STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195248	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Park Nursing & Rehab Ctr, LLC	9111 Linwood Avenue Shreveport, LA 71106

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview the facility failed to ensure the most recent survey results were readily accessible to the residents, family members or anyone to review. Findings: An observation on 09/08/2025 at 10:00 a.m. failed to reveal the most recent survey result was in the facility's survey binder. During an interview on 09/08/2025 at 10:01 a.m. with S1 Administrator confirmed most the recent survey was not in survey binder and should have been.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews, the facility failed to ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms for 3 (#15, #58, #139) of 3 (#15, #58, #139) residents reviewed for restraints . The facility failed to ensure:1. a pre-restraint assessment and written consent were in place for the use of Resident #15's lap buddy and 2. a pre-restraint assessment and written consent were in place for the use of Resident #58 and Resident #139's self-releasing seat belt. Findings: Review of the facility's undated policy for Restraints: Physical revealed in part:Policy:A physical restraint is defined as any manual method or mechanical, physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of a restraint, such as:3. Using devices in conjunction with a chair such as trays, tables, bars or belts that the resident cannot remove easily that prevent a resident from rising out of the chair. Restraint use should be a last resort and only used after all other measures of dealing with the problem have been exhausted. Informed consent must be obtained prior to initiation of a restraint. The facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. In effect, restraint use can reduce independence, functional capacity, and quality of life. In the case of a resident who is incapable of making decision, the surrogate or representative may exercise this right based on the same information that would have been provided to the resident. Before a resident is restrained, the facility must complete a pre-restraining assessment and they must demonstrate the presence of a specific medical symptom that requires the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident's safety and assist in reaching the highest level of physical and psychological well-being. Resident #15Review of Resident #15's medical record revealed an admit date of 07/12/2024 with diagnoses including in part major depressive disorder, recurrent, severe with psychotic symptoms, other symptoms and signs involving cognitive functions and awareness, and dementia in other diseases classified elsewhere, severe, with mood disturbance.Review of Resident #15's physician orders revealed an order dated 01/17/2025 for lap buddy to wheelchair at all times to aid with positioning while sitting. Nursing to monitor for placement every shift. Review of Resident #15's annual MDS (Minimum Data Set) dated 06/12/2025 revealed in part a BIMS (Brief Interview of Mental Status) was not performed as Resident #15 was rarely/never understood.Further review of Resident #15's medical record failed to reveal a pre-restraint assessment and written consent for the use of a lap buddy were in place. Observation on 09/09/2025 at 8:20 a.m. revealed Resident #15 sitting in wheelchair with a soft lap buddy in use. Observation on 09/10/2025 at 8:00 a.m., revealed S16CNA (Certified Nursing Assistant) applied and secured a soft lap buddy under the arm rests of Resident #15's wheelchair, while Resident #15 was seated in the wheelchair. Further observation failed to reveal Resident #15 could remove his soft lap buddy from his wheelchair upon request of S16CNA. During an interview on 09/10/2025 at 8:00 a.m., S16CNA acknowledged Resident #15 was not able to remove his soft lap buddy when asked to remove it. Resident #58Review of Resident #58's medical record revealed an admit date of 10/18/2023 with diagnoses including in part cognitive communication deficit, fracture of superior rim of left pubis, Alzheimer's disease with late onset, repeated falls, need for assistance with personal care, dementia in other diseases classified elsewhere-moderate-with agitation, and lack of coordination. Review of (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58's physician orders revealed in part an order dated 03/18/2025 for self-release seatbelt to wheelchair at all times while in chair every shift.Review of Resident #58's quarterly MDS dated [DATE] revealed in part Resident #58 had severe cognitive impairment.Further review of Resident #58's medical record failed to reveal an assessment or consent for the use of a self-releasing seat belt. Observation on 09/09/2025 at 10:30 a.m. revealed Resident #58 sitting in a wheelchair with a self-releasing seat belt in place. Further observation failed to reveal Resident #58 could remove her self-releasing seat belt as requested by S7LPN (Licensed Practical Nurse) and S8CNA. During an interview on 09/09/2025 at 10:30 a.m., S7LPN and S8CNA reported Resident #58 would scoot to the end of