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	01/29/2025

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on record reviews and interviews, the facility failed to immediately consult the resident's physician when a resident had a change in condition or started a new treatment for 1 (#1) of 3 (#1, #3, and #4) residents reviewed for accidents. The deficient practice was evidenced by the nurse failing to notify the physician in a timely manner after she observed blisters on resident #1's skin. Findings: Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses which included in part, acquired absence of right leg below knee, Type 1 diabetes with diabetic neuropathy, and hypertensive chronic kidney disease. Review of the significant change in status assessment dated [DATE] revealed resident #10 had a brief interview for mental status score of 15 which indicated the resident was cognitively intact with his daily decision making skills. Further review of the assessment revealed that resident #1 was independent with his ability to eat. Review of the medical record revealed a physician's order dated 01/11/2025 for Silvadene External Cream 1% (Silver Sulfadiazine) apply to right thigh topically one time a day related to patient's other non-compliance with medication regimen; Burn to right thigh-apply Silvadene and cover with Bordered gauze or wrap with Kerlix daily and as needed until healed. Review of the Incidents By Incident Type Report revealed that resident #1 had a documented skin impairment incident on 01/11/2025 at 3:00 a.m. Review of the incident description revealed: resident called night nurse to room and said he burned himself with some noodles, looked at right thigh and noticed blisters. Review of the resident description revealed the following documentation: I warmed up my noodles and I had just made it to the door and I spilled the noodles over my leg. I called the Certified Nursing Assistant (CNA) and she cleaned off the noodles from my leg. I got in bed and was getting changed by another CNA and she noticed that I had a blister on my leg. I told her I wasted noodles on my leg. I called for the nurse and I showed it to her. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/2025 at approximately 2:15 p.m., an interview with resident #1 revealed that he had self-propelled himself to the activity room where he heated up a cup of noodles. Resident #1 further revealed that when he got back to his room door, he had gotten distracted and spilled the cup of noodles on himself. He revealed that the juice from the noodles had gotten on the left thigh a little bit, but more so on his right thigh. Resident #1 could not recall the exact time, but approximately an hour later, his CNAs came to change his brief and noticed that the areas on his thigh were burned. He further revealed that the CNAs had told his nurse (Referring to S3Licensed Practical Nurse (LPN) and she had come to his room to look at his skin. On 01/23/2025 at 4:11 p.m., a telephone interview with S3LPN revealed that during her shift on 01/11/2025 at approximately 3:00 a.m., she was notified by one of the CNAs that resident #1 had spilled some noodles on his leg. S3LPN further revealed that she (S3LPN) had assessed resident #1 and observed 2-3 water blisters, 1/2 to 1 inch blister length to the resident's right knee. S3LPN revealed that she had notified the oncoming nurse (S5LPN) during morning report. She confirmed that she (S3LPN) did not notify the physician of resident #1 having blisters on his skin. On 01/23/2025 at 4:32 p.m., S4Registered Nurse (RN) revealed that resident #1 had told her that he had spilled noodle juice on himself, just as he was leaving out of the facility to go to dialysis. She revealed the date was on 01/11/2025 at approximately 11:00 a.m. She further revealed that resident #1 had asked her if she would look at his leg when he got back and that he had a little burn. S4RN revealed that she assessed the resident's leg after he returned back to the facility and observed a burned area that looked to be a large blister with 1/2 of the blistered area that had burst and the other 1/2 with the layer of skin gone on the resident's right thigh. S4RN revealed she then contacted the physician and received an order for Silvadene cream 1% to be applied to resident #1's burned skin every day until healed. On 01/27/2025 at approximately 2:40 p.m. S1Administrator was notified of the above findings. On 01/29/2025 at 10:15 a.m., an interview with S5LPN revealed she had worked the 7:00 a.m. to 7:00 p.m. shift on 01/11/2025. She further revealed that she did not recall S3LPN reporting to her that resident #1 had burned himself that a.m. S5LPN confirmed that she did not become aware of the burn until S4RN was informed of resident #1 with a burn to his skin on 01/11/2025 at approximately 11:00 a.m.

