Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Green Meadow Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 1110 Ringgold Avenue Coushatta, LA 71019	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews the facility failed to ensure a resident received reasonable accommodation of needs by failing to have an assistive device accessible to 1 (#3) of 19 sampled residents.Findings:Review of Resident #3's medical record revealed an admission date of 05/16/2025 with diagnoses including, in part, spinal stenosis, lumbar region without neurogenic claudication; adult failure to thrive; contracture, right knee; and contracture, left knee.Review of Resident #3's Quarterly MDS (Minimum Data Sheet) assessment dated [DATE] revealed, in part, Resident #3 had a BIMS (Brief Interview for Mental Status) score of 7 indicating severe impaired cognition. Further review of Resident #3's MDS revealed Resident #3 was dependent on staff for all ADL (Activities of Daily Living) care. Review of Resident #3's care plan dated 07/17/2025 revealed Resident #3 had contractures of the right and left hands. During an observation on 08/19/2025 at 10:45 a.m., S11 ADON (Assistant Director of Nursing) placed the call bell button on the bed beside Resident 3#'s left elbow. Further observation revealed Resident #3 attempted to move both arms and hands and was unable to utilize the call bell button.During an interview on 08/19/2025 at 10:45 a.m. Resident #3 reported she had not been able to press the call bell button for assistance. During an interview on 08/19/2025 at 10:45 a.m. S2 DON (Director of Nursing) acknowledged Resident #3 was unable to press the button on the call light for assistance due to contractures of her arms and hands.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure a resident with an order for psychotropic medication as needed (PRN) was not subjected to chemical restraints for 1 (#4) of 6 (#1, #2, #4, #9, #12, and #51) residents reviewed for unnecessary medications. The facility failed to ensure Resident #4's PRN order for psychotropic medication was limited to 14 days. Findings:Review of Resident #4's medical record revealed an admit date of 01/04/2025 with diagnoses of but not limited to Alzheimer's disease, anxiety disorder, and schizophrenia.Review of Resident #4's physician orders revealed an order dated 07/07/2025 for Ativan Oral Tablet 1 MG (milligram) (Lorazepam); Give 1 tablet by mouth every 6 hours as needed for anxiety, end date indefinite. Review of Resident #4's August 2025 MAR (Medication Administration Record) revealed Ativan 1 MG was administered on the following dates/times:08/03/2025 7:20 p.m.08/04/2025 4:13 p.m. and 11:20 p.m.08/05/2025 9:29 p.m.08/06/2025 5:00 a.m.08/07/2025 9:34 p.m.08/08/2025 1:36 p.m. and 7:27 p.m.08/09/2025 8:34 p.m.08/10/2025 8:33 p.m.08/11/2025 5:10 a.m.08/12/2025 4:28 a.m. and 11:01 p.m.08/13/2025 7:47 p.m.08/18/2025 10:26 p.m.08/19/2025 11:40 a.m. and 10:04 p.m.08/20/2025 5:36 a.m. and 1:54 p.m.During an interview on 08/19/2025 at 12:11 p.m. S10 LPN (Licensed Practical Nurse) reported Resident #4 had been receiving PRN Ativan for anxiety.During an interview on 08/20/2025 at 3:11 p.m. S2 DON (Director of Nursing) reported Resident #4 had a PRN order for Ativan Oral Tablet 1 MG (Lorazepam) dated 07/07/2025 and had been receiving doses in August.

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F 0628

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record reviews and interviews, the facility failed to provide written notice to residents and/or their RP (Responsible Party) which specified the reason for transfer, effective date, location and statement of the resident's appeal rights and duration of the bed hold for 3 (#4, #81, #89) of 3 (#4, #81, #89) residents reviewed for transfers. Findings:

Resident #4

Review of Resident #4's medical record revealed an admit date of 01/04/2017 with diagnoses of, but not limited to, fracture of unspecified part of neck of left femur, Alzheimer's disease with early onset, vascular dementia, unspecified severity, paranoid schizophrenia, and generalized anxiety disorder.

