

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Twin Oaks Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34608</p> <p>Based on record reviews and interviews, the facility failed to ensure an allegation of verbal and physical abuse was reported to the required state survey agency for 1 (Resident #1) of the 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure titled Policy for Prohibition of Abuse, Neglect and Misappropriation of Property with a revision date of 09/26/2017 revealed, in part, all alleged violations and all substantiated incidents should be reported to the required state agency, and any employee who becomes aware of an allegation of abuse should report the incident to a supervisor, Director of Nursing, or Administrator immediately. Further review of the policy revealed the facility will report all allegations of abuse to the state agency.</p> <p>Review of Resident #1's closed medical record revealed, in part, Resident #1 was admitted to the facility on [DATE] with diagnoses, in part, Alzheimer's disease, schizophrenia, depressive disorder, dementia, and anxiety.</p> <p>Review of Resident #1's Physician's Emergency Certificate (PEC) dated 06/03/2024 revealed, in part, Resident # assaulted the nursing home administrator. Further review of the PEC revealed Resident #1 alleged the nursing home administrator pushed her.</p> <p>Review of the police report document with a disposition/completion date and time of 06/03/2024 at 1:41 p.m. revealed, in part, Resident #1 stated S1Administrator pushed her on 06/03/2024.</p> <p>In a telephone interview on 06/25/2024 at 10:50 a.m., Resident #1's Responsible Party (RP) stated Resident #1 reported she was pushed by S1Administrator on 06/03/2024.</p> <p>In a telephone interview on 6/25/2024 at 11:34 a.m., the facility's Ombudsmen stated Resident #1's RP informed her Resident #1 was pushed by S1Administrator during an incident on 06/03/2024.</p> <p>In a telephone interview on 06/25/2024 at 11:53 a.m., Resident #1 stated S1Administrator pushed her on 06/03/2024 and Resident #1 informed the police deputy and facility staff of the incident.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 06/25/2024 at 1:42 p.m., S1Administrator stated Resident #1's RP called S2Regional Administrator 06/04/2024 and reported S1Administrator yelled at and pushed Resident #1. S1Administrator further stated Resident #1's allegation of abuse was not reported to the state agency.</p> <p>In an interview on 06/25/2024 at 2:28 p.m., S1Administrator denied the previously documented interview and indicated she was inconsistent in reporting her source of information. S1Administrator further indicated she must have obtained Resident #1's allegation of abuse from the police report.</p> <p>In an interview on 06/25/2024 at 2:30 p.m., S2Regional Administrator verified Resident#1 alleged she was abused by S1Administrator the after reviewing the police report and the PEC report. S2Regional Administrator indicated he was not made aware of Resident #1's allegation until today (06/25/2024) and further confirmed the incident was not reported to the state agency as required.</p> <p>In an interview on 06/26/2024 at 9:53 a.m., S3Director of Nursing (DON) stated she reviewed Resident #1's PEC and was aware Resident #1 alleged S1Administrator pushed her on 06/03/2024. S3DON further stated she was not aware if the incident was reported to the state agency and confirmed she did not report the alleged abuse of Resident #1 by S2Administrator to corporate management as required.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>34608</p> <p>Based on record reviews and interviews, the facility failed to conduct a thorough investigation following an allegation of physical abuse for 1(Resident #1) of the 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure titled Policy for Prohibition of Abuse, Neglect and Misappropriation of Property with a revision date of 09/26/2017 revealed, in part, the facility will thoroughly investigate all alleged violations of abuse and take appropriate actions.</p> <p>Review of Resident #1's Physician's Emergency Certificate (PEC) dated 06/03/2024 revealed Resident #1 alleged claimed S1Administrator pushed her.</p> <p>Review of the police report document case with a disposition/completion date and time of 06/04/2024 at 1:41 p.m. revealed, in part, Resident #1 stated S1Administrator pushed her.</p> <p>There was no documented evidence, and the facility did not present any documented evidence Resident #1's allegation of abuse by S2Administrator was investigated.</p> <p>In an interview on 06/25/2024 at 1:42 p.m., S1Administrator stated Resident #1's allegation of abuse by S1Administrator was not investigated.</p> <p>In an interview on 06/25/2024 at 2:30 p.m., S2Regional Administrator confirmed the allegation of abuse of Resident #1 by S1Administrator was not investigated.</p>

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>30587</p> <p>Based on record review and interview, the facility failed to implement a training program for 1 (S1Administrator) of 6 (S1Administrator, S6Sunshine Aide, S7Social Services, S8Certified Nursing Assistant [CNA], S9CNA, and S10CNA) sampled personnel files reviewed for training.</p> <p>Findings:</p> <p>Review of S1Administrator's Personnel File revealed a date of hire of 07/22/2015. Further review revealed, no documented evidence and the facility presented no documented evidence, S1Administrator received training on Quality Assurance and Performance Improvement (QAPI) program, behavioral health training, ethics training, and resident rights.</p> <p>In an interview on 06/27/2024 at 3:05 p.m., S2Regional Administrator indicated the facility did not have documented evidence S1Administrator had received trainings for QAPI, behavioral health, ethics, abuse, and resident rights.</p>