

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Ouachita Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 Millhaven Road Monroe, LA 71203	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observation and interview the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes or enhances his or her quality of life for 2 (#143, #14) of 2 residents.</p> <p>Findings:</p> <p>On 03/09/2025 at 1:06 p.m. observation of resident #143 revealed he was sitting in a high back wheelchair with a clean disposable brief behind his head cushioning his head and neck against the wheelchair headrest.</p> <p>On 03/11/2025 at 2:03 p.m., record review revealed diagnoses in part of Parkinson's disease, coronary artery disease, hypertension, dysphagia following cerebrovascular disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed resident #143 had a Brief Interview Mental Status (BIMS) of 11 indicating resident #143 had moderate cognitive impairment. Further review of the MDS revealed resident #143 was dependent on staff for activities of daily living.</p> <p>On 03/11/2025 at 3:29 p.m. S2Director of Nursing (DON) was notified of the disposable brief that was placed behind resident #143 head while in the high back wheelchair.</p> <p>32231</p> <p>Resident #14</p> <p>Review of resident #14's medical record revealed that he was admitted to the facility on [DATE] with diagnoses including Parkinson's disease.</p> <p>Review of the Quarterly MDS assessment dated [DATE] revealed resident #14 had a brief interview for mental status score of 12, which indicated that she had moderate cognitive impairment with daily decision making skills. Further review of the MDS revealed that resident #14 had a self-care deficit and he needed set-up or clean up assistance with eating.</p> <p>Review of resident #14's record revealed he was care planned for having an activities of daily living self-care performance deficit related to the disease process Parkinson's and impaired balance.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/10/2025 at 8:05 a.m., an observation revealed resident #14 sitting in his wheelchair in the main dining room, eating his breakfast. Further observation revealed resident #14 was served a diet that consisted of in part, a patty sausage, scrambled eggs, and a biscuit. There were pieces of the patty sausage, scrambled eggs, and the biscuit observed lying on top of and in direct contact with the table top. Further observation revealed resident #14 picked up the food items directly from with his hand then in his mouth. S11Licensed Practical Nurse (LPN) was standing near to resident #14 at that time and observed resident #14 retrieving the pieces of the patty sausage, scramble eggs, and biscuit from the table top with his hand. S11LPN, S12Certified Nursing Assistant (CNA) and S13CNA was observed standing in the dining area, but did not address resident #14 eating his breakfast meal from the table top with his hand.</p> <p>On 03/10/2025 at 8:17 a.m., S8Assistant Director of Nursing was notified of the observation regarding resident #14 picking up his food from the table top and eating it with his hands without being offered assistance by staff during that time. S8ADON confirmed the staff should have offered to assist the resident with his meal.</p> <p>On 03/11/2025 at 3:45 p.m., S2Director of Nursing was notified of the observation regarding resident #14 eating his breakfast meal directly from the table top with his hands without assistance from the staff.</p> <p>On 03/11/2025 at 3:55 p.m., S1Administrator was notified of the above findings.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observation, record review, and interview the facility failed to ensure the resident's call light was within reach for 3 (#102, #141 #143) of 3 residents observed with call lights out of reach and were high risk for falls.</p> <p>Findings:</p> <p>Resident #102</p> <p>On 03/10/2025 at 10:45 a.m., observation of resident #102's room revealed the call light was out of the resident's reach. Resident #102 was in a wheelchair and call light was out of reach on the bed. She agreed she would not be able to call for assistance if needed.</p> <p>Review of the medical record for resident #102 revealed diagnoses in part of cerebral infarction, psychotic disorders with delusions, chronic respiratory failure with hypercapnia, major depressive disorder with psychotic symptoms, vascular dementia with behavioral disturbances, neuropathy, convulsions, type 2 diabetes, and heart failure.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment revealed resident #102 had a Brief Interview Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed resident #102 was always incontinent of bladder and bowel and was dependent on staff for all activities of daily living.</p> <p>Review of the current fall risk assessment revealed resident #102 was at high risk for falls.</p> <p>Resident 141</p> <p>On 03/10/2025 at 10:50 a.m. observation of resident #141 revealed he was lying in bed and the call light was draped over the back of the recliner at the foot of the resident's bed out of the resident's reach. At that time the resident asked for a glass of water and he was unable to call for assistance.