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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthaven Living Center	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's call light was within reach for 2 (#2 and #51) of 22 residents reviewed for accommodation of needs. Review of the facility's policy, Resident Call Light System, revised 06/2023, revealed the following, in part:Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General Guideline: 4. Ensure that the call light is easily reachable by the resident. Resident #2Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Bilateral Primary Osteoarthritis of Hip, Mild Neurocognitive Disorder with Behavioral Disturbance, Wedge Compression Fracture of T9-T10 Vertebra, Intellectual Disabilities, Schizophrenia, and Cerebral Infarction. Review of Resident #2's MDS with an ARD of 12/03/2025, revealed a BIMS score of 11, which indicated she was moderately cognitively impaired. Review of Resident #2's current Care Plan revealed resident was to have a working and reachable call light and encouraged to use it for assistance as needed. On 01/12/2026 at 9:40 a.m., an observation was made of Resident #2's call light located on the floor and not within Resident #2's reach. On 01/12/2026 at 9:50 a.m., an interview was conducted with S13CNA. S13CNA confirmed Resident #2 was able to use the call light. S13CNA further confirmed Resident #2's call light was not within the resident's reach. Resident #51Review of Resident #51's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, Difficulty in Walking, Other Lack of Coordination, Primary Generalized Osteoarthritis, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Muscle Wasting and Atrophy.Review of Resident #51's MDS with an ARD of 11/14/2025 revealed a BIMS score of 07, which indicated she was severely cognitively impaired. Review of Resident #51's current Care Plan revealed she required assistance from staff for ADLs, a working, reachable call light, and to encourage resident to use call light for assistance. On 01/12/2026 at 9:01 a.m., an observation was made of Resident #51 sitting in a geri-chair with her call light rolled up on the bedside table not within her reach. On 01/12/2026 at 9:20 a.m., an interview was conducted with S12SUP. S12SUP confirmed Resident #51's call light was not within resident's reach and should have been. S12SUP further confirmed Resident #51 was capable of using call light to call for assistance. On 01/14/2026 at 10:25 a.m., an interview was conducted with S2DON. S2DON stated he was aware of the call lights being found out of the reach of Resident #2 and Resident #51. S2DON stated it is the facility's process to place the call lights within the resident's reach prior to exiting a resident's room. S2DON stated he expected the staff ensure all call lights were within reach for each resident at all times.

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status. The facility failed to ensure staff accurately coded the correct discharge location for 1 (#92) of 3 residents reviewed for closed records.Review of Resident #92's Discharge Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 12/10/2025 revealed Resident #92 was discharged to a Short-Term General Hospital. Review of Resident #92's Nurse's Notes revealed the following, in part:12/10/2025 at 11:20 a.m. Resident #92 left facility via wheelchair accompanied by his own transportation. On 01/14/2026 at 5:00 p.m., an interview was conducted with S9MDS. S9MDS confirmed Resident #92 left the facility against medical advice. She reviewed Resident #92's Discharge MDS with an ARD of 12/10/2025 and confirmed it indicated he discharged to a Short-Term General Hospital. S9MDS confirmed Resident #92's discharge status was not coded accurately and should have been coded as discharged to home/community. On 01/14/2026 at 5:20 p.m., an interview was conducted with S2DON. S2DON stated he expected MDS nurses to complete all assessments to accurately reflect each residents' discharge status.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident with an identified mental health diagnosis was referred for a Preadmission Screening Resident Review (PASRR) Level II evaluation with accurate mental health diagnoses for 1 (#67) of 2 sampled residents' records reviewed for PASRR.Review of Resident #67's Clinical Record revealed Resident #67 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Bipolar Disorder, Depression, and Anxiety Disorder. Review of Resident #67's PASRR Level 1 Form dated 07/30/2025 revealed mental health diagnoses which included Major Depression and Anxiety Disorder. Further review revealed Bipolar Disorder diagnosis was not listed. An interview was conducted on 01/14/2026 at 5:25 p.m. with S10LPNADM. S10LPNADM stated she completed Resident #67's PASRR Level 1 Form, dated 07/30/2025. S10LPNADM stated she reviewed Resident #67's clinical records from the referring Hospice Agency, and the clinical records did not include the Bipolar Disorder diagnosis. She stated she did not review Resident #67's initial admission clinical records, dated 10/03/2024, because she did not have access at that time. After review of the above mentioned clinical records, she confirmed the Bipolar Disorder diagnosis should have been included in the PASRR Level 1 Form and was not. An interview was conducted on 01/14/2026 at 5:15 p.m. with S11QI. S11QI reviewed the above Resident #67's Clinical Records and confirmed the Bipolar Disorder diagnosis should have been included on Resident #67's PASRR Level 1 Form, dated 07/30/2025, and was not.