STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195624	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthaven Living Center	1301 Harrison Street Bogalusa, LA 70427

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status for 1 (#4) of 4 (#1, #2, #3, and #4) residents reviewed for MDS. Findings: Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #4 was diagnosed with Major Depressive Disorder on 03/02/2024. Review of Resident #4's quarterly MDS with an ARD of 03/14/2024 revealed Major Depressive Disorder was not coded as an active diagnosis in Section I. An interview was conducted on 04/18/2024 at 1:11 p.m. with S2MDS. She stated she was responsible for residents' MDS assessments. She stated when the MDS assessment was performed, all diagnoses should have been coded accurately for every resident. She reviewed the quarterly MDS for Resident #4 and confirmed the MDS was not coded accurately for active diagnoses in Section I. An interview was conducted on 04/18/2024 at 1:20 p.m. with S1DON. She confirmed if a resident had an active diagnosis, the MDS should have been coded accurately with those diagnoses.

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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NAME OF PROVIDER OR SUPPLIER Resthaven Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Harrison Street Bogalusa, LA 70427	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 50093 Based on record reviews and interviews, the facility failed to ensure services were provided to meet quality professional standards for 2 (#1 and #3) of 3 (#1, #2, and #3) residents reviewed for falls. The facility failed to ensure staff documented neurological assessments after unwitnessed falls. Findings: Review of the facility's policy titled Falls-Clinical Protocol revealed the following: 2. In addition, the nurse shall asses and document/report the following as needed: e. Neurological status; Resident #1 Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Repeated Falls, Cerebrovascular Disease, Cerebral Infarction due to Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery, Unspecified Osteoarthritis, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Other Lack of Coordination. Review of the facility's Fall Investigation Reports for Resident #1 revealed he had unwitnessed falls on 12/25/2023, 01/09/2024 and 02/04/2024. Review of Resident #1's clinical record revealed there was no documented neurological assessments following the unwitnessed falls on 12/25/2023, 01/09/2024 and 02/04/2024. On 04/22/2024 at 3:03 p.m., a telephone interview was conducted with S5LPN. S5LPN stated she was taking care of Resident #1 when he had unwitnessed falls on 12/25/2023 and 01/09/2024. She stated she performed neuro checks following both falls and the documentation would be in the back of the narcotic book. On 04/23/2024 at 08:20 a.m., a telephone interview was conducted with S6LPN. She verified neuro checks should be done after all unwitnessed falls. After reviewing the fall which occurred on 02/04/24, she stated she more than likely completed neuro checks. She stated she would have documented the neuro checks if I didn't forget. On 04/23/2024 at 11:28 a.m., an interview was conducted with S1DON. S1DON confirmed she was unable to provide documentation of neurological assessments for the above dates. Resident #3 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's clinical record revealed she was readmitted to the facility on [DATE] and had diagnoses, which included Polyosteoarthritis, Lack of Coordination, Muscle Wasting, Dementia, and Difficulty in Walking. Review of the facility's Fall Investigation Reports for Resident #3 revealed she had unwitnessed falls on 03/10/2024, 03/14/2024 at 10:15 a.m. and at 10:30 p.m., 03/20/2024 at 3:00 p.m. and 6:00 p.m. Review of Resident #1's clinical record revealed there was incomplete documentation of neurological assessments following the unwitnessed falls on 03/10/2024, 03/14/2024 at 10:15 a.m. and at 10:30 p.m., 03/20/2024 at 3:00 p.m. and 6:00 p.m On 04/23/2024 at 11:28 a.m., an interview was conducted with S1DON. She stated neuro checks are completed for all unwitnessed falls and/or if a resident hits their head. S1DON stated the neuro checks should be completed and documented every fifteen minutes for one hour, every thirty minutes for two hours, every hour for four hours, every four hours for sixteen hours, and then every shift to complete 72 hours. After reviewing Resident #3's Neurological assessment flowsheets dated 03/10/2024, 03/14/2024, and 03/20/2024, she confirmed the documentation on the flowsheets were incomplete.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on interviews and record reviews, the facility failed to ensure residents' drug regimens were free from unnecessary psychotropic medications for 1 (#3) of 3 (#1, #2, and #3) residents reviewed for unnecessary psychotropic medications. The facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days and indicated the duration for the PRN order for Resident #3. Findings: Review of the facility's policy titled Tapering Medications and Gradual Dose Reduction, reviewed on 04/22/2024, dated 04/2007 revealed the following, in part: Policy Interpretation and Implementation: 10. Residents who use antipsychotic drugs shall receive gradual reductions. Review of Resident #3's clinical record revealed he was readmitted to the facility on [DATE] and had diagnoses, which included Dementia, Schizophrenia, Major Depressive Disorder, and Anxiety. Review of Resident #3's active Physician Orders revealed the following: Start Date: 12/29/2023-Lorazepam 1mg by mouth every 4 hours prn for anxiety. Start Date: 12/29/2023-Temazepam 15mg one by mouth every 24 hours prn for insomnia. Further review revealed neither order had a documented end date. Review of Resident #3's Psychoactive Gradual Dose Reduction Form dated 01/16/2024 revealed the following: 1. Lorazepam 1mg q4h PRN anxiety 2. Temazepam 15mg q24h PRN insomnia 3. Psychotropic medications that are PRN are limited to 14 days and require the prescriber to evaluate the resident prior to extending the order and provide a duration for the pharmacotherapy. On 04/22/2024 at 12:00 p.m., an interview was conducted with Consultant Pharmacist. The Consultant Pharmacist confirmed orders for PRN psychotropic medications should be limited to 14 days and required the prescriber to evaluate the resident prior to extending the order and provide a duration for the pharmacotherapy. On 04/23/2024 at 11:28 a.m., an interview was conducted with S1DON. She could not answer to whether or not hospice PRN medications were limited to 14 days.

