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	05/07/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on observations, record review, and interview the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 (#73) of 2 (#73, #76) residents reviewed for positioning and mobility. The deficient practice was evidenced by the facility failing to ensure a resident in a geri chair received proper support of her lower extremities. Findings: Review of the record revealed resident #73 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, atherosclerotic heart disease, hypertension, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 2 indicating that resident #73 was severely cognitively impaired. Further review of the MDS revealed she required extensive 2 person assistance with most activities of daily living. Review of resident #73's active care plan revealed the facility identified the resident needed monitoring related to a history of neck surgery with residual stiffness present. Further review revealed resident #73 may use a geri chair as needed due to her above condition. On 05/05/2025 at 9:52 a.m., resident # 73 was observed in a geri chair in the day area. Further observation revealed her feet were dangling with no support to her lower extremities. On 05/06/2025 at 9:11 a.m. and 3:25 p.m., observations revealed resident #73 was in a geri chair in the day area. Further observation revealed her feet were dangling with no support to her lower extremities. On 5/07/2025 at 9:43 a.m., resident # 73 was observed in a geri chair in the day area. Further observation revealed her feet were dangling with no support to her lower extremities. On 05/07/2025 at 2:15 p.m., the surveyor and S4Licensed Practical Nurse (LPN)/Clinical Manager observed resident # 73 in her geri chair in the day area. Further observation revealed her feet were dangling with no support to her lower extremities. S4LPN/Clinical Manager confirmed her legs and feet should be supported when she is up in the geri chair. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/2025 at 3:00 p.m., S2Director of Nursing was informed that resident #73 was observed in her geri chair multiple times during the survey with her feet dangling with no support to her lower extremities.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on observations, interviews, and record reviews, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote healing and prevent the development of new pressure ulcers for 2 (#7, #30) of 5 (#7, #30, #61, #66, #136) residents investigated for pressure ulcers. The deficient practice was evidenced by the facility failing to provide pressure reducing devices for a resident with a stage 3 pressure ulcer (#7) and for a resident who was at a moderate risk for developing pressure ulcers (#30). Findings: Review of the facility Pressure Injury Prevention and Management Policy revised 06/21/2024 revealed the following, in part: Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, and prevent the development of additional pressure ulcers/injuries. 4. Interventions for Prevention and to Promote Healing: c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: iii. Provide appropriate, pressure-redistributing, and support surfaces. Resident #7 Review of the record revealed resident #7 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, type 2 diabetes mellitus with diabetic nephropathy, cerebral infarction, chronic obstructive pulmonary disease, polyneuropathy, unspecified dementia, peripheral vascular disease, congestive heart failure, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 3, which indicated she was severely cognitively impaired. Resident #7 required extensive 2 person assistance for most activities of daily living (ADLs). Further review revealed she was at risk for developing pressures and there was no pressure reducing device for her chair. On 05/06/25 at 8:31 a.m., resident # 7 was observed in her wheelchair in her room. S4Certified Nursing Assistant (CNA) confirmed there was no pressure relieving cushion in the seat of resident #7's wheelchair. On 05/06/2025 at 12:00 p.m., resident #7 was observed in her wheelchair in the dining area and there was no pressure relieving cushion noted in the seat of her wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #7's active physician orders revealed she was receiving treatment for a stage 3 pressure injury to her right posterior thigh and a suspected deep tissue injury to her right heel. Review of resident #7's active care plan revealed the facility had identified she was at a high risk for pressure ulcers with an intervention to follow the facility policies and procedures for the prevention and treatment of skin breakdown. On 05/06/25 at 01:53 p.m., S2Director of