STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195471	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Manor Nursing and Rehab Ctr, LLC	9919 Jefferson Hwy. Baton Rouge, LA 70809

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343 Based on record review, video observation, and interviews the facility failed to ensure the residents' right to be free from neglect for all residents who resided on Hall A (Rooms ,d+[DATE]). Nursing staff neglected to respond to call lights and provide any care and services to all resident's residing on Hall A from 11:00 p.m. to 2:30 a.m. on the night of [DATE]. As a result of the identified noncompliance, serious harm, serious impairment, death, or psychosocial harm was likely to occur to the residents residing on Hall A. This deficient practice resulted in an Immediate Jeopardy (IJ) situation on [DATE] at approximately 11:00 p. m. when Resident #1, who had a physician's order for staff to visually check the resident every 2 hours, activated her call light for staff assistance. No staff responded to her call until approximately 2:39 a.m. when S6CNA found Resident #1 in here room on the floor, kneeling on a fall mat at the bedside, unresponsive and pulseless. Resident #1 expired after unsuccessful CPR was initiated. On [DATE] at approximately 2:53 a.m., S6CNA found Resident #3, who had a physician's order for staff to visually check the resident every 2 hours, lying on the floor. This resulted in psychosocial harm for Resident #3 who verbalized in an angry tone that she felt aggravated and neglected when staff did not help her after she slid out of bed and had to stay on the floor for a long time. Interviews with staff revealed the last time staff visualized or provided care for any residents residing on Hall A on [DATE] was at 10:00 p.m.; and not again until 2:30 a.m. on [DATE]. S2ADM was notified of the Immediate Jeopardy on [DATE] at 7:02 p.m. The Immediate Jeopardy was removed on [DATE] at 1:31 p.m., as confirmed by onsite verification through record reviews and interviews. The facility implemented an acceptable Plan of Removal (POR) prior to survey exit. This deficient practice continued at a potential for more than minimal harm to the remaining 100 residents residing in the facility. Findings: Review of the facility's policy titled Abuse/Neglect Prevention Program with a revision date of [DATE], revealed the following in part: Abuse/Neglect Policy Statement: Each resident also has the right to be free from neglect. (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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. Neglect- Failure to provide goods and services necessary to avoid physical harm, mental or mental illness. Resident #1 Review of Resident #1's Clinical Record revealed she was readmitted to the facility on [DATE] with diagnoses, which included Foot Drop of Right and Left Foot, Repeated Falls, Muscle Weakness (generalized), Muscle Wasting and Atrophy, Primary Insomnia, Primary Generalized Osteoarthritis, Abnormal Posture, Cognitive Communication Deficit, and Need Assistance for Personal Care. Further review revealed Resident #1 resided on Hall A when she expired on [DATE]. Review of Resident #1's most recent completed Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #1 was dependent on staff assistance with bed mobility and transfers. Review of Resident #1's [DATE] Physician's Orders revealed an order was implemented on [DATE] for visual checks to be completed by staff every 2 hours for the resident's location. Review of Resident #1's Nurses' Note dated [DATE] revealed the following, in part: On [DATE] at 2:42 a.m.: Upon doing rounds, aide walked into room and found Resident #1 unresponsive on fall mat. Nurse was immediately called to the room. Upon entering room, nurse noticed resident on her fall mat in a kneeling position facing the bed. Unable to obtain pulse or blood pressure upon assessment. Initiated CPR immediately. 911 notified. CPR in progress. At 2:53 a.m., fire department arrived and continued CPR. Coroner's office notified, family notified. At 3:43 a.m., attempted to contact physician. At 4:00 a.m., coroner arrived, okay to release the body to funeral home. Signed by: S5LPN. Resident #3 Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Muscle Wasting, Muscle Weakness, and Lack of Coordination. Review of Resident #3's most recent completed MDS, with an ARD of [DATE], revealed a Brief Interview of Mental Status (BIMS) of 15, which indicated the resident was cognitively intact. Further review revealed she required partial to substantial/max assist with bed mobility and transfers. Review of Resident #3's [DATE] active Physician's Orders revealed an order was on [DATE] for visual checks to be completed by staff every 2 hours for the resident's location. Review of Resident #3's Nurses Note dated [DATE] revealed the following, in part: On [DATE] at 2:53 a.m.: Upon doing rounds, aide found Resident #3 lying