</p> <p>On 03/10/2025 at 11:05 a.m. observation again of resident #141's room revealed the call light remained out of reach of the resident and draped over the back of the recliner at the foot of the resident's bed out of the resident's reach.</p> <p>On 03/10/2025 at 2:10 p.m. observation again of resident #141's room revealed the call light remained draped over the back of the recliner out of the resident's reach.</p> <p>Review of the medical record for resident #141 revealed diagnoses in part of metabolic encephalopathy, unspecified protein calorie malnutrition, interstitial pulmonary disease with fibrosis, chronic atrial fibrillation, dysphagia following cerebrovascular disease, muscle wasting and atrophy lower leg and multiple sites, falls, seizures, anxiety, dementia mild with anxiety, and depression.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the significant change MDS assessment dated [DATE] revealed resident #141 had a BIMS score of 2 indicating significant cognitive impairment. Further review of the MDS revealed resident #141 was always incontinent of bladder and bowel and was dependent on staff for all activities of daily living.</p> <p>Further review of the medical record revealed resident #141 was at high risk for falls.</p> <p>Resident 143</p> <p>On 03/10/2025 at 10:50 a.m. observation of resident #143's room revealed the resident was sitting up in a high back wheelchair. Further observation revealed the call light was lying on the bed out of the reach of the resident.</p> <p>Review of the medical record for resident #143 revealed diagnoses in part of Parkinson's disease, coronary artery disease, dysphagia following cerebrovascular disease.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #143 had a BIMS score of 11 indicating moderate cognitive impairment. Further review of the MDS revealed resident #143 was always incontinent of bladder and bowel and required assistance from staff for all activities of daily living.</p> <p>Further review of the medical record revealed resident #143 was at high risk for falls.</p> <p>On 03/11/2025 at 3:27 p.m., S2Director of Nursing (DON) was notified of the call bells being out of reach of the residents #102, #141 and #143 who were all at high risk for falls and required assistance from staff.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098</p> <p>Based on observation, record review and interview the facility failed to ensure resident personal privacy was maintained during care for 1 (#102) of 1 residents observed exposed to the hallway during care.</p> <p>Findings:</p> <p>On 03/09/2025 at 1:45 p.m., observation from the hallway into resident #102's room revealed resident #102 was lying on the bed with no sheets covering her. Further observation revealed resident #102 was lying in the bed with her brief exposed to the hallway.</p> <p>On 03/09/2025 at 1:47 p.m., an interview with S6Certified Nurse Aide (CNA) and S7CNA revealed when S7CNA left out of the room the door must have swung back open when they went to get a gown for the resident. S6CNA and S7CNA agreed the door was open to the hallway and resident #102 was lying on the bed with no sheets covering her and her brief was exposed to the hallway, not maintaining the resident's privacy.</p> <p>Review of the record for resident #102 revealed diagnoses of cerebral infarction, psychotic disorders with delusions, chronic respiratory failure with hypercapnia, major depressive disorder with psychotic symptoms, and vascular dementia with behavioral disturbances.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #102 had a Brief Interview for Mental Status (BIMS) of 15 indicating the resident was cognitively intact. Further review of the MDS revealed resident #102 was always incontinent of bladder and bowel and was dependent on staff for all activities of daily living.</p> <p>On 03/11/25 at 1:45 p.m., an interview with resident #102 revealed she did not like when the staff came into her room to change her and left the door open, causing her to be exposed in her room with a brief on.</p> <p>On 03/11/2025 at 3:28 p.m. S2Director of Nursing (DON) was notified of the resident being left exposed during 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** 32231</p> <p>Based on observations and interviews, the facility failed to provided a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 2 (#14,#63) of 3 (#14,#25,#63) residents reviewed for ADL (Activities of Daily Living), by failing to ensure residents #14 and #63 received assistance with personal hygiene.</p> <p>Findings:</p> <p>Resident #14</p> <p>Review of resident #14's medical record revealed that he was admitted to the facility on [DATE] with diagnoses including Parkinson's disease.</p> <p>Review of the quarterly minimum data set assessment dated [DATE] revealed resident #14 had a brief interview for mental status score of 12, which indicated that he had moderate cognitive impairment with daily decision making skills. Further review revealed resident #14 required partial to moderate assistance with personal hygiene that included shaving.