

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on interview and record review, the facility failed to ensure that individual financial records are available to the resident through quarterly statements for 1 (#6) of 1 (#6) residents reviewed for personal funds out of a total sample of 37 residents. Findings:Review of the facility's Resident Funds policy (undated) revealed in part:Purpose: Ensure that an individual record is established for each resident on which only those transactions involving his/her personal funds are recorded and maintained. Procedure:3. The individual financial record must be available to the resident through quarterly statements and upon request. Review of the medical record for Resident #6 revealed a Brief Interview of Mental Status score of 14 which indicated that the resident is cognitively intact.On 07/23/2025 at 1:30 p.m., a phone interview with S5Business Office Manager (BOM) related to the management of resident finances was conducted. During the interview, S5BOM was asked to confirm the delivery method of quarterly statements. S5BOM stated that quarterly statements are mailed by way of the postal service. On 07/23/2025 at 3:06 p.m., an interview was conducted with Resident #6 related to the availability of quarterly statements. Resident #6 voiced that she had not received her most recent quarterly statement. On 07/23/2025 at 3:10 p.m., an interview was conducted with S6Social Services Director (SSD) related to the delivery of resident mail. S6SSD voiced that she does not recall if quarterly statements were delivered.On 07/23/2025 at 3:40 p.m., an interview was conducted with an anonymous source who stated that quarterly statements are not being received by residents.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 4 (#1, #2, #22, #43) of 6 (#1, #2, #6, #22, #40, #43) sampled residents reviewed for environmental concerns. The facility failed to ensure that residents' wheelchairs were maintained in good repair. Findings:</p> <p>Resident #1</p> <p>Review of Resident #1's record revealed he was admitted to the facility on [DATE] with diagnoses including acquired absence of left leg below knee, Type 2 diabetes, and epilepsy. Further review revealed an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 used a wheelchair for ambulation and required supervision/touch assistance for most activities of daily living.</p> <p>On 07/21/2025 at 9:50 a.m., Resident #1 was in his wheelchair in the hall. An observation of his wheelchair revealed the left wheelchair arm padding was cracked and needed to be repaired. Further observation revealed the wheelchair wheels had a build-up of dirt and grime.</p> <p>On 07/22/2025 at 3:46 p.m., Resident #1 was in bed in his room and his wheelchair was next to his bed. Further observation revealed the left wheelchair armrest padding and the wheelchair seat was cracked and were in need of repair. Also, it was noted that the wheelchair wheels had a build-up of dirt and grime.</p> <p>On 07/23/2025 at 1:10 PM, an observation of Resident #1's wheelchair was conducted with S3Director of Nursing (DON) and S4Director of Maintenance. They confirmed that Resident #1's left armrest padding and seat of his wheelchair was cracked and needed to be repaired. S3DON and S4Director of Maintenance also confirmed the wheelchair needed to be cleaned.</p> <p>Resident #22</p> <p>Review of the record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, schizophrenia, and major depressive disorder. Further review revealed a Quarterly MDS assessment dated [DATE] revealed that Resident #22 used a wheelchair for ambulation and required moderate assistance for most activities of daily living.</p> <p>On 07/21/2025 at 9:33 a.m. and 07/22/2025 at 9:12 a.m., observations revealed Resident #22 was in her wheelchair. Observations of her wheelchair revealed the right wheelchair arm padding was cracked and needed to be repaired.</p> <p>On 07/23/2025 at 1:10 PM, an observation of Resident #22's wheelchair was conducted with S3DON and S4Director of Maintenance. They confirmed that Resident #22's right wheelchair armrest padding was cracked and needed to be repaired.</p> <p>Resident #2</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the record for Resident #2 admitted to the facility on [DATE] with diagnoses including unspecified open wound of lower back and pelvis without penetration into retroperitoneum, paraplegia, bipolar disorder, anxiety disorder, and acquired absence of left leg below knee.</p> <p>On 07/21/2025 at 9:18 a.m., 07/22/2025 at 9:32 a.m., and 07/23/2025 at 8:45 a.m., observations of Resident #2's wheelchair revealed the wheelchair arm padding to be cracked and torn.</p> <p>On 07/23/2025 at 1:10 p.m., an observation conducted with S3DON and S4Director of Maintenance confirmed that Resident #2's wheelchair armrest padding was cracked, torn, and in need of repair</p> <p>Resident # 43</p> <p>Review of the record revealed Resident #43 admitted to the facility on [DATE] with diagnoses including alcohol abuse with other alcohol-induced disorder; essential (primary) hypertension; cerebrovascular disease, aphasia and other seizures.</p> <p>Review of quarterly Minimal Data Set (MDS) assessment dated [DATE] section GG revealed that Resident # 43 is ambulatory by walker and wheelchair.</p> <p>On 07/22/2025 at 8:35 a.m., 07/22/2025 at 1:05 p.m., and 07/23/2025 at 8:10 a.m., observations of Resident #43's wheelchair revealed the wheelchair arm padding to be cracked and torn.</p> <p>On 07/23/2025 1:10 p.m., an observation conducted with S3DON and S4Director of Maintenance confirmed that Resident #2's wheelchair armrest padding was cracked, torn, and in need of repair.