down on the floor, nurse was immediately called to the room. Signed by: S5LPN. Review of the CNA Daily Assignment Sheet from 10:00 p.m. to 6:00 a.m. dated [DATE] revealed the following, in part: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	S7CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] S8CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] S6CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] On [DATE] at 2:04 p.m., a review of the facility's video surveillance footage of Hall A, dated [DATE] from 12:00 a.m. until approximately 4:45 a.m., was conducted with S2ADM. Prior to reviewing the footage, S2ADM stated he did not have access to any surveillance footage prior to [DATE] at 12:00 a.m. The surveillance footage revealed from 12:00 a.m. to approximately 2:35 a.m., staff failed to perform visual checks on Resident #1 and #3 every two hours as ordered, or any other residents on Hall A. The surveillance footage further revealed during that time, staff neglected to provide any care and services to any resident's residing on Hall A, and at 12:35 a.m., a call light was observed to be on in Hall A but S2ADM was unable to identify if it was coming from Resident #1's room or the room next to her. S2ADM confirmed the above review of the facility footage revealed no staff rounded on or provided care to any resident on Hall A from 12:00 a.m., on [DATE] until approximately 2:37 a.m. On [DATE] at 11:58 a.m., an interview was conducted with S6CNA. She stated she worked the 10:00 p.m. to 6:00 a.m. shift on [DATE] and was assigned to provide care for Resident #1 and Resident #3, as well as the residents in Rooms ,d+[DATE] on Hall A. S6CNA stated Resident #1 and #3 required staff assistance to get out of bed. She stated Resident #1 and #3 were ordered to have visual checks every 2 hours, which meant the staff were to visualize the resident every two hours. She stated she typically rounded on her residents every two hours, beginning at 10:00 p.m., then again at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. She stated CNAs should sit on the halls, in the section they were assigned, so they could respond to call lights and assist residents with needs because there was no ward clerk responsible to answer call lights after 10:00 p.m. She stated S5LPN notified her on [DATE], at the beginning of her shift that staff could not walk on the floor to get to the resident's rooms on Hall A due to floor maintenance. She stated she did not notify administration about not being able to see the residents and no staff monitored or provided care to any of the residents on Hall A from 10:00 p.m. to 2:30 a.m., when the floor maintenance was completed. She stated she sat in the day room across from the nurse's station with another aid waiting until the floors were finished and she could see call lights going off on Hall A. She stated she could not remember which residents needed assistance aside from Resident #1, and stated she did not respond to the call lights. She stated Resident #1's call light was on from approximately 10:00 p.m. to 2:30 a.m. She stated once the floor maintenance was completed at approximately 2:30 a.m., she started rounding on her residents. She stated she went into Resident #1's room first because she knew Resident #1's call light had been on for a while. She confirmed this was the first time during her shift she had visualized her assigned residents. She stated when she entered Resident #1's room she found the resident kneeling on the fall mat beside her bed, arm gripping the bed rail, unresponsive, cold, and pale. She stated she immediately notified S5LPN and left the room once help arrived. She stated she then rounded on Resident #3 and found Resident #3 lying on the floor uninjured. She stated Resident #3 did not say much to her other than she was not hurt and did not want to go to the emergency room . She stated she did not know how long Resident #3 was lying on the floor prior finding. She stated she notified S5LPN. She stated staff not performing visual checks or providing care to the residents on Hall A from 10:00 p.m. until 2:30 a.m., was neglect. She stated she should have performed visual checks and responded to call lights regardless of the floor maintenance and confirmed she had not. She stated she notified S2ADM once he had arrived to the facility, that staff were unable to perform rounds on residents on Hall A. