STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195423	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Health and Rehab LLC	307 N Castleman St Oak Grove, LA 71263

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 18118 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff by having environmental concerns throughout the inside and outside of the building. This deficient practice had the potential to affect 51 residents that resided in the building. Findings: On 11/04/2024 at 8:45 a.m. observation of the kitchen revealed the ceiling contained acoustic suspended tiles. The ceiling tiles were observed to have old water stains, the tiles by the ceiling vents were sagging, and 2 holes in the ceiling approximately 4 inches by 4 inches were observed. On 11/12/2024 at 11:40 a.m., an interview with S5Dietary Manager confirmed the ceiling tiles in the kitchen were stained with water damage, sagging, had 2 holes in the ceiling, and the ceiling needed to be repaired. On 11/4/2024 at 2:30 p.m. observation of the hallway floors throughout the facility revealed the floors had a buildup of dirt and grime and needed to be cleaned. On 11/04/2024 at 4:00 p.m. S1Administrator was notified of the hallway floors throughout the facility had a buildup of dirt and grime and needed to be cleaned. On 11/04/2024 at 12:40 p.m. observation of the whirlpool room revealed the window was open and the screen was not attached, a box fan was observed sitting in the opened window. On 11/04/2024 at 12:45 p.m. S1Administrator went to the whirlpool room with the surveyor. S2Administrator confirmed the staff should not have been putting the box fan in the window without a screen attached. On 11/06/2024 at 10:15 a.m. observations of the outside of the facility revealed 2 mop buckets, 3 gray barrels, 1 old mattress on the ground by the dumpster, an old mattress was leaning against the outside of the building, and a bed frame was directly on the ground. Further observations revealed pieces of sheet rock, a shower chair, a Christmas tree, a broken glass picture frame, pieces of a shower, and rusted pipes were observed on the ground. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/2024 at 10:45 a.m. observations of the laundry room revealed rotten wood was observed on the outside bottom part of the building. Observations of the inside of the laundry room behind the clean sink and eye wash station revealed rotten wood, and the floor was wet behind the washer and contained a black substance. On 11/06/2024 at 10:45 a.m. S6Laundry Worker confirmed behind the clean sink and eye wash station revealed rotten wood, and the floor was wet behind the washer and contained a black substance. On 11/06/2024 at 1:15 p.m. S1Administrator was informed of the environmental issues outside of the building and in the laundry area.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review and interviews the facility failed to ensure the residents' environment remained as free of accident hazards as is possible for 1 (#5) of 3 (#1, #5 and #8) residents reviewed for accident hazards. The facility failed to complete an Accident and Incident Report per the facility's policy and the facility failed to perform a thorough investigation after resident #1 was found to have illegal drugs in his possession. Findings: Review of the facility's Accident and Incident Documentation and Investigation Resident Incident policy undated revealed: Policy: Accidents and/or incidents involving resident care will be investigated and documented on the Risk Assessment section of Point Click Care (PCC) system. An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents. Review of the medical record for resident #5 revealed an admitted [DATE] with diagnoses of end stage renal disease, reflux, hyperlipidemia, epilepsy, type 2 diabetes mellitus, schizoaffective disorder and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated resident #5 was cognitively intact for daily decision making. Further review of the MDS revealed the resident had no range of motion impairment of the upper extremities, had impairment on one side of the lower extremity and used a wheelchair for locomotion. Review of the nurses notes dated 10/14/2024 at 6:37 a.m. revealed resident #5 was out in the smoking area when another resident came and got the nurse stating he (referring to resident #5) was not acting right. S7Licensed Practical Nurse (LPN) assessed the resident his eyes were very dilated and glossy and he was not making any sense when attempting to answer questions and he had a very strong marijuana odor. The physician was notified of the resident's condition with