

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 03/18/2026
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 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, interviews, and record reviews, the facility failed to ensure a safe, clean, comfortable, and homelike environment was maintained for 2 of 2 (#5 and #58) residents reviewed for environment. Resident #5 Review of Resident #5's clinical record revealed she was admitted to the facility on [DATE] with diagnoses, which included Idiopathic Peripheral Autonomic Neuropathy, Chronic Ischemic Heart Disease, Morbid Severe Obesity due to Excess Calories, and Acute on Chronic Diastolic Congestive Heart Failure.</p> <p>Review of Resident #5's Quarterly MDS with an ARD of 03/04/2026 revealed a BIMS of 13, which indicated the resident was cognitively intact.</p> <p>An observation was made on 03/15/2026 at 1:26 p.m. of Resident #5's room. Behind her bed was a brown substance splattered on the wall.</p> <p>An interview was conducted on 03/15/2026 at 1:27 p.m. with Resident #5. She stated the brown substance had been on the wall for months. She stated she had asked staff to clean it, but no one ever had.</p> <p>An observation was made on 03/16/2026 at 9:02 a.m. of Resident #5's room. Behind her bed was a brown substance splattered on the wall.</p> <p>An interview was conducted on 03/16/2026 at 9:06 a.m. with S16CNA while in Resident #5's room. S16CNA confirmed the above observations. She stated, That has been there. She stated it was the housekeepers' responsibility to clean it.</p> <p>An interview was conducted on 03/16/2026 at 9:22 a.m. with S10HSK. She stated it was the housekeepers' responsibility to clean all of the residents' rooms including the walls if something was visibly dirty.</p> <p>An interview was conducted on 03/16/2026 at 9:14 a.m. with S1ADM while in Resident #5's room. He confirmed the above observations. He stated it was the housekeepers' responsibility to clean the resident's rooms. He confirmed resident's rooms should be cleaned daily including the walls when visible substances were on them.</p> <p>Resident #58 Review of Resident #58's clinical record revealed she was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's Disease. Review of the Quarterly MDS with ARD of 01/21/2026 revealed a BIMS of 5, which indicated the resident was severely cognitively impaired. An observation was made on 03/15/2026 at 10:45 a.m. of Resident #58's room. Observed (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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>resident's pillow with no pillow case at this time and had multiple areas of red, brown, and yellow dried substances. Observed dried brown substance located on both of the resident's bed rails.</p> <p>An interview was conducted on 03/15/2026 at 10:45 a.m. with Resident #58's daughter visiting Resident #58. Resident #58's daughter stated she visited Resident #58 every weekend and multiple days during the week. Resident #58's daughter stated during most of her visits, Resident #58 did not have a clean pillow case on her pillow and the bed rails were not cleaned. An observation was made on 03/16/2026 at 9:50 a.m. of Resident #58's room. Observed resident's pillow with no pillow case at this time and had multiple areas of red, brown, and yellow dried substances. Observed dried brown substance located on both of the resident's bed rails. An interview was conducted on 03/16/2026 at 9:51 a.m. with Resident #58. She stated she would like a pillow case because that is nasty. An interview was conducted on 03/16/2026 at 9:58 a.m. with S13HSK. She observed the resident's pillow and bed rails. She stated it was housekeeping's responsibility to clean the resident's bed rails daily. She confirmed there was a dried brown substance located on both of the resident's bed rails. She stated it was the aide's responsibility to place clean linens on the resident's bed which included the pillow case. An interview was conducted on 03/16/2026 at 10:02 a.m. with S8CNAS. She observed the resident's pillow and bed rails. She stated it was housekeeping's responsibility to clean the resident's bed rails daily. She confirmed there was dried brown substance located on both of the resident's bed rails. She confirmed the pillow did not have a pillow case in place and the pillow was stained with a brown, red, and yellow dried substance. She stated it was the aide's responsibility to place clean linens on the resident's bed which included the pillow case. An interview was conducted on 03/16/2026 at 10:15 a.m. with S1ADM. He stated he would get staff to get her a clean pillow immediately. He stated housekeeping was responsible for cleaning the resident's bed rails daily.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure services provided as outlined in the comprehensive care plan met professional standards of quality by failing to ensure nursing staff primed insulin pen needles prior to administering insulin for 3 (#12, #129, and #144) of 5 residents reviewed for insulin administration. Findings:</p> <p>Review of the facility's insulin pen needle product insert revealed the following:</p> <p>2. Prepare the pen needle:</p> <p>Check that the pen needle is attached correctly and prime the pen according to the manufacturer's instructions for use.