STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195575	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehabilitation and Healthcare Center	1515 Highway 107 Center Point, LA 71323

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, The facility failed to ensure a cognitively impaired resident (#61) who was identified as being at high risk for elopement, wandering and exhibited exit seeking behaviors did not exit the building without supervision; and failed to ensure the resident's (#61) environment remained as free of accident hazards as possible for 1 (#61) of 5 sampled residents reviewed for elopement risk. This deficient practice resulted in an Immediate Jeopardy situation on 03/26/2026 at approximately 7:50 p.m., when S3CNA who failed to recognize Resident #61 as an elopement risk, unlocked a facility door, and allowed Resident #61, who had a BIMS score of 3, was severely cognitively impaired, and wore a wanderguard, to exit the building unsupervised. Resident #61 was found by S6CNA standing on the side of a busy two-lane highway that runs in front of the facility, with a posted speed limit of 55 miles per hour. Facility administration were made aware of a door wanderguard system malfunction since 02/13/2026 and did not implement appropriate interventions to prevent elopement. This deficient practice continued at a potential for more than minimal harm for the 5 residents in the facility who were identified to require supervision, were assessed as being at risk for elopement, and wore a wanderguard bracelet. S1Admin was notified of the immediate jeopardy on 04/15/2026 at 3:58 p.m. The Immediate Jeopardy was removed on 04/16/2026 at 5:47 p.m. when the facility submitted an acceptable plan of removal, and the surveyors determined through record reviews, interviews, and observations that the Plan of Removal have been initiated and/or implemented. Findings:On 04/15/2026, review of the facility's policy titled Elopements and Wandering Residents with a revision date of 09/01/2024 read in part. This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.Definitions: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so.Policy Explanation and Compliance Guidelines:1. The facility is equipped with door locks/alarms to help avoid elopements. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement and unsafe wandering, including identification and assessment of risk.4. Monitoring and managing residents at risk for elopement and unsafe wandering include:c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.d. Adequate supervision will be provided to help prevent accidents or elopements. On 04/15/2026 review of the facility's undated policy titled Resident Alarms read in part.It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being.Policy Explanation and Compliance Guidelines:1. The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include:e. Wander/elopement alarms-includes the devices such as bracelets, pins/buttons worn on the residents clothing, or building/unit exit sensors worn/ attached to the resident that alert staff when the resident nears or exits an area or building.6. Monitoring and modification:a. Supervision shall be provided to the resident in accordance with the resident's plan of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	care. Review of Resident #61's medical record revealed an admission date of 09/17/2025, with diagnoses that included, in part. Dementia in other Diseases, Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Mild Neurocognitive Disorder due to Known Physiological Condition with Behavioral Disturbance; Cognitive Communication Deficit; Major Depressive Disorder; Anxiety Disorder; and Type Two Diabetes Mellitus with Hyperglycemia. Review of a Quarterly MDS with an ARD of 03/18/2026, revealed Resident #61 had a BIMS score of 3, indicating severe cognitive impairment. Resident #61 was ambulatory without the use of assistive devices and required supervision or touching assistance from staff during transfers and ambulation. Resident #61 utilized a wanderguard/elopement alarm on a daily basis. Review of Resident #61's Care Plan initiated on 10/20/2025 read in part.Resident #61 was an elopement risk/wanderer related to attempts to leave the facility unattended. Interventions in place prior to the elopement included: wander alert bracelet placed on resident's right ankle, staff verification/skin inspection at band location, and confirmation of signal operation. On 04/14/2026 at 1:15 p.m., interview with S5CNA revealed Resident #61 was known to exhibit exit-seeking behaviors, including verbalizing a desire to go home and attempting to leave the facility. S5CNA reported that Resident #61 had recently been found outside of the facility by S6CNA. On 04/14/2026 at 1:25 p.m., an interview with Resident #61's Responsible Party revealed Resident #61 frequently verbalized a desire to return home, had attempted to leave the facility on multiple occasions, and wears a wanderguard. The Responsible Party stated he was notified of a recent incident, though unable to recall the exact date, in which Resident #61 was found outside in the parking lot and was subsequently escorted back into the facility. On 