orders to send to the emergency department for evaluation. S7LPN notified Emergency Medical System (EMS), administrative staff and the responsible party as well as calling in a report to the hospital. This nurse received instructions to go through resident #5's personal belongings due to the fact he admitted to EMS that he smoked weed and took a pill. This nurse along with three coworkers as witnesses went through a bag that resident #5 had and he had what appeared to be marijuana in a pill bottle as well as marijuana rolled in a cigar tube half smoked. This nurse along with a fell ow nurse took the substance and placed it in a double bag and locked it up in the narcotic box. Review of the nurses notes signed by S3Registered Nurse (RN) dated 10/14/2024 at 1:05 p.m. revealed disposed of marijuana and witnessed by S5Licensed Practical Nurse (LPN). Further review of nurses' notes revealed the marijuana was flushed down the toilet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital notes dated 10/13/2024 at 9:09 p.m. revealed the patient stated he only smoked marijuana. On 11/06/2024 at 1:20 p.m. S1Administrator revealed she was notified by S3RN of the incident with resident #5. S1Administrator confirmed the facility did not complete an Accident and Incident Report and a thorough investigation was not performed to determine where and how the resident obtained the marijuana. On 11/06/2024 at 2:00 p.m. an interview with resident #5 revealed he denied having or bringing any illegal drugs into the facility. On 11/12/2024 at 11:53 a.m., during a phone interview with S7LPN, S7LPN revealed she worked on 10/13/2024 from 7:00 p.m. - 7:00 a.m. when resident #5 started acting funny and they found marijuana in a bag in his room. The physician was notified and resident #5 was sent to the emergency department as ordered. On 11/12/2024 at 12:10 p.m. interview with S3Registered Nurse (RN) revealed on 10/13/2024 S7LPN called to inform him of resident #5 was acting funny and he was sent to the emergency department and he told the EMS that he had smoked marijuana. S3RN revealed he notified S1Admnistrator and she instructed him to tell S7LPN to search resident #5's room. S3RN revealed S7LPN and another nurse found marijuana in resident #5's room and S7LPN double bagged the marijuana and locked it in the narcotic box. S3RN revealed on 10/14/2024 he and S4LPN disposed of the marijuana by flushing it down the toilet as directed by the Administrator.

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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** 18118 Based on record reviews and interviews, the facility failed to ensure that nursing staff were able to demonstrate competencies and skills necessary to care for residents needs for 4 (#1, #2, #3, and #6) of 4 residents. The facility failed to have documentation of wound care, tracheostomy care, and medication administration. Findings: Review of Medication Administration General Guidelines policy and procedure dated 07/2024 revealed the following, in part: Procedure: 9. Only licensed or legally authorized personnel who prepare a medication may administer it. This individual records the administration on the resident's Medication Administration Record (MAR)/electronic MAR or Treatment Administration Record (TAR)/electronic TAR after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/TAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. Resident #1 Review of the medical record for resident #1 revealed an admitted [DATE] with diagnoses including paraplegia, bipolar disorder, neuromuscular dysfunction of the bladder, congestive heart failure, colostomy, and absence of left leg below knee. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating resident #1 was cognitively intact for daily decision making. Review of the care plan dated 09/12/2024 revealed resident #1 had a stage 3 to the right lateral and right distal leg. The interventions were to administer medications as ordered, administer treatments as ordered and monitor for effectiveness, and to perform treatment to right distal and right lateral leg per orders. Review of the physician orders revealed an order dated 09/12/2024 to clean right proximal and right distal lower extremity with Hibiclens, pat dry with 4x4 gauze, apply Medihoney to wound bed, cover with border gauze, wrap with roll gauze, and secure with tape. Change dressing as needed if soiled or dislodged, one time a day for wound care. Review of the Treatment Administration Record (TAR) for October 2024 revealed no documented evidence of the dressings changed daily on 10/15/2024, 10/16/2024, 10/23/2024 and 11/02/2024 as ordered. