STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46361 Based on interviews and record reviews, the facility failed to protect the residents' right to be free from verbal and physical abuse by other residents. This deficient practice was identified for 6 (Resident #4, Resident #5, Resident #6, Resident #8, Resident #9, and Resident #10) of 10 sampled residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10) reviewed for abuse. Findings: Resident #4 Review of facility documents related to an incident dated 03/17/2024 revealed, in part, Resident #3 struck Resident #4 in the face in the facility dining room. In an interview on 05/01/2024 at 10:30 a.m., S4Food and Nutrition Manager stated she witnessed Resident #3 approach Resident #4, who had his eyeglasses on and was sitting in his wheelchair. Resident #3 then stated that was her glasses. Resident #3 removed Resident #4's eyeglasses and pulled her hand back and struck Resident #4 in the face. In an interview on 05/02/2024 at 11:26 a.m., S1Administrator stated she reviewed the facility video tape of the incident which occurred on 03/17/2024 between Resident #3 and Resident #4 and confirmed Resident #3 did strike Resident #4 in the face. Resident #5 and Resident #6 Review of Resident #5's progress note dated 04/05/2024 at 4:31 p.m. revealed, in part, S5Laundry Supervisor reported to the nurse she was talking to Resident #6, and Resident #5 walked up to them and got into Resident #6's face and shouted at Resident #6 to go to his room. Record review further revealed Resident #6 then shoved Resident #5. In an interview on 05/01/2024 at 11:37 a.m., S5Laundry Supervisor indicated she was in the hallway on Hall Z and Resident #5 was in his wheelchair next to her clothing cart. S5Laundry Supervisor indicated Resident #6 became aggressive toward Resident #5. S5Laundry Supervisor indicated she witnessed Resident #6 lean down close to Resident #5, point her finger in Resident #5's face, and yelled at him to go to his room. Resident #5 then pushed Resident #6 backwards into the clothing cart. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's documents related to the incident on 04/05/2024 revealed, in part, Resident #6 was verbally abusive to Resident #5, and Resident #5 then shoved Resident #6. The documentation further revealed both Resident #5 and Resident #6 were at fault; however, the incident was unsubstantiated by the facility. In an interview on 05/02/2024 at 2:59 p.m., S1Administrator confirmed Resident #6 acted aggressively towards Resident #5 when she leaned down into his personal space and yelled at him to go to his room. S1Administrator confirmed Resident #5 then pushed Resident #6 into the clothing cart. S1Administrator confirmed Resident #5 should not have pushed Resident #6. Resident #8 Review of facility documents related to an incident dated 04/06/2024 revealed, in part, Resident #7 hit Resident #8 in the head. Further reviewed that Random Resident R1 witnessed the incident which occurred in the dining room. In an interview on 05/02/2024 at 9:30 a.m., Random Resident R1 with a Brief Interview for Mental Status of 14 (cognitive), stated on 04/06/2024 Resident #8 was sitting in the dining room next to her when Resident #7 walk up to them and hit Resident #8 on the forehead. In an interview on 05/02/2024 at 10:15 a.m., S1Administrator indicated she reviewed the video footage for 04/06/2024 related to the above mentioned incident and observed Resident #7 hit Resident #8 on the front forehead. Resident #9 Review of facility documents related to an incident dated 04/11/2024 revealed, in part, Resident #2 slapped Resident #9 in the dining room. Further review revealed, in part, this incident was witnessed. In an interview on 05/01/2024 at 1:40 p.m., S3Treatment (Tx) Nurse indicated she witnessed Resident #2 intentionally slap Resident #9 in the dining room right after S3Tx Nurse had pushed Resident #9 to the front table and seated Resident #2 next to Resident #9. S3Tx Nurse indicated Resident #9 told her that was a good spot because she knew him. S3Tx Nurse indicated she witnessed Resident #2 look at Resident #9 and then Resident #2 intentionally swung with his left hand and hit Resident #9. S3Tx Nurse also indicated Resident #2 was cognitive enough to know what he was doing when he swung and hit Resident #9. In an interview on 05/01/2024 at 2:05 p.m., Resident #2 indicated he remembered the day when he hit Resident #9. When asked if Resident #2 knew it was wrong to hit someone at the facility, he nodded his head yes. In an interview on 05/02/2024 at 12:00 p.m., S1Administrator indicated she had no doubt Resident #2 slapped Resident #9. Resident #10 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's medical record reveal a nurse's note dated 04/01/2024 which revealed Resident #1 verbally abused resident #10, quoting I'm gonna kill you if you don't shut up! shouted at Resident #10. In an interview on 05/01/2024 2:51 p.m., S1Administrator confirmed this would be considered resident-to-resident verbal abuse. In an interview on 05/02/2024 at 2:10 p.m., S8Licensed Practical Nurse (LPN) confirmed Resident #1 stood over Resident #10 