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	09/05/2024

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 - Few	Respond appropriately to all alleged violations. 46361 Based on record reviews and interviews, the facility failed to ensure a thorough investigation was completed for an allegation of neglect for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for neglect. Findings: Review of the facility's Policy for Prohibition of Abuse, Neglect and Misappropriation of Property revised on 08/05/2024 revealed, in part, the facility will have evidence of a thorough investigation of all alleged violations. Review of the facility's records revealed a report dated 08/21/2024 revealed, in part, in which the allegation of neglect was reported and investigated for Resident #1. Further review revealed Resident #1 was sent to the hospital due to a drop in blood pressure on 08/21/2024. In the emergency room Resident #1 was found to have gauze and an empty ketchup packet lodged in the back of his throat. Further review of the report revealed the lunch meal on 08/21/2024 included French fries served with ketchup. Further review revealed the camera footage was reviewed by the facility and the footage showed multiple staff members were present in the dining room, Resident #1 had fed himself, and Resident #1 had not placed a ketchup packet in his mouth. The facility's report further revealed Resident #1 did not require wound care and speculated Resident #1 obtained the gauze during the emergency transport to the hospital or when he arrived to the hospital. Review of Resident #1's August 2024 Physician Orders revealed, in part, Resident #1 had a physician's order implemented on 08/15/2024 to Apply a Bordered Gauze Pad (Gauze Pads & Dressings) to the right knee topically one time a day related to an unspecified open wound to the right knee. Review of Resident #1's August 2024 Electronic Treatment Administration Record (ETAR) revealed, in part, Resident #1 received the above mentioned application of a gauze pad and/or dressings to his right knee on 08/15/2024 through 08/21/2024. (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
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's camera footage on 09/04/2024 at 12:18 p.m. with S1Administrator and S3CNA Supervisor present revealed, in part, on 08/21/2024 Resident #1 was seated at a table with Random Resident #4 for the lunch meal service. Further review revealed S4Dietary Aide placed Resident #1's lunch tray in front of him on the table. Further review revealed Resident #1 was seen bringing his hands to his face and/or mouth multiple times; however, the footage was out of focus and you could not identify what items Resident #1 brought to his face and/or mouth. Further review revealed S5Housekeeper was observed walking near and/or around Resident #1 while he sat at the table in the dining room. In an interview on 09/04/2024 at 12:27 p.m., S5Housekeeper indicated the facility administrative staff had not questioned her or asked her to provide a statement of any observations S5Housekeeper made of Resident #1 in the dining room during lunch meal service on 08/21/2024. In an interview on 09/04/2024 at 12:33 p.m., S4Dietary Aide confirmed she often assisted residents in the dining room during meals services. S4Dietary Aide further indicated the facility administrative staff had not questioned her or asked her to provide a statement of any observations S4Dietary Aide made of Resident #1 in the dining room during lunch meal service on 08/21/2024. Review of Random Resident #4 revealed, in part, Random Resident #4 had a Brief Interview of Mental Status score of 15 which indicated her cognition was intact. In an interview on 09/05/2024 at 12:18 p.m., Random Resident #4 indicated the facility staff had not questioned her or asked Random Resident #4 to provide a statement of any observations Random Resident #4 made of Resident #1 while she sat at the table with Resident #1 during the lunch meal service on 08/21/2024. Review of the facility's investigative documents for Resident #1's facility report on 08/21/2024 revealed, in part, no documented evidence and the facility did not present any documented evidence S5Housekeeper, S4Dietary Aid, or Random Resident #4 was interviewed by administrative staff and/or that a statement was obtained. In an interview on 09/05/2024 at 2:38 p.m., S1Administrator confirmed Resident #1 had an active wound care order to apply a gauze dressing to Resident #1's right knee which was completed as ordered on August 8/15/2024 through 08/21/2024. S1Administrator indicated she was not aware of the above mentioned wound care orders for Resident #1. S1Administrator confirmed the facility's report for Resident #1 on 08/21/2024 indicated Resident #1 did not have orders for wound care and the information was inaccurate. S1Administrator confirmed Random Resident #4 was not interviewed by the facility's administrative staff of her observation of Resident #1 during the lunch meal service on 08/21/2024. S1Administrator confirmed the facility did not obtain interviews and/or statements from all staff who observed Resident #1 during the lunch meal service on 08/21/2014. S1Administrator further indicated the facility could have done a better job formalizing the information gathered during Resident #1's investigation.