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	06/10/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents were free of chemical restraints by failing to ensure a resident had an appropriate diagnosis for the use of an antipsychotic medication for 1 (#13) of 5 residents reviewed for unnecessary medication. Findings: Review of Resident #13's record revealed an admission date of 04/17/2023 with diagnoses including unspecified dementia without behavioral, psychotic, or mood disturbances, generalized anxiety disorder, and major depressive disorder recurrent.Review of Resident #13's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Further review of the MDS revealed resident received antipsychotic medication and diuretic medication. Review of Resident #13's June 2026 Physician's Orders revealed an order dated 02/06/2026 for Abilify (antipsychotic medication) 5 mg oral tablet give 2.5 mg (1/2 tab) by mouth one time a day. Interview on 06/10/2026 at 9:58 a.m. with S3ADON revealed Resident #13 was currently receiving Abilify, which was an antipsychotic medication, and had a diagnosis of unspecified dementia without behavioral disturbances. S3ADON confirmed Resident #13 did not have an appropriate diagnosis for the use of an antipsychotic medication.

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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews the facility failed to ensure that a resident receive treatment and care in accordance with professional standards of practice by failing to identify a wound for 1 (#33) of 3 residents reviewed for non-pressure related skin conditions.Findings: Review of Resident #33's medical record revealed diagnoses which included chronic systolic congestive heart failure, unilateral primary osteoarthritis (right hip), atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, unspecified protein-calorie malnutrition, and major depressive disorder.Review of the annual MDS assessment dated [DATE] for Resident #33 revealed a BIMS score of 7 which indicated severe cognitive impairment. Further review revealed she required substantial-maximal assistance with most ADLs. Resident #33 was assessed to be at moderate risk for pressure ulcers and had no current pressure ulcers and no other skin problems identified.An interview with Resident #33's family member on 06/08/2026 at 9:40 a.m. revealed the resident had an area on her bottom that she did not think they were treating.During a head to toe physical assessment of Resident #33's skin with S5LPN, observation revealed a small scabbed area was noted on her right upper buttock. S5LPN confirmed she was not aware of the scabbed area on her right upper buttock.Observation of Resident #33's skin with S2DON and S3ADON on 06/09/2026 at 1:40 p.m. confirmed there was a small scabbed area to her right upper buttock. They reported no staff had informed them of the above area and were not aware of the wound.An interview with S6CNA on 06/09/2026 at 1:48 p.m. revealed she worked with Resident #33 on 06/05/2026 and she saw an abrasion on her right upper buttock. S6CNA revealed she reported the area to the resident's nurse (she was unsure of her name).Review of the Weekly Skin Assessments from 05/07/2026 to 06/04/2026 revealed there was no documentation Resident #33 had any skin conditions or wounds.Review of Wound assessment dated [DATE] for Resident #33 revealed the following: right gluteus; other skin issue - scab; new wound, acquired in-house; 1.39 cm length x 1.22 cm width; and no sign or symptom of infection; no odors, pain, undermining, tunneling, or exudate.Interviews with S2DON and S3ADON confirmed the above area to Resident #33's right upper buttock should have been identified timely and reported to S3ADON.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident needs by not 1) having documentation of a change of condition regarding a resident's low blood pressure and/or low pulse for 1 (#84) of 3 closed records reviewed, and 2) notifying a resident's physician for a high blood sugar reading for 1 (#10) of 1 residents reviewed for insulin.Findings: Resident #84Review of the facility's Charting and Documentation policy and procedure (undated) revealed the following in part:Policy StatementAll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication the interdisciplinary team regarding the resident's condition and response to care.Policy Interpretation and ImplementationDocumentation in the medical record may be electronic, manual or a combination.The following information is to be documented in the resident medical record:d. changes in the resident's condition.Review of the medical record for Resident #84 revealed an admission date of 07/01/2025.Resident #84 had diagnoses that included dementia, anxiety, diabetes mellitus, heart disease, myocardial infarction, COPD, hyperlipidemia, dysphagia, and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #84 had a BIMS score of 3 which indicated severe cognitive impairment for daily decision making. Review of the vital signs record for Resident #84 revealed the following:On 04/01/2026 at 5:02 p.m. revealed a blood pressure reading of 80/69;04/02/2026 at 11:00 a.m. revealed a blood pressure reading of 130/49 and pulse was 41, and at 4:49 p.m. blood pressure of 95/55 and pulse of 56;04/03/2026 at 8:00 a.m. revealed a blood pressure reading of 70/51; and04/04/2026 at 9:47 a.m. revealed a blood pressure reading of 96/51.Review of the medical record revealed there was no documented evidence of the resident's change of condition regarding Resident #84's low blood pressure and/or low pulse.On 06/10/2026 at 12:45 p.m. interview with S3ADON confirmed there was no documented evidence in the medical record of the resident's change of condition regarding Resident #84's low blood pressure and/or low pulse. Resident #10 Review of the medical record revealed Resident #10 had an admission date of 06/25/2025 with a diagnosis of diabetes.Review of the June 2026 physician orders revealed an order for accuchecks before meals and at bedtime and to notify the physician for accucheck results greater than 400. Review of the June 2026 MAR revealed on the morning of 06/05/2026, Resident #10 had an accucheck result of 517. There was no documentation in the progress notes that the physician was notified of the accucheck results greater than 400. On 06/09/2026 at 2:30 p.m., interview with S3ADON confirmed there was no documentation that the physician was notified of the accucheck result greater than 400.