</p> <p>Review of resident #14's record revealed he was care planned for having an activities of daily living self-care performance deficit related to the disease process Parkinson's and impaired balance. The documented approaches included that resident #14 required one staff assistance with personal hygiene.</p> <p>On 03/09/2025 at 8:17 a.m., an observation revealed resident #14 lying in bed resting. Further observation revealed the resident's eyebrows were long and untrimmed. Attempted an interview with resident #14, but he could not answer the questions appropriately.</p> <p>On 03/10/2025 at 8:03 a.m., S8ADON (Assistant Director of Nursing) was notified of the observation of resident #14 having long, untrimmed eyebrow hair to both eyebrows.</p> <p>On 03/10/2025 at 8:15 a.m., an observation of resident #14 and interview with S8ADON confirmed that resident #14's eyebrows needed to be trimmed.</p> <p>On 03/11/2025 at 3:45 p.m., S2Director of Nursing was notified of the observation of resident #14 having long and untrimmed eyebrows.</p> <p>On 03/11/2025 at 3:55 p.m., S1Administrator was notified of the above findings.</p> <p>Resident #63</p> <p>Review of resident #63's medical record revealed she was admitted to the facility on [DATE] with diagnoses including, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, weakness, and dementia.</p> <p>(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>Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed resident #63 had a brief interview for mental status score of 03, which indicated that she had severe cognitive impairment with daily decision making skills. Further review of the MDS revealed that resident #63 had an impairment to one side of the upper extremity, she had a self-care deficit, and was dependent upon staff with personal hygiene that included shaving.</p> <p>Review of resident #63's medical record revealed the resident was care planned as she required staff assistance with activities of daily living care related to cardiovascular vascular accident with right sided hemiplegia and osteoarthritis. The documented approaches included in part, assist the resident with hygiene and grooming tasks.</p> <p>On 03/09/2025 at 8:02 a.m., an observation revealed resident #63 in bed, resting. Further observation revealed a large amount of long, untrimmed hair on resident #63's chin.</p> <p>On 03/10/2025 at 8:08 a.m., S8ADON was notified of the observation of resident #63 having long and untrimmed chin hair.</p> <p>On 03/10/2025 at 8:11 a.m., an observation of resident #63 and an interview with S8ADON confirmed that resident #63's chin hair needed to be trimmed.</p> <p>On 03/11/2025 at 10:41 a.m., S2Director of Nursing was notified of the observation of resident #63.</p> <p>On 03/11/2025 at 3:55 p.m., S1Administrator was notified of the above findings.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 19121</p> <p>Based on record review, observations and interviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure oxygen was administered as ordered by the physician for 2 (#48, #138) of 3 (#29, #48, #138) residents reviewed for oxygen therapy.</p> <p>Findings:</p> <p>Review of the Oxygen Administration Policy and Procedure revised 11/16/2024 revealed the following in part:</p> <p>Policy:</p> <p>Oxygen Administration will be performed as ordered by the physician.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Check physician's order for liter flow and method of administration. 5. e. Set the flow meter to the rate ordered by the physician. 6. Nasal Cannula: connect tubing to humidifier outlet and adjust liter flow as ordered. Place prongs of cannula in the resident's nares. Adjust elastic loosely around head, above the ears. If cannula does not have elastic adjustment, lop the plastic around the ears and under the chin. Adjust the plastic slide to hold cannula in place. <p>Resident #138</p> <p>Review of the medical record revealed sample resident #138 was admitted to the facility on [DATE] with diagnosis that included subdural hemorrhage, insomnia, abnormal weight loss, depression, abnormalities of gait and mobility, muscle wasting, chronic atrial fibrillation, left artificial hip joint, hypertension, cardiomegaly, and altered mental status.</p> <p>Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] revealed the resident has a Brief Interview for Mental Status (BIMS) score of 12 which indicates the resident is cognitively aware and able to make daily decisions. Further review revealed the resident is dependent on staff with activities of daily living. Review of the health conditions revealed the resident has shortness of breath or trouble breathing with exertion and wears oxygen.</p> <p>Review of the March 2025 physician's orders revealed sample resident #138 has an order dated 07/12/2024 for continuous oxygen at 3 liters per nasal cannula.</p> <p>Observation on 03/10/2025 at 9:20 a.m. and 03/11/2025 at 1:30 p.m. revealed sample resident #138 was sitting up in bed with oxygen per nasal cannula in place. Observation of the oxygen concentrator at both times revealed the oxygen set at 2 liters.