

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  08/27/2025
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)
F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (#5) of 5 (#1, #2, #3, #4, and #5) residents reviewed for dignity. The facility failed to ensure staff treated Resident #5 with respect and dignity. Review of Resident #5's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis of Unspecified Dementia. Review of Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/25/2025 revealed Resident #5 had a BIMS (Brief Interview for Mental Status) of 11, which indicated the resident had moderately impaired cognition. Further review revealed Resident #5 required substantial assistance for ADLs. Review of the most current Care Plan for Resident #5 revealed the following: Problem: Resident #5 required assistance with ADLs. Interventions: Assist with ADLs On 08/26/2025 at 9:46 a.m., an interview was conducted with Resident #5. She stated on 08/08/2025, S3CNA grabbed her arm rough when assisting her. She stated she removed S3CNA's hand grip with her other hand and told her, You are being too rough. After S3CNA left the room, Resident #5 told S2LPN that S3CNA was always rude and disrespectful when she provided care to her. On 08/27/2025 at 3:34 p.m., an interview was conducted with S3CNA. She stated on 08/08/2025, she and S4CNA had just exited Resident #5's room from providing incontinent care and placing Resident #5 in her bed. She stated S4CNA stood outside of Resident #5's room and called her over to observe Resident #5. She stated she and S4CNA observed Resident #5 sitting on the side of her bed after they had just laid her down in the bed. S3CNA stated she entered Resident #5's room and asked, what are you doing?. She stated Resident #5 told her she wanted to go for a walk. S3CNA told Resident #5 she could not go for a walk because she cannot walk. S3CNA stated the nurse came into the room and before she grabbed Resident #5's arm to assist in transferring her, Resident #5 stated you are being too rough. S3CNA stated she exited the room at that time. On 08/27/2025 at 10:27 a.m., an interview was conducted with S4CNA. She stated on 08/08/2025, she and S3CNA had just exited Resident #5's room from providing incontinent care and placing Resident #5 in her bed. S4CNA stated she was standing outside of Resident #5's room and called S3CNA over to observe Resident #5. S4CNA stated she and S3CNA observed Resident #5 sitting on the side of her bed after they had just laid her down in the bed. S4CNA stated S3CNA entered Resident #5's room, she observed from outside of the room, and called S2LPN over because Resident #5 was not following S3CNA's request. S4CNA stated S3CNA and Resident #5 were verbally going back and forth disagreeing. On 08/26/2025 at 3:02 p.m., an interview was conducted with S2LPN. She stated on 08/08/2025, S3CNA observed S4CNA and Resident #5 in the residents room and called her to assist with Resident #5. She stated when she entered Resident #5's room, she heard S3CNA telling Resident #5 to stop in an aggravated and frustrated tone of voice. S2LPN intervened by speaking calmly and explaining to Resident #5 they would assist her getting up. She stated when she and S3CNA began to assist Resident #5 transfer to the wheelchair, Resident #5 told S3CNA to stop because she was being too rough. She stated S3CNA exited the room at that time. She stated she did not see S3CNA grab Resident #5's arm because she was assisting on her side but S3CNA was visibly frustrated and exhibited aggravation by her tone of voice and body language when she entered Resident #5's room. She stated after S3CNA left the room, Resident #5 stated S3CNA was always rude when she provided care. S2LPN confirmed S3CNA's behaviors were not appropriate when providing care to residents. On 08/27/2025 at 2:50 p.m., an interview was conducted with S1DON. He confirmed staff should never argue or disagree with residents and all residents should be treated with dignity and respect.</p>		