Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195404	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony House Nursing and Rehabilitation Center, I	1825 Laurel St. Shreveport, LA 71103

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2025

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, observations, and interviews, the facility failed to ensure residents were free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms for 1 (#13) of 1 (#13) resident reviewed for restraints. The facility failed to ensure Resident #13's pre-restraint assessment was completed and a written consent was obtained prior to the use of lap tray. Findings:Review of the facility's undated policy for Restraints: Physical revealed in part:Policy:A physical restraint is defined as any manual method or mechanical, physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of a restraint, such as:3. Using devices in conjunction with a chair such as trays, tables, bars or belts that the resident cannot remove easily that prevent a resident from rising out of the chair.4. Placing a resident in a chair that prevents rising.Restraint use should be a last resort and only used after all other measures of dealing with the problem have been exhausted. Informed consent must be obtained prior to initiation of a restraint. The facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. If the restraint use is considered, that facility will explain how the use of restraints would treat the resident's medical condition and assist the resident in attaining or maintaining their highest practicable level of physical or psychological well being. Review of Resident #13's medical record revealed an initial admission date of 02/18/2025 with diagnoses that included, in part, restlessness and agitation, hypotension unspecified, Alzheimer's disease unspecified, dementia, and schizophrenia unspecified. Review of Resident #13's physician orders revealed an order dated 04/09/2025 for geri (geriatric) chair with lap tray for positioning to enable resident to be out of bed related to muscle wasting, unsteadiness on feet, and reduced mobility. Monitor every 30 minutes, release every 2 hours for 10 minutes for range of motion and toileting needs, as appropriate. Review of Resident #13's September 2025 MAR (Medication Administration Record) revealed the order for geri chair with lap tray was documented as in place. Review of Resident #13's 07/28/2025 quarterly MDS (Minimum Data Set) assessment revealed Resident #13 had a BIMS (Brief Interview Mental Status) score of 3, which indicated severe cognitive impairment. Further review of Resident #13's 07/28/2025 quarterly MDS revealed Resident #13 was dependent with all ADLs (Activities of Daily Living) and chair/bed-to-chair transfers. Review of Resident #13's medical record failed to reveal a pre-restraint assessment was completed and a written consent was obtained prior to the use of Resident #13's lap tray. Observation on 09/30/2025 at 3:28 p.m. revealed Resident #13 was seated in a geri chair with a lap tray in place. Observation on 10/01/2025 at 8:45 a.m. revealed Resident #13 was seated in geri chair with a lap tray in place. During an interview on 10/01/2025 at 1:00 p.m. S7 RN (Registered Nurse) and S8 MDS Nurse reviewed Resident #13's physician orders and reported since the lap tray was being used as a positioning device, it was not considered a restraint and did not require a consent or restraint assessment. During an interview on 10/01/2025 at 2:00 p.m. S2 DON (Director of Nursing) reported the lap tray on Resident #13's geri chair was utilized so Resident #13 could get out of bed and was not used as a restraint. S2 DON further confirmed there was not a pre-restraint assessment completed or a written consent in place prior to use of Resident #13's lap tray.