</p> <p>Select the insulin dose.</p> <p>Review of the Regular Insulin and Insulin Aspart insulin pen manufacturer's instructions for use revealed the following:</p> <p>Giving the airshot before each injection:</p> <p>Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <p>E. Turn the dose selector to select 2 units.</p> <p>F. Hold your insulin pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.</p> <p>G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip.</p> <p>Resident #12</p> <p>Review of Resident #12's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus.</p> <p>Review of Resident #12's current Physician Orders revealed the following, in part:</p> <p>Insulin Aspart 100 unit/mL inject 18 units subcutaneously before meals.</p> <p>An observation was made of S4LPN administering Insulin Aspart to Resident #12 on 03/16/2026 at 8:36 a.m. S4LPN applied an insulin pen needle to the insulin pen, dialed up 18 units of insulin, and administered the insulin to Resident #12. S4LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #12.</p> <p>An interview was conducted with S4LPN on 03/16/2026 at 8:47 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #12. (continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #129</p> <p>Review of Resident #129's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus.</p> <p>Review of Resident #129's current Physician Orders revealed the following, in part:</p> <p>Regular Insulin 100 unit/mL inject per sliding scale subcutaneously before meals and at bedtime.</p> <p>An observation was made of S5LPN administering Regular Insulin to Resident #129 on 03/16/2026 at 11:45 a.m. S5LPN applied the insulin pen needle, dialed up 4 units of insulin, and administered the insulin to Resident #129. S5LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #129.</p> <p>An interview was conducted with S5LPN on 03/16/2026 at 11:52 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #129.</p> <p>Resident #144</p> <p>Review of Resident #144's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 1 Diabetes Mellitus.</p> <p>Review of Resident #144's current Physician Orders revealed the following, in part:</p> <p>Insulin Aspart 100 unit/mL inject 14 units subcutaneously before meals.</p> <p>An observation was made of S7LPN administering Insulin Aspart to Resident #144 on 03/16/2026 at 9:20 a.m. S7LPN applied an insulin pen needle to the insulin pen, dialed up 14 units of insulin, and administered the insulin to Resident #144. S7LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #144.</p> <p>An interview was conducted with S7LPN on 03/16/2026 at 9:17 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #144.</p> <p>An interview was conducted with S2DON on 03/17/2026 at 10:17 a.m. She stated insulin pen needles should have been primed prior to dialing up and administering the ordered dose of insulin. She explained priming an insulin pen needle was a standard of care.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good hygiene for 3 (#7, #98, and #144) of 3 residents reviewed for ADLs. The facility failed to ensure: Resident #7 and #144 received their shower as scheduled; and Resident #98 was dressed in clean attire daily. Findings:</p> <p>1.</p> <p>Resident #7</p> <p>Review of Resident #7's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis, which included Radiculopathy, Lumbar Region.</p> <p>Review of Resident #7's Quarterly MDS with an ARD of 12/12/2025 revealed BIMS of 11, which indicated the resident was moderately cognitively impaired. Further review revealed Section GG0130. Self-Care: Partial/moderate assistance for shower/bathe self.</p> <p>Review of Resident #7's current Care Plan revealed the following:</p> <p>Focus: The resident requires staff assistance for ADL care.</p> <p>Interventions: Assist resident with bathing.</p> <p>Review of Resident #7's Shower Documentation dated March 2026 revealed she was scheduled to receive a shower every Tuesday, Thursday, and Saturday. Further review of the Shower Documentation revealed Resident #7 received two showers on the week of 03/08/2026. Resident #7 did not receive her scheduled shower on 03/14/2026.</p> <p>Resident #144</p> <p>Review of Resident #144's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis, which included Multiple Sclerosis.</p> <p>Review of Resident #144's Quarterly MDS with an ARD of 01/01/2026 revealed a BIMS of 14, which indicated the resident was cognitively intact. Further review of the MDS revealed Resident #144 required partial/moderate assistance with ADLs.</p> <p>Review of Resident #144's current Care Plan revealed the following:</p> <p>Focus: The resident requires staff assistance for ADL care.</p> <p>Interventions: Assist resident with bathing.