Nursing (S2DON) was informed there was no pressure relieving cushion in resident # 7's wheelchair. S2DON confirmed resident #7 should have had a pressure relieving cushion in her wheelchair since she currently had a pressure ulcer to her right posterior thigh. Resident #30 Resident #30 was admitted to the facility on [DATE] with diagnoses that included morbid obesity, reduced mobility, muscle weakness and repeated falls. Review of the most recent MDS assessment dated [DATE] revealed resident #30 had a BIMS score of 13 which indicated she was cognitively intact. Resident #30`s most recent weight was measured on 04/07/2025 and revealed a weight of 311 pounds. Review of the most recent quarterly Braden scale for predicting pressure sore risk assessment dated [DATE] revealed resident #30 had a score of 13. The score of 13 indicated resident #30 was at moderate risk for developing pressure ulcers. On 05/05/2025 at 12:13 p.m., observation and interview revealed resident #30 did not have a cushion for her wheelchair as she was sitting at the dining room table for lunch. Resident #30 reported she sat in the wheelchair most of the day because she could not walk. Resident #30 also reported she would like a cushion in her chair but was never offered a cushion. On 05/06/2025 at 08:21 a.m., resident # 30 was observed in the dining room eating breakfast while sitting in wheelchair. There was no pressure relieving cushion observed in her wheelchair. Resident # 30 confirmed there was no cushion and complained of her wheelchair being uncomfortable. On 05/06/2025 at 01:50 p.m., an interview with S2DON confirmed resident # 30 should have a cushion in her wheelchair to reduce risk for developing a pressure ulcer. 40238

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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** 51983 Based on record review and interview, the facility failed to maintain acceptable parameters of nutritional status by failing to follow up with the physician in a timely manner to implement the registered dietician's (RD) recommendation for 1 (#14) of 4 (#6, #14, #51, #63) residents reviewed for nutrition. Findings: Review of the medical record for resident #14 revealed an admitted [DATE] with diagnoses including muscle wasting and atrophy, muscle weakness, cognitive communication deficit, chronic obstructive pulmonary disease, chronic atrial fibrillation, Alzheimer's disease with late onset, and vitamin deficiency. Review of the record revealed that resident #14 had a weight of 179.0 pounds on 01/07/2025 and a weight of 162.5 pounds on 03/06/2025 showing a weight loss of 16.5 pounds. Review of active May 2025 physician orders revealed that resident #14 was not currently taking an appetite stimulant. Review of the medical records revealed on 04/01/2025 the RD sent a note to the physician with the recommendation for resident #14 to receive an appetite stimulant. On 05/06/2025 at 3:10 p.m., an interview with S2Director of Nursing (DON0 confirmed the facility did not follow up with the physician in a timely manner to implement the RD recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 13974 Based on observation and interviews, the facility failed to ensure drugs were accessible to only authorized personnel by failing to ensure a medication remained locked away when not in use by having a medication stored at a resident's bedside for 1 (#66) of 1 (#66) reviewed for medication storage. Findings: On 05/05/25 8:56a.m., observation in the resident's room revealed there was a fluticasone inhaler on the bedside table of resident #66. Interview with resident #66 confirmed the inhaler belonged to her. Resident #66 reported the nurse left the inhaler at her bedside. On 05/05/2025 at 9:02a.m., interview with S5 Licensed Practical Nurse (LPN) confirmed the inhaler belonged to resident #66 and the inhaler should not have been left in the resident's room. On 05/07/2025, interview with S2Director Of Nursing (DON) confirmed the inhaler should not have been left at the bedside of resident #66.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40238 Based on record review and interview the facility failed to have quarterly quality assessment and assurance (QAA) meetings with required members of the QAA committee present. The failed practice was evidenced by the facility`s medical director not being present for the quarterly meetings reviewed.  Review of the (QAA) meetings revealed meetings were held on 01/30/2025, 11/12/2024, 07/30/2024, and 03/28/2024. Review of the attendance roster revealed the medical director`s signature was not recorded on the roster. On 05/07/2025 at 02:25 p.m., an interview with S1 Administrator confirmed the medical director was not present for above quarterly QAA meetings.