04/14/2026 at 2:07 p.m., interview with S6CNA revealed on 03/26/2026, at approximately 7:30 p.m., she observed Resident #61 standing next to the road, outside of the facility, without staff supervision. S6CNA reported she notified S8CNA, and both staff members attempted to redirect the resident back into the facility. S6CNA stated Resident #61 was agitated and not easily redirected. S6CNA further reported that S8CNA entered the facility to obtain additional assistance from S9CNA. On 04/14/2026 at 2:13 p.m., interview with S3CNA revealed on 03/26/2026, between 7:00 p.m. and 7:30 p.m., Resident #61 was observed standing near exit door A. S3CNA stated at the time, she believed Resident #61 was a family member and did not recognize him as a resident. S3CNA reported she asked Resident #61 if he needed to exit the facility, to which he responded yes. S3CNA then entered the door code and allowed Resident #61 to exit the facility. S3CNA confirmed she did not accompany Resident #61 outside, as she believed he was a visitor. S3CNA reported that she was unaware Resident #61 wore a wanderguard and that no alarm sounded when Resident #61 exited the building. On 04/14/2026 at 2:25 p.m., interview with S8CNA revealed on 03/26/2026, between 7:00 p.m. and 7:30 p.m., S6CNA notified her that Resident #61 was standing next to the highway, outside of the facility. S8CNA stated that upon observing Resident #61, he was standing next to the road with his thumb raised, appearing to attempt to obtain a ride. S8CNA reported that Resident #61 appeared agitated and initially resisted returning to the facility. S8CNA stated that she and S6CNA obtained assistance from S9CNA to safely return Resident #61 to the facility. On 04/14/2026 at 2:59 p.m., interview with S2DON confirmed that on the evening of 03/26/2026 Resident #61 had been let out of the facility by a staff member. S2DON reported that S7LPN notified her that Resident #61 had exited the facility and walked toward the roadway. On 4/14/2026 at 4:40 p.m., interview with S9CNA revealed he was notified by S8CNA that Resident #61 was walking along the road, outside of the facility, appeared agitated, and was not allowing S6CNA or S8CNA to escort him back into the facility. S9CNA stated that upon arrival outside, Resident #61 was observed standing next to the roadway. S9CNA stated that staff were able to safely redirect Resident #61 back into the facility. S9CNA stated that when Resident #61 re-entered the building through exit door B, the alarm did not activate, indicating the wanderguard system was not functioning properly. On 4/14/2026 at 5:19 p.m., observations were conducted of the facility's wanderguard system. Observation revealed multiple exits, including Exit Door A, Exit Door B, and Exit Door C, failed to alarm and did not remain locked (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	when residents wearing wanderguard devices were in close proximity to the doors and staff entered the door code. On 04/14/2026 at 6:05 p.m., interview with S7LPN revealed she was working the evening shift on 03/26/2026, when Resident #61 was found outside of the facility. S7LPN stated that she last observed Resident #61 at approximately 7:29 p.m. in the day room, at which time S7LPN checked Resident #61's blood glucose. S7LPN reported she was notified by S8CNA that Resident #61 had been found in the parking lot, but was unsure of the exact time. S7LPN stated that she was informed S3CNA entered the door code and allowed Resident #61 to exit the building. S7LPN confirmed that Resident #61 is identified as an elopement risk and wears a wanderguard bracelet. S7LPN reported that she contacted S2DON at approximately 7:55 p.m. on 03/26/2026, to inform her that Resident #61 had been found outside in the parking lot. On 04/15/2026 at 9:08 a.m., interview with Resident #61 revealed he was able to recall the evening he exited the facility. Resident #61 reported that it was beginning to get dark outside. Resident #61 stated he exited the facility and began walking along the roadside. Resident #61 confirmed he was outside alone and that no staff members were present with him. Resident #61 reported as he continued walking down the road, three staff members, identified as two females and one male, approached him. Resident #61 acknowledged that he became agitated and resisted staff, stating he wanted to go to town. At the time of interview, Resident #61 was noted to be wearing a wanderguard bracelet. On 4/15/2026 at 9:55 a.m., interview with S11LPN/CNASup stated she was informed by S3CNA that she entered the door code and allowed Resident #61 to exit the facility, believing Resident #61 was a visitor. S11LPN/CNAsup reported S3CNA worked on Resident #61's hall three days prior to the incident and should have been able to identify Resident #61. S11LPN/CNAsup reported CNAs are expected to familiarize themselves with the residents and their care needs on assigned halls prior to working the shift. On 04/16/2026 at 3:33 p.m., Interview with S1Admin and S4RNC revealed that properly functioning entrance/exit doors should remain locked and trigger an alarm when a wanderguard device is in close proximity, even when a staff member enters