</p> <p>Review of Resident #144 Shower Documentation dated February 2026 to present revealed she was scheduled to receive showers on Tuesday, Thursday, and Saturday. Further review of the Shower Documentation revealed Resident #144 received two showers on the weeks of 02/01/2026, 02/22/2026, and 03/08/2026. Resident #144 did not receive a shower on 02/07/2026, 02/28/2026, (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and 03/14/2026.</p> <p>On 03/15/2026 at 8:46 a.m., an interview was conducted with Resident #144. She stated she has not been receiving all of her scheduled showers. She stated her shower schedule is Tuesday, Thursday, and Saturday. She stated she did not get her scheduled shower on Saturday, 03/14/2026.</p> <p>On 03/15/2026 at 2:06 p.m., an interview was conducted with S9CNA. She stated Resident #7 had showers scheduled on Tuesdays, Thursdays, and Saturdays. She stated she was responsible to provide Resident #7's shower on Saturday, 03/14/2026. S9CNA stated she did not provide Resident #7's shower on 03/14/2026 as scheduled and should have. She stated Resident #144 had scheduled showers on Tuesdays, Thursdays, and Saturdays. She stated she was responsible to provide Resident #144's shower on 02/07/2026, 02/28/2026, and 03/14/2026. S9CNA stated she did not provide Resident #144's shower on 02/07/2026, 02/28/2026, and 03/14/2026 as scheduled and should have.</p> <p>On 03/17/2026 at 9:32 a.m., an interview was conducted with S8CNAS. She stated the CNAs were responsible to document when residents received showers. She reviewed Resident #7's shower documentation and confirmed there was no documentation Resident #7 received a shower on 03/14/2026 as scheduled. S8CNAS stated Resident #7 should have received her shower as scheduled. She reviewed Resident #144 shower documentation and confirmed there was no documentation Resident #144 received a shower on 02/07/2026, 02/28/2026, and 03/14/2026 as scheduled. She stated Resident #144 should have received her shower as scheduled.</p> <p>On 03/17/2026 at 9:57 a.m., an interview was conducted with S2DON. S2DON stated residents should receive their shower on their scheduled shower day. S2DON stated Resident #7 should have received her shower on Saturday, 03/14/2026 as scheduled. S2DON stated Resident #144 should have received her shower on 02/07/2026, 02/28/2026, and 03/14/2026.</p> <p>2.</p> <p>Resident #98</p> <p>Review of Resident #98's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Age-Related Osteoporosis, Transient Cerebral Ischemic Attack, and Alzheimer's Disease. Further review revealed the resident was currently on Hospice.</p> <p>Review of Resident #98's Quarterly MDS with an ARD of 01/28/2026 revealed BIMS of 01, which indicated the resident was severely cognitively impaired.</p> <p>Review of Resident #98's current Care Plan revealed the following:</p> <p>Focus: The resident requires staff assistance for ADL care dressing and hygiene related to Alzheimer's, Depression/Anxiety, and Hypertension.</p> <p>Interventions: Assist the resident with dressing. Assist the resident with hygiene and grooming task.</p> <p>On 03/15/2026 at 11:55 a.m., an interview was conducted with Resident #98's family member #1. She stated hospice bathed Resident #98 3 times a week on Tuesdays, Thursdays, and Saturdays. She stated when Resident #98 was bathed, she stayed in the same night gown until her next bath due to (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>staff not changing her attire daily. She stated her last bath was on 03/14/2026.</p> <p>On 03/15/2026 at 11:55 a.m., an observation was made of Resident #98 in bed wearing a blue and white flower nightgown.</p> <p>On 03/16/2026 at 8:10 a.m., an observation was made of Resident #98 in bed wearing the same blue and white flower nightgown.</p> <p>On 03/16/2026 at 8:15 a.m., an interview was conducted with Resident #98's family member #2. She stated on Saturday, 03/14/2026, Resident #98 was bathed by Hospice. Surveyor observed the resident's dirty clothesbasket. There was only 1 gown in the basket. Resident #98's family member #2 stated that was the gown the resident had on 03/14/2026 before being bathed. She stated the resident had been in the same gown since Saturday 03/14/2026, and would not receive her next bath until tomorrow, 03/17/2026 from Hospice in which she would be placed in a fresh gown. She stated Resident #98 did not get changed in between Hospice coming to tend to her.</p> <p>On 03/16/2026 at 12:42 p.m., an observation was made of Resident #98 in bed wearing the same blue and white flower nightgown.</p> <p>On 03/17/2026 at 8:50 a.m., an observation was made of Resident #98 in bed wearing the same blue and white flower nightgown.</p> <p>On 03/17/2026 at 8:52 a.m., an interview was conducted with the Hospice CNA. She stated she was the aide who was responsible for bathing Resident #98. She stated she bathed her on Tuesdays, Thursdays, and Saturdays. She stated she bathed her this past Saturday 03/14/2026. She confirmed she dressed Resident #98 in the blue and white flower gown she was currently wearing.</p> <p>On 03/17/2026 at 9:57 a.m., an interview was conducted with S2DON. S2DON confirmed Resident #98 should be dressed daily in clean attire.