</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure residents have the right to be free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms by having residents with orders for psychotropic medications greater than 14 days for 2 (#5 and #23) of 5 (#1, #5, #6, #12 and #23) residents reviewed for unnecessary medications. Findings: Resident #5</p> <p>Review of the medical record for Resident #5 revealed an admission date of 06/13/2025. Resident #5 had diagnoses that included chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, major depressive disorder, and dementia without behavioral disturbance.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #5 was cognitively intact for daily decision making.</p> <p>Review of the July 2025 physician's orders revealed an order for Klonopin 1 milligram (mg) to be given by mouth every 8 hours as needed for anxiety.</p> <p>Review of the Gradual Dose Reduction (GDR) letter dated 07/07/2025 revealed the request by the pharmacist to provide a specific duration and stop date for the as needed Klonopin.</p> <p>On 07/23/2025 at 11:15 a.m., an interview with S3Director of Nursing (DON) confirmed that the physician did not address the stop date for the as needed medication as requested by the pharmacist. S3DON further confirmed that the medication had been ordered for greater than 14 days.</p> <p>Resident #23</p> <p>Review of the medical record for Resident #23 revealed an admission date of 08/19/2024. Resident #23 had diagnoses that included edema, heart failure, depressive disorder, and anxiety.</p> <p>Review of the MDS assessment dated [DATE] revealed that Resident #23 had intact cognition for daily decision making with a BIMS score of 14.</p> <p>Review of the July 2025 physician orders revealed an order dated 08/28/2024 for Klonopin 0.5 mg as needed for alcoholism.</p> <p>Review of the GDR letter dated 05/01/2025 revealed the request by the pharmacist to provide a specific duration and stop date for the Klonopin 0.5 mg as needed. Further review revealed that the physician did not address the recommendation for the psychotropic medication.</p> <p>On 07/23/2025 at 11:15 a.m., an interview with S3DON confirmed that the physician did not address the stop date for the as needed medication as requested by the pharmacist. S3DON further confirmed that the medication had been ordered for greater than 14 days.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 1 (#40) of 1 resident reviewed for contractures and 2 (#72, #73) of 3 (#8, #72, #73) residents reviewed for elopement. Findings: Resident 73</p> <p>Review of the record for Resident #73 revealed an admission date of 07/15/2025 with diagnoses of vascular dementia, hemiplegia, cerebrovascular accident, heart failure, and mild cognitive impairment.</p> <p>Review of the Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment for daily decision making.</p> <p>Review of the Elopement Risk Evaluation dated 07/15/2025 revealed Resident #73 was at risk for elopement.</p> <p>Review of the record revealed no documented evidence of a care plan developed upon admission to address the elopement risk for Resident #73.</p> <p>On 07/28/2025 at 9:30 a.m. interview with S3Director of Nursing (DON) confirmed there was not an elopement care plan developed for Resident #73 upon admission.</p> <p>Resident 72</p> <p>Review of the medical record for resident #72 revealed an admission date of 07/02/2025. Resident #72 had diagnoses which included hyperlipidemia, rhabdomyolysis, hypertension, dementia and depression.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #72 had a BIMS score of 3, which indicated severe cognitive impairment for daily decision making.</p> <p>Review of the Elopement Risk Evaluation dated 07/02/2025 revealed Resident #72 was at risk for elopement.</p> <p>Review of the record revealed no documented evidence of a care plan developed upon admission to address the elopement risk for Resident #72.</p> <p>On 07/28/2025 at 9:15 a.m. interview with S3DON confirmed there was not an elopement care plan developed for Resident #72 upon admission.</p> <p>Resident 40</p> <p>Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included paraplegia incomplete, polyosteoarthritis and idiopathic neuropathy.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>On 07/21/2025 at 10:24 a.m., observation revealed Resident #40 had bilateral contractures to both hands. Resident #40 reported she has requested splints and they put wash cloths in her hands a few times but not on a regular basis.</p> <p>On 07/23/2025 9:23 a.m., an interview with S7Therapy Director revealed Resident #40 had braces for both hands but she was noncompliant with wearing them, so she ordered new braces for both hands.</p> <p>Record review revealed there was no active care plan related to Resident #40`s contracted hands.</p> <p>On 07/23/2025 10:18 a.m., an interview with S3DON confirmed there was not an active care plan related to Resident #40`s bilateral hand contractures.