the door code. S1Admin confirmed the facility's security system was evaluated on 02/13/2026, by an outside contractor, at which time deficiencies were identified that required replacement of the wanderguard system. S1Admin confirmed that no additional supervision measures were put in place to prevent elopements after being made aware of a needed system replacement, as staff relied on the doors remaining locked. The Facility's plan of removal included:1. Review of the elopement and wandering policy reviewed by administrator, DON, and RNC with no identified changes needed on 04/14/2026.2. All residents identified as being an elopement risk had a care plan review completed by DON and MDS nurse to ensure wandering and elopement risk are identified and interventions and supervision needs are in place on 4/14/26.3. All current residents will have updated elopement risk assessments completed.4. The MDS nurse reviewed section E of the MDS for all residents on 4/14/26. Care plans were reviewed and updated to ensure they reflect audit findings. No concerns were identified.5. The DON and MDS nurse re-evaluated residents at risk for wandering/elopement using an elopement risk assessment tool on 4/14/26. No changes in status noted.6. Effective 4/15/26, a staff member was specifically placed at each wanderguard equipped exit door that was identified as not properly functioning with an alarm system and this direct supervision will remain in place until the door alarm system is fully repaired and verified as operational. These staff members are responsible for verifying all persons exiting the facility and intervening immediately if a resident attempts to leave unsupervised. A door watch observation log will be maintained and visual aids will be provided to door monitors on residents identified for elopement risk.7. Wanderguards and door systems were tested and verified by Maintenance Supervisor on 4/14/26 and it was identified that the door locking mechanism was functioning properly, however the audible wanderguard alarm chime was intermittently not functioning properly. The wander guard system will be discontinued to promote individualized resident centered care. Policies related to wanderguard systems revised to reflect system changes of the facility, effective 4/16/26. 8. Elopement Risk Identification Binders, which includes visual identification, will be utilized (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	for identify residents who are at risk to elope. Only staff who are successfully trained on elopement will have the door codes.9. In-service education initiated for all staff on 4/14/26 by DON regarding wandering, elopement, elopement drill protocol, identifying residents at risk for elopement and resident safety. New hires will be included in this training during orientation process. Any staff on leave will receive in-service education and understanding verified by DON or Administrator prior to start of next shift. Posttest required to be completed with 100% pass rate to ensure retention of information. Elopement prevention and identifying residents at risk for elopement is included in all staff new hire orientation and training.10. Effective 4/16/26, the DON or designee will audit new admissions, quarterly assessments and significant change assessments for elopement risk and ensure appropriate interventions are in place.11. Effective 4/16/26, the DON or designee will audit completed MDS's to ensure the care plan reflects needs/concerns identified in the CAA's.12. Effective 4/15/26, an Elopement Quality Assurance Performance Improvement plan was implemented by DON to review and interpret all audit findings. All findings will be discussed at the weekly QAPI meeting for a minimum of three months or until the pattern of compliance is maintained.13. Effective 4/15/26, a posttest focused on monitoring staff comprehension about elopement prevention and identifying residents at risks for elopement will be utilized to ensure staff comprehension and compliance. This will be done on 3 random staff 3 times a week. 14. Regional Nurse Consultant will monitor Administrator and DON weekly x3 month to ensure an effective system of adequate supervision and monitoring of residents at risk for elopement is maintained by all staff to prevent future elopements. 15. Effective 4/16/26, Maintenance will check the door locking mechanism daily x 3 weeks then continue weekly.16. RN supervisor or charge nurse will assess all new admissions for elopement risks after business hours.The facility asserts the Likelihood for serious harm to any recipient no longer exists 4/16/26.