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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** 32231 Based on observations, record reviews, and interviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 (#7) of 1 (#7) residents observed smoking in an unsafe manner. The deficient practice was evidenced by resident #7 tossing his lit cigarette butt on the concrete when left unsupervised outside in the smoking area. Findings: Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including dementia and nicotine dependence. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed that resident #1 had a Brief Interview for Mental Status score of 05 which indicated the resident had severe cognitive impairment with his daily decision making skills. Review of the care plan revealed that resident #7 was a smoker. Further review revealed the approaches included that resident #7 required supervision while smoking. On 01/28/2025 at approximately 12:18 p.m., an observation revealed resident #7 smoking a cigarette in the designated outside smoking area, unsupervised. When he had finished smoking, resident #7 tossed the remainder of the lit cigarette butt onto the concrete instead of using the fire safety ashtray that was located directly in front of him. On 01/28/2025 at 12:34 p.m., S1Administrator was notified of the observation regarding resident #7 smoking unsupervised and tossing his lit cigarette butt onto the concrete when finished. S1Administrator confirmed that resident #7 needed to be re-evaluated for safe smoking.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on observations, record reviews and interviews, the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment and to help prevent cross contamination for 1 (#1) of 1 (#1) residents observed for wound care. The deficient practice was evidenced by the Wound Care Nurse (WCN) contaminating a cream used to treat a resident's burn and by storing a contaminated bottle of Dermal Wound Cleanser (DWC) inside of the wound care cart. Findings: Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses which included in part, acquired absence of right leg below knee, Type 1 diabetes with diabetic neuropathy, and hypertensive chronic kidney disease. Review of the medical record revealed a physician's order dated 01/11/2025 for Silvadene External Cream 1% (Silver Sulfadiazine) apply to right thigh topically one time a day related to patient's other non-compliance with medication regimen; Burn to right thigh-apply Silvadene and cover with Bordered gauze or wrap with Kerlix daily and as needed until healed. On 01/27/2025 at 3:15 p.m., an observation revealed S2WCN preparing for resident #1's wound care procedure. During the preparation, S2WCN opened a jar of Silvadene Cream 1% (a cream used to treat burns). S2WCN retrieved a small medication cup from inside of the wound care cart with her bare hand and dipped the cup down and into the Silvadene Cream using a scooping motion. Both the inside and outside of the medication cup was in direct contact with the topical cream. S2WCN was further observed placing a bottle of DWC on top of and indirect contact with resident #1's over-the-bed table. S2WCN did not sanitize the table prior to placing the cleanser on the table top. After the wound care procedure was completed, S2WCN gathered up her supplies and returned to the wound care cart. She placed the bottle of DWC on top of the cart then shortly afterwards, she returned the bottle to the inside of the bottom drawer next to other wound care supplies. S2WCN did not sanitize the bottle of DWC prior to setting the bottle down on the top of the wound care cart and prior to returning it back inside of the cart. S2WCN revealed that the Silvadene Cream was not specific to just resident #1, but was available for any resident who may require the cream. S2WCN was notified of the findings and she confirmed that she had not used proper infection control techniques to help prevent possible cross contamination. On 01/27/2025 at 3:45 p.m., S1Administrator was notified of the above findings.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on record reviews and interviews, the facility failed to ensure policies were being followed for 1 (#10) of 7 (#5, #7, #8, #9, #10, #11, and #12) residents reviewed for smoking. The deficient practice was evidenced by the facility not having documented evidence of a Safe Smoking Evaluation completed quarterly for resident #7. Findings: Smoking/Tobacco Usage Waiver Smoking Policy (Undated): Review of the policy revealed it is the policy of the nursing facility to enforce a smoke-free environment within the facility for both residents and staff to ensure the rights, safety, and well-being of all residents and staff. Review of the smoking procedure included, but was not limited to: Residents who smoke will be assessed on admission, quarterly, and when there is a significant change in the resident's ability to handle their smoking products. Findings: Review of the medical record revealed that resident #10 was admitted to the facility on [DATE]. Review of the physician's progress notes dated 12/07/2024 revealed resident #10 had a documented diagnosis of chronic schizophrenia. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed resident #10 had a documented Brief Interview for Mental Status score of 15 which indicated that resident #10 was cognitively intact with his daily decision making skills. Review of resident #10's medical record revealed a Safe Smoking Evaluation sheet. The words non- smoker had been hand -written at the top of ride side of the sheet and resident #10's name was hand-written at the left lower portion of the sheet. Further review revealed there had been no other information entered on the Safe Smoking Evaluation sheet and it was not dated. Review of resident #10's medical record further revealed a second Safe Smoking Evaluation sheet dated 01/09/2024 indicating the resident was a deemed as a safe smoker. On 01/28/2025 at 1:03 p.m., an interview with S6Social Services revealed that date of 01/09/2024 was incorrect and should have been 01/09/2025. Upon further review, there was no documented evidence of a Safe Smoking Evaluation being completed quarterly for resident #10. On 01/28/2025 at 2:50 p.m., S1Administrator was notified of the above findings. S1Administrator confirmed there was no documented evidence of a Safe Smoking Evaluation being completed for resident #10 on a quarterly basis.