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents received care consistent with professional standards of practice to prevent pressure ulcers for 1 (#11) of 3 (#11, #47, #50) residents reviewed for pressure ulcers. Findings: Review of the facility's policy (undated) related to Skin and Wound Management revealed the following in part: Pressure Ulcers/Skin Breakdown - Clinical Protocol Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). Record review revealed Resident #11 was admitted on [DATE] with diagnoses which included dementia, epilepsy, abnormal posture, melanoma of scalp, and age related disability. Record review of Resident #11's skin assessment using the Braden Score System dated 06/27/2025 revealed a score of 18 which indicated he was at risk for developing pressure ulcers. Review of the active care plan for July 2025 revealed Resident #11 used a wheelchair for ambulation. Further review of the care plan revealed he was at risk for skin impairment and had an intervention to place a cushion to the seat of his wheelchair. On 07/21/2025 at 10:06 a.m., Resident #11 was observed sleeping in bed with his clothes on and his wheelchair was at his bedside in the locked position. Further observation revealed the wheelchair did not have a pressure reducing device in the seat. Velcro was observed in the wheelchair seat and appeared to be where a cushion should be applied. On 07/22/2025 at 9:05 a.m. and 07/23/2025 at 9:31a.m., observations revealed Resident #11 was observed sleeping in bed. Further observation revealed his wheelchair was observed at the bedside with no pressure relieving device in the seat of the chair. On 07/22/2025 10:19 a.m., an observation of Resident #11 was conducted in his room with S3Director of Nursing (DON). S3DON confirmed Resident #11 did not have a pressure relieving device in his chair. S3DON confirmed Resident #11 once had a cushion in his chair and needed one placed back in it.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** I. Based on observation, record reviews and interviews the facility failed to have an adequate system in place to ensure residents at risk for elopement are supervised to prevent elopement from the facility for 1 (#73) of 3 (#8, #72, and #73) residents reviewed for elopement. The deficient practice resulted in an Immediate Jeopardy for Resident #73 on 07/21/2025. Resident #73 was last observed on 07/21/2025 at 9:51 p.m. Resident #73 was picked up by police on 07/22/2025 at 6:28 a.m. after being notified of Resident #73 pacing on the four-lane highway approximately 0.9 miles from the facility. The police returned Resident #73 to the facility on [DATE] at 6:52 a.m. without injury. Resident #73 exited the building through a window in his room. The deficient practice had the likelihood to cause more than minimal harm to any residents residing in the facility at risk for elopement. S1Manager and S3Director of Nursing (DON) were notified of the Immediate Jeopardy on 07/24/2025 at 7:54 p.m. The Immediate Jeopardy was removed on 07/25/2025 at 3:47 p.m. when it was determined the facility had implemented an acceptable Plan of Removal (POR) as confirmed through onsite interviews, record reviews and observations prior to the survey exit.</p> <p>Findings:</p> <p>Review of the facility's Elopement/Missing Resident Policy undated revealed in part:</p> <p>Purpose: Ensure a safe and secure environment for all residents.</p> <p>Procedure:</p> <p>1. All newly admitted residents will be screened for the potential of wandering and/or elopement, including past history and current cognitive status. Observation of the resident's behavior that may indicate the potential for wandering and/or elopement will continue for the initial 14 days in the facility. Such potential will be included in the baseline care plan for that resident within the initial 48 hours following admission. If identified after that 48-hour period, interventions to ensure the resident's safety will be added to the baseline care plan and included in the initial comprehensive plan of care.</p> <p>4. Appropriate facility staff will monitor resident whereabouts including the monitoring of responses/reactions to events/ activity in surroundings at the time wandering and report unusual behaviors to the supervisor immediately.</p> <p>Review of the medical record for Resident #73 revealed an admission date of 07/15/2025. Resident #73 had diagnoses including vascular dementia, hemiplegia, cerebrovascular accident, heart failure, and mild cognitive impairment.</p> <p>Review of the Elopement Risk Evaluation dated 07/15/2025 revealed Resident #73 was at risk for elopement with a score of 2.0 and had a BIMS score of 6 which indicated Resident #73 had severe cognitive impairment for daily decision making. Further review of the assessment revealed Resident #73 had a history of elopement or an attempted elopement while at home and a history of attempting to leave the facility without informing staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment for daily decision making.</p> <p>Review of the physician's orders revealed no documented evidence of any orders regarding elopement prior to the incident on 07/21/2025.</p> <p>Review of the interim care plan revealed no documented evidence of an elopement risk focused area noted in the care plan.</p> <p>Review of the Sheriff's Department Offense/Incident Report dated 07/22/2025 revealed the Sheriff's department received a call on 07/22/2025 at 6:22 a.m. regarding a male pacing on the highway carrying a book and almost got hit by two vehicles. The Sheriff's department arrived at the scene at 6:28 a.m. and Resident #73 was returned to the nursing facility on 07/22/2025 at 6:52 a.m.</p> <p>Review of the Incident/Accident report dated 07/22/2025 at 6:50 a.m. written by S17Licensed Practical Nurse (LPN) revealed a local emergency department called and asked if we had a resident named _____. S17LPN went and checked the room and the curtain was pulled and the window was opened. The Sheriff's department found Resident #73 at a store. A Certified Nursing Assistant (CNA) made rounds and he wasn't in his bed at 11:00 p.m. and the CNA thought he was in the hospital. The Sheriff's department brought him back at 7:15 a.m., Resident #73 did not have any injuries.