STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343 Based on observation, interviews, and record review, the facility failed to maintain a sanitary environment for 1 (#163) of 3 (#56, #59, and #163) residents reviewed for environment in the final sample. Findings: Review of Resident #163's Clinical Record revealed an admitted [DATE]. Review of Resident #163's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/31/2024 revealed he was frequently incontinent of bowel. On 02/17/2025 at 10:09 a.m., observation of Resident #163's room revealed 8 quarter sized spots of dried brown liquid stool on the floor between his bed and the bathroom door. Observation further revealed a dried brown smear on the fitted sheet on Resident #163's bed. On 02/17/2025 at 10:11 a.m., an interview was conducted with Resident #163. He stated he an episode of stool incontinence on Saturday, 02/15/2025, evening while getting to the restroom. He stated staff did not clean all of the liquid stool from the floor and left his fitted sheet soiled. On 02/17/2025 at 10:23 a.m., an observation was made of S7CNA entering Resident #163's room. Surveyor entered the room and an interview was conducted with S7CNA. She stated she first noticed the stool on Resident #163's floor and fitted sheet between 8:00 a.m. and 9:00 a.m. on 02/17/2025 and did not clean it. She confirmed the brown stool on Resident #163's floor and fitted sheet should have been cleaned as soon as a staff member was made aware of it and had not been. On 02/19/2025 at 3:25 p.m., an interview was conducted with S1ADM. He stated it was the responsibility of the nursing staff, including the CNAs (Certified Nursing Assistants), to promote a clean, homelike environment. He confirmed it was not appropriate for stool to remain on a resident's floor or sheets and he expected nursing staff to clean up bodily fluids immediately when observed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on interviews and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (#23) of 3 (#23, #75, and #135) residents reviewed for hospice. The facility failed to ensure Resident #23 was coded correctly for hospice. Findings: Review of Resident #23's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Adult Failure to Thrive. Review of Resident #23's Physician Orders revealed in part, the following: Admit to Hospice, active 05/31/2024. Review of quarterly MDS assessment with ARD of 07/30/2024 revealed in Section O0110.K1. Hospice care: While a resident: No. Review of quarterly MDS assessment with ARD of 10/02/2024 revealed in Section O0110.K1. Hospice care: While a resident: No. An interview was conducted on 02/18/2025 at 2:15 p.m. with S4MDS. She reviewed Resident #23's MDS assessments dated 07/30/2024 and 10/02/2024. She confirmed both quarterly MDS assessments were not coded correctly for Hospice and should have been. An interview was conducted on 02/19/2025 at 11:15 a.m. with S2DON. She reviewed Resident #23's MDS assessments dated 07/30/2024 and 10/02/2024. She confirmed both quarterly MDS assessments were not coded correctly for Hospice and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on record reviews and interviews, the facility failed to coordinate assessments with the resident's Pre-Admission Screening and Resident Review (PASRR) Level II by failing to incorporate a PASRR Level II determination and recommendations into a resident's care plan for 1 (#167) of 4 (#23, #50, #108, and #167) residents reviewed for PASRR. Findings: Review of Resident #167's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Generalized Anxiety Disorder, Schizophrenia, and Paranoid Schizophrenia. Further review revealed he was approved for admission by Level II Authority for a temporary period effective 12/07/2024 through 12/06/2025. Review of Resident #167's Level II Evaluation Summary & Determination Notice revealed the following, in part: OBH approving 365 days for nursing facility placement and the following to occur: Behavioral Health IOP, Crisis Planning, and Assessment for Dementia. On 02/19/2025 at 8:55 a.m., review of Resident #167's current Care Plan revealed no documentation of a PASRR Level II determination and recommendations. On 02/19/2025 at 1:22 p.m., an interview was conducted with S6SSD. She stated she was responsible for incorporating recommendations for residents from their PASRR Level II determinations. She verified Resident #167 had a current PASRR Level II with recommendations. She stated if a resident had a PASRR Level II, the recommendations should be incorporated into the resident's care plan. She stated the care plan nurse was responsible for adding the PASRR Level II information to the resident's care plan. On 02/19/2025 at 2:18 p.m., an interview was conducted with S5MDS. She stated she was responsible for completing Resident #167's care plan. She verified Resident #167 had a PASRR Level II. She reviewed Resident #167's current care plan and stated prior to today, Resident #167's PASRR Level II determination and recommendations were not incorporated