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 (#61) of 5 sampled residents reviewed for elopement. The facility failed to ensure staff were knowledgeable and able to identify residents at risk for elopement. This deficient practice resulted in an Immediate Jeopardy situation on 03/26/2026 at approximately 7:50 p.m., when S3CNA who failed to recognize Resident #61 as an elopement risk, unlocked a facility door, and allowed Resident #61, who had a BIMS score of 3, was severely cognitively impaired, and wore a wanderguard, to exit the building unsupervised. Resident #61 was found by S6CNA standing on the side of a busy two-lane highway that runs in front of the facility, with a posted speed limit of 55 miles per hour. Facility administration were made aware of a door wanderguard system malfunction since 02/13/2026 and did not implement appropriate interventions to prevent elopement. This deficient practice continued at a potential for more than minimal harm for the 5 residents in the facility who were identified to require supervision, were assessed as being at risk for elopement, and wore a wanderguard bracelet. S1Admin was notified of the immediate jeopardy on 04/15/2026 at 5:16 p.m. The Immediate Jeopardy was removed on 04/16/2026 at 5:47 p.m. when the facility submitted an acceptable plan of removal, and the surveyors determined through record reviews, interviews and observations that the Plan of Removal have been initiated and/or implemented. Findings:On 04/14/2026, review of an undated facility policy titled Training Requirements read in part.It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Policy Explanation and Compliance Guidelines:4. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program.6. Training content includes, at a minimum:g. Dementia management and care of the cognitively impaired Review of a Quarterly MDS with an ARD of 03/18/2026, revealed Resident #61 had a BIMS score of 3, indicating severe cognitive impairment. Resident #61 was ambulatory without the use of assistive devices and required supervision or touching assistance from staff during transfers and ambulation. Resident #61 utilized a wanderguard/elopement alarm on a daily basis. Review of Resident #61's Care Plan initiated on 10/20/2025 read in part.Resident #61 was an elopement risk/wanderer related to attempts to leave the facility unattended. Interventions in place prior to the elopement included: wander alert bracelet placed on resident's right ankle, staff verification/skin inspection at band location, and confirmation of signal operation. On 04/14/2026 at 2:07 p.m., an interview with S6CNA revealed that on 03/26/2026, at approximately 7:30 p.m., while taking trash to the dumpster, S6CNA observed Resident #61 standing next to the roadway outside of the facility without staff supervision. S6CNA stated she did not recognize Resident #61 as a resident but didn't feel right about it, and subsequently notified S8CNA. S6CNA reported she and S8CNA attempted to redirect the resident back into the facility; however, Resident #61 was agitated and not easily redirected. S6CNA further reported that S8CNA re-entered the facility to obtain additional assistance from S9CNA. S6CNA stated she was unsure how to determine if a resident was at high risk for elopement. On 04/14/2026 at 2:13 p.m., interview with S3CNA revealed Resident #61 was observed standing near Exit Door A. S3CNA stated that at the time, she believed Resident #61 was a family member and did not recognize him as a resident. S3CNA confirmed she had previously observed Resident #61 in the facility sitting in common areas; however, S3CNA believed Resident #61 was a visitor rather than a resident. S3CNA reported she asked Resident #61 if he needed to exit the facility, to which he responded yes. S3CNA then entered the door code and allowed Resident #61 to exit the facility. S3CNA stated the alarm did (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	not sound when Resident #61 exited the building. S3CNA reported that she was unaware Resident #61 wore a wanderguard bracelet and stated she was unsure how to determine if a resident was at high risk for elopement. On 4/14/2026 at 2:59 p.m., interview with S2DON revealed that staff receive education on elopement upon hire as well as during monthly in-services. S2DON stated staff should be aware of the red binder located at the front desk, which contains identifying information and photographs of residents who were high risk for elopement but were not. On 4/14/2026 at 4:40 p.m., interview with S9CNA revealed he was notified by S8CNA that Resident #61 was walking along the road, outside of the facility, appeared agitated, and was not allowing S6CNA or S8CNA to escort him back into the facility. S9CNA stated that upon arrival outside, Resident #61 was observed standing next to the roadway. S9CNA stated that staff were able to safely redirect Resident #61 back into the facility. S9CNA stated he was unsure how to determine if a resident was at high risk for elopement. On 04/14/2026 at 6:05 p.m., interview with S7LPN revealed she was working the evening shift on 03/26/2026, when Resident #61 was found outside of the facility. S7LPN stated that she was informed S3CNA entered the door code and allowed Resident #61 to exit the building, believing Resident #61 was a visitor. S7LPN confirmed that Resident #61 was identified as an elopement risk and wore a wanderguard bracelet. S7LPN stated she was unsure how to identify residents on other halls that were determined to be high risk for elopement. On 4/15/2026 at 9:55 a.m., interview with S11LPN/CNAsup revealed S3CNA told her that she entered the door code and allowed Resident #61 to exit the facility, believing Resident #61 was a visitor. S11LPN/CNAsup reported S3CNA had worked on Resident #61's hall three days prior to the incident and should have been familiar with the resident. On 04/15/2026 at 1:25 p.m., interview with S14CNA revealed she had been employed at the facility for six months. S12 CNA stated she was unsure how to identify residents in the facility that were at high risk for elopement. 