

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Golden Age Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 27090 Hwy 16 Denham Springs, LA 70726	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121</p> <p>Based on interviews and record reviews, the facility failed to ensure nursing staff communicated a resident's significant change in condition to the physician when a nurse identified a deformity in a resident's leg for 1 of 1 (#3) residents reviewed for an injury of unknown origin.</p> <p>Findings:</p> <p>Review of the facility policy titled, Change in Condition Policy and Procedure with a revision date of 08/27/2018 revealed the following, in part:</p> <p>Procedure:</p> <p>3. The resident's primary physician or designated alternative will be contacted promptly of a significant change in the resident's status.</p> <p>Review of Resident #3's clinical record revealed the Resident was admitted to the facility on [DATE] and had diagnoses, which included Restless Leg Syndrome, Pain Unspecified, Thrombocytopenia Unspecified, and Age-Related Osteoporosis without Current Pathological Fracture.</p> <p>Review of Resident #3's Quarterly MDS with an ARD of 07/10/2024 revealed a BIMS of 6 which indicated severe cognitive impairment.</p> <p>On 10/08/2024 at 9:27 a.m., an interview was conducted with S3LPN. S3LPN stated the aide reported Resident #3's left leg looked deformed early in the morning on 09/26/2024. S3LPN stated she assessed Resident #3's left leg and it was deformed. S3LPN was unable to provide an exact time this occurred. S3LPN stated Resident #3 never complained of pain on her shift S3LPN confirmed Resident #3's deformed left leg was not reported to the physician. S3LPN confirmed she should have reported Resident #3's deformed left leg to the physician.</p> <p>On 10/08/2024 at 12:49 p.m., an interview was conducted with S5NP. S5NP confirmed S3LPN did not report Resident #3's left leg deformity. S5LPN confirmed she was made aware of Resident #3's left leg deformity when S4LPN notified her mid-morning on 09/26/2024. S5NP stated Resident #3 was not in pain. S5NP stated when she attempted to move the left leg the resident only winced and said ooh. S5NP stated Resident #3 did not holler during the assessment. S5NP confirmed she would have expected S3LPN to report Resident #3's deformed left leg.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/08/2024 at 10:02 a.m., an interview was conducted with S2DON. S2DON confirmed S3LPN did not report Resident #3's left leg deformity. S2DON confirmed if staff saw the deformity of Resident #3's left leg she would expect staff to notify her and the Nurse Practitioner.</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** 39121</p> <p>44965</p> <p>Based on observations, interviews, and record review, the facility failed to implement a resident's comprehensive person-centered care plan by failing to implement Physician's Orders for 2 (#6 and #7) of 6 (#1, #2, #3, #6, #7, and #8) residents reviewed for comprehensive care plans. The facility failed to ensure the following Physician Orders were implemented:</p> <ol style="list-style-type: none"> 1. Resident #6's wheelchair alarm and visual cue to wheelchair brakes; and 2. Resident #7's TED hose. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Resident #6</p> <p>Review of Resident #6's Clinical Record revealed an admitted [DATE] and diagnoses, which included Acquired Absence of Right Leg Below Knee, Acquired Absence of Left Leg Below Knee, History of Falling, and Generalized Muscle Weakness.</p> <p>Review of Resident #6's Current Physician Orders dated October 2024 revealed the following, in part:</p> <p>Start date: 09/25/2024 - Chair alarm to wheelchair</p> <p>Start date: 06/03/2024 - Visual cue to wheelchair brakes</p> <p>Review of Resident #6's Quarterly MDS with an ARD of 09/11/2024 revealed, in part, a BIMS summary score of 13, which indicated she was cognitively intact.</p> <p>An observation and concurrent interview was conducted with Resident #6 on 10/09/2024 at 9:10 a.m. She was seated in her room in her wheelchair. There was no alarm in her wheelchair. There was no visual cue for her wheelchair brakes present. Resident #6 stated she had not had an alarm in her wheelchair.</p> <p>An observation was made of Resident #6 on 10/09/2024 at 9:18 a.m. with S2DON present. S2DON confirmed Resident #6 did not have a visual cue for wheelchair brakes or a wheelchair alarm present.</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>An interview was conducted with S6LPN on 10/09/2024 at 9:21 a.m. She reviewed Resident #6's current Physician Orders and confirmed there were orders for visual cue to wheelchair brakes and a chair alarm to wheelchair. She confirmed Resident #6 had been up in her wheelchair today and had not had a wheelchair alarm and no visual cue to wheelchair brakes. She confirmed the orders should have been implemented and were not.</p> <p>An interview was conducted with S7ADON on 10/09/2024 at 10:16 a.m. She confirmed the orders for Resident #6's wheelchair alarm and wheelchair brake cues should have been implemented as ordered.</p> <p>2.