified administration when she was unable to locate Resident #1. In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated due to Resident #1's wander guard/elopement status, the nurse should have completed a visual check of Resident #1 every 2 hours as per the physician's orders. In an interview on 09/05/2024 at 12:35 p.m., S2Director of Nursing (DON) indicated nurses should be rounding on residents identified as wanderers/elopement risk every 2 hours as per the physician's orders. 2. Cross Reference F658 In an interview on 09/05/2024 at 12:35 p.m., S2DON indicated S4LPN should not have documented she gave medication to Resident #1 at 8:23 p.m. on 08/28/2024 when she did not enter Resident #1's room at that time. S2DON further indicated that S3LPN should not have documented she checked the placement of Resident #1's wander guard when she had never visualized Resident #1. 3. Cross Reference F689 In an interview on 09/04/2024 at 10:45 a.m., S1Administrator indicated due to Resident #1's wander guard/elopement status, the nurse should have completed a visual check of Resident #1 every 2 hours as per the physician's orders. In an interview on 09/05/2024 at 12:35 p.m., S2Director of Nursing (DON) indicated nurses should be rounding on residents identified as wanderers/elopement risk every 2 hours as per the physician's orders. 4. Cross Reference F725 In an interview on 09/04/2024 at 11:52 a.m., S20Assistant Director of Nursing (ADON) indicated that when she arrived to the facility on the morning shifts, she did not accept the responsibility of residents' direct care. S20ADON further indicated that more than 1 direct care nurse was needed for 109 to 110 residents. S20ADON confirmed she assigned 3 direct care nurses for a night shift with 109 to 110 residents. 5. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 Idaho Street Kenner, LA 70062	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Cross Reference F725 In an interview on 09/05/2024 at 9:55 a.m. S2Director of Nursing (DON) indicated if a nurse had to leave during their assigned shift or if the oncoming nurse was running late to their assigned shift, the nurse should notify administrative staff so a nurse could be assigned to the group of affected residents. S2DON further indicated residents should not be without an assigned nurse at any time. S2DON indicated on 08/21/2024 she had identified that nurses were leaving their assigned shift prior to the oncoming nurse arriving at the facility, leaving residents without an assigned nurse. S2DON confirmed administrative staff was not made aware of the above mentioned time periods where residents were left without an assigned nurse to care for them. S2DON indicated she was unaware of how frequently nurses were leaving residents without an assigned nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195203	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 30587 Based on record reviews and interview, the facility failed to ensure a certified nurse aide's (CNA) criminal background check was completed for 1 (S6CNA) of 5 (S6CNA, S30CNA, S31CNA, S32CNA, and S33CNA) sampled CNAs' personnel files reviewed. Findings: Review of Louisiana Revised Statue 40:1203.2 revealed prior to any employer making an offer to employ or to contract with a non-licensed person or any licensed ambulance personnel to provide nursing care, health-related services, medic services, or supportive assistance to any individual, the employer shall request that a criminal history and security check be conducted on the non-licensed person. Review of S6CNA's personnel file revealed S6CNA had a date of hire of 12/30/2021. Further review revealed no documented evidence, and the facility presented no documented evidence, S6CNA had a criminal background check completed prior to hire or thereafter. Review of the facility's time sheets and room assignments revealed S6CNA provided care to the following rooms on the following dates and times: -11:53 p.m. on 08/22/2024 through 7:00 a.m. on 08/23/2024 for Room Assignment aa; -11:37 p.m. on 08/23/2024 through 7:02 a.m. on 08/24/2024 for Room Assignment bb; -11:46 p.m. on 08/24/2024 through 7:00 a.m. on 08/25/2024 for Room Assignment bb; -11:49 p.m. on 08/25/2024 through 6:59 a.m. on 08/26/2024 for Room Assignment bb; -on 08/28/2024 S6CNA had a clock-out time of 7:00 a.m. with no documented clock-in time record with Room Assignment cc; -11:41 p.m. on 08/28/2024 through 7:11 a.m. on 08/29/2024 for Room Assignment dd; and, -11:01 p.m. on 08/29/2024 through 7:02 a.m. on 08/30/2024 for Room Assignment dd. In an interview on 09/04/2024 at 12:24 p.m., S34Human Resources Director indicated the facility did not have any documented evidence S6CNA had a criminal background check completed as required. In an interview on 09/05/2024 at 3:42 p.m., S1Administrator indicated the facility had no further information to present, and did not have a criminal background check completed as required for S6CNA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 30587 Based on record review and interview, the facility failed to ensure the Facility Assessment Tool: 1. Was reviewed and updated as necessary annually; 2. Addressed contracts; 3. Had involvement from the certified nursing assistants (CNAs); and 4. Used input from residents and residents' representatives. Findings: 1. Review of the Facility Assessment Tool revealed the facility assessment date or update date was documented as 07/24/2023. In an interview on 09/03/2024 at 2:38 p.m., S1Administrator indicated the facility had not reviewed or updated the Facility Assessment since 07/24/2023. 