the wheelchair seat and try to get out. Resident #139Review of Resident #139's medical record revealed an admit date of 11/12/2018 with diagnoses including in part muscle wasting and atrophy, cognitive communication deficit, dementia with mood disturbance.Review of Resident #139's physician orders revealed an order dated 03/11/2024 for self-releasing seat belt while in wheelchair due to multiple falls secondary to dementia with muscle weakness and atrophy. Review of Resident #139's quarterly MDS dated [DATE] revealed a BIMS was not performed as Resident #139 was rarely understood.Further review of Resident #139's medical record failed to reveal a pre-restraint assessment or written consent for the use of a self-releasing seat belt were in place. Observation on 09/08/2025 at 10:39 a.m. revealed Resident #139 sitting in a wheelchair with a lap self-releasing seat belt in use. During an interview on 09/09/2025 at 2:18 p.m., S9Medicare Case Manager reported the facility does not consider a lap buddy or self-releasing seat belt as a restraint so no assessment or consent was required. During an interview on 09/10/2025 at 9:20 a.m., S3Corporate Nurse acknowledged the use of lap buddies and self-releasing seat belts for wheelchairs required a pre-restraint assessment and informed consent prior to use.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure a resident with an order for psychotropic medication as needed (PRN) was not subjected to chemical restraints for 1 (#139) of 4 (#3, #7, #10 and #139) residents reviewed for unnecessary medications. The facility failed to ensure Resident #139's PRN order for psychotropic medication was limited to 14 days. Findings:Review of Resident #139's medical record revealed an admit date of 11/12/2018 with diagnoses including in part muscle wasting and atrophy, cognitive communication deficit, dementia in other diseases classified elsewhere, severe, with mood disturbance.Review of Resident #139's physician orders revealed an order dated 01/28/2025 for Vistaril oral capsule 25 mg (milligram) (Hydroxyzine Pamoate); give 1 capsule by mouth every 8 hours as needed for anxiety and/or restlessness without a stop date.During an interview on 09/09/2025 at 1:00 p.m., S4DON (Director of Nursing) acknowledged Resident #139 had a PRN Vistaril order for anxiety greater than 14 days. S4DON reported the prn Vistaril order should have had an end date and did not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure resident assessments accurately reflected the resident's status for 1(#137) of 1(#137) resident out a total of 46 sampled residents whose assessments were reviewed. The facility failed to complete Resident #137's discharge assessment. Findings: Review of Resident #137's medical record revealed an admission date of 03/11/2025 and a discharge date of 03/17/2025 with a diagnosis of but not limited to low back pain, schizophrenia, hypertensive chronic kidney disease with stage 4 chronic kidney disease, generalized muscle weakness, essential hypertension, and muscle wasting and atrophy. Review of Resident #137's MDS (minimum data set) assessments failed to reveal a discharge assessment had been completed when Resident #137 was discharged from the facility on 03/17/2025. Further review of Resident #137's MDS tracking revealed the following statement: Discharge ARD (assessment reference date) of 03/17/2025, 162 days overdue. During an interview on 09/09/2025 at 10:07 a.m. S10 MDS nurse and S9 Medicare Case Manager confirmed Resident #137's discharge MDS assessment had not been completed and should have been.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to refer a resident with newly evident or possible severe mental disorder, intellectual disability, or related conditions for a Level II PASARR (Pre-admission Screening and Resident Review) services for 1 (#23) of 2 (#10, #23) residents reviewed for PASARR. The failure had the potential for residents to not be provided with specialized rehabilitation services, causing feelings of boredom, hopelessness, and a diminished quality of life. Findings:Review of Resident #23's medical record revealed an admit date of 07/11/2019.Review of Resident #23's PASARR dated 07/10/2019 revealed no diagnoses of mental illness and a Level II PASARR was not indicated. Review of Resident #23's medical record revealed a diagnosis of brief psychotic disorder dated 06/04/2020 and a diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms dated 01/01/2025.Further review of Resident #23's medical record failed to reveal a new PASARR had been submitted related to diagnoses received after admission which included brief psychotic disorder and major depressive disorder, recurrent, severe with psychotic symptoms.During an interview on 09/09/2025 at 12:50 p.m. S4DON (Director of Nursing) acknowledged a new PASARR had not been resubmitted upon new diagnosis of mental illness after admission to the facility and should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop an individualized person-centered care plan to meet the needs of 5 (#3, #5, #58, #69, #111) residents out of 5 (#3, #5, #58, #69, #111) residents reviewed for plan of care. The facility failed to ensure:1. Resident #3's plan of care included appropriate approaches for current diagnosis of non-Alzheimer's Dementia.2. Resident #5's care plan included diagnosis of anxiety and receiving anti-anxiety medications. 