Review of Resident #4's medical record revealed Resident #4 was sent to the ED (Emergency Department) on 06/08/2025 for evaluation.

Further review of Resident #4's medical record failed to reveal a written notice of transfer/discharge had been provided to Resident #4 and/or RP at the time of transfer/discharge.

Resident #81

Review of Resident #81's medical record revealed an initial admit date of 02/19/2025 with diagnoses of, but not limited to to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cerebral infarction, vascular dementia, hypo-osmolality and hyponatremia, and atherosclerotic heart disease of native coronary artery without angina pectoris.

Review of Resident #81's progress notes revealed Resident #81 was discharged to a local ER (Emergency Room) on 04/19/2025 with return to the facility on [DATE], discharged to a local ER on [DATE] with return to the facility on [DATE], and discharged to a local ER on [DATE] with return to the facility on [DATE].

Review of Resident #81's medical record failed to reveal Resident #81 and/or RP had been provided bed hold notice prior to transfer/discharge on [DATE], 05/13/2025, and 05/18/2025.

Resident #89

Review of Resident #89's medical record revealed an initial admit date of 04/21/2025 and a discharge on [DATE] with diagnoses of, but not limited to, hypertensive chronic kidney disease, COPD (chronic obstructive pulmonary disease) unspecified, and hemiplegia unspecified affecting right dominant side.

Review of Resident #89's 07/10/2025 Nurses Notes revealed Resident #89 was to be admitted to ________Rehab Center and was transported to the rehab.

Review of Resident #89's medical record failed to reveal Resident #89 or RP had been provided bed hold notice prior to discharge on [DATE].