</p> <p>On 07/24/2025 at 12:10 p.m. observation and interview of Resident #73 revealed he was sitting on the side of the bed and he had an orange band on his right wrist. Resident #73 was unable to verbalize where he currently was, but did state that he climbed out of the window the other night trying to get back home. Resident #73 denied injuring himself when he climbed out of the window.</p> <p>On 07/24/2025 at 12:30 p.m. review of the video surveillance dated 07/21/2025 at 9:51 p.m. revealed S19CNA went into Resident #73's room and came out of the room with a trash bag.</p> <p>On 07/24/2025 at 2:32 p.m. interview with S3DON confirmed she did not reinspect all staff after Resident #73 eloped from the facility on 07/21/2025.</p> <p>On 07/24/2025 at 2:45 p.m. a phone interview with S18Certified Nursing Assistant (CNA) revealed she was working 11:00 p.m. - 7:00 a.m. shift the night of 07/21/2025 when Resident #73 eloped from the facility. S18CNA revealed she went to check on Resident #73 at approximately 11:45 p.m., he wasn't in the room and she assumed he was in the bathroom. S18CNA further revealed at approximately 2:00 a.m. she went to check on Resident #73, he wasn't in the room and she assumed he was in the hospital. S18CNA confirmed she did not notify the nurse when she was unable to locate Resident #73. S18CNA revealed she was not aware that Resident #73 was at risk for elopement prior to the incident.</p> <p>On 07/24/2025 at 4:45 p.m. a phone interview with S19CNA revealed he worked on 07/21/2025 from 3:00 p.m. - 11:00 p.m. with Resident #73. Further interview with S19CNA revealed he provided incontinent care to Resident #73 on 07/21/2025 at approximately 9:30 p.m. S19CNA confirmed he was not aware that Resident #73 was at risk for elopement, and he was unsure if Resident #73 was wearing an orange wrist band to indicate at risk for elopement on 07/21/2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/24/2025 at 5:45 p.m. interview with S3DON revealed she performed the elopement risk assessment on 07/15/2025 for Resident #73. S3DON confirmed she informed the day shift nurse on 07/15/2025 of Resident #73's risk for elopement but she did not inform any other staff members.</p> <p>On 07/25/2025 at 10:35 a.m. a phone interview with S17LPN revealed she worked the 11:00 p.m. to 7:00 a. m. shift on 07/21/2025. She revealed she gave his night time medications at approximately 9:00 p.m. S17LPN further revealed on 07/22/2025 at approximately 6:30 a.m. she received a call from the Sheriff's department and was informed they had Resident #73. Resident #73 was brought back to the nursing facility by the Sheriff's department, he was assessed and no injuries were noted.</p> <p>On 07/28/2025 at 9:30 a.m. interview with S3DON confirmed when Resident #73 was assessed to be at risk for elopement on 07/15/2025 and a care plan was not developed for Resident #73's at risk for elopement upon admission.</p> <p>On 07/28/2025 at 1:45 p.m. interview with S3DON revealed prior to the incident on 07/21/2025 with Resident #73, the facility did not have a plan in place to make sure the staff were informed of the residents that were at risk for wandering.</p> <p>The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit.</p> <p>The facility's POR submitted on 07/25/2025:</p> <p>Actions the facility will take-</p> <p>07/22/2025 DON or Designee will screen all new admits or readmits for potential wandering and/or elopement, including history and current cognitive status and continue with ongoing elopement risk assessments.</p> <p>07/22/2025 hourly observations for Resident #73 was initiated. 07/25/2025 hourly observations for all high risk for elopement residents were initiated.</p> <p>07/22/2025 ensured all high risk for elopement residents had on orange wristbands.</p> <p>07/22/2025 Maintenance Director secured all windows.</p> <p>07/22/2025 DON or Designee will be responsible for updating the elopement binders for all high-risk new admissions and readmissions for elopement. To be placed at each nurses station with face sheets continuously.</p> <p>07/22/2025 elopement policy updated to include: any elopement risk resident will wear an orange wrist band as an identifier.</p> <p>07/25/2025 Charge nurses will meet with all staff (CNAs, nurses, any other direct/indirect care staff) at beginning of each shift to communicate high risk elopement residents.</p> <p>Education/Training Plan -</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Castleman St Oak Grove, LA 71263	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>07/22/2025 DON and ADON inserviced nurses to complete hourly observations of high risk elopement residents and document on monitoring tool &ndash; completed inservice on 07/25/2025.</p> <p>07/22/2025 DON inserviced MDS nurse to update care plan to reflect elopement risk residents. Inservice was completed on 07/24/2025 by DON and ADON to all staff on elopement risk and orange wristbands. Education also added to the new hire orientation process.</p> <p>Monitoring of Implemented Actions -</p> <p>07/22/2025 DON or Designee will observe and document high risk elopement residents&rsquo; behaviors for initial 14 days in facility after new admission or readmission.</p> <p>07/22/2025 inserviced staff began using the hourly observations monitoring tool for Resident #73.</p> <p>07/24/2025 DON or Designee will monitor the completion of the hourly observations of high risk residents and the documentation on monitoring tool is complete 5 days a week times 2 weeks, then 3 days a week times 2 weeks, then randomly thereafter until compliance is met.