04/15/2026 at 2:23 p.m., S1Admin acknowledged that staff members were unable to identify residents throughout the facility who were at high risk for elopement, but should have been. S1Admin confirmed that additional staff training was needed and acknowledged their training had not been effective. The Facility's plan of removal included:1. On 3/26/26, affected resident was returned to the facility and assessed by nurse to ensure no harm was noted as well as checking placement and functionality of wander guard.2. Administrator, DON and RNC reviewed elopement and wandering resident's policy with no identified changes needed on 4/14/263. All residents identified as being an elopement risk had care plan review completed by DON and MDS nurse to ensure wandering and elopement risk are identified and interventions and supervision needs are in place on 4/14/26.4. All current residents will have updated elopement risk assessments completed on 4/16/26.5. The MDS nurse reviewed section E of the MDS for all residents on 4/14/26. Care plans were reviewed and updated to ensure they reflect audit findings. No concerns were identified.6. The DON and MDS nurse re-evaluated residents at risk for wandering/elopement using an elopement risk assessment tool on 4/14/26. No changes in status noted.7. Effective 4/15/26, staff member was specifically placed at each wander guard equipped exit door that was identified as not properly functioning with an alarm system and this direct supervision will remain in place until the door alarm system is fully repaired and verified as operational. These staff members are responsible for verifying all persons exiting the facility and intervening immediately if a resident attempts to leave unsupervised. Effective 4/15/26, a door watch observation log and visual aides of residents at risk to elope will be provided to door monitors8. Wanderguards and door systems were tested and verified by Maintenance Supervisor on 4/14/26 and it was identified that the door locking mechanism was functioning properly, however the audible wander guard alarm chime was intermittently not functioning properly. Final root cause analysis identified that the facility has maintained a functioning secured door system in place at all times. The wander guard system will be discontinued to promote individualized resident centered care. Policies related to wanderguard systems revised to reflect system changes of the facility, effective 4/16/26. Elopement Risk Identification Binders, which includes visual identification, will be utilized for identify residents who are at risk to elope. Only staff who are successfully trained on (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	elopement will have the door codes.9. Regional Nurse Consultant in-serviced Administrator and Director of Nursing on 4/15/26 regarding administering the facility in a manner that enables it to use its resources effectively including having an effective system in place to ensure residents at high risk for elopements are adequately supervised, ensuring staff are trained to identify all residents who are at risk for elopement, and responding appropriately to identification of malfunctioning equipment.10. All staff in-service education initiated on 4/14/26 by DON regarding wandering, elopement, elopement drill protocol, identifying residents at risk for elopement and resident safety. Any staff on leave will receive in-service education and understanding verified through post testing by DON or Administrator prior to start of next shift. Door staff competence has been completed. 11. Elopement Prevention and identifying residents is included in new hire orientation and training for all staff.12. Effective 4/16/26, the DON or designee will audit new admissions, quarterly assessments and significant change assessments for elopement risk and ensure appropriate interventions are in place.13. Effective 4/16/26, the DON or designee will audit completed MDS's to ensure the care plan reflects needs/concerns identified in the CAA's.14. Effective 4/15/26 an Elopement Quality Assurance Performance Improvement plan was implemented by DON to review and interpret all audit findings. All findings will be discussed at the weekly QAPI meeting for a minimum of three months or until the pattern of compliance is maintained.15. Effective 4/15/26, a post test focused on monitoring staff comprehension about elopement prevention and identifying residents at risks for elopement will be utilized to ensure staff comprehension and compliance. This will be done on 3 random staff 3 times a week. 16. Regional Nurse Consultant will monitor Administrator and DON weekly x3 month to ensure an effective system of adequate supervision and monitoring of residents at risk for elopement is maintained by all staff to prevent future elopements. 