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5% by failing to give medications as ordered for 2 (#67 and #85) of 5 residents observed during medication administration. A total of 25 opportunities were observed with 3 medication errors, which resulted in a medication error rate of 12.00%. Findings: Review of the facility's policy titled, Administering Medications with revision date April 2019 revealed the following, in part:Policy StatementMedications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation3. Medications are administered in accordance with prescriber orders, including any required time frame. 9. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication Resident #67On 01/13/2026 at 10:37 a.m., an observation was made of S4LPN during medication pass for Resident #67. S4LPN prepared and administered Sertraline HCL 25 mg 1 tablet by mouth. Review of the current physician orders for Resident #67 revealed the following medication orders:Sertraline HCL 50 mg. Give 1 tablet by mouth one time a day. Order date 10/29/2025. 01/13/2026 at 1:00 p.m., an interview was conducted with S4LPN. She reviewed Resident #67's physician orders and confirmed the order for Sertraline was for 50 mg by mouth. She reviewed the Sertraline medications card and confirmed she administered Sertraline 25 mg by mouth and this was incorrect. She stated she should have checked the dosage prior to administering the medication and did not. Resident #85On 01/13/2026 at 10:50 a.m., an observation was made of S5LPN during medication pass for Resident #85. S5LPN prepared and administered Zinc 50 mg, 1 capsule by mouth and Vitamin D3 10 mcg, 1 tablet by mouth.Review of the current physician orders for Resident #85 revealed the following medication orders:Zinc Sulfate Capsule 220 mg. Give 1 capsule by mouth one time a day. Order date: 08/23/2023.Vitamin D3 Oral Capsule. Give 1250 mcg by mouth in the morning, every Tuesday and Saturday. Order date: 08/09/2024. On 01/13/2026 at 1:28 p.m., an interview was conducted with S5LPN. She reviewed Resident #85's physician orders and confirmed the order for Zinc was for 220 mg by mouth. She observed the bottle of Zinc and confirmed she administered Zinc 50 mg by mouth and this was incorrect. She further confirmed the physician order for Vitamin D3 was for 1250 mcg by mouth. She observed the bottle of Vitamin D3 and confirmed she administered Vitamin D3 10 mcg and this was incorrect. She stated she should have checked the medication dosages prior to administering the medications and did not. On 01/13/2026 at 3:11 p.m., an interview was conducted with S2DON. He was made aware of the above-mentioned medication errors. He stated he expected staff to check medications with the physician's order prior to administering. He confirmed medications administered to residents should be the correct dosage ordered by the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, and distribute foods under sanitary conditions. The facility failed to ensure:1. The ice machine was maintained in safe operating and sanitary condition; and2. Pots and pans were sanitized.This deficient practice had the potential to affect all 81 residents who ate from the kitchen. Findings: 1. On 01/11/2026 at 8:30 a.m., an observation was made of the ice machine in the kitchen with a low level of ice mixed with pink sludge. Further observation revealed pink sludge in the right front corner. On 01/11/2026 at 8:34 a.m., an interview was conducted with S3DM. She stated the ice machine was serviced and cleaned on 01/09/2026. She observed and confirmed the pink sludge in the ice machine and confirmed this was not sanitary. 2. On 01/11/2026 at 8:45 a.m., an observation was made of S8CK washing pots in the 3 compartment sink. She stated pots and pan were washed and sanitized in the 3 compartment sink. She showed her method while stating she washed, sanitized, and rinsed. Further observation was made of the sanitation dispenser in the second sink labeled, rinse. On 01/11/2026 at 8:46 a.m., an observation and interview was conducted with S3DM. She confirmed the sanitation dispenser should be in the third sink to ensure proper sanitation and was not. She further confirmed the proper method was to wash, rinse, and sanitize. On 01/11/2026 at 10:00 a.m., an interview was conducted with S1ADM. He confirmed the ice machine should be in good working condition and not have pink sludge in the ice. He further confirmed to ensure proper sanitation, the 3 compartment sink should be used in the sequence of wash, rinse, sanitize.