STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195315	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaplan Healthcare Center	1300 W. Eighth Street Kaplan, LA 70548

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure CNAs (Certified Nurse Aides) and Shower Aides provided showers and baths for 2 (Resident #5, Resident #R1) of 2 (Resident #1, Resident #R1) sampled residents investigated for ADLs (Activities of Daily Living). Findings:On 10/1/2025, a review of the facility's policy titled, Bath, Shower/ Tub with a revision date of 2/2018 read in part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident.Resident #5Review of Resident #5's electronic health record revealed the resident was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Major Depressive Disorder, Anxiety Disorder, and Legal Blindness, as defined in the USA (United States of America). Record review of Resident #5's care plan revised on 09/11/2025 revealed a focus area which stated, ADL self-care performance deficit, and interventions which included substantial maximal assistance to shower/ bathe. Record review of Resident #5's Quarterly MDS (Minimum Data Set) dated 09/11/2025 revealed a BIMS (Brief Interview Mental Status) of 12, indicating intact cognition. During an interview with Resident #5 on 09/29/2025 at 9:30 a.m., he stated his shower days were on Mondays, Wednesdays, and Fridays in the mornings. Resident #5 stated he asked for his shower this morning when a staff member came into his room. The staff member stated to him they were short staffed then left the room. Resident #5 stated he worked out with his weights in his room. He sweats and did not like to smell musty. Resident #5 stated and would like to have a shower this morning. A follow-up interview was conducted with the Resident #5 on 09/29/2025 at 3:30 p.m. Resident #5 stated he asked another staff member after lunch for a shower, and the staff member stated they are short staffed. He stated he did not receive a shower. During the follow up interview, Resident #5's roommate, Resident #R2 stated he heard Resident #5 ask for a shower this morning and after lunch, and the employee replied that they are short staffed. Review of Resident #R2's most recent MDS assessment dated [DATE] revealed he had a BIMS score of 15, indicating his cognition was fully intact. A review of Resident #5's record did not show any evidence or documentation that the resident had received a shower on Monday 09/29/2025 during the day shift or in the morning as requested.On 09/30/2025 at 9:00 a.m., an interview with S1CNA was conducted. S1CNA stated they were sometimes short staffed. She stated when there are no shower aides on the schedule, sometimes all the showers do not get done for the day. She confirmed that if there are no shower aides then the floor aides have to do showers, as well as all other duties and the work does not always get done. On 09/30/2025 at 9:50 a.m., an interview with S7CNA was conducted. S7CNA stated Resident #5 asked to have his shower on the morning of 09/29/2025. She was unable to give him a shower because they were short staffed. S7CNA stated they are short staffed sometimes and they do the best they can to shower residents, but are not always able to shower every resident that is scheduled for a shower. S7CNA further stated they were not always able to shower residents who requested showers on their unscheduled shower days. S7CNA stated Resident #R1 asked her when he would get his shower on the morning of 09/29/2025. S7CNA stated she was also not able to shower Resident #R1 because they were short staffed.On 10/1/2025 at 1:27 p.m., an interview and review of the nursing staff schedule was conducted with S3CorpNurse and S4ADM. S4ADM confirmed that two CNA's called in and one CNA came in to work, looked at the schedule and left. S4ADM stated she was short 3 CNA's on Monday (09/29/2025). The staffing schedule for Tuesday (09/30/2025) revealed two CNA's called in. When asked if they were short staffed for CNAs on these dates, S4ADM stated no they redistributed duties to cover the shifts. S4ADM and S3CorpNurse stated when the shower aides are not available, the floor aides should provide the residents' showers. Both stated they were not aware Residents #5 and#R1 had not received their showers. S3CorpNurse stated that if a resident was scheduled for a shower on a certain day of the week, they should receive that shower on that day. If they request a shower on the day shift then they should have their shower on the day shift.Resident #R1Review of Resident #R1's electronic health record revealed an admission date of 07/05/2024. A review of Resident #R1's care plan revealed: shower/ bathe self, requires set up or clean up assistance. Review of the facility's shower schedule revealed Resident #R1's shower days were Mondays, Wednesdays, and Fridays. Further review of Resident #R1's records revealed no shower was given on 09/29/2025, and no shower given on 09/30/2025. Review of Resident #R1's Quarterly MDS 08/27/2025 revealed he had a BIMS score of 15, indicating his cognition was fully intact. On 10/01/2025 at 2:25 p.m., an interview with Resident #R1 was conducted in his room. Resident #R1 stated his shower days were on Mondays, Wednesdays, and Fridays

