

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Forest Haven Nursing & Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 171 Thrasher Drive Jonesboro, LA 71251	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure the kitchen prepared and served food in accordance with professional standards for food service safety. This had the potential to affect 121 diets served from the kitchen. Findings: On 06/22/2026 at 10:25 a.m. observation of the lunch meals revealed they were serving herb baked chicken, riced dressing, squash and zucchini and chocolate and strawberry cake. Observation of the alternate foods available revealed they had a choice of pulled pork, mashed potatoes and cabbage. For the mechanical chopped meat, residents were served chopped chicken. On 06/22/2026 at 11:30 a.m. S5Production Manager began serving trays from the steam table. Observation revealed there were no steam table temperatures taken on the following food items that were served: rice dressing, mashed potatoes, pulled pork, cabbage, chopped chicken, pureed chicken, pureed rice dressing, and the pureed squash and zucchini. Further observation in the kitchen revealed S7Dietary used her bare hands to put the chocolate and strawberry cake in the blender to make the pureed dessert. During the serving of the lunch meal S6Cook made 2 grilled cheese sandwiches and used her bare hands to obtain bread out of the package and then used the same bare hands to grab cheese out of a plastic bag and place it on the bread. Further observation of S6Cook revealed she then made a chef salad with her bare hands by getting lettuce out of a plastic bag and cutting the lettuce into pieces, then got sliced turkey and used her bare hands to cut up the turkey and placed it on the lettuce, S6Cook then cut up a tomato and placed it on the salad with her bare hands and also got grated cheese out of a plastic bag with her bare hands and placed it on the salad. On 06/22/2026 at 2:00 p.m., an interview with S5Production Manager confirmed the food temperatures were not taken of the rice dressing, mashed potatoes, pulled pork, cabbage, chopped chicken, pureed chicken, pureed rice dressing, and the pureed squash and zucchini on the steam table prior to serving the lunch meal. S5Production Manager agreed that S6Cook should not have used her bare hands to make a grilled cheese sandwich and should not have used her bare hands to make the chef salad.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure it developed a comprehensive person-centered care plan for each resident by failing to develop a care plan for catheter care for 1 (#14) of 3 residents reviewed for urinary catheters. Findings: Review of the medical record for Resident #14 revealed he was admitted on [DATE] with a diagnosis of chronic kidney disease. Review of the June 2026 Physician orders revealed Resident #14 had a urinary catheter. Review of the care plan revealed it did not address the resident's urinary catheter. On 06/23/2025 at 3:30 p.m., interview with S2DON confirmed the resident had a urinary catheter and the care plan did not address the urinary catheter of Resident #14.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, and interviews, the facility failed to ensure that a resident who received respiratory care was provided such care, consistent with professional standards of practice by not having signage on the outside of the resident's room to indicate oxygen was in use for 2 (#99 and #125) of 2 residents reviewed for oxygen. Findings: Review of the facility's Oxygen Administration Policy (undated) revealed the following in part: Policy: While oxygen is in use, No Smoking, signs will be posted at the entrance to the room. Procedure 13. Place the No Smoking, Oxygen in Use warning sign on the resident's room door or in other appropriate location. Resident 99 Review of the medical record revealed Resident #99 had an admission date of 04/14/2026. Resident #99 had diagnoses that included orthostatic hypotension, vascular dementia and heart disease. Review of the physician orders dated 06/21/2026 revealed an order for Oxygen at 1 liter per nasal cannula continuously. Observations on 06/22/2026 at 1:02 p.m., 06/23/2026 at 8:30 a.m. and 10:45 a.m. revealed Resident #99 was in the room and received Oxygen 1 liter per nasal cannula, signage was not posted outside of the resident's room door to indicate Oxygen was in use. On 06/23/2026 at 11:15 a.m. observation of Resident #99 with S2DON revealed the resident was in the room and received Oxygen at 1 liter per nasal cannula, no signage was observed outside of Resident #99's room to indicate Oxygen was in use. At this time S2DON confirmed signage to indicate Oxygen in use should have been posted on the outside of the resident's room door. Resident 125 Review of the medical record for Resident #125 revealed an admission date of 06/12/2026. Resident #125 had diagnoses that included heart failure, hypotension, atrial fibrillation, pulmonary embolism, and shortness of breath. Review of the June 2026 physician orders revealed an order for Oxygen at 2 liters per nasal cannula as needed related to diagnoses of shortness of breath. Observations on 06/22/2026 at 8:30 a.m., and 10:30 a.m. revealed Resident #125 was in the bed and received Oxygen at 2 liters per nasal cannula, signage was not posted outside of the resident's room to indicate Oxygen was in use. On 06/23/2026 at 11:10 a.m. observation of Resident #125 with S2DON revealed the resident was in the room and received Oxygen at 2 liters per nasal cannula, no signage was observed outside of Resident #125's room to indicate Oxygen was in use. At this time S2DON confirmed signage to indicate Oxygen in use should have been posted on the outside of the resident's room door.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure CNAs were competent in the skill of incontinent care for 1 (#7) of 2 residents observed during incontinent care. Findings: On 06/22/2026 at 9:08 a.m. Resident #7 requested to have her brief changed. Resident #7 pushed her call light and S3CNA and S4CNA entered the room. S3CNA stated at that time she normally worked in medical records, but she was also a CNA. Observation revealed Resident #7 had urinated in her brief. Further observation revealed S4CNA obtained a new brief from Resident #7's dresser and Resident #7 stated that she was out of personal wipes. Further observation revealed S3CNA went into Resident #7's bathroom and came back with wet paper towels. Observation revealed S3CNA wiped Resident #7's perineal area with the wet paper towel and did not dry the area. Resident #7 was then turned onto her side and again S3CNA wiped the resident's buttocks with wet paper towels and did not dry the area before a new brief was put on the resident. On 06/22/2026 at 9:45 a.m., an interview with S3CNA confirmed she used wet paper towels to wipe the urine off Resident #7 and did not dry Resident #7 prior to putting a new brief on the resident.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the attending physician included a handwritten clinical rationale for the denial of a dose reduction of a psychotropic medication for 2 (#2, #55) of 5 residents reviewed for unnecessary medications. Findings:Resident #2Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses which included depression and delusional disorders. Review of the physician orders revealed Resident #2 was receiving the psychotropic medication Seroquel 50 mg three times daily. Review of the Pharmaceutical Consultant Report revealed on 01/19/2026, the consultant pharmacist requested a dose reduction for Seroquel 50mg. The physician denied a dose reduction. The physician failed to provide a hand written valid clinical rationale for the denial of a dose reduction. On 06/23/2026 at 2:45 p.m., interview with S2DON confirmed the physician failed to provide a hand written valid clinical rationale for the denial of a dose reduction. Resident #55Review of the medical record revealed Resident #55 had an admission date of 03/12/2026 with diagnoses which included impulse disorder and major depression. Review of the physician orders revealed Resident #55 received Oxcarbazepine 150mg and Depakote 125mg for impulse control disorder and Sertraline 50mg for major depression. Review of the Pharmaceutical Consultant report revealed on 01/19/2026, the consultant pharmacist requested a dose reduction for medications which included Zoloft 25mg daily, Oxcarbazepine 150mg bid and Depakote 125mg bid. The physician denied the dose reductions. The physician failed to supply a hand written valid clinical rationale for the denial to conduct a dose reduction of the medications. On 06/23/2026 at 2:45 p.m., interview with S2DON confirmed the physician failed to provide a handwritten rational for the denial of a dose reduction.		