3. Resident #58's plan of care included a focus for wound care with appropriate interventions 4. Resident #69's plan of care included appropriate approaches for the current wound care.5. Resident #111 care plan included a focus on use of bed rail/side rail with appropriate interventions. Findings: Resident #3 Review of Resident #3's medical record revealed an admission date 07/15/2025 and diagnoses that included Non-Alzheimer's dementia. Review of Resident #3's comprehensive care plan failed to reveal Resident #3 had been care planned with appropriate interventions for dementia care. During an interview on 09/09/2025 at 1:06 p.m. S10 MDS (Minimum Data Sets) Nurse reported Resident #3 had diagnosis of Non-Alzheimer's Dementia and comprehensive care plan did not include appropriate interventions for Non-Alzheimer's Dementia and should have. Resident #5 Review of Resident #5's face sheet revealed an admission date on 02/04/2021 revealed a diagnoses of generalized anxiety disorder. Review of Resident #5's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 14 indicating intact cognition. Further review of Resident #5's Quarterly MDS revealed Resident #5 received anti-anxiety medication for the last 7 days of the look back period. Review of Resident #5's September 2025 physician orders revealed an order dated 07/01/2024 for Buspirone HCl (hydrochloride) Tab 5 MG (milligram); Give 1 tablet orally two times a day related to generalized anxiety disorder. Review of Resident #5's care plan failed to reveal appropriate interventions were in place for diagnosis of anxiety disorder. During an interview on 09/09/2025 at 9:45 a.m. S6 Care Plan Nurse reviewed Resident #5's care plan and confirmed Resident #5's care plan did not include appropriate interventions for diagnosis of anxiety disorder. During an interview on 09/09/2025 at 11:00 a.m. S4 DON (Director of Nursing) confirmed Resident #5 had a diagnosis of anxiety and received anti-anxiety medications. S4 DON confirmed Resident #5's care plan should have interventions for anxiety disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58 Review of Resident #58's medical record revealed an admit date of 10/18/2023 with diagnoses that include in part unstageable pressure ulcer of left heel. Review of Resident #58's medical record revealed a skin and wound assessment dated [DATE] -Pressure ulcer to left medial foot-unstageable-noted, RP (responsible party) notified, MD (medical doctor) with new orders noted. Review of Resident #58's comprehensive care plan failed to reveal a focus for Resident #58's unstageable pressure ulcer with appropriate interventions. Resident #69 Review of Resident #69's medical record revealed an admit date of 11/03/2022 with readmission date of 09/22/2023 and diagnoses that include in part unsteadiness on feet and repeated falls. Review of Resident #69's physician orders revealed in part: 07/14/2025 Skin tear to right shin: cleanse with wound cleanser; pat dry with 4 x 4 gauze; apply xeroform to wound bed; cover with border dressing prn (as needed) for soilage/dislodgement. 07/14/2025 Skin tear to right shin: cleanse with wound cleanser; pat dry with 4 x 4 gauze; apply xeroform to wound bed; cover with border dressing 3 x times a week MWF (Monday, Wednesday, Friday) until resolved. Review of Resident #69's comprehensive care plan failed to reveal a focus for Resident #69's skin tear to the right shin with appropriate interventions for the skin tear to the right shin. During an interview on 09/09/2025 at 12:05 p.m. with S10 MDS Nurse confirmed Resident #58 had not been care planned for the current foot wound, and Resident #69 had not been care planned for the current shin wound and should have been. Resident #111 Review of Resident #111's face sheet revealed an admission date of 09/12/2022 including the following diagnoses but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, lack of coordination, muscle wasting and atrophy to multiple sites. Review of Resident #111's September 2025 physician orders revealed an order dated 04/23/2025 for Bed Rails: side rails upper half of bilaterally to bed related to weakness, secondary to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side to enable resident to assist in turn and repositioning, bed mobility and transfers in/out of bed. Monitor resident for safety concerns with side rails every 2 hours when used. Review of Resident #111's Annual MDS dated [DATE] revealed a BIMS score of 15 indicating cognition intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #111's care plan failed to reveal a focus on the use of bed rails/side rails with appropriate interventions. Observation on 09/08/2025 at 11:00 a.m. revealed Resident #111 had hand assist bars bilaterally to head of bed. During an interview on 09/09/2025 at 10:30 a.m. S6 LPN (Licensed Practical Nurse) care plan nurse reviewed Resident #111's care plan and confirmed Resident #111's care plan did not include a focus