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/11/2025 at 2:00 p.m. with S9Licensed Practical Nurse (LPN), confirmed the resident's oxygen concentrator was set at 2 liters per nasal canula and the physician's order was to be at 3 liters per nasal canula. The nurse changed the oxygen concentrator to 3 liters per nasal canula at this time.</p> <p>Interview on 03/11/2025 at 4:00 p.m. with S2Director of Nurses (DON) confirmed resident #138's oxygen was ordered for 3 liters per nasal canula.</p> <p>43405</p> <p>Resident #48</p> <p>Review of resident #48's record revealed an admitted [DATE] with diagnoses including other speech and language deficits following other cerebrovascular disease, personal history of pulmonary embolism, hemiplegia and hemiparesis following other cerebrovascular disease affecting left non dominant side, dyspnea, shortness of breath, and chronic obstructive pulmonary disease.</p> <p>Review of resident #48's March 2025 Physician's Orders revealed an order dated 07/01/2024 for oxygen at 2 liters per minute per nasal cannula continuous.</p> <p>Review of resident #48's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating cognitively intact. Further review revealed oxygen therapy marked on the MDS.</p> <p>Review of resident #48's current careplan revealed resident has oxygen therapy related to respiratory illness and intervention included oxygen via nasal prongs at 2 Liters continually humidified.</p> <p>Observations on 03/09/2025 at 10:30 a.m. and 03/11/2025 at 8:00 a.m. of resident #48 revealed resident's oxygen concentrator was set at 3.5 liters per minute.</p> <p>An interview on 03/11/2025 at 8:00 a.m. with resident #48 revealed she wears her oxygen all the time, and her oxygen should be set at 2 liters per minute. Resident #48 reported she does not adjust her oxygen settings.</p> <p>An interview on 03/11/2025 at 8:05 a.m. with S17LPN confirmed that resident #48 has an order for oxygen at 2 liters per minute per nasal cannula continuously. S17LPN confirmed during observation of resident #48 that her oxygen was set at 3.5 liters per minute, changed oxygen settings to 2 liters per minute.</p> <p>An interview on 03/11/2025 at 8:25 a.m. with S2DON confirmed that resident #48's oxygen should be set at 2 liters per minute per nasal cannula.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>19098</p> <p>Based on record review, observation, and interview the facility failed to ensure the menus were followed for 7 of 7</p> <p>(#5, #39, #63, #72, #80, #104, and #127) pureed diets by not serving pureed cornbread as per the menu.</p> <p>Findings:</p> <p>On 03/09/2025 review of the lunch menu for the pureed diets revealed they were supposed to receive a dinner roll but facility substituted cornbread on the menu. Further review of the menu for the pureed diets revealed they were supposed to be served pureed cornbread.</p> <p>On 03/09/2025 at 11:00 a.m., observation of the lunch meal revealed residents #5, #39, #63, #72, #80, #104, and #127 did not receive the pureed cornbread.</p> <p>On 03/10/2025 review of the lunch menu for the pureed diets revealed they were supposed to receive pureed cornbread with their meal.</p> <p>On 03/10/2025 at 11:00 a.m., observation again of the lunch meal revealed residents #5, #39, #63, #72, #80, #104, and #127 did not receive the pureed cornbread.</p> <p>On 03/10/2025 at 3:00 p.m., an interview with S3Dietary Manager agreed the pureed diets were not served cornbread.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>19098</p> <p>Based on observation and interview the facility failed to store and distribute and serve food in accordance with professional standards for food service safety. There were 168 diets served from the kitchen.</p> <p>Findings:</p> <p>On 03/09/2025 at 8:06 a.m. observation of the reach in freezer revealed a personal drink was inside. Interview with S4Dietary confirmed the staff personal drink should not be in the refrigerator.</p> <p>At 8:10 a.m., observation of the walk in refrigerator revealed there was a pan of pureed rib meat that was not fully covered, and was not dated, there was also a pan of taco soup with a date of 02/27/2025 that should not have been available for resident consumption. At the time of the observation, S5Cook confirmed the items in the walk in refrigerator.</p> <p>At 8:20 a.m., observation of 2 large containers of powdered mashed potatoes revealed the scoop and handle were laying inside the powdered potatoes. Interview again with S5Cook confirmed the scoop and handles should not be stored inside the mashed potato bins.</p> <p>Further observation of the kitchen environment revealed the bowl, divided plates, regular plates, and insulated covers were stored facing in the upright position and not inverted. At that time S3Dietary Manager was notified of the dishes that were being stored in the upright position.</p> <p>At 11:00 a.m. observation of the lunch meat revealed S3Dietary Manager and S18Assistant Dietary Manager were picking up the cornbread with gloved hands after touching other items such as spoon handles, desserts, and drinks.