17. Effective 4/16/26, Maintenance will check the door locking mechanism daily x 3 weeks then continue weekly.18. All ongoing monitoring will be completed weekly x3 months unless otherwise specified.19. RN supervisor or charge nurse will assess all new admissions for elopement risks after business hours.The facility asserts the Likelihood for serious harm to any recipient no longer exists 4/16/26.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, and interview, the facility failed to administer its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for 1 (Resident #61) of 5 sampled residents reviewed for elopement. The facility failed to:1. Ensure a cognitively impaired resident (#61) who was identified as being at high risk for elopement, wandering and exhibited exit seeking behaviors did not exit the building without supervision;2. Ensure staff were knowledgeable and able to identify residents at risk for elopement;3. Implement appropriate interventions and/or increase supervision after identifying the wanderguard security system was not functioning properly; and4. Ensure the resident's environment remained as free of accident hazards as possible. This deficient practice resulted in an Immediate Jeopardy situation on 03/26/2026 at approximately 7:50 p.m., when S3CNA who failed to recognize Resident #61 as an elopement risk, unlocked a facility door, and allowed Resident #61, who had a BIMS score of 3, was severely cognitively impaired, and wore a wanderguard, to exit the building unsupervised. Resident #61 was found by S6CNA standing on the side of a busy two-lane highway that runs in front of the facility, with a posted speed limit of 55 miles per hour. Facility administration were made aware of a door wanderguard system malfunction since 02/13/2026 and did not implement appropriate interventions to prevent elopement. This deficient practice continued at a potential for more than minimal harm for the 5 residents in the facility who were identified to require supervision, were assessed as being at risk for elopement, and wore a wanderguard bracelet. S1Admin was notified of the Immediate Jeopardy situation on 04/15/2026 at 3:58 p.m. The Immediate Jeopardy was removed on 04/16/2026 at 5:47 p.m. when the facility submitted an acceptable plan of removal, and the surveyors determined through record reviews, interviews and observations that the Plan of Removal have been initiated and/or implemented. Findings:Cross refer to F689 and F726 On 04/15/2026, review of the facility's policy titled Elopements and Wandering Residents with a revision date of 09/01/2024 read in part. This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.Definitions: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so.Policy Explanation and Compliance Guidelines:1. The facility is equipped with door locks/alarms to help avoid elopements. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement and unsafe wandering, including identification and assessment of risk.4. Monitoring and managing residents at risk for elopement and unsafe wandering include:c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.d. Adequate supervision will be provided to help prevent accidents or elopements. On 04/15/2026 review of the facility's undated policy titled Resident Alarms read in part.It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being.Policy Explanation and Compliance Guidelines:1. The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include:e. Wander/elopement alarms-includes the devices such as bracelets, pins/buttons worn on the residents clothing, or building/unit exit sensors worn/ attached to the resident that alert staff when the resident nears or exits an area or building.6. Monitoring and modification:a. Supervision shall be provided to the resident in accordance with the resident's plan of care.b. When alarms are utilized, additional monitoring shall be provided, included but not limited to:i. Verifying alarms are used in accordance with residents care plan.ii. Verifying alarms are working properly. On 04/14/2026 at 2:13 p.m., interview with S3CNA revealed Resident #61 was observed standing near Exit Door A. S3CNA stated that at the time, she believed Resident #61 was a family member and did not recognize him as (continued on next page)

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	195575	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehabilitation and Healthcare Center	1515 Highway 107 Center Point, LA 71323

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	intermittently not functioning properly. Final root cause analysis identified that the facility has maintained a functioning secured door system in place at all times.8. The wanderguard system will be discontinued to promote individualized resident centered care. Policies related to wanderguard systems revised to reflect system changes of the facility, effective 4/16/26. 9. Elopement Risk Identification Binders, which includes visual identification, will be utilized for identify residents who are at risk to elope. Only staff who are successfully trained on elopement will have the door codes.10. Regional Nurse Consultant in-serviced Administrator and Director of Nursing on 4/15/26 regarding administering the facility in a manner that enables it to use its resources effectively including having an effective system in place to ensure residents at high risk for elopements are adequately supervised, ensuring staff are trained to identify all residents who are at risk for elopement, and responding appropriately to identification of malfunctioning equipment. 