</p> <p>07/24/2025 inserviced staff began using the hourly observations monitoring tool for all high risk elopement residents.</p> <p>07/25/2025 Maintenance Director will monitor windows to 3 random rooms a day times 5 days for 4 weeks, then randomly until compliance is met. All findings will be reported to Quality Assurance (QA) committee weekly.</p> <p>07/25/2025 hourly monitor tool binder on high risk elopement residents to be completed for the initial 14 days after new admission or readmission.</p> <p>07/25/2025 DON or Designee will monitor orange wristbands to ensure it is intact and to be changed as needed if soiled or dislodged on high risk residents 5 days a week times 2 weeks, then 3 days a week times 2 weeks, then randomly thereafter until compliance is met.</p> <p>07/25/2025 DON or Designee will complete elopement drills 3 times a week, 1 per shift times 2 weeks until compliance is met. All findings will be reported to the QA committee weekly.</p> <p>Date facility asserts the likelihood for serious harm to any recipient no longer exists: 07/25/2025.</p> <p>II. Based on observations, record reviews, and interviews, the facility failed to ensure the resident's environment remained as free of accident hazards as is possible by failing to ensure bedrails were properly secured for 3 (#2, #6, #50) of 4 (#2, #6, #50, #65) residents reviewed for bedrails.</p> <p>Findings:</p> <p>Review of the undated facility policy for Bedrails revealed the following, in part:</p> <p>Purpose: Ensure correct installation, use and maintenance of bedrails.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Procedure: This facility will attempt to use appropriate alternatives prior to installing a side or bedrail.</p> <p>If a bed or side rail is used, this facility must ensure correct installation, use and maintenance of bedrails, including but not limited to the following elements:</p> <p>1) Assess the resident for risk of entrapment from bedrails prior to installation and ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>4) Follow the manufacturers' recommendations and specifications for installing and maintaining bedrails.</p> <p>When installing and using bedrails, the facility should:</p> <ul style="list-style-type: none"> -Ensure that the bed's dimensions are appropriate for the resident. -Confirm that the bed rails to be installed are appropriate for the size and weight of the resident using the bed. -Install bedrails using the manufacturer's instructions to ensure a proper fit. -Inspect and regularly check the mattress and bed rails for areas of possible entrapment. <p>Resident #6</p> <p>Review of Resident #6's medical record revealed an admission date of 01/27/2024 with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14, which indicated no cognitive impairment. Further review of the MDS revealed Resident #6 had no impairment on both sides of upper and lower extremities.</p> <p>On 07/21/2025 at 9:20 a.m., 07/22/2025 at 9:25 a.m., and 07/23/2025 at 9:50 a.m., observations revealed Resident #6 was in bed and had quarter bedrails in place on both sides of her upper bed. The quarter bedrails were loose and were not secured properly to her bed.</p> <p>On 07/23/2025 at 1:10 p.m., S3DON and S4Director of Maintenance observed Resident #6's right bedrail and confirmed the bedrail was loose and needed to be repaired.</p> <p>Resident #50</p> <p>Review of Resident #50's medical record revealed an admission date of 04/22/2025 with diagnoses of acute kidney failure, adult failure to thrive, and cirrhosis of the liver.</p> <p>Review of Resident #50's MDS assessment dated [DATE] revealed a BIMS of 12 which indicated he was moderately cognitively impaired. Further review of the MDS revealed Resident #50 had no impairment on both sides of upper and lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/21/2025 at 1:04 p.m., 07/22/2025 at 2:28 p.m., and 07/23/2025 at 9:45 a.m., observations revealed Resident #50 was in bed and had a raised quarter rail in place on the right side of his upper bed. The quarter bedrail was loose and was not secured properly to his bed.</p> <p>On 07/23/2025 at 1:10 p.m., S4Director of Maintenance and S3DON observed Resident #50's right quarter bedrail and confirmed the bedrail was loose and needed to be repaired.</p> <p>Resident #2</p> <p>Review of the medical record for Resident #2 revealed an admission date of 12/19/2023 with diagnoses including unspecified open wound of lower back and pelvis without penetration into retroperitoneum, paraplegia, unspecified, bipolar disorder, unspecified, anxiety disorder, unspecified, and acquired absence of left leg below knee.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 15, which indicated intact cognition for daily decision making.</p> <p>On 07/21/2025 at 9:18 a.m., 07/22/2025 at 9:32 a.m., and 07/23/2025 at 8:45 a.m. observations of Resident #2's bed revealed a metal half bedrail attached to the upper left side of the resident's bed. Further observation of the bedrail revealed the rail was loose and not secured properly to the bed.</p> <p>On 07/23/2025 at 1:10 p.m., S4Director of Maintenance and S3DON observed Resident #2's bedrail and confirmed the bedrail was loose and needed to be repaired.