2. Review of the Facility Assessment Tool dated 07/24/2023 revealed no documented evidence, and the facility presented no documented evidence, of facility contracts required for resident care. In an interview on 09/03/2024 at 2:38 p.m., S1Administrator indicated the facility had not included information about contract services as part of the facility assessment. 3. Review of the Facility Assessment Tool dated 07/24/2023 revealed no documented evidence, and the facility presented no documented evidence, the facility had involvement from the certified nursing assistants for the development of the facility assessment. In an interview on 09/03/2024 at 2:38 p.m., S1Administrator indicated the facility had not involved the certified nursing assistants in the development of the Facility Assessment. 4. Review of the Facility Assessment Tool dated 07/24/2023 revealed no documented evidence, and the facility presented no documented evidence, the facility had used input from residents and residents' representatives for the development of the facility assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	In an interview on 09/03/2024 at 2:38 p.m., S1Administrator indicated the facility had not included input from the residents and/or residents' representatives for the development of the facility assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 30587 Based on record reviews and interviews the facility failed to ensure its Quality Assessment and Assurance Committee met at least quarterly to evaluate the activities under the Quality Assurance and Performance Improvement (QAPI) program. Findings: Review of the facility's Quality Assurance Committee sign in sheets revealed the only Quality Assurance Committee meetings documented were on 11/14/2023 and 06/28/2024. Further review revealed no documented evidence, and the facility presented no documented evidence, a Quality Assurance Committee meeting was held between 11/14/2023 and 06/28/2024 to meet the requirement of quarterly meetings. In an interview on 09/05/2024 at 10:25 a.m., S1Administrator indicated the facility had no documented evidence a Quality Assurance Committee meeting had been held between 11/14/2023 and 06/28/2024. In an interview on 09/05/2024 at 3:42 p.m., S1Administrator indicated she had no additional documentation to present regarding the above mentioned deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Waldon Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Idaho Street Kenner, LA 70062	

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 30587 Based on record reviews and interview the facility failed to ensure certified nursing assistants (CNAs) were provided Quality Assurance and Performance Improvement (QAPI) training for 4 (S6CNA, S31CNA, S32CNA, and S33CNA) of 5 (S6CNA, S30CNA, S31CNA, S32CNA, and S33CNA) sampled CNAs reviewed for training requirements as required. Findings: Review of S6CNA's Personnel File revealed S6CNA had a date of hire of 12/30/2021. Further review of S6CNA's Personnel File revealed no documented evidence, and the facility presented no documented evidence, S6CNA had received QAPI training as required. Review of S31CNA's Personnel File revealed S31CNA had a date of hire of 04/11/2024. Further review of S31CNA's Personnel File revealed no documented evidence, and the facility presented no documented evidence, S31CNA had received QAPI training as required. Review of S32CNA's Personnel File revealed S32CNA had a date of hire of 06/20/2024. Further review of S32CNA's Personnel File revealed no documented evidence, and the facility presented no documented evidence, S32CNA had received QAPI training as required. Review of S33CNA's Personnel File revealed S33CNA had a date of hire of 08/15/2024. Further review of S33CNA's Personnel File revealed no documented evidence, and the facility presented no documented evidence, S33CNA had received QAPI training as required. In an interview on 09/04/2024 at 12:24 p.m., S34Human Resources Director indicated the facility did not have documented evidence of QAPI training for the above mentioned employees. In an interview on 09/05/2024 at 3:42 p.m., S1Administrator indicated she had no additional documentation to present regarding the above mentioned deficient practice. In an interview on 09/05/2024 at 4:39 p.m., S2Director of Nursing (DON) indicated the facility did not have evidence of the above mentioned employees had QAPI training as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide training in compliance and ethics. 30587 Based on record review and interviews, the facility failed to ensure a Certified Nursing Assistant (CNA) received ethics training for 1 (S6CNA) of 5 (S6CNA, S30CNA, S31CNA, S32CNA, and S33CNA) sampled CNAs' personnel files reviewed for training requirements. Findings: Review of S6CNA's personnel file revealed S6CNA had a date of hire of 12/30/2021. Further review revealed no documented evidence, and the facility presented no documented evidence S6CNA had received ethics training. In an interview on 09/04/2024 at 12:24 p.m., S34Human Resources Director indicated the facility did not have any documented evidence S6CNA had received ethics training as required. In an interview on 09/05/2024 at 3:42 p.m., S1Administrator indicated the facility had no additional documentation to present regarding the above mentioned deficient practice.