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/2024 at 8:55 a.m., an interview with S2Director of Nursing (DON) confirmed the wound care was not documented as done for resident #1 on 10/15/2024, 10/16/2024, 10/23/2024 and 11/02/2024. Resident #6 Review of the medical record for resident #6 revealed an admitted [DATE] with diagnoses including pressure ulcer to the sacral area, diabetes mellitus, malignant neoplasm of the colon, dementia, and an ileostomy. Review of the quarterly MDS assessment dated [DATE] revealed resident #6 scored a 15 on the BIMS indicating resident #6 was cognitively intact for daily decision making. Review of the care plan for resident #6 revealed he had a stage 4 pressure ulcer to sacral region (present upon admission). Interventions were to administer treatments as ordered and monitor effectiveness. Review of the physician orders revealed an order dated 09/12/2024 to cleanse the stage 4 sacral pressure ulcer with normal saline, pat dry with 4x4 gauze, apply collagen powder to the wound bed, and cover with a sterile border gauze change as needed and every Monday, Wednesday and Friday. Review of the Treatment Administration Record (TAR) for October 2024 revealed no documented evidence of the dressings changed as ordered on 10/16/2024, 10/18/2024 and 10/25/2024. On 11/12/2024 at 8:55 a.m., an interview with S2DON confirmed the wound care was not documented as done for resident #6 on 10/16/2024, 10/18/2024 and 10/25/2024. 43405 Resident #2 Review of resident #2's medical record revealed an admitted [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease, abdominal pain, severe sepsis, bacterial peritonitis, abscess of vulva, peripheral vascular disease, schizophrenia, bipolar disorder, and end stage renal disease. Review of the resident #2's current Physician's Orders revealed the following an order dated 10/29/2024 to clean right labia with dermal wound cleanser (DSW), pat dry with 4x4 gauze, apply Dakin's wet to dry dressing change 2 times a day (bid) and as needed (prn) soilage/dislodgement. Review of the 5 day Medicare MDS assessment dated [DATE] revealed a BIMS score of 15 indicating cognitively intact. Further review of the MDS revealed resident requires substantial to maximal assistance with activities of daily living. Review of resident #2's November TAR revealed the nurses failed to document wound care to right labia 6 times. Review of the November 2024 nurses notes revealed no documentation regarding refusal of wound care by resident #2. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confirmation on 11/12/2024 at 12:30 p.m. with S2DON confirmed the nurses failed to document resident #2's wound care to right labia 6 times on the November 2024 TAR. S2DON further confirmed there were no documentation in the November nurses notes of resident #2 refusing wound care. Resident #3 Review of the record for resident #3 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, other sequelae of cerebral infarction, chronic obstructive pulmonary disease, type 2 diabetes mellitus, epilepsy, other seizures, pressure ulcer of sacral region stage 4, left hemiparesis, tracheostomy status, wheezing, gastroesophageal reflux disease, secondary hypertension, and other seizures. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. Further review of the MDS revealed resident #3 was dependent on staff with 1 to 2 physical assist for all activities of daily living. Review of resident #3's Physician's Orders revealed the following orders: 06/27/2024 suction type: oral and trach frequency and why: per shift and as needed 2 times a day, trach suction every (q) shift and as needed (prn) q 4 hours as needed, 2 times a day, tracheostomy- change ties when soiled and as needed 2 times a day, change suction tip: yanker and suction catheter 2 times a day, change suction tubing 2 times a day, and 08/20/2024-tracheostomy- assess skin around stoma site and under ties during trach care1 time a day 09/16/2024 Gentamycin Sulfate solution use 80 milligrams (mg) intravenous (IV) every (q) 24 hours (hrs), and 09/17/2024- Imipenem-Cilastatin IV solution reconstituted 500 milligrams (mg) - use 500 mg intravenous (IV) every (q) 6 hours for 7 days. Review of the September 2024 Medication Administration Record (MAR) revealed the following: Change suction tip: Yanker and suction catheter 2 times a day- not documented 10 times, and Gentamycin Sulfate solution use 80 mg IV q 24 hrs (9:00 p.m.)