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that a resident received appropriate treatment and services to prevent urinary tract infections for 1 (#75) of 2 (#4 & #75) residents reviewed for urinary catheter. Findings:Review of the facility's Urinary Catheter Care Policy dated September 2014 revealed in part:Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control2.b. Be sure the catheter tubing and drainage bag are kept off the floor. Review of the record for Resident #75 revealed an admission dated of 01/08/2019 with diagnoses that included diabetes mellitus, heart disease, urinary retention, and dementia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated that Resident #75 had moderate cognitive impairment for daily decision making. On 07/21/2025 at 11:40 a.m. and 07/22/2025 at 9:05 a.m., observations of Resident #75 revealed the resident's catheter bag was observed lying on the floor in a plastic bag and the catheter tubing was lying directly on the floor. On 07/21/2025 at 11:45 a.m., interview with S20Licensed Practical Nurse (LPN) revealed the catheter bag and tubing should not have been on the floor and the catheter bag should not be stored in a trash bag. On 07/23/2025 at 9:20 a.m., an observation of Resident #75 with S3Director of Nursing (DON) revealed the indwelling catheter tubing was lying directly on the floor. S3DON confirmed that the tubing should not be on the floor.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to 1) ensure a physician's order for bed rails was obtained for residents, 2) assess residents for risk of entrapment from bed rails prior to the installation of bed rails, and 3) ensure care plans reflected the use of bed rails for 4 (#2, #6, #50, #65) of 4 residents reviewed for bedrails. Findings:</p> <p>Review of the undated facility policy for Bedrails revealed the following, in part:</p> <p>1.) Assess the resident for risk of entrapment from bedrails prior to installation and ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>The facility will assess the resident's need for bedrails and all factors involved, including alternatives. Alternatives to bedrails will always be attempted before consideration of bedrail application. Documentation in the resident's record will reflect this assessment and related information, including how the alternatives failed to meet the resident's assessed needs.</p> <p>What assessed medical needs would be addressed by the use of bedrails; the resident's benefits from the use of bed rails and the likelihood of these benefits; the resident's risks from the use of bedrails and how these risks will be mitigated and alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.</p> <p>Resident #6</p> <p>Review of Resident #6's medical record revealed an admission date of 01/27/2024 with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Further review of the MDS revealed Resident #6 had no impairment on both sides of upper and lower extremities.</p> <p>Further review of Resident #6's medical record revealed there was no documentation of the following regarding the use of bilateral quarter bedrails: physician's order, entrapment assessment prior to the installation of the bedrails, and care plan for the use of the quarter bedrails.</p> <p>On 07/21/2025 at 9:20 a.m., 07/22/2025 at 9:25 a.m., and 07/23/2025 at 9:50 a.m., observations revealed resident #6 was in bed and had bilateral quarter bedrails in place on both sides of her upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3Director of Nursing (DON) confirmed the facility failed to have the following documentation regarding Resident #6's quarter bedrail: physician order, risk for entrapment, and the care plan was not developed.</p> <p>Resident #50</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Castleman St Oak Grove, LA 71263	
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #50's medical record revealed an admission date of 04/22/2025 with diagnoses of acute kidney failure, adult failure to thrive, and cirrhosis of the liver.</p> <p>Review of Resident #50's MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated he was moderately cognitively impaired. Further review of the MDS revealed Resident #50 had no impairment on both sides of upper and lower extremities.</p> <p>Further review of Resident #50's medical record revealed there was no documentation of the following regarding the use of a bilateral quarter bedrail: physician's order, entrapment assessment prior to the installation of the bedrails, and care plan for the use of the quarter bedrail.</p> <p>On 07/21/2025 at 1:04 p.m., 07/22/2025 at 2:28 p.m., and 07/23/2025 at 9:45 a.m., observations revealed resident #50 was in bed and had a raised quarter rail in place on the right side of his upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3DON confirmed the facility failed to have the following documentation regarding Resident #50's quarter bedrail: physician order, risk for entrapment, and a care plan was not developed.</p> <p>Resident #2</p> <p>Review of the record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including unspecified open wound of lower back and pelvis without penetration into retroperitoneum; paraplegia, bipolar disorder, anxiety disorder and acquired absence of left leg below knee.</p> <p>Review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated no cognitive impairment.</p> <p>On 07/21/2025 at 9:18 a.m., 07/22/2025 at 9:32 a.m., and 07/23/2025 at 8:45 a.m., observations of Resident #2's bed revealed a metal 1/2 bedrail attached to upper left side of resident's bed.</p> <p>On 07/22/2025 at 11:00 a.m., record review revealed the following: no order for bedrail use, no care plan for bedrail, and no bedrail entrapment assessment.</p> <p>On 07/23/2025 9:30 a.m., an interview with S3DON confirmed the facility did not have the following: a physician's order for side rail use, an entrapment risk assessment completed, or a care plan for side rail usage.