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/19/2025 at 9:30 a.m. S8 MDS (Minimum Data Set) Coordinator reported bed hold notifications are not sent with residents or resident's RP upon discharge/transfer. During an interview on 08/20/2025 at 10:00 a.m. S1 Administrator reported the Bed Hold notice was not being provided to residents' and/or their RP at transfer/discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a physician's order was implemented for 1 (#16) of 1 (#16) resident reviewed for urinary catheter. The facility failed to ensure Resident #16 received a referral appointment to Urology. Findings: Review of Resident #16's medical record revealed an admission date of 06/09/2025 with diagnoses, which included in part, displaced intertrochanteric fracture of left femur, Type 2 diabetes and generalized anxiety disorder.Review of Resident #16's admission MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 11, which indicated moderately impaired cognition. Further review of Resident #16's admission MDS revealed Resident #16 had an indwelling catheter in place. Review of Resident #16's written physician's orders revealed an order by S5NP (Nurse Practitioner) dated 06/30/2025 which read in part: Refer to Urology; Diagnosis: acute urinary retention. Review of Resident #16's medical record revealed a visit summary dated 06/30/2025 by S5NP which read in part: . seen today for evaluation of urinary retention.over the weekend, Resident #16 required another Foley catheter placement last night. Plan: Resident #16 experienced altered mental status and confusion, possibly related to urinary retention. Refer to Urology for further evaluation before attempting another voiding trial due to previous failure. Further review of Resident #16's medical record failed to reveal Urology referral appointment had been scheduled. During an interview on 08/20/2025 at 9:00 a.m., S9Ward Clerk reported she was responsible for scheduling referral appointments. S9Ward Clerk acknowledged Resident #16 had not been referred to Urology. During an interview on 08/20/2025 at 8:50 a.m., Resident #16 reported foley catheter was re-inserted a few months ago and S5NP was referring her to Urology. Resident #16 further reported the facility had not notified her of an Urology appointment. During an interview on 08/20/2025 at 9:50 a.m., S2DON (Director of Nursing) acknowledged Resident #16 had an order for a referral to Urology dated 06/30/2025 related to urinary retention. S2DON further acknowledged Resident #16 had not been scheduled an appointment to Urology and should have been.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to have a system in place to prevent accident hazards for 1 (#67) of 4 (#4, #46, #67, #84) sampled residents investigated for accidents. The facility failed to ensure coffee was served at a safe temperature to prevent burn injuries.The deficient practice resulted in an actual harm on 08/13/2024 at approximately 8:40 a.m. when Resident #67 spilled her breakfast coffee onto her lap. Resident #67 was not aware she had a burn to her left anterior thigh until S6 CNA (Certified Nursing Assistant) came to help her clean up and her left anterior thigh had a reddened area with blisters. S5 NP (Nurse Practitioner) was notified and identified the burn as a partial thickness burn of left upper thigh (2nd degree) and burn treatment began. The deficient practice had the likelihood to cause serious injury or harm to all of the 81 residents in the facility.Findings:Review of the American Burn Association Scald Injury Prevention Educator's Guide revealed in part: The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. Older adults, identified as a high risk group, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications .Scald injuries result in considerable pain, prolonged treatment, possible lifelong scarring, and even death. Third degree burns can occur within 1 second with hot water temperatures at 155 degrees Fahrenheit (F), within 2 seconds at 148 degrees F, within 5 seconds at 140 degrees F, within 15 seconds at 133 degrees F, and within 1 minute at 127 degrees F. All facility policies related to scald prevention were requested of S1 Administrator on 08/19/2025 at 1:34 p.m. and S1 Administrator reported there were no official policies in effect related to scald prevention.Review of Resident #67's record revealed an admit date of 11/04/2020 with a readmit date of 06/23/2025 with diagnoses that included type 1 diabetes mellitus with hyperglycemia and diabetic chronic kidney disease as well as unspecified polyneuropathy. Review of Resident #67's MDS (Minimum Data Set) assessment dated [DATE] revealed intact cognition with a BIMS (Brief Interview for Mental Status) score of 15, no functional impairment in range of motion, and set up only assistance required with eating. Further review of Resident #67's MDS revealed most recent assessment dated [DATE] indicated intact cognition with a BIMS of 14, no functional impairment in range of motion, and set up only assistance required with eating.Review of the facility's incident log revealed an injury incident regarding Resident #67 on 08/13/2024. Review of Resident #67's incident report dated 08/13/2024 at 12:42 p.m. prepared by S7 LPN (Licensed Practical Nurse) revealed in part: this nurse was notified by CNA of red marks on Resident #67's leg and a blister. Nurse entered the