</p> <p>Resident #7</p> <p>Review of Resident #7's Clinical Record revealed an admitted [DATE] and diagnoses, which included Encounter for Other Orthopedic Aftercare.</p> <p>Review of Resident #7's current Physician's Orders dated October 2024 revealed, in part, to apply TED hose in the morning and remove at bedtime.</p> <p>An observation was made of Resident #7 on 10/08/2024 at 3:20 p.m. Resident #7 did not have on her TED hose.</p> <p>An observation was made of Resident #7 on 10/08/2024 at 3:26 p.m. with S8CNA present. Resident #7 did not have on her TED hose. S8CNA confirmed Resident #7 was not wearing the TED hose. S8CNA located Resident #7's TED hose on the top of the microwave and stated they were in the same place she put them yesterday evening.</p> <p>An interview was conducted with S9LPN on 10/09/2024 at 3:23 p.m. She confirmed she was the day nurse for Resident #7 on 10/08/2024. She confirmed Resident #7 did not have on her TED hose on 10/08/2024 as ordered and should have.</p> <p>An interview was conducted with S2DON on 10/09/2024 at 3:28 p.m. She confirmed if a resident had TED hose ordered, they should have been on the resident as ordered.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 44965</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the resident's environment remained as free of accident hazards as possible by failing to implement an intervention after a fall for 1 (#6) of 3 (#1, #3, and #6) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Incident and Accident Policy and Procedure dated 05/08/2018 revealed the following, in part:</p> <p>Purpose:</p> <p>To assure that any resident who is involved in an incident or accident is evaluated and received treatment as warranted and that we monitor the resident's status with appropriate intervention applied to prevent further incidents.</p> <p>Procedure:</p> <p>4. Investigative Action:</p> <p>c. The Director of Nursing or designee ensures that the resident is assessed for intervention to prevent future incidents.</p> <p>7. Instructions for further follow-up by Director of Nursing or designee:</p> <p>a. This discussion should include intervention and update of plan of care.</p> <p>b. The Director of Nursing or designee should review incidents and accidents in high risk meeting to follow up and evaluate the effectiveness of interventions implemented.</p> <p>Review of Resident #6's Clinical Record revealed an admitted [DATE] and diagnoses, which included Acquired Absence of Right Leg Below Knee, Acquired Absence of Left Leg Below Knee, History of Falling, and Generalized Muscle Weakness.</p> <p>Review of Resident #6's Current Physician Orders dated October 2024 revealed the following, in part:</p> <p>Start date: 09/25/2024 - Chair alarm to wheelchair</p> <p>Review of Resident #6's Quarterly MDS with an ARD of 09/11/2024 revealed, in part, a BIMS summary score of 13, which indicated she was cognitively intact.</p> <p>Review of Resident #6's Incident Report dated 09/23/2024 revealed the following, in part:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Description: Called by CNA to resident's room at 10:50 p.m. Upon arrival, resident was lying on the floor.</p> <p>Review of the Incident Audit Report for incident date of 09/23/2024 revealed the following, in part:</p> <p>Nurse Practitioner ordered chair alarm to be placed in wheelchair.</p> <p>Review of Resident #6's current Care Plan revealed the following, in part:</p> <p>Problem:</p> <p>The resident at risk for falls related to Bilateral Below the Knee Amputations. 09/23/2024 Resident was found on the floor in her room.</p> <p>Interventions:</p> <p>09/23/2024 - Chair alarm to wheelchair</p> <p>An observation and concurrent interview was conducted with Resident #6 on 10/09/2024 at 9:10 a.m. She was seated in her room in her wheelchair. There was no alarm in her wheelchair. Resident #6 stated she had not had an alarm in her wheelchair.</p> <p>An observation was made of Resident #6 on 10/09/2024 at 9:18 a.m. with S2DON present. S2DON confirmed Resident #6 did not have a wheelchair alarm present.</p> <p>An interview was conducted with S10CNA on 10/09/2024 at 9:30 a.m. She stated Resident #6 fell recently. She stated she always encouraged Resident #6 to call for assistance before trying to get up on her own, however, a lot of times Resident #6 performed things without calling for assistance. She confirmed Resident #6 did not have a wheelchair alarm in her chair.</p> <p>An interview was conducted with S6LPN on 10/09/2024 at 9:21 a.m. She stated Resident #6 had a fall recently. She reviewed Resident #6's current Physician Orders and confirmed there was an order for a chair alarm to her wheelchair. She stated the wheelchair alarm was an intervention to help prevent Resident #6 from falling, and it should have been implemented. She confirmed Resident #6 had been up in her wheelchair today and had not had a wheelchair alarm.</p> <p>An interview was conducted with S7ADON on 10/09/2024 at 10:16 a.m. She stated the intervention for Resident #6's fall on 09/23/2024 was a chair alarm in her wheelchair. She stated the wheelchair alarm should have been in place to help prevent falls for Resident #6, and it was not.</p>		