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interviews, the facility failed to ensure refuse containers were in good condition and waste was properly contained. This deficient practice had the potential to affect 82 residents residing in the facility. Findings: On 01/11/2026 at 9:15 a.m., an observation was made of a large open bulk grease disposal container outside, next to the facility wall, behind the kitchen with the lid open. A further observation was made of a large amount of black grease on top of the container and on the surrounding concrete area with leaves mixed in. On 01/11/2026 at 9:16 a.m., an interview was conducted with S3DM. She stated the bulk grease disposal container was in poor condition. She confirmed the lid was open and had grease on top and on the surrounding concreate area since September 2025. She confirmed this was unsanitary. On 01/11/2026 at 10:00 a.m., an interview was conducted with S1ADM. He stated he was aware of the bulk grease disposal container located behind the kitchen. He stated the lid had been left open and when it rained the grease spilled over onto the surrounding concrete area. He confirmed the container had been in poor condition for some time and needed to be removed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection for 1 (#95) of 3 residents reviewed for infection control. The facility failed to ensure staff wore proper PPE while providing direct care to Resident #95, who was on Enhanced Barrier Precautions.Findings: Review of the facility's policy titled Implementation of Standard and Transmission-Based Precautions with a revision date of 03/2024, revealed the following, in part:3. Enhanced Barrier Precautions - Expand the use of PPE and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. I. Examples of EBP residents:-Indwelling Medical Devices- Include central linesII. EBP are indicated during:-Device care or use: central lineb. PPE:-Gowns and glove.-PPE for EBP is only necessary when performing high-contact care activities. Review of Resident #95's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #95's current Physician Orders revealed the following:Nursing Intervention: Implement and maintain EBP when performing high contact care, start date 11/19/2025.May access port, Order. Date: 08/24/2023.Vancomycin HCl Intravenous Solution, use 1.75 gram intravenously one time a day for sacral wound infection, Order date: 01/02/2026. On 01/13/2026 at 1:00 p.m., an observation was made of Resident # 95's door with an EBP sign and PPE in a bin outside of the door. The EBP sign read in part, the following:Enhanced Barrier Precautions: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use . On 01/13/2026 at 1:02 p.m., an observation was made of S4LPN administer Vancomycin to Resident #95 via port to the right chest. S4LPN was observed with no gown in place while administering the IV antibiotic. On 01/13/2026 at 1:10 p.m., an interview was conducted with S4LPN. She confirmed Resident #95 was on EBP due to his port and wounds. She confirmed she should have worn a gown while providing direct resident care and did not. On 01/13/2026 at 3:11 p.m., an interview was conducted with S2DON. He stated when a resident was on EBP he expected staff to wear the appropriate PPE when providing direct resident care. He confirmed EBP was initiated when a resident had indwelling medical devices such as a port. He further confirmed appropriate PPE should be worn during IV medication administration through a port.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews the facility failed to ensure a safe, sanitary and comfortable environment. The facility failed to ensure the residents' Shower Room A was comfortable and sanitary. Findings: On 01/13/2026 at 3:00 p.m., an observation was made of Shower Room A. The observation revealed a black, fuzzy substance on the tile below the shower head where the wall tile met the floor. On 01/13/2026 at 3:03 p.m., an interview was conducted with S6CNA. She confirmed the above observation. She stated Shower Room A was not a comfortable and sanitary environment. She stated the black fuzzy substance had been present for a long time and was an ongoing problem. She stated S7MNT and S1ADM were both aware of Shower Room A's condition. On 01/13/2026 at 3:30 p.m., an interview was conducted with S7MNT. He stated he was aware Shower Room A used by residents had a black fuzzy substance on the tile below the shower head where the wall met the floor. He stated the substance had been present for months. He confirmed Shower Room A was not maintained in a comfortable and sanitary manner. On 01/13/2026 at 4:03 p.m., an interview was conducted with S1ADM. He stated he was aware residents' Shower Room A had a black fuzzy substance. He confirmed this substance should not have been present. He confirmed Shower Room A should have been maintained in a comfortable and sanitary manner.