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure nursing staff had the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and plans of care. The facility failed to ensure nursing staff had competencies and skill sets to: Accurately administer insulin via insulin pens for 3 (#12, #129, and #144) of 5 residents reviewed for insulin administration; and Properly clean a non-invasive mechanical ventilation mask and tubing for 1 (#10) of 2 residents reviewed for respiratory care. Findings:</p> <p>1.</p> <p>Review of the facility's insulin pen needle product insert revealed the following:</p> <p>2. Prepare the pen needle:</p> <p>Check that the pen needle is attached correctly and prime the pen according to the manufacturer's instructions for use.</p> <p>Select the insulin dose.</p> <p>Review of the Regular Insulin and Insulin Aspart insulin pen manufacturer's instructions for use revealed the following:</p> <p>Giving the airshot before each injection:</p> <p>Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <p>E. Turn the dose selector to select 2 units.</p> <p>F. Hold your insulin pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.</p> <p>G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip.</p> <p>Resident #12</p> <p>Review of Resident #12's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus.</p> <p>Review of Resident #12's current Physician Orders revealed the following, in part:</p> <p>Insulin Aspart 100 unit/mL inject 18 units subcutaneously before meals.</p> <p>An observation was made of S4LPN administering Insulin Aspart to Resident #12 on 03/16/2026 at 8:36 a.m. S4LPN applied an insulin pen needle to the insulin pen, dialed up 18 units of insulin, and (continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>administered the insulin to Resident #12. S4LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #12.</p> <p>An interview was conducted with S4LPN on 03/16/2026 at 8:47 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #12. She stated insulin pen needles did not have to be primed prior to administering insulin.</p> <p>Resident #129</p> <p>Review of Resident #129's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus.</p> <p>Review of Resident #129's current Physician Orders revealed the following, in part:</p> <p>Regular Insulin 100 unit/mL inject per sliding scale subcutaneously before meals and at bedtime.</p> <p>An observation was made of S5LPN administering Regular Insulin to Resident #129 on 03/16/2026 at 11:45 a.m. S5LPN applied the insulin pen needle, dialed up 4 units of insulin, and administered the insulin to Resident #129. S5LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #129.</p> <p>An interview was conducted with S5LPN on 03/16/2026 at 11:52 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #129. She stated priming insulin pen needles was optional.</p> <p>Resident #144</p> <p>Review of Resident #144's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis of Type 1 Diabetes Mellitus.</p> <p>Review of Resident #144's current Physician Orders revealed the following, in part:</p> <p>Insulin Aspart 100 unit/mL inject 14 units subcutaneously before meals and at bedtime.</p> <p>An observation was made of S7LPN administering Insulin Aspart 100 unit/mL inject 14 units subcutaneously to Resident #144 on 03/16/2026 at 9:20 a.m. S7LPN applied an insulin pen needle to the insulin pen, dialed up 14 units of insulin, and administered the insulin to Resident #144. S7LPN did not prime the insulin pen needle prior to dialing up the insulin and administering the insulin to Resident #144.</p> <p>An interview was conducted with S7LPN on 03/16/2026 at 9:17 a.m. She confirmed she did not prime the insulin pen needle prior to dialing up and administering insulin to Resident #144. She stated insulin pen needles did not have to be primed prior to administering insulin.</p> <p>An interview was conducted with S2DON on 03/17/2026 at 10:14 a.m. She stated insulin pen needles should have been primed prior to dialing up and administering the ordered dose of insulin. She stated the nurses should have known insulin pen needles should have been primed. She explained priming an insulin pen needle was a standard of care. (continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.</p> <p>Review of the facility's policy dated 11/04/2014 and titled, BiPAP and CPAP Machine Cleaning Policy and Procedure revealed the following, in part:</p> <p>Purpose: The keep BiPAP and CPAP machine and equipment clean.</p> <p>Policy: Resident's BiPAP and/or CPAP machine will be kept clean when in resident room.</p> <p>Procedure:</p> <p>4. Clean the tubing daily with warm water and soap. Rinse thoroughly and air dry.</p> <p>5. Clean the mask daily with warm water and soap, rinse thoroughly and air dry.</p> <p>Resident #10</p> <p>Review of Resident #10's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Acute and Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Shortness of Breath.</p> <p>Review of Resident #10's current Physician Orders revealed the following, in part:</p> <p>Clean non-invasive mechanical ventilation mask every morning and let air dry.