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NAME OF PROVIDER OR SUPPLIER: Resthaven Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1301 Harrison Street Bogalusa, LA 70427	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on interviews and record reviews, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#3) of 4 (#1, #2, #3, and #4) residents reviewed. The facility failed to ensure S10LPN documented administered narcotic medications on Resident #3's Medication Administration Record. Findings: Resident #3 Review of Resident #3's Clinical Record revealed she was readmitted to the facility on [DATE] and had diagnoses, which included Polyosteoarthritis, Lack of Coordination, Muscle Wasting, Dementia, and Difficulty in Walking. Review of Resident #3's Narcotic drug log for Morphine revealed Morphine 0.25mL was removed from stock on 04/04/2024, by S10LPN. Review of Resident #3's Medication Administration Record revealed no documentation Morphine 20mg/mL was administered on 04/04/2024. On 04/23/2024 at 11:24 a.m., a phone interview was conducted with S10LPN. She confirmed she was Resident #3's nurse on 04/04/2024. S10LPN stated Resident #3 complained of pain during brief change on 04/04/2024. She stated she could not recall if she documented the administered medication on the Resident #3's MAR, but she administered it. S10LPN confirmed if she administered a medication she should have signed it out and documented the administered medication on the MAR. On 04/23/2024 at 11:28 a.m., an interview was conducted with S1DON. After reviewing the MAR, S1DON confirmed she expected staff to document on the MAR any medication which have been administered.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on interviews and record review, the facility failed to designate a member of the facility's interdisciplinary team to be responsible for working with hospice representatives to coordinate care as evidence by the facility failing to ensure hospice binders were up to date for 1(#3) of 1(#3) resident reviewed for hospice care. Findings: Review of the facility's policy titled Hospice Program, reviewed on 04/22/2024, dated 07/2017 revealed the following, in part: Policy Interpretation and Implementation: 12. Our facility has designated, Name and Title, to coordinate care provided to the resident by our facility staff and the hospice staff. He or she is responsible for following: d. Obtaining the following information from hospice: (1) the most recent hospice plan of care specific to each resident Review of Resident #3's Clinical record revealed she was readmitted to the facility on [DATE] and admitted to hospice services on 01/02/2024. Review of the Hospice Binder for Resident #3 revealed no plan of care documents. On 04/22/2024 at 2:25 p.m., an interview was conducted with S3LPN. She stated she would refer to hospice binder for plan of care. On 04/18/2024 at 1:45 p.m., an interview was conducted with S1DON. She stated there is not a designated staff member responsible to coordinate care with hospice and should have. After review of the hospice binder, S1DON confirmed there were no plan of care documents in Resident #3's hospice binder and should have been.