room, Resident #67 was in the bathroom, her left upper leg was visibly red with 2 blisters. Resident #67 said she spilled her coffee on her. Wound Care Nurse, NP (Nurse Practitioner), and resident's responsible party were notified. Wound care nurse measured the burn and applied Silvadene cream. Resident #67 reported she reached up to get her coffee off the bedside table and it hit the end of the table and spilled on her. Resident #67 reported she guessed she was still half asleep when it happened and didn't know it had burned her leg until she went to wash herself off in the bathroom and saw it. Review of Resident #67's Nurses Notes revealed the following notes in part: 08/13/2024 at 11:48 a.m. the nurse was notified by S6 CNA at 8:40 a.m. while bathing the resident she noted a red mark with some blisters. Resident #67 reported she spilt coffee on her leg but didn't think it burned her. S3 RN (Registered Nurse)/Wound Care Nurse applied cream. Will continue plan of care. No other complaints at this time. 08/14/2024 at 10:23 a.m. Resident #67 remains in acute care following incident on 08/13/2024 related to burn to upper left leg. No acute distress at this time. Resident has no (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	complaints of pain or discomfort. Educated resident on importance of allowing coffee to cool down before trying to move it from table. Review of Resident #67's S5 NP Notes revealed the following notes in part:08/13/2024 at 12:00 a.m. seen today to evaluate a burn on her legs. She spilled coffee on her lap this AM and nursing aids noticed later she had some redness on her legs and blisters. She reports not hurting badly and is more concerned with knee pain.partial thickness burn of thigh. Apply Silvadene cream. Wound care nurse to monitor. 08/20/2024 at 12:00 a.m. seen today for follow up on burns on her upper left leg/groin. She spilled coffee on legs last week and had 2nd degree burns on her groin and upper leg. She reports it is feeling some better and doesn't really hurt that much. Bandages have a hard time staying on due to the area and when she does therapy exercises.continue to keep clean with wound cleanser. pat dry, apply Silvadene, cover with Xeroform and dry dressing every other day and as needed until healed. Type 1 diabetes mellitus with other skin complication: complicates burn. Healing rate may be delayed as a result. Monitor glucoses closely. Review of Resident #67 S4 Wound Care NP notes revealed the following notes in part:08/16/2024 at 9:32 a.m. burns (second or third degree) left anterior thigh.tissue painful.no signs or symptoms of infection. Continue with current treatment orders.08/22/2024 at 11:02 a.m. second degree thermal burn to left anterior thigh. Wound status improving. Decrease in size. No signs or symptoms of infection. Continue with treatment order. 08/29/2024 at 11:27 a.m. left anterior thigh partial thickness burn assessed.pt is at high risk of wound incidence due to impaired mobility, co-morbid conditions, impaired blood flow, inevitable effect of aging, scar tissue, and diabetes.09/05/2024 left anterior thigh partial thickness burn resolved. During an observation and interview on 8/19/2025 at 10:50 a.m. Resident #67 was sitting in a wheelchair in her room visiting with her daughter and son-in-law. A single serve pod coffee maker was noted in Resident #67's room. Resident #67 was asked about the burn she sustained. Resident #67 reported she fell asleep holding a cup of coffee and spilled it in her lap. Resident #67 was asked was the coffee from the single serve pod coffee maker in her room or was it the facility coffee. Resident #67 reported it was the facility coffee she spilled. Resident #67 reported she drank about half of it before she spilled it and never would have thought it would have caused a burn like it did. Resident #67 reported she did not realize she had burned herself until she went to clean herself up. Resident #67 reported they assessed and treated her burn and it healed with no concerns. Resident #67's daughter confirmed the facility notified her of the incident and denied any concerns. During an interview on 08/19/2025 at 12:35 p.m. S6 CNA reported it had been a while ago, but recalled when she was assisting Resident #67 in the bathroom she had noted a red area with a blister on Resident #67's hip and notified the nurse. S6 CNA reported Resident #67 told her she dozed off after she drank some of the coffee and spilled it on herself while she was in bed. When asked about any in-services after Resident #67 spilled coffee, S6 CNA reported the CNAs and LPNs in-serviced on ensuring the residents were awake and alert when serving coffee. During an interview on 08/19/2025 at 12:45 p.m. S7 LPN recalled being notified by the CNA that Resident #67 had a red area.S7 LPN reported when she went to assess Resident #67 she was on the toilet and she had a red area with blisters on her hip. S7 LPN reported Resident #67 told her she dozed off after drinking some coffee and spilled it on herself. S7 LPN reported she notified the wound care nurse, the NP and Resident #67's responsible party. S7 LPN reported after the incident the nurses and CNAs were in-serviced on making sure the coffee was not too hot when served. S7 LPN was asked how they ensured the coffee was not too hot and she reported she did not know if any temperatures were being taken but knew the coffee was not