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:29 p.m., an interview was conducted with S5LPN. S5LPN stated she was assigned to provide care for Resident #1, #3, and all of the residents on Hall A on [DATE] and worked the 10:00 p.m. to 6:00 a.m. shift. She confirmed Resident #1 and #3 had visual checks ordered every two hours which indicated staff were to visualize the resident every two hours. She stated Resident #1 and #3 required staff assistance to get out of bed. She stated she typically rounded on her residents beginning at 11:00 p.m., then again at 1:00 a.m., 3:00 a.m., and 5:00 a.m. She stated CNAs should sit on the halls, in the section they were assigned, so they could respond to call lights and assist residents with needs because there was no ward clerk responsible to answer call lights after 10:00 p.m. She stated on the night of [DATE], Hall A had floor maintenance being completed and the staff could not walk on the floor to get to the resident's rooms. She stated the floor maintenance started around 10:00 p.m., and did not finish until approximately 2:00 a.m. She stated during that time nursing staff did not round on the residents or provide any care on Hall A. She confirmed she did not communicate this with administration. She stated she was able to see all the resident on Hall A at 10:00 p.m., but did not see them again until approximately 2:30 a.m. She stated from 10:00 p.m. to 2:30 a.m., the CNAs were not allowed to sit on their assigned areas on the hall to respond to call lights and provide care like they normally would. She stated she sat behind the nursing station where the computers were at the charge nurse desk and could not see any call lights. She stated S6CNA went into Resident #1's room around 2:30 a.m., and found the resident unresponsive. She stated she immediately went into Resident #1's room and found Resident #1 on the floor kneeling on a fall mat at her bedside, unresponsive and pulseless. She stated shortly after that, S6CNA came to her and notified her Resident #3 had also been found on the floor. She stated once she got to Resident #3, she was lying on the floor, uninjured, with a pillow under her head. She confirmed staff not performing visual checks or providing care to the residents on Hall A from 10:00 p.m. until 2:30 a.m., was neglect. She stated the first time S2ADM was notified of staff not being able to round on the residents was when S2ADM arrived onsite around 4:00 a.m., after she had notified him of Resident #1's passing. On [DATE] at 10:58 a.m., an interview was conducted with S8CNA. S8CNA stated she worked the 10:00 p. m. to 6:00 a.m., shift on [DATE], and was assigned to Rooms ,d+[DATE] on Hall A. She stated she typically rounded on her residents every two hours, beginning at 10:00 p.m., then again at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. She stated the CNAs should sit on the halls in the section they were assigned so they could respond to call lights and assist residents with needs because there was no ward clerk responsible to answer call lights after 10:00 p.m. She stated on [DATE], she did not go to any of the resident's rooms or provide care for the residents on Hall A due to floor maintenance. She stated she was able to round on her residents at 10:00 p.m., but not again until approximately 2:30 a.m. She stated during that time, she sat at the beginning of Hall A and could see the call lights on Hall A. She stated she saw three call lights on from her assigned residents, but did not recall which residents had requested assistance. She stated she did not to respond to the call light or provide any care to those residents and should have. She stated once the floor maintenance was completed at approximately 2:30 a.m., she started rounding on her residents. She stated staff not performing visual checks on the residents and not providing care on Hall A from 10:00 p.m. until 2:30 a.m., was neglect. She stated she should have performed visual checks and responded to call lights regardless of the floor maintenance and confirmed she had not. She confirmed she did not notify S2ADM staff were unable to perform rounds or care on residents on Hall A. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:20 p.m., an interview was conducted with S7CNA. She stated she worked the 10:00 p.m. to 6:00 a.m., shift on [DATE], and was assigned to Rooms ,d+[DATE] on Hall A. She stated she typically rounded on her residents every two hours, beginning at 10:00 p.m., then again at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. She stated CNAs should sit on the halls, in the section they were assigned, so they could respond to call lights and assist residents with needs because there was no ward clerk responsible to answer call lights after 10:00 p.m. She stated S5LPN informed her staff could not get to the resident's rooms on Hall A due to floor maintenance. She explained the hall had been blocked off so she sat in the door way of the chapel and saw a resident call light on for about an hour at approximately 1:00 a.m. She stated she was unable to recall which resident required assistance, but she stated she did not respond to the call light. She stated once the floor maintenance was done around 2:30 a.m., all 3 CNAs working went down the hall to perform visual checks on the residents. She stated S6CNA found Resident #1 kneeling on her fall mat at her bedside, and Resident #3 lying on the floor in her room. She confirmed nursing staff not performing visual checks on their