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy and procedure reviews, the facility failed to maintain clean and sanitary kitchen equipment to prevent cross contamination and the likelihood of foodborne illnesses by failing to clean a Dumbwaiter Cart.Findings:Review of the facility's policy, Sanitization, with a last revised date of August 2025, revealed the following in part: Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 13. Dumbwaiters may be used to transport food to dining areas and soiled dishes back to the dietary department provided that the compartment is sanitized between the transportation of soiled dishes and food. On 09/29/2025 at 12:07 p.m., an interview and observation was conducted with S14DM (Dietary Manager) of an empty dumbwaiter cart outside of the kitchen door. The cart was observed to have multiple dried clumps of yellow, brown, food matter; and dried thin layers of yellow food matter on multiple shelves. S14DM confirmed that the cart was used to deliver the lunch trays today. She stated that the cart should have been cleaned after each use. She stated based on her observations of the cart, the cart obviously was not cleaned last night nor after the last meal, and should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and policy and procedure review, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections as evidenced by failing to:1. ensure staff wore proper PPE (Personal Protective Equipment) while providing care for 2 (#1 and #2) of 2 (#1 and #2) residents who were on Enhanced Barrier Precautions in a final sample of 6 (#1, #2, #3, #4, #5, #6) residents investigated for infection control practices; and2. ensure the shower facilities and shower equipment were cleaned and disinfected between residents for 1 (Shower room A) out of 4 shower rooms (Shower room A, Shower room B, Shower room C, Shower room D) observed.Findings:1.Review of facility policy and procedure titled, Enhanced Barrier Precautions (EBP) with a review date of 06/30/2025, read in part . Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multidrug-resistant organisms (MDROs) to staff hands and clothing. Further review of the policy indicated when EBP should be used based on the resident's status as follows: Has a chronic wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO: Use EBP- yes; Donning PPE for Residents on EBP Based on Activity Provided/Assistance While in Resident -Room: Transfer a resident- [NAME] Gloves and Gown-Yes; Changing briefs or assisting with toileting- [NAME] Gloves and Gown- Yes; Turn and Reposition or assist with bed mobility- Yes. Resident #1: Review of Resident #1 Electronic Medical Record (EMR) revealed she was admitted on [DATE] with diagnoses which included venous insufficiency, cerebral infarction, end stage renal disease, and unspecified open wound, left lower leg. A review of Resident #1's current Order Summary Report revealed a physician's order with a start date of 10/25/2024 that read; Enhanced Barrier Precautions every shift. A review of Resident #1's current Clinical Care Plan Detail revealed in part: Focus- Resident requires Enhanced Barrier Precautions r/t (related to) Wounds - Interventions/Tasks - EBP used during high-contact resident care activities as applicable, such as: Transferring, Changing briefs or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/2025 at 4:10 p.m., an observation was made outside Resident #1's room. A sign on Resident #1's door was observed stating in part: Stop- Enhance Barrier Precautions: Providers and Staff Must: Wear gloves and a gown for the following High-Contact Resident Care Activities. Transferring, Changing briefs or assisting with toileting. At this time, S1CNA (Certified Nursing Assistant) was observed entering Resident #1's room without wearing a gown. S1CNA was observed minutes later exiting the resident's room with a clear bag containing used incontinent supplies. S1CNA confirmed that she had just changed Resident #1's brief and that she wore only gloves to do this. On 09/30/2025 at 4:23 p.m., an observation was made of Resident #1 being transferred by S1CNA and S2LPN (Licensed Practical Nurse) with a mechanical lift. S1CNA was not observed wearing gloves or a gown, and S2LPN was observed without a gown on. S1CNA was then observed adjusting Resident #1's clothing after the transfer was complete. Both S1CNA and S2LPN stated that gowns did not have to be worn for care of this resident because the resident was not on EBP; the EBP sign on the door was for the resident's roommate. S1CNA stated that she did not wear gloves because she did not touch the resident. On 09/30/2025 at 4:49 p.m. an observation of the EBP sign as well as a plaque on the door frame labeled A with a picture of stop sign containing the letters EBP posted on Resident #1's door was conducted with S3CorpNurse (Corporate Nurse). S3CorpNurse stated that she was the acting Infection Preventionist for the facility. S3CorpNurse confirmed that Resident #1 was on EBP and that the plaque on the door frame with the EBP stop sign labeled A indicated which resident was on EBP. S3CorpNurse confirmed the plaque indicated that Resident #1 was on EBP. On 10/01/2025 at 1:27 p.m., an interview was conducted with S3CorpNurse and S4ADM (Administrator). S3CorpNurse confirmed that staff should have worn a gown and gloves while transferring and changing Resident #1's brief since the resident was on EBP. Resident #2: Review of Resident #2 EMR (Electronic Medical Record) revealed she was admitted on [DATE] with diagnoses which included, but not limited to peripheral pressure-induced deep tissue damage of left heel, pressure ulcer of right buttock, need for assistance with personal care, type 2 diabetes mellitus, other fecal abnormalities. The resident had an unstageable pressure ulcer on right buttock, stage IV pressure ulcer to right buttock, left heel deep tissue pressure injury, right heel deep tissue pressure injury, which required wound care. A review of Resident #2's quarterly MDS (Minimum Data Set) dated 9/20/2025, revealed a BIMS (Brief Interview Mental Status) of 15, indicating the resident's cognition was intact. A review of Resident #2's Clinical Care Plan with a review start date of 07/29/2025 and target completion date of 12/17/2025, revealed the resident required EBP (Enhanced Barrier Precautions) with a goal to