STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195265	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Nursing Center	7726 US Hwy. 165 Columbia, LA 71418

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on observations, record review and interviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (#231) of 1 resident reviewed for dignity. The facility failed to respect resident #231's request for a more textured diet. Findings: Review of the medical record revealed the resident was admitted on [DATE] with diagnoses including dysphagia following cerebral infarction, severe protein - calorie malnutrition, muscle wasting and atrophy, malignant neoplasm of lower right lobe, iron deficiency anemia, and abnormal weight loss. Review of the Admission Minimum Data Set assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had independent cognitive skills for daily decision making. The resident required set up or clean up assistance with eating. Review of the physician order dated 04/10/2024 revealed the resident's diet was changed from minced and moist to pureed texture. Review of the nurses notes dated 04/20/2024 at 5:47 p.m. revealed the following: ate 50% or less for 2 or more meals in the day, resident accepts supplements, resident complains of having to eat puree. Review of the nurses notes dated 04/21/2024 at 2:29 p.m. revealed the following: ate 50% or less for 2 or more meals in the day, resident refusing to eat the pureed diet prescribed, resident frequently encouraged to eat, given and accepted supplements. Observation of the lunch meal on 04/21/2024 at 12:30 p.m. revealed the resident received a pureed meal. The resident was drinking his health shake. An interview with the resident at this time revealed he did not want a pureed diet. Observation of the breakfast meal on 04/22/2024 at 8:30 a.m. revealed the resident received a pureed meal. An interview with the resident at this time revealed he didn't want his food pureed. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the resident on 04/22/2024 at 1:30 p.m. revealed he makes his own decisions about his medical care. An interview with S3Assistant Director of Nursing (ADON) on 04/22/2024 at 11:28 a.m. confirmed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had independent cognitive skills for daily decision making. S3ADON further confirmed the resident makes his own decisions. An interview with S1Director of Nursing (DON) on 04/23/2024 at 10:50 a.m. confirmed the resident was competent to make his own decisions. S1DON further confirmed the facility should have offered the resident to sign a waiver for him to eat his diet in a texture he desired.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829 Based on observations, interviews, and record reviews the facility failed to ensure a resident maintained acceptable parameters of nutrition by failing to provide a diabetic nutritional supplement as ordered by the physician for a resident who had a recent significant weight loss for 1 (#27) of 3 (#25, #27, #231) residents reviewed for nutrition. Findings: Record review revealed resident #27 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, atherosclerotic heart disease, hypokalemia, major depressive disorder, need for assistance with personal care, generalized muscle weakness, muscle wasting and atrophy, dysphagia, and cognitive communication deficit. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 3 which indicated resident #27 had severe cognitive impairment. Further review revealed resident #27 was dependent on staff for all activities of daily living that required substantial/maximal assistance. Review of resident #27's April 2024 physician orders revealed an active order for a diabetic house supplement two times a day to increase calorie intake due to significant weight loss. Review of resident #27's weights revealed 10/11/2023 = 140.7 pounds, 11/01/2023 = 120.0 pounds, 01/10/2023 = 113.0 pounds, 03/10/2024 = 111.5 pounds, and 04/10/2024 = 115.0 pounds. Review of the April 2024 Electronic Medication Administration Record (EMAR) revealed no documentation of resident #27 receiving the diabetic house supplement twice daily since it was ordered on 04/04/2024. On 04/22/2024 at 1:20 p.m. an interview with S4LPN (Licensed Practical Nurse) confirmed resident #27 had an order for diabetic house supplement twice a day. S4LPN confirmed she did not administer the diabetic house supplement. On 04/22/2024 at 02:25 p.m. an interview with S3ADON (Assistant Director of Nursing) confirmed resident #27 had order for diabetic house supplement two times a day. S3ADON confirmed resident #27 should have received the diabetic house supplement as ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41829 Based on interview and record review, the facility failed to ensure residents were free from unnecessary medication use for 1 (#74) of 5 (#16, #34, #59, #70, #74) sampled residents reviewed for unnecessary medications. The physician failed to ensure a psychotropic medication (Vistaril) was not ordered to be given as needed for a time period greater than 14 days for resident #74. Findings: Record review revealed resident #74 was admitted to the facility 01/27/2024 with diagnoses that include bipolar disorder, major depressive disorder, primary insomnia, unspecified dementia unspecified severity with mood disturbance, fibromyalgia, other forms of scoliosis lumbar region, long term (current) use of opiate, migraine, and anxiety disorder. Review of active April 2024 Physician Orders revealed an order dated 01/28/2024 for Vistaril 50 milligrams (mg) capsule, give one capsule by mouth every 12 hours as needed (prn) for anxiety. Review of the Pharmaceutical Consultant Report dated 02/18/2024 revealed pharmacist recommended that Vistaril prn psychotropic medication should be limited to 14 days. The consultant pharmacist further recommended the physician to provide specific duration/stop date for Vistaril 50 mg q 12 hours prn anxiety. On 04/22/2024 the physician assistant denied the gradual dose reduction, failed to provide a duration/stop date for Vistaril 50 mg every 12 hours prn anxiety, and failed to provide a rationale to continue the medication. Review of the April 2024 (Electronic Medication Administration Record (EMAR) revealed documentation resident #74 received Vistaril 50 mg on the following dates/times: 04/02/2024 at 1553, 04/03/2024 at 1408, 04/04/2024 at 1333, 04/05/2024 at 1550, 04/06/2024 at 1618, 04/07/2024 at 1512, 04/08/2024 at 1538, 04/09/2024 at 1427, 04/10/2024 at 1510, 04/11/2024 1344, 04/12/2024 at 1346, 04/13/2024 at 1332, 04/14/2024 at 1505, 04/15/2024 at 1520, 04/16/2024 at 1403, 04/17/2024 at 1509, 04/18/2024 at 1526, and 04/22/2024. On 04/23/2024 at 1:50 p.m. an interview with S2DON (Director of Nursing) and S3ADON (Assistant Director of Nursing) confirmed that Vistaril (psychotropic) should not be administered as needed greater than 14 days. S3ADON confirmed the physician assistant continued a prn psychotropic medication past 14 days for resident #74 without a documented end date or a rationale for it to be continued.