</p> <p>Resident #65</p> <p>Review of Resident #65's medical record revealed an admission date 07/16/2024. Resident #65 had diagnoses including diabetes mellitus, morbid obesity, heart disease, osteoarthritis, and muscle weakness.</p> <p>Review of Resident #65's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS of 13, which indicated intact cognition for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #65's medical record revealed there was no documentation of the following regarding the use of bilateral quarter bed rails: physician's order, entrapment assessment prior to the installation of the bedrails, and a care plan for the use of the quarter bed rails.</p> <p>On 07/21/2025 at 1:12 p.m. and 07/23/2025 at 9:00 a.m., observations revealed Resident #65 was in bed and had quarter bedrails in place on both sides of her upper bed.</p> <p>On 07/23/2025 at 9:30 a.m., an interview with S3DON confirmed the facility failed to have the following documentation regarding Resident # 65's quarter bedrails: physician order, risk for entrapment, and a care plan was not developed for the use of bed rails.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on record review and interview, the facility failed to ensure there was sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services. The facility had: 1) excessively low weekend staff during Fiscal Year Quarter 2 2025 dated 01/01/2025 to 03/31/2025 and 2) insufficient staff on: 06/08/2025, 06/14/2025, 06/22/2025, and 06/28/2025. Findings: Review of the facility's Payroll-Based Journal (PB&J) Staffing Report revealed the facility triggered excessively low weekend staff for Fiscal Year Quarter 2 2025 dated 01/01/2025 to 03/31/2025. Review of the facility's January 2025 weekend personnel staffing pattern revealed insufficient staff for the following dates: 01/04/2025, 01/05/2025, 01/11/2025, 01/12/2025, 01/18/2025, 01/19/2025, 01/25/2025, and 01/26/2025. Review of the facility's February 2025 weekend personnel staffing pattern revealed insufficient staff for the following dates: 02/01/2025, 02/02/2025, 02/08/2025, 02/09/2025, 02/15/2025, 02/16/2025, 02/22/2025, and 02/23/2025. Review of the facility's March 2025 weekend personnel staffing pattern revealed insufficient staff for the following dates: 03/01/2025, 03/02/2025, 03/08/2025, 03/09/2025, 03/15/2025, 03/16/2025, 03/22/2025, 03/23/2025 and 03/30/2025. Review of the personnel staffing pattern dated 06/01/2025 - 06/14/2025 revealed insufficient staff on 06/08/2025 and 06/14/2025. Review of the personnel staffing pattern dated 06/15/2025 - 06/28/2025 revealed insufficient staff on 06/22/2025 and 06/28/2025. On 07/23/2025 at 8:50 a.m. interview with S3 Director of Nursing (DON) confirmed the facility had low staffing for the dates listed above and did not meet the required hours.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor lab results for a resident receiving anti-seizure medication for 1 (#12) of 5 (#1, #5, #6, #12, #23) residents reviewed for unnecessary medications. Findings: Review of the record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness, initial encounter; other seizures; altered mental status and encephalopathy. On 07/22/2025 at 10:00 a.m., a review of Resident #12's current care plan revealed the facility should obtain lab/diagnostic work as ordered and report results to physician. On 07/22/2025 at 10:15 a.m., a review of Resident #12's active physician orders revealed an order for Valproic Acid oral solution 15 milliliters (ml) by mouth every morning ordered 04/10/2025 and Valproic Acid oral solution 20 ml by mouth every evening for seizures ordered 04/09/2025. Further review revealed a physician's order dated 05/01/2025 for a Depakote (Valproic Acid) level to be drawn every month. On 07/23/2025 at 11:05 a.m., a record review revealed no documented Depakote lab results in Resident #12's chart. On 07/23/2025 at 11:45 a.m., an interview with S3 Director of Nursing confirmed Resident #12 did not have Depakote levels drawn while in facility.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation of medication administration, record review, and interview, the facility failed to ensure the medication error rate was not 5% or greater. The facility had a 19.35% medication error rate with 6 medication errors for 2 (#26, #29) of 5 (#26, #29, #46, #49, #57) residents observed for medication administration. The facility had 6 medication administration errors out of 31 opportunities. The facility's current census was 65 residents. Findings:Review of the facility's Administering Medications Policy revised December 2012 revealed the following, in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretations and Implementation: 3. Medications must be administered within one (1) hour of their prescribed time frame. Resident #26 An interview with S10Licensed Practical Nurse (LPN) on 07/23/2025 at 10:15 a.m., revealed she had not started to give medications for the residents on her hall, which was the hall where resident #26 resided. On 07/23/2025 at 10:40 a.m., an observation during medication administration pass with S10LPN revealed she administered the following medications for Resident #26: Norvasc (anti-hypertensive) 5 milligrams (mg) by mouth (po) 1 every day; Colace (laxative)100mg 1 po every day; Ferrous Sulfate (Iron) 325mg 1 po every day; Levaquin (antibiotic) 500mg 1 po every day; and Xarelto (blood thinner)10mg 1 po every day. Review of the Resident #26's July 2025 physician orders revealed the following orders: Norvasc 5mg po 1 every day; Colace 100mg 1 po every day; Iron Oral Tablet 325mg 1 po every day; Levaquin 500mg 1 po every day; and Xarelto 10mg 1 po every day. Review of Resident #26's