into his care plan and should have been. On 02/19/2025 at 2:36 p.m., an interview was conducted with S4MDS and S2DON. They verified Resident #167 had a PASRR Level II. They confirmed Resident #167's care plan should have been updated to incorporate the PASRR Level II determination and recommendations in December 2024 when the facility received the PASRR Level II from OBH, and it was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47546 Based on interviews and record review the facility failed to ensure each resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene by failing to ensure each resident received scheduled showers for 1 (#56) of 4 (#56, #57, # 63, and #110) residents reviewed for ADLs. Findings: Review of facility's policy titled, Bath, Shower Policy and Procedure, dated 09/14/2014 revealed the following in part: Policy: Showers are to be given as scheduled and/or as needed. Resident #56 Review of Resident #56's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Orthopedic Surgery, Seizures, Morbid Obesity, and Unsteadiness on feet. Review of Resident #56's Quarterly MDS with ARD of 01/01/2025 revealed a BIMS of 15, which indicated she was cognitively intact. Further review of the MDS revealed she used a wheelchair for mobility and required supervision or touching assistance with showering. Review of Resident #56's Current Care Plan revealed the following, in part: Problem: Problem: Resident has an ADL self-care performance deficit r/t right shoulder fracture, Osteoarthritis debility, and generalized weakness. Staff assists with bed mobility, transfers, eating, toileting, bathing, personal hygiene, dressing and grooming. Review of Resident #56's ADL Documentation revealed she was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. Further review of ADL Documentation revealed she did not receive her scheduled shower on Saturday 02/08/2025 which left her without a shower for 4 days. On 02/17/25 at 01:59 p.m. an interview was conducted with Resident #56. She stated she did not get a shower for a week when shower aide was scheduled off for vacation. She stated she was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays and she never refused her showers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/18/25 at 12:50 p.m. an interview was conducted with S12CNA. She stated she was one of two shower aides in the facility. She stated she was on vacation from 02/07/2025 to 02/16/2025, returning on 02/17/2025. She stated when she is off the hall CNAs should shower the residents. She stated if a resident refused a shower she would let the CNA or nurse on the hall know and it was documented in the computer under ADLs. She confirmed Resident #56 received showers on Tuesdays, Thursdays, and Saturdays. She stated Resident #56 informed her she did not receive a shower for the week she was out on vacation. She further stated Resident #56 never refused a shower. She stated there should be documentation if a resident misses a shower and a reason given. On 02/18/25 at 1:15 p.m. an interview was conducted with S14SUP. She stated hall CNAs assist residents with showers if the shower aid is out. She stated residents should receive showers on their assigned days and it should be documented in the computer. On 02/19/25 at 1:59 p.m. an interview was conducted with S11CNA. She confirmed she was one of the aides assigned to Resident #56's hall. She stated it was her responsibility to shower residents if the shower aide was off. She further stated she always documented when a shower was given or a reason a shower was not given. She confirmed if there was no documentation on the ADL Documentation, then the shower was not given. On 02/19/2025 at 1:45 p.m. an interview was conducted with S10CNA. She confirmed she was one of the aides assigned to Resident #56's hall. She stated it was her responsibility to shower residents if the shower aid was off. She stated she had not showered Resident #56 at all in the month of February 2025. She confirmed if there was no documentation on the ADL Documentation, then the shower was not given. On 02/18/25 at 1:34 p.m. an interview was conducted with S13ADON. She reviewed Resident #56's ADL Documentation and confirmed there was no documentation for a shower being given on Saturday 02/8/2025. She confirmed if a shower was given there should have been documentation. She stated Resident #56 should have received a shower on Saturday 02/8/2025 and according to documentation she did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615 Based on observation, interviews and record review the facility failed to administer parenteral fluids consistent with professional standards of practice for 1(#57) of 1(#57) residents reviewed for IV (Intravenous) fluid therapy. The facility failed to monitor, flush, and replace the saline lock IV access site according to professional standards. Findings: Review of the undated facility Policy Titled, Intravenous Therapy Flush and Dressing Protocol revealed, in part: Peripheral Device: 1. Follow SASH protocol daily and as needed. Flush device with 3ML Normal Saline and 2ML Heparin 100 units/ML 2. Change dressing every three days and as needed according to policy. 