for use of side rails/bed rails with appropriate interventions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews, observations and interviews, the facility failed to provide services that met professional standards for 1 (#6) of 3 (#6, #42, and #111) residents reviewed for accident hazards and supervision. The facility failed to ensure safe medication administration practices by leaving medications at the bedside. Findings:Review of the facility's Medication Administration undated policy revealed in part:Medications are administered as prescribed, in accordance with good nursing principles and practices and only by person legally authorized to do so. Personnel authorized to administer medications de no only after they have familiarized themselves with the medication.5. Residents are allowed to self-administer medications when specifically authorized by the IDT (Interdisciplinary team) which includes the attending physician and in accordance with procedures for self-administration of medications. (See policy for self-administration of medications)6. Medications are administered at the time they are prepared. Medications are not pre-poured, unless the facility uses the bottle system with individual medication cards for each medication.Essential Points to Remember:5. The person administering medication must remain with the resident until all medication has been swallowed.Review of Resident #6's medical record included an admission date of 10/06/2023 and a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment.Review of Resident #6's medical record revealed diagnoses included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other chronic pain, and dysphagia, oropharyngeal phase.Review of physician's orders for Resident #6 revealed, in part:Order date 06/25/2024: Eliquis oral tablet 2.5 mg (Milligram) (Apixaban); give 1 tablet orally two times a day related to other persistent atrial fibrillation Order date 07/01/2024: Ascorbic acid tab 500 mg; give 1 tablet orally two times a day related to pressure ulcer of right buttock, stage 2 Order date 07/01/2024: multivitamin adult oral tablet (multiple vitamin); give 1 tablet orally two times a day related to pressure ulcer of right buttock, stage 2 Order date 07/01/2024: Zinc sulfate tab 220 mg (50 mg Zinc equivalent); give 1 tablet orally one time a day related to pressure ulcer of right buttock, stage 2 Order date 07/01/2024: Carvedilol tab 25 mg; give 1 tablet orally two times a day related to essential (primary) hypertension Order date 07/01/2024: Clopidogrel bisulfate tab 75 mg give 1 tablet orally one time a day related to atherosclerotic heart disease of native coronary artery without angina pectoris Order date 07/01/2024: Lisinopril oral tablet 40 mg; give 1 tablet orally one time a day related to essential (primary) hypertension Order date 08/15/2025: Gabapentin oral tablet 100 mg; give 2 tablet by mouth one time a day related to polyneuropathy, unspecified Further review of Resident #6's physician orders failed to reveal an order for self-administration of medication. Observation on 09/08/2025 at 1:20 p.m. of Resident #6's bedside table revealed medication in a cup containing various (8) pills on the bedside table.During an interview on 09/08/2025 at 1:21 p.m. Resident #6 reported S11 LPN (Licensed Practical Nurse) left pills on the bedside table while he was in the bathroom.Observation on 09/08/2025 at 1:25 p.m. with S11 LPN revealed Resident #6's bedside table had medications in a cup containing various (8) pills on the bedside table.During an interview on 09/08/2025 at 1:26 p.m. S11 LPN confirmed medication should not be left at the bedside without an order.During an interview on 09/08/2025 at 1:30 p.m. S4 DON (Director of Nursing) confirmed medications should not be left at the beside without an order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of practice and follow facility's policies for 3 (#49,# 69, #150) of 3 (#49, #69, #150) residents reviewed for respiratory care. The facility failed to ensure resident #49's oxygen concentrator filter was clean and an oxygen in use sign was placed on the outside of resident #69 and #150's room entrance door.Findings: Review of the facility's Oxygen Administration (concentrator or tank) undated policy revealed in part: Policy: While oxygen is in use, No Smoking, signs will be posted at the entrance to the room. .Concentrator filter should be cleaned weekly or as needed. Procedure: 13. Place the No Smoking, Oxygen in Use warning sign on the resident's room door or in other appropriate locations. Resident #49 Review of Resident #49's face sheet revealed an admission date of 07/25/2025 with the following diagnoses but not limited to (COPD) chronic obstructive pulmonary disease with (acute) exacerbation, dependence on supplemental oxygen, and acute and chronic respiratory failure with hypoxia. Review of Resident #49's September 2025 Physician Orders revealed the following orders related to oxygen therapy: 07/25/2025: oxygen at 2 liters/nasal cannula continuously related to a diagnosis of COPD/respiratory failure with hypoxia 7/25/2025: Change oxygen tubing, nasal cannula, humidifier bottle and