</p> <p>Further observation revealed the residents who received the alternate meal choice of a chicken salad sandwich also received chips. Observation revealed when dietary staff handed S3Dietary Manager the bag of chip it fell on the floor. S3Dietary Manager picked up the bag of chips and handed it to S5Cook who then reached into the bag with the same hands that touched the outside of the bag that had fallen on the floor and got chips out of the bag. S5Cook continued to serve the lunch meal without changing her gloves. Further observation revealed S3Dietary Manager did not change her gloves after picking up the bag off the floor and continued to touch the bread to make chicken salad sandwiches and serve cornbread.</p> <p>On 03/10/2025 at 10:30 a.m., an interview with S5Cook while pureeing food revealed the menu for the lunch meal was beans, rice, spinach, ham, cornbread and dessert. S5Cook said she pureed the rice and beans together, pureed the ham with some broth and pureed the spinach with some broth.</p> <p>At 11:40 a.m. observation of the lunch meal revealed the cornbread again was served with gloved hands after touching other trays, plates, glasses and dessert bowls. Further observation revealed S19Dietary was observed using her gloved hand to take the dessert out of regular serving bowl and place into a styrofoam container for 2 isolation residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Ouachita Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 Millhaven Road Monroe, LA 71203	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>S19Dietary was then noted to spill chocolate milk on the tray that contained pre-prepared milk, she then picked up a towel to wipe up the spill and then continued to serve the cornbread without changing her gloves and touching the cornbread with the same gloves she touched the towel with.</p> <p>At 12:30 p.m. observation of the food prep sink revealed there were three 10 pound tubes of hamburger meat thawing in standing water without out cold water running over the meat.</p> <p>On 03/10/2025 at 3:00 p.m. S3Dietary Manager was notified of the findings.</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>32231</p> <p>Based on observations and interviews, the facility failed to maintain a sanitary environment and to help prevent the development and transmission of communicable diseases and infections by, having employee's personal items lying on top of and in direct contact with tables that were designed for the folding of clean clothing and linen items.</p> <p>Findings:</p> <p>On 03/11/2025 at 3:09 p.m., an observation of the laundry department revealed S14Laundry Worker and S15Laundry Worker standing in the designated clean laundry room. S14Laundry Worker was holding a cell phone in her hand. Observation revealed S14Laundry Worker placing the cell phone on the top of and in direct contact with a table that contained clean clothing items and a bed pad. S14Laundry Worker confirmed the cell phone belonged to her (S14Laundry Worker). S14Laundry Worker further confirmed the table was designed for folding clean resident clothing and linen items. Observation of the clean laundry room further revealed a second table that had a cell phone lying on the table top of and in direct contact with the table top. S15Laundry Worker confirmed the table was also used for the folding of resident items such as clothing, linens, and bed pads.</p> <p>On 03/11/2025 at 3:15 p.m., S16Laundry Supervisor entered the clean laundry room and she was notified of the observations regarding the cell phones. S16Laundry Supervisor confirmed that the laundry worker's personal belongings should not have been placed on the top of and in direct contact with the two tables that were designated for the folding of the resident's clean clothing, linens, and bed pads due to potential cross contamination.</p> <p>On 03/11/2025 at 3:55 p.m., S1Administrator was notified of the findings regarding the laundry department.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Ouachita Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 Millhaven Road Monroe, LA 71203	

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>19098</p> <p>Based on observation and interview the facility failed to ensure mechanical equipment was in safe operating condition by having the manual can opener with metal shavings. There were 168 diets served from the kitchen.</p> <p>Findings:</p> <p>On 03/09/2025 at 8:00 a.m., an observation of the large mechanical can opener revealed there was a buildup of metal shavings. At that time an interview with S5Cook confirmed the metal shavings on the can opener.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Ouachita Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 Millhaven Road Monroe, LA 71203	

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>19098</p> <p>Based on observation and interview, the facility failed to maintain an effective pest control program so that the facility is free of pests by having ants in the dry pantry area. This failed practice had the potential to affect the 168 residents receiving meals from the kitchen.</p> <p>Findings:</p> <p>On 03/09/2025 at 7:45 a.m., an observation of the dry food storage area of the kitchen revealed there were small black ants on the large containers of grits and sugar. At this time, S5Cook confirmed there were little black ants and they had been having issues with them.</p>