July Medication Administration Record (MAR) revealed the above medications were to be administered at 9:00 a.m. On 07/23/2025 at 10:50 a.m., an interview with S10LPN confirmed the above morning medications for Resident #26 were due today at 9:00 a.m. and she was late giving them since the medications were given at 10:40 a.m. On 07/23/2025 at 11:00 a.m. S3Director of Nursing (DON) confirmed that resident #26's above medications were not given on time during the morning medication pass on 07/23/2025. Resident #29 On 07/23/2025 at 8:04 a.m., an observation during medication administration pass with S9LPN revealed she failed to administer Resident #29's Thiamine Hydrochloride (Vitamin B-1) 100 mg one po every day. Review of the July 2025 physician orders for Resident #29 revealed an order dated 04/25/2025 for Thiamine Hydrochloride 100mg one po every day. Review of Resident #29's July 2025 MAR revealed the Thiamine Hydrochloride was scheduled to be administered at 9:00 a.m. On 07/23/2025 4:10 p.m., S9LPN confirmed she failed to administer Resident #29's Thiamine Hydrochloride 100mg po every day at 9:00 AM during the above medication pass. S9LPN revealed she thought the medication was not available earlier. S3DON, S9LPN, and the surveyor observed the Thiamine Hydrochloride on the S9LPN's medication cart. S9LPN confirmed she was unaware it was on her medication cart during morning medication pass.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility failed to properly store the ice scoop utilized in serving ice to residents in a sanitary manner. Findings: On 07/21/2025 at 8:15 a.m., an observation of the facility's kitchen revealed that an ice scoop was being stored inside an ice chest that contained ice for resident use. On 07/21/2025 at 8:22 a.m., an observation with S8Dietary Supervisor confirmed the ice scoop was being stored in the ice chest containing resident ice. On 07/23/2025 at 11:45 a.m., S3Director of Nursing (DON) was informed of dietary staff storing an ice scoop in the ice chest for resident use.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on record review and interview the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. Findings:Review of the facility assessment revealed the last facility assessment was done on 06/25/2024. On 07/23/2025 at 9:40 a.m. interview with S3Director of Nursing (DON), S2Corporate Registered Nurse (RN) and S1Manager confirmed the last facility assessment was noted on 06/25/2024.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview the facility failed to ensure the Quality Assessment and Assurance (QAA) committee met at least quarterly with all required members present. Findings: Review of the QAA committee meetings revealed quarterly meetings with required staff present were recorded on 08/08/2024, 11/21/2024, and 04/24/2025. On 07/23/2025 at 4:20 p.m., an interview/observation with S2Corporate Registered Nurse (RN) confirmed records of the quarterly meetings with required staff present were recorded on 08/08/2024, 11/21/2024, and 04/24/2025. On 07/23/2025 at 4:20 p.m., an interview with S3Director of Nursing confirmed four quarterly QAA committee meetings with all required staff present had not been completed in the past year.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment by failing to ensure that Enhanced Barrier Precautions (EBP) were implemented as ordered for 1 (#47) of 3 (#11, #47, #50) residents reviewed for pressure ulcers. Findings: Review of the undated EBP policy revealed, in part: Purpose: Prevent the spread of novel or targeted multi-drug resistant organisms (MDROs) EBP expand the use of personal protective equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP apply to: Wounds and/or indwelling medical devices (i.e., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. On 07/21/2025 at 9:36 a.m. and 07/22/2025 at 9:02 a.m., observations of Resident #47's room revealed no EBP signage posted. Review of the medical record for Resident #47 revealed an admission date of 04/21/2025 with diagnoses that included end stage renal disease, hypothyroidism, hypertension, and unstageable pressure ulcer of left heel. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated that Resident #47 is cognitively intact for daily decision making. Review of the July 2025 physician's orders revealed an order for EBP dated 06/26/2025. On 07/23/2025 at 9:15 a.m., S3 Director of Nursing (DON) confirmed that EBP signage should have been posted on Resident #47's door. S3DON also confirmed that the signage was not posted at this time.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on record reviews and interview, the facility failed to provide in-services, at least 12 hours in a year, sufficient to ensure the continued competence of Certified Nursing Assistants (CNA) for 3 (S12CNA, S14CNA, S15CNA) of 5 (S11CNA, S12CNA, S13CNA, S14CNA, S15CNA) CNAs reviewed for in-service training. Findings: Review of the personnel record for S12CNA revealed a hire date of 07/02/2021. Further review of the personnel file revealed no documented evidence of 12 hours of annual training. Review of the personnel record for S14CNA revealed a hire date of 04/19/2023. Further review of the personnel file revealed no documented evidence of 12 hours of annual training. Review of the personnel record for S15CNA revealed a hire date of 05/30/2012. Further review of the personnel file revealed no documented evidence of 12 hours of annual training. On 07/22/2025 at 4:40 p.m., an interview with S3Director of Nursing (DON) confirmed that the required annual in-service training had not been provided to S12CNA, S14CNA and S15CNA.</p>