as hot as it used to be when it is poured into the cups. During an interview on 08/19/2025 at 12:50 p.m. S12 DM (Dietary Manager) was asked how they monitor temperatures on the brewed coffee. S12 DM reported the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	coffee was brewed in an industrial coffee maker that heats to 200 degrees F (Fahrenheit) then begins brewing the coffee into an insulated dispenser pot. S12 DM reported the kitchen staff brews coffee the first thing when they get in at 5:00 a.m. and the insulated dispenser pots were put on a stand on a cart in prep for service to the halls. S12 DM reported the CNAs got in at 6:00 a.m. and usually did not pick up the coffee pots to pass coffee on halls until about 6:30 a.m. so the pot has been sitting for about an hour and a half before being served. S12 DM reported other than the temperature reached for the coffee maker to brew there were no other temperatures measured. During an interview on 08/19/2025 at 1:10 p.m. S2 DON (Director of Nursing) reports she started as DON in June of 2025. S2 DON further reported S3 RN/Wound Care Nurse no longer worked at the facility. During an interview on 08/19/2025 at 1:15 p.m. S11 ADON (Assistant Director of Nursing) reported she recalled the previous DON talking with staff regarding burns and coffee after Resident #67's burn from spilled coffee but did not recall a formal in-service training with a sign in sheet. During an interview on 08/19/2025 at 1:34 p.m. S1 Administrator reported after the burn incident with Resident #67 the previous DON had worked on a scalding policy regarding hot liquids and resident assessments for serving coffee/hot liquids. S1 Administrator acknowledged there were no official assessments or policies in effect to ensure residents could safely drink coffee. S1 Administrator reported he did not know of any ongoing monitoring of coffee temperatures following Resident #67's burn incident. During an interview on 08/19/2025 at 1:44 p.m. S2 DON provided the working policy and resident assessment regarding scalding and hot liquids. S2 DON reported the policy and assessments had not been implemented and could not provide any documentation of formal in-service training of staff on scalding and hot liquids. During observation and interview on 08/19/2025 at 4:35 p.m. S12 DM started brewing a pot of coffee in the industrial coffee maker into an insulated dispenser pot. S12 DM reported it took about 7 minutes to brew the full pot of coffee. While the coffee was brewing surveyor went with S12 DM to measure the temperature of the coffee in two self-serve warming coffee pots noted on the counter outside the kitchen in the dining room. S12 DM reported the coffee in the pots was brewed and poured into the pots about an hour ago. S12 DM measured the temperature of the coffee from each warming pot after being poured into cups. One pot measured 147.8 degrees F and the other 161.7 degrees F. During observation on 08/19/2025 at 4:43 p.m. the coffee had completed brewing into the insulated dispenser pot. S12 DM transferred the insulated dispenser pot to a stand on a cart. S12 DM then measured the temperature of a poured cup from the insulated dispenser pot to read 164.8 degrees F. The coffee poured from the same insulated dispenser pot was measured by S12 DM an hour after brewing completed and then again an hour and a half after brewing. Temperatures were observed being measured by S12 DM and read 157.4 degrees F at 5:45 p.m. and read 163.2 degrees F at 6:16 p.m. During observation and interview with S13 LPN on 08/19/2025 at 5:04 p.m. Resident #67's left anterior thigh at the groin was observed to have a slightly darkened/shiny scarred skin area approximately one inch in length. Resident #67 indicated she could hardly see the area and indicated she noticed it most when she gets in the whirlpool and only because she knew it was there. During a phone interview on 08/20/2025 at 10:20 a.m. S5 NP recalled going to assess Resident #67 after a reported burn. S5 NP reported Resident #67 reported she spilled coffee on herself but Resident #67 played the burn off and had more pertinent concerns. S5 NP reported once noted and treatment began, Resident #67 became fixated on the burn. S5 NP indicated Resident #67 was anxious and had several issues so she saw Resident #67 frequently. S5 NP reported Resident #67 was a type 1 diabetic so there was some delay in wound healing but there were no complications with the wound or treatment. S5 NP reported S4 Wound Care NP was consulted and followed Resident #67 until the wound healed as well. S5 NP reported she had been coming to the facility for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	about a year and 8 months and had not known of any other residents being burned with coffee or any other hot liquid.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to electronically submit Payroll Based Journal (PBJ) Staffing Data Report 1705D for Fiscal Year Quarter 2 2025 (January 1 - March 31). Findings: Review of the facility's Payroll Based Journal (PBJ) Staffing Data Report 1705D Fiscal Year (FY) Quarter 2 2025 (January 1 - March 31) revealed the facility failed to submit staffing data for the quarter.During an interview on 08/19/2025 at 3:15 p.m. S1 Administrator acknowledged the PBJ Staffing Data Report 1705D for FY Quarter 2 (January 1 - March 31) was not submitted and should have been.