clean filter every week and as needed; every night shift every Friday Review of Resident #49's admission MDS (Minimum Data Set) Assessment revealed a BIMS (Brief Interview of Mental Status) of 15 indicating intact cognition. Further review of admission MDS revealed Resident #49 had oxygen in use. Review of Resident #49's care plan revealed resident has congestive heart failure with interventions for oxygen settings: humidified oxygen via nasal cannula at 2 liters per minute. Observation on 09/08/02025 at 9:00 a.m. revealed Resident #49's oxygen concentrator filter was coated in a gray fuzzy substance. Observation on 09/08/2025 at 10:28 a.m. revealed Resident #49's oxygen concentrator filter was coated in a gray fuzzy substance. Observation on 09/08/2025 at 2:26 p.m. with S15 RN (Registered Nurse) revealed Resident #49's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen concentrator filter was coated in a gray fuzzy substance. During an interview on 09/08/2025 at 2:26 p.m. S15 RN confirmed Resident #49's oxygen concentrator filter need to be cleaned. Resident #69 Review of Resident #69's medical record revealed an admit date of 11/03/2022, readmission date of 09/22/2023 with diagnoses that include in part simple chronic bronchitis, chronic obstructive pulmonary disease with acute exacerbation and dependence on supplemental oxygen. Review of Resident #69's physician orders revealed in part and order dated 12/16/2024 for continuous oxygen at 3 liters per minute via nasal cannula every shift related to chronic obstructive pulmonary disease with (acute) exacerbation. Observation on 09/08/2025 at 10:40 a.m. revealed resident sitting in her room with oxygen in use at 3 liters/minute per nasal cannula via oxygen concentrator. Further observation failed to reveal signage posted on resident's room doorway indicating oxygen was in use. Resident #150 Review of Resident #150's medical record revealed an admit date of 09/05/2025 with diagnoses that include in part acute respiratory failure with hypoxia, and acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. Review of Resident #150's physician orders revealed in part an order dated 09/05/2025 for Oxygen at 2 liters per nasal cannula continuously related to a diagnosis of acute respiratory failure with hypoxia every shift. Observation on 09/08/2025 at 9:00 a.m. revealed Resident #150 in his room with oxygen in use per nasal cannula. Further observation failed to reveal signage posted on resident's room doorway indicating oxygen was in use. Observation on 09/08/2025 at 1:00 p.m. with S4 DON (Director of Nursing) failed to reveal resident #69 and #150 had oxygen in use signage posted outside the room. During an interview on 09/08/2025 at 1:00 p.m. with S4 DON verified there should be an oxygen in use sign posted outside resident #69 and #150's room and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195248	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Park Nursing & Rehab Ctr, LLC	9111 Linwood Avenue Shreveport, LA 71106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, and interviews, the facility failed to ensure proper infection control techniques were practiced to prevent cross contamination during incontinence care for 1 (#124) of 1 (#124) Resident reviewed for urinary catheter and UTI (Urinary Tract Infection). Findings:Review of the facility's Catheter Management undated policy revealed in part: Procedurec. Female resident: separate labia with thumb and forefinger of non-dominant hand and cleanse the area with a wash cloth, soap, and water or personal cleanser using downward strokes. While applying gentle traction to the catheter, cleanse it six inches from the insertion site using downward strokes as well. Flip or change washcloth with each wipe. Review of Resident #124's medical record revealed an admission date of 08/29/2025 and diagnosis of subsequent encounter for closed fracture with routine healing. Review of Resident #124's physician orders revealed an order dated 08/29/2025: Catheter care with soap and water; every day shift An observation on 09/10/2025 at 8:15 a.m. of Resident #124's perineal-care and catheter care with S12 CNA (Certified Nursing Assistant) and S13 CNA revealed Resident #124 had a bowel movement. Further observation revealed S12 CNA failed to cleanse catheter six inches from the insertion site during perineal-care for Resident #124. During an interview on 09/10/2025 at 8:25 a.m. S12 CNA confirmed she failed to cleanse Resident #124's catheter six inches from the insertion site during perineal-care and should have. During an interview on 09/10/2025 at 9:01 a.m. S14 IP (Infection Preventionist) reported Resident #124 had an UTI and S12 CNA's failure to cleanse Resident #124's catheter six inches from the insertion site during perineal-care could lead to a worsening UTI by introducing new or more bacteria. S14 IP confirmed S12 CNA should have cleansed Resident #124's catheter six inches from the insertion site during perineal-care. During an interview on 09/10/2025 at 8:26 a.m. S3 Corporate Nurse confirmed Resident #124's catheter should have been cleansed six inches from the insertion site during perineal-care.