</p> <p>An interview was conducted with S5LPN on 03/17/2026 at 2:56 p.m. She stated she cleaned Resident #10's non-invasive mechanical ventilation mask every morning. She explained she cleaned the mask with a perineal wipe each morning and let it air dry. S5LPN retrieved wipes from a green pack, which was labeled personal cleansing wipes, and S5LPN cleaned the inside of Resident #10's non-invasive mechanical ventilation mask. S5LPN stated she had never cleaned the non-invasive mechanical ventilation tubing because she had no way to clean it.</p> <p>An interview was conducted with S6LPN on 03/18/2026 at 8:57 a.m. She stated she cleaned Resident #10's non-invasive mechanical ventilation mask daily. She explained when she cleaned Resident #10's non-invasive mechanical ventilation mask, she cleaned the outside of the mask with an alcohol wipe and the inside of the mask with a water soaked paper towel. She stated she then dried the mask with a dry paper towel. She stated she had never cleaned or changed the non-invasive mechanical ventilation tubing. She stated Resident #10 only had one AVAPS mask. She stated she had never received training on cleaning non-invasive mechanical ventilation masks and tubing.</p> <p>An interview was conducted with S3NP on 03/18/2026 at 9:06 a.m. She stated she expected the nurses to follow the facility's policy on cleaning non-invasive mechanical ventilation masks and tubing.</p> <p>An interview was conducted with S2DON on 03/18/2026 at 9:42 a.m. She stated she expected the nurses to clean the non-invasive mechanical ventilation equipment with soap and water as listed in the policy listed above. She stated it was not appropriate to clean the non-invasive mechanical ventilation mask with a personal cleansing wipe. She stated it was not appropriate to clean the outside of the mask with alcohol wipes and the inside of the mask with water soaked paper towels. (continued on next page)</p>		

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 03/18/2026
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.			
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>She stated she expected the nurses be competent in cleaning and care of non-invasive mechanical ventilation masks and tubing.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure respiratory care was provided consistent with professional standards of practice and the comprehensive care plan by failing to properly clean non-invasive mechanical ventilation equipment for 1 (#10) of 2 residents reviewed for respiratory care. Findings: Review of the facility's policy dated 11/04/2014 and titled, BiPAP and CPAP Machine Cleaning Policy and Procedure revealed the following, in part: Purpose: The keep BiPAP and CPAP machine and equipment clean. Policy: Resident's BiPAP and/or CPAP machine will be kept clean when in resident room. Procedure: 4. Clean the tubing daily with warm water and soap. Rinse thoroughly and air dry. 5. Clean the mask daily with warm water and soap, rinse thoroughly and air dry. Resident #10 Review of Resident #10's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Acute and Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Shortness of Breath. Review of Resident #10's MDS with an ARD of 01/23/2026 revealed she utilized a non-invasive mechanical ventilator and Oxygen therapy. Review of Resident #10's current Physician Orders revealed the following, in part: AVAPS-AE ventilator (non-invasive mechanical ventilation) for home use at bedtime full face mask; and Clean non-invasive mechanical ventilation mask every morning and let air dry. Review of Resident #10's current Care Plan revealed the following, in part: Problem: The resident has Chronic Obstructive Pulmonary Disease. She has a non-invasive mechanical ventilation machine as ordered. Tubing and humidification changed per protocol. An interview was conducted with S5LPN on 03/17/2026 at 2:56 p.m. She stated she cleaned Resident #10's non-invasive mechanical ventilation mask every morning. She explained she cleaned the mask with a perineal wipe each morning and let it air dry. S5LPN retrieved wipes from a green pack, which was labeled personal cleansing wipes. S5LPN used the personal cleansing wipes and cleaned the inside of Resident #10's non-invasive mechanical ventilation mask. S5LPN stated she had never cleaned the non-invasive mechanical ventilation tubing because she had no way to clean it. An interview was conducted with S6LPN on 03/18/2026 at 8:57 a.m. She stated she cleaned Resident #10's non-invasive mechanical ventilation mask daily. She explained when she cleaned Resident #10's non-invasive mechanical ventilation mask, she cleaned the outside of the mask with an alcohol wipe and the inside of the mask with a water soaked paper towel. She stated she then dried the mask with a dry paper towel. She stated she did not use soap to clean the mask. She stated she had never cleaned or changed the AVAPS tubing. She stated she had never received training on cleaning non-invasive mechanical ventilation masks and tubing. An interview was conducted with S3NP on 03/18/2026 at 9:06 a.m. She stated she expected the nurses to follow the facility's policy on cleaning non-invasive mechanical ventilation masks and tubing. An interview was conducted with S2DON on 03/18/2026 at 9:42 a.m. She stated she expected the nurses to clean the non-invasive mechanical ventilation equipment with soap and water as listed in the policy listed above. She stated it was not appropriate to clean the non-invasive mechanical ventilation mask with a personal cleansing wipe. She stated it was not appropriate to clean the outside of the mask with alcohol wipes and the inside of the mask with water soaked paper towels.