3. IV site to be monitored for complications. 4. IV site to be rotated every three days and as needed as appropriate. Review of Resident #57's Medical Record revealed the resident was admitted to the facility on [DATE] with a diagnoses which included Pneumonia and Dehydration. Review of Resident #57's MDS (Minimum Data Set) ARD (Assessment Reference Date) 01/20/2025 revealed BIMS (Brief Interview for Mental Status) of 15 indicating Resident #57 was cognitively intact. Review of Resident #57's physician orders, dated February 2025, revealed an order on 02/11/2025 and 02/12/2025 for Resident #57 to receive IV fluids. Further review revealed no physician orders for an assessment daily, flushing daily, or discontinuation of Resident #57's peripheral IV site. Review of Resident #57's Medication Administration Record (MAR), dated February 2025, revealed no documented evidence of an assessment daily, flushing daily, or discontinuation of Resident #57's peripheral IV site. On 02/17/2025 at 12:06 p.m., an observation of Resident #57's peripheral IV site to his right forearm was not visible and covered with an undated non-transparent, elastic ace dressing. On 02/18/2025 at 10:49 a.m., an observation of Resident #57's peripheral IV site to his right forearm was not visible and covered with an undated non-transparent, elastic ace dressing. An interview was conducted at this time, Resident #57 stated his IV hurt when he moved his hand and it had not been changed, flushed, or used since 02/12/2025 when he received IV fluids. On 02/18/2025 at 3:00 p.m., an observation of Resident #57's peripheral IV site to his right forearm was not visual and covered with an undated non-transparent, elastic ace dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/18/2025 at 3:15 p.m., an observation of Resident #57's IV site was conducted with S8LPN. S8LPN confirmed Resident #57's peripheral IV site to his right forearm was not visual and covered with an undated non-transparent, elastic ace dressing. An interview was conducted at this time with S8LPN who stated she was assigned to Resident #57 on 02/17/2025 and 02/18/2025. She stated she did not know when Resident #57 received the peripheral IV site or when the last time the site was flushed. She confirmed she did not flush Resident #57's peripheral IV site on 02/17/2025 and 02/18/2025. On 02/18/2025 at 4:50 p.m., an interview was conducted with S2DON. S2DON confirmed Resident #57's IV site was inserted in his right forearm on 02/11/2025 and it was discontinued on 02/18/2025. She stated IV sites should be assessed and flushed daily and changed every 3 days. She further stated the above should be documented on the MAR. S2DON confirmed there was no documented evidence Resident #57's IV site was assessed or flushed daily and should have been changed or removed by 02/14/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195524	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Healthcare and Rehabilitation Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47173 Based on observations and interviews, the facility failed to store food under sanitary conditions by failing to ensure food was properly labeled and stored in unit refrigerators. This deficient practice had the potential to affect 81 residents who were able to store and consume food in the facility's unit refrigerator. Findings: Review of the facility's policy titled Use and Storage of Food from Outside the Facility dated 12/11/2017 revealed the following, in part: Procedure: 1. The resident may maintain food brought in by family or visitors .in the facility refrigerator as long as it is maintained/stored in a sanitary conditions: a. storage conditions: i. Sealed container, with resident's name and date. On 02/17/2025 at 11:15 a.m., a tour was made of NS1 with S3LPN. An observation was made of the resident's unit refrigerator which contained the following items: 1 brown paper bag with a wrapped breakfast sandwich with no date or name; 1 plastic container with a lid containing an unknown food with no date; 1 plastic container with a lid containing an unknown food with no date or name; 1 20 ounce foam cup with a lid containing a pink liquid with no date or name; and 1 plastic container with a lid containing an unknown food with no date or name. On 02/17/2025 at 11:18 a.m., an interview was conducted with S3LPN. She stated staff should label all outside food items with the resident's name and a date. S3LPN confirmed the above mentioned items were not properly labeled and should have been. On 02/18/2025 at 1:25 p.m., an interview was conducted with S2DON. She stated she was made aware of the unlabeled resident food items stored in the unit refrigerator located in NS1. She confirmed any food items brought in from outside of the facility should be labeled with a date and the resident's name when stored in the unit refrigerator located in NS1.