and stated he would F-ing kill him if he didn't shut up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46361 Based on record review and interviews, the facility failed to ensure an allegation of resident-to-resident abuse was: 1. Reported to the State Survey Agency for 1 (Resident #10) of 10 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10) sampled residents reviewed for abuse; and, 2. Reported timely to the State Survey Agency for 2 (Resident #6 and Resident #9) of 9 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9) sampled residents reviewed for timeliness of reporting of abuse allegations. Findings: #1 Review of Resident #1's medical record reveal, in part, a nurse's note dated 04/01/2024 documenting Resident #1 verbally threatened Resident #10 by shouting I'm gonna kill you if you don't shut up! Review of Morning Leadership Meeting minutes dated 04/01/2024 revealed an incident of Resident #1 yelling at Resident #10 and had been discussed by the leadership team. In an interview on 05/01/2024 2:51 p.m., S1Administrator indicated a State Incident Management Systems (SIMS) report should have been filed and it was not. In an interview on 05/02/2024 at 2:10 p.m., S8 Licensed Practical Nurse (LPN), indicated she was caring for Resident #1 and Resident #10 on the night of 03/31/2024-04/01/2024. S8LPN further indicated during the shift a certified nursing assistant informed her that Resident #1 threatened Resident #10 by shouting he would F-ing kill him if he didn't shut up. S8LPN stated she should have written an incident report and she did not. There was no evidence, and the facility failed to provide evidence, that verbal abuse had been reported to the state agency as required. #2 Resident #6 Review of facility documents related to an incident dated 04/05/2024 revealed, in part, an incident of physical abuse was discovered on 04/05/2024 at 2:20 p.m. Further review revealed the incident was reported to the State Incident Management System (SIMS) at 04/05/2024 at 5:46 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/02/2024 at 12:00 p.m., S1Administrator confirmed the entry times of the SIMS were pass the 2 hour mark of required reporting. S1Admnistrator also stated she was the only one who had access to SIMS and responsible for reporting. Resident #9 Review of facility documents related to an incident dated 04/11/2024 revealed, in part, an incident of physical abuse was discovered on 04/11/2024 at 2:00 p.m. Further review revealed the incident was reported to the SIMS at 04/11/2024 at 5:05 p.m. In an interview on 05/02/2024 at 12:00 p.m., S1Administrator confirmed the entry times of the SIMS were past the 2 hour mark of required reporting. S1Admnistrator also indicated she was the only one who had access to SIMS and responsible for reporting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195303	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Nursing Home	506 West 5th Street Laplace, LA 70068

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46361 Based on record reviews and interviews, the facility failed to conduct a thorough investigation following an allegation of verbal abuse between 2 (Resident #1 and Resident #10) of 10 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10) sampled residents investigated for abuse. Findings: Resident #1 was admitted on [DATE] with diagnoses which included fractured left femur, pressure ulcer of right heel, hyperlipidemia, hypertension, chronic kidney disease, type 2 diabetes, cerebral infarction, depression, left BKA, lack of coordination/muscle weakness, repeated falls. Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 04/17/2024 revealed, in part, Resident #1's cognition was moderately impaired. Further review revealed Resident #1 did not have physical or verbal symptoms directed toward others. Resident #10 was admitted on [DATE] with diagnoses which included closed skull fracture, difficulty in walking/lack of coordination, cognitive communication deficit, altered mental status, epilepsy, progressive spinal muscle atrophy, and pain. Review of Resident #10's Quarterly Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 04/05/2024 revealed, in part, Resident #10's cognition was moderately impaired. Further review revealed Resident #10 exhibited frequent physical and verbal behavioral symptoms directed toward others. Review of Resident #1's nurses notes reveal a note dated 04/01/2024 documenting Resident #1's irate behavior towards staff and resident #10, quoting I'm gonna kill you if you don't shut up! shouted at Resident #10. Review of Morning Leadership Meeting minutes dated 04/01/2024 revealed the incident between Resident #1 and Resident #10 had been discussed by the leadership team, but there was nothing indicating that an investigation had been conducted. In an interview on 05/01/2024 2:51 p.m., S1Administrator confirmed the incident was resident-to-resident abuse, S1Administrator indicated an investigation should have been conducted for the above, and it was not. There was no evidence, and the facility failed to provide evidence, that an investigation for resident-to-resident verbal abuse had been conducted.