11. All staff in-service education initiated on 4/14/26 by DON regarding wandering, elopement, elopement drill protocol, identifying residents at risk for elopement and resident safety. Any staff on leave will receive in-service education and understanding verified through post testing by DON or Administrator prior to start of next shift.12. Door staff competence has been completed. 13. Elopement Prevention and identifying residents is included in new hire orientation and training for all staff.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post nurse staffing information on a daily basis that included in part the total number and actual hours worked by RNs, LPNs and CNA staff directly responsible for resident care per shift. The facility census was 93.Findings:Observation on 04/13/2026 at 7:30 a.m. revealed a Staffing Reporting Form dated 04/10/2026 on display at the front desk. There was no updated Actual Hours Worked for the date at the top of the form, nor another form dated today's date.Observation on 04/14/2026 at 9:45 a.m. revealed a Staffing Reporting Form dated 04/14/2026. There was no posted form with actual hours worked from the previous day (04/13/2026). There was also no binder available at the front desk with the previous forms available.Interview on 04/15/2026 at 11:10 a.m. with S1Admin and S2DON confirmed that they were unaware that Actual Hours Worked on the Staffing Reporting Form were required to be updated and posted or kept where the public could access the forms.Interview on 04/15/2026 at 11:30 a.m. with S15 AdminAsst confirmed that she was unaware that the updated Staffing Forms were required to be posted. Therefore, the previous days' forms had not been posted.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews, the facility failed to ensure pureed foods were prepared using methods that preserved its nutritional value. The facility failed to follow a recipe regarding portion size and ingredients while preparing pureed food, thereby compromising the nutritional adequacy of the meal for all 12 residents on a puree diet. Total facility census was 93. Findings:Review of facility policy titled Puree Food Preparation revised 2025, revealed in part. It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance. 6. Resident receiving puree diets should always receive portions equivalent to those served on the regular or therapeutic diet ordered per policy and procedure. Observation of S12 Dietary [NAME] on 04/13/2026 at 5:38 a.m. revealed the following:1. There was no recipe being followed to prepare pureed ham. S12 Dietary Cook, stated I judge the amount of ham to use.2. S12 Dietary [NAME] used a glass to pour chicken broth on the pureed ham. S12 Dietary Cook, stated I was told to just pour the chicken broth in until the ham starts to thicken up, then hold a spatula in it to see if it was the right consistency.3. S12 Dietary [NAME] poured two boxes of egg mixture in a pan, and put it in the oven. When asked if she had to measure how much egg mixture to use, S12 Dietary [NAME] stated, I have been doing this long enough to know, I don't need to measure. Interview at the time of observation with S12 Dietary [NAME] confirmed she did not follow an approved recipe to prepare pureed ham or eggs, but should have. Observation of S13 Dietary Manager on 04/13/2026 at 6:25 a.m. revealed the following:1. There was no recipe being followed to prepare pureed bread and no measuring utensils were utilized during this observation. 2. S13 Dietary Manager removed an unmeasured amount of bread from the package and placed it in the blender. S13 Dietary Manager added an unmeasured amount of sugar from a bowl and put it into the blender with the bread, then poured an unmeasured amount of milk from a jug and put into the blender with the bread and sugar; S13 Dietary Manager also added vanilla to the bread in the blender, by pouring it in the cap. Interview at the time of observation with S13 Dietary Manager confirmed she did not follow an approved recipe to prepare pureed bread, but should have. Interview on 04/13/26 at 9:12 a.m. with S1 Administrator confirmed S12 Dietary [NAME] and S13 Dietary Manager should have followed an approved recipe to prepare pureed foods.

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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. Based on observation and interview the facility failed to maintain a clean, sanitary environment and ensure food was served in accordance with professional standards for food service safety. Total facility census was 93. Findings:Observation on 04/13/2026 at 5:10 a.m. accompanied by S13 Dietary Manager revealed:1. A box of biscuits open to air in the freezer.2. A box of steak fingers open to air in the freezer. Interview at the time of observation with S13 Dietary Manager confirmed the above listed items were open to air, and should not have been.