reduce the potential spread of MDRO (Multidrug-resistant organism).Interventions/ Tasks: apply signage outside resident room, EBP used during high-contact resident care activities as applicable, such as: dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheter), wound care and other areas determined to require EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #2's orders revealed: EBP every shift with a start date of 04/29/2025 and active as of 10/01/2025. On 09/29/2025 at 3:48 p.m., an observation outside of Resident #2's room revealed EBP signage. On 09/29/2025 at 3:50 p.m., an observation was made of S1CNA (Certified Nursing Assistant) and S5LPN (Licensed Practical Nurse) in Resident #2's room. S1CNA was observed providing personal care to Resident #2 while the resident was in bed. S1CNA did not have a gown on. On 09/29/2025 at 3:55 p.m., an interview was conducted with S5LPN. She confirmed there was an EBP sign on the outside of Resident #2's door. She stated staff should wear gloves and a gown when providing care to the resident such as checking a brief for a bowel movement or transferring using the Hoyer lift. She confirmed that S1CNA did not have a gown on when providing care for Resident #2. On 09/29/2025 at 4:00 p.m., an observation was made of S1CNA and S11CNA transferring Resident #2 from her bed to her wheelchair with the Hoyer lift. S1CNA and S11CNA had on gloves, but were not observed wearing gowns. On 09/30/2025 at 1:30 p.m., an observation was made of S13CNA and S8CNA transferring Resident #2 from a stretcher to her wheelchair using the Hoyer lift. S13CNA and S8CNA were not observed wearing gloves or a gown. On 09/30/2025 at 1:55 p.m., an interview with S13CNA was conducted. S13CNA stated she knew Resident #2 was on EBP, and pointed to the sign on the resident's door. She stated she thought she only had to wear a gown and gloves when bathing the resident or changing her brief. She confirmed that the sign on the outside of the resident's door listed transferring as an interaction that required a gown and gloves. On 09/30/2025 at 2:00 p.m., an interview with S8CNA was conducted. S8CNA stated that she was aware that Resident #2 was on EBP. She stated that when staff transfer the resident from bed to wheelchair and wheelchair to bed, the staff should wear gowns and gloves. On 10/01/2025 at 1:27 p.m., an interview with S3CorpNurse (Corporate Nurse) was conducted. S3CorpNurse verbally confirmed that Resident #2 was on EBP. She confirmed that staff should wear gloves and a gown when transferring Resident #2 from bed to wheelchair and wheelchair to bed by Hoyer lift as well as all other care listed on the EBP sign. 2. Shower Room A A review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, with a last reviewed date of 06/30/2025, read in part, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standards. Reusable items are cleaned and disinfected or sterilized between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/2025 at 9:10 a.m., an observation was made in Shower Room A with S9CNA (Certified Nursing Assistant) present. S9CNA stated she had showered 4 to 5 residents this morning. The shower chair was observed with pale brown, dried, elongated drops of matter. S9CNA confirmed that she also observed the pale brown, dried, elongated drops of matter on the chair. During continued observations, dark brown, dried circular matter was observed on the wall next to the shower chair. S9CNA sprayed the cleaner/ disinfectant on the wall and shower chair, then wiped it with the washcloth. The matter easily wiped off the wall. She stated the facility's process for cleaning the shower room included that showers were to be cleaned after every resident's shower was complete and again at the end of each day. S9CNA stated she had not used that shower chair yet today, and that upon observing it, it must not have been cleaned yesterday. On 10/01/2025 at 9:25 a.m., S10CNA was observed exiting Shower Room A with a resident and returned to the shower room. Upon her return, an observation was conducted of Shower Room A with S10CNA. Upon entering, there was a strong and noticeable odor of feces. A mound of feces was observed on the shower floor inside the shower stall. S10CNA stated she had just finished a resident's shower, then she donned gloves and picked up the mound of feces off the shower floor using paper towels. S10CNA placed the feces in a clear plastic bag then discarded the bag into a trash can inside the shower room. S10CNA then proceeded to rinse the shower stall with water from the shower head. S10CNA was not observed using any cleaning products or disinfectant cleaner to clean and disinfect the shower floor or shower walls. After rinsing the shower, S10CNA opened the shower room door and assisted a resident who was waiting for a shower into the shower room. S10CNA helped the resident take off her clothes then sat the resident in the shower chair. S10CNA rolled the shower chair into the same shower stall the mound of feces was observed during the earlier part of observations. S10CNA closed the shower curtain and allowed the resident to shower. S10CNA stated that she was supposed to clean the shower with Rapid Multi Surface Disinfectant Cleanser after each resident. S10CNA stated I aint gonna lie, I don't use it after every resident. On 10/01/2025 at 10:50 a.m., an interview was conducted with S3CorpNurse (Corporate Nurse) who was the facility's Infection Preventionist and S4ADM (Administrator). S3CorpNurse stated showers should be cleaned and disinfected after each resident with the Rapid Multi Surface Spray Disinfectant. S3CorpNurse also stated that if a resident has a bowel movement on the shower floor during their shower the entire shower should be cleaned and disinfected with Rapid Multi Surfaced Spray Disinfectant.