- not documented 3 times on 09/20/2024, 09/21/20224, and 09/22/2024, and Imipenem-Cilastatin IV solution reconstituted 500 mg- use 500 mg intravenous (IV) every (q) 6 hours for 7 days - not documented 9 times. Review of the September 2024 TAR revealed the following: Tracheostomy- assess skin around stoma site and under ties during trach care 1 time a day- not documented 9 times Suction type: oral and trach frequency and why: per shift and as needed 2 times a day (9:00 a.m./9:00 p.m.)- not documented 7 times (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Trach care every day and as needed every day shift (7:00 a.m.)- not documented 9 times. Review of the October 2024 TAR revealed the following: Tracheostomy- assess skin around stoma site and under ties during trach care 1 time a day- not documented 10/01/2024, 10/04/2024, and 10/05/2024 (3 times); and Trach care every day and as needed every day shift (7:00 a.m.)- not documented 10/01/2024, 10/04/2024, and 10/05/2024 (3 times). Review of resident #3's September 2024 and October 2024 MAR and TAR revealed no documented evidence of tracheostomy suctioning from 09/28/2024-09/30/2024, and 10/01/2024-10/05/2024. Review of the resident's current care plan revealed tracheotomy related to hypoxia/respiratory failure and interventions included change suction set up weekly per orders, change suction tip, yanker and suction catheter per facility protocol, document sputum color and amount 2 times per day (bid) per orders, ensure trach ties and secured at all times, monitor/document restlessness, agitation, confusion, increased heart rate (tachycardia), and bradycardia, monitor/document level of consciousness, mental status, and lethargy prn, monitor respiratory rate, depth, and quality, check and document q shift/as ordered, provide good oral daily and prn, provide means of communication and procedural information, reassure that help is available immediately, provide paper and pencil if needed, work with resident to develop communication system that will work in an emergency, reassure resident to decrease anxiety, suction as necessary, tracheotomy care q shift q day, assess skin around stoma site q day, use universal precautions as appropriate. An interview on 11/12/2024 at 12:05 p.m. with S8Registered Nurse (RN) confirmed no documentation of suctioning on resident #3 for 7 times in September and 10 times in October, trach care not documented 9 times in September and 3 times in October, Imipenem Cilastatin not documented 9 times in September, Gentamycin not documented 3 times in September, and assessing skin around stoma site (tracheostomy) - not documented 9 times in September and not documented 3 times in October.

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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** 43405 Based on record reviews, observations, policy review, and interviews, the facility failed to implement policies and procedures for enhanced barrier precautions (EBP) for 1 (#2) of 3 (#1, #2, and #6) residents reviewed for enhanced barrier precautions. Findings: Review of the facility's Enhanced Barrier Precautions (EBP) policy dated 04/01/2024 revealed Definition and Scope Enhanced Barrier Precautions are infection control interventions designed to reduce transmission of multidrug-resistant organisms (MDROs). Example of Use EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) Review of resident #2's medical record revealed an admitted [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease, abdominal pain, severe sepsis, bacterial peritonitis, abscess of vulva, peripheral vascular disease, schizophrenia, bipolar disorder, and end stage renal disease. Review of the resident #2's current physician's orders revealed an order dated 10/29/2024 to clean right labia with dermal wound cleanser (DWC), pat dry with 4 by 4 gauze, apply Dakin's wet to dry dressing change 2 times a day (bid) and as needed (prn) soilage/dislodgement. Review of the 5 day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 indicating cognitively intact. Further review of the MDS revealed the resident required substantial to maximal assistance with activities of daily living. Observations on 11/04/2024 at 11:20 a.m., 11/06/2024 at 8:30 a.m., and 11/06/2024 at 3:45 p.m. revealed no enhanced barrier precaution sign on resident #2's door. An interview on 11/12/2024 at 10:00 a.m. with S3Registered Nurse (RN) revealed he is the infection preventionist. S3RN revealed when residents are to be placed on enhanced barrier precautions he posts the sign on the door and he verbally notifies staff of residents that are on EBP. An interview on 11/12/2024 at 12:30 p.m. with S2Director of Nursing (DON) confirmed that resident #2 required EBP and did not have an EBP sign posted on her door on 11/04/2024 and 11/06/2024. 18118