</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 observations, interviews, and record review, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure staff:1. Properly utilized Enhanced Barrier Precaution (EBP) Personal Protective Equipment (PPE) during direct care for 2 (#6 and #45) of 3 residents observed who required EBP; and2. Performed appropriate Standard PPE glove precautions during incontinence care for 1 of 1 (#45) residents observed for urinary catheter care.Review of the facility's policy titled Enhanced Barrier Precautions Policy and Procedure dated 04/01/2024 revealed in part, the following:EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.1. EBP are indicated for residents with any of the following:ii. Indwelling medical device examples include central lines and urinary catheters.4. For residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities:f. Changing briefs or assisting with toileting.g. Device care or use (central line, urinary catheter)Resident #6Review of Resident #6's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed she currently had a Peripherally Inserted Central Catheter (PICC) line inserted.An observation was made on 03/15/2026 at 9:55 a.m. of Resident #6 in her room. No EBP signage was observed on the resident's door or in the resident's room. S15LPN entered the room, with only gloves applied, disengaged an antibiotic from Resident #6's PICC line, and flushed the PICC line with Heparin. S15LPN did not wear a gown during this direct care for Resident #6.An interview was conducted on 03/15/2026 at 10:00 a.m. with S15LPN. She stated Resident #6 did not require EBP, did not have an EBP sign, and did not have any physician orders for EBP. She stated she would wear a gown and gloves if a resident required EBP. She stated Resident #6 had the PICC line for approximately 3 days.Resident #45Review of Resident #45's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Retention of Urine. Further review revealed she currently had a urinary catheter in place.Review of Resident #45's current Physician Orders revealed in part, the following:Enhanced barrier precautions: utilize gown and gloves during high contact care activities for residents with indwelling medical devices. Start date: 02/23/2026.An observation was made on 03/17/2026 at 9:30 a.m. of S12LPN and S14CNA performing catheter care and incontinence care for Resident #45. There was an EBP sign on her door which read, in part Enhanced Barrier Precautions. When providing high contact care, staff must: wear gown and wear gloves. Examples of high contact care: device care and changing briefs. Resident #45 was observed to have had a bowel movement in her brief. S12LPN and S14CNA applied gloves, changed Resident #45's soiled brief, cleaned her perineal area with wipes, performed urinary catheter care, and disposed the soiled brief in the trash. S12LPN and S14CNA then, without changing gloves, retrieved a clean brief and applied it to Resident #45. S12LPN and S14CNA did not wear gowns during this direct care for Resident #45.An interview was conducted on 03/17/2026 at 9:40 a.m. with S12LPN. She stated Resident #45 was on EBP, which consisted of staff wearing gown and gloves when direct care was provided. She stated she should have worn a gown during urinary catheter care and incontinence care. She stated she should have changed her gloves after cleaning the feces soiled brief from the resident, before performing urinary catheter care, and again before touching a clean brief.An interview was conducted on 03/17/2026 at 9:42 a.m. with S14CNA. She stated Resident #45 was on EBP, which consisted of staff wearing gown and gloves when direct care was provided. She stated she should have worn a gown during urinary catheter care and incontinence care. She stated she should have changed her gloves after cleaning the feces soiled brief from the resident and before touching a clean brief.An interview was conducted on 03/17/2026 at 11:25 a.m. with S2DON. She confirmed residents (continued on next page)</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>with a PICC line or a urinary catheter required EBP. She stated medical devices requiring EBP was discussed in morning meetings. She stated Resident #6's PICC line had been in place for 3 days. She stated EBP initiation for Resident #6 was missed. She confirmed EBP consisted of wearing a gown and gloves and should have been worn during direct resident care. She stated she expected staff to change their gloves after cleaning feces from a resident, before performing urinary catheter care, and again before touching a clean brief.</p>		