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interviews, the Pharmacist failed to identify and report irregularities to the attending Physician, the facility's Medical Director and DON for 1 (#13) of 5 residents reviewed for unnecessary medications. Findings: Review of Resident #13's record revealed an admission date of 04/17/2023 with diagnoses including unspecified dementia without behavioral, psychotic, or mood disturbances, generalized anxiety disorder, hypertension, chronic obstructive pulmonary disease, and major depressive disorder. Review of Resident #13's June 2026 physician's orders revealed an order dated 02/06/2026 for Abilify (antipsychotic medication) 5 mg oral tablet give 2.5 mg (1/2 tab) by mouth one time a day and an order dated 09/26/2025 for Lasix (diuretic medication) oral tablet 20 mg one tablet by mouth one time a day (monitor for edema).Review of the record revealed Resident #13 did not have an appropriate diagnosis for the use of an antipsychotic medication (Abilify).Review of Resident #13's May and June 2026 MARs revealed the resident was administered a Lasix (diuretic) and an Abilify daily. Further review of the MAR revealed no documented evidence of monitoring for edema while the resident was on Lasix. Interview on 06/10/2026 at 11:40 a.m. with S3ADON revealed the Pharmacist failed to notify the facility of the need for an appropriate diagnosis for the use of Abilify on the pharmacy reviews dated 04/29/2026 and 05/28/2026 for Resident #13. S3ADON confirmed the Pharmacist failed to notify the facility of Resident #13 not having documentation of monitoring for edema while the resident was on Lasix on the pharmacy review on 05/28/2026.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents were free from unnecessary medications for 1 (#13) of 5 residents reviewed for unnecessary medications. The facility failed to monitor for edema for Resident #13 while on receiving Lasix (diuretic medication).Findings: Review of Resident #13's record revealed an admission date of 04/17/2023 with diagnoses including unspecified dementia without behavioral, psychotic, or mood disturbances, generalized anxiety disorder, and major depressive disorder recurrent.Review of Resident #13's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Further review of the MDS revealed resident received a diuretic medication. Review of Resident #13's June 2026 Physician's Orders revealed an order dated 09/26/2025 for Lasix oral tablet 20 mg one tablet by mouth one time a day (monitor for edema).Review of Resident #13's May and June 2026 MARs revealed no documented evidence of monitoring for edema while resident was receiving Lasix.Interview on 06/10/2026 at 11:40 a.m. with S3ADON confirmed Resident #13 received Lasix and failed to have documented evidence of monitoring for edema.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to 1) ensure food item packages were sealed and not left open to air, 2) document refrigerator and freezer temperatures, and 3) document steam table food temperatures. Findings:On 06/08/2026 at 7:50 a.m. observation of the kitchen revealed one package of garlic bread and french toast were stored in the freezer open to air and not sealed properly. One package of hamburger buns was open to air and not sealed properly. Review of the temperature logs revealed no documented evidence of steam table food temperatures from 06/03/2026 - 06/07/2026. Further review of the logs revealed no documented evidence of refrigerator or freezer temperatures from 06/03/2026 - 06/07/2026. On 06/08/2026 at 8:00 a.m. S4DM confirmed the food item packages were open to air and not sealed properly, and no documentation of the steam table food temperatures, or refrigerator and freezer temperatures from 06/03/2026 - 06/07/2026.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to provide an infection prevention and control program designed to provide a safe, sanitary and comfortable environment by failing to ensure biohazardous waste was not accessible to unauthorized personnel. Findings:Observations of the biohazardous waste storage closet on 06/08/2026 at 11:24 a.m. and 06/09/2026 at 11:38 a.m. revealed it was unlocked and the contents were accessible to residents and the public, including several filled sharps containers.On 06/10/2026 at 10:05 a.m., interview with S1Administrator confirmed the biohazard door should remain locked and should not be accessible to residents or the public.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assess residents for self-administration of medications for 1 (#35) of 1 sampled residents observed for medications available at the bedside. Findings: Review of the medical record for Resident #35 revealed an admission date of 04/10/2025. Resident #35 had diagnoses that included rheumatoid arthritis, hypothyroidism, anxiety, edema, hypertension and depression.Review of the annual MDS assessment dated [DATE] revealed Resident #35 had a BIMS score of 15 which indicated intact cognition for daily decision making.Review of the June 2026 physician orders revealed Resident #35 had a skin tear to the left shin, and an order dated 05/02/2026 to clean with wound cleanser, pat dry, apply Mupirocin ointment, apply non adherent dressing wrap daily and as needed until healed.On 06/08/2026 at 8:35 a.m., and 11:23 a.m. observations of Resident #35's room revealed a tube of Mupirocin ointment on the over bed table.On 06/08/2026 at 11:25 a.m. interview with Resident #35 revealed the nurse left the ointment in the room yesterday. On 06/09/2026 at 1:00 p.m. S3ADON was notified of the Mupirocin ointment in Resident #35's room on the over bed table. S3ADON confirmed Resident #35 should not have medications at the bedside and the resident had not been assessed to self-administer medications.