residents every two hours or providing care for the residents from 10:00 p.m. until 2:30 a.m., was neglect. She stated she should have performed visual checks and responded to call lights regardless of the floor maintenance and confirmed she had not. She stated she notified S2ADM once he had arrived to the facility, that staff were unable to perform rounds on residents on Hall A. On [DATE] at 4:15 p.m., an interview was conducted with Resident #3. She stated on [DATE] she slid out of bed onto the floor. She stated she tried calling for assistance before she slid out the bed, but no one came to help her. She stated once she was on the floor it took a long time for staff to come. She stated she did not try to get back in bed on her own because she needed staff assistance. She stated she called when she was on the floor with the call button and it took a long time for staff to come. She stated, in an angry tone, it made her feel neglected and very aggravated when the staff did not come help her after calling for help and lying on the floor. On [DATE] at 1:17 p.m., an interview was conducted with S3DON. She stated nursing staff were expected to perform visual checks on the residents every two hours based on their Physician's Order and provide any needed care. She stated staff should have notified the administrator immediately if they were ever unable to follow physician's orders, perform visual checks, or provide care to residents for any reason. She stated she expected staff to respond to call lights in a timely manner and as quickly as possible. She stated neglect would be staff not providing care to residents and ignoring the needs of residents. On [DATE] at 4:36 p.m., an interview was conducted with S2ADM. He stated through his investigation it was discovered that the floor maintenance impeded care by not allowing the nursing staff to perform visual checks or provide care to residents on Hall A from 10:00 p.m. until approximately 2:30 a.m., on [DATE]. He confirmed Resident #1 and #3 were both found on the floor on [DATE], and by the time Resident #1 was found she was unresponsive. He stated staff should have notified him immediately when the maintenance vendor did not allow staff on Hall A. He confirmed if a resident had an order for visual checks every 2 hours he expected staff to follow the physician's order and they had not. He stated he preferred for a call light to be responded to by staff between 30 to 45 minutes at most. The facility implemented the following actions to correct the deficient practice: 1. Resident #1 and Resident #3 were identified as having been affected by the alleged deficient practice of not making Q2 visual checks per physician order. All residents had the potential to be affects as the result of the alleged non-compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. a. An in-service was conducted on [DATE] by the Administrator, DON and ADON for all CNA's and LPN's regarding Q2hr visual rounds. The in-service also included if there was anything that would prevent them making Q2hr rounds they should immediately notify the Administrator. To ensure that the staff understood the in-service a questionnaire was initiated on [DATE]. b. Staff unable to be in-serviced on [DATE] and forward will not be permitted to work until they are in-serviced. All new employees will be in-serviced regarding the information listed above during their orientation period. c. A log of each resident arranged by room was reimplemented on [DATE] to document direct observation checks every two hours on each shift. The monitor is broken into 2-hour increments and designated nursing staff are to sign off that the observations have been made. This monitoring will continue 24 hours/day 7 days/week for two weeks and then will be reviewed by the DON/designee. d. On [DATE], the Administrator notified the Vendor that the company employee will not be allowed to perform floor services in the absence of the Administrator. The Administrator will ensure a schedule is set for floor service times that will ensure the vendor reports directly to him at the time of the floor service. e. A QAPI monitor was reimplemented on [DATE] to ensure Q2hr rounds are completed 24hr a day 7 days a week. A nurse will be assigned to complete the Q2hr visual rounds and document the rounds on the QA Monitor. The QA Monitor will be ongoing. f. Effectiveness of the corrective actions will be discussed weekly for 6 weeks at the Quality Assurance and Performance Improvement Meeting with findings added to the QAPI minutes. Additional in-services and/or corrective actions will be implemented as needed. 3. As of [DATE], the facility has resolved the likelihood of serious harm or injury to any resident no longer exists. Throughout the survey from [DATE] to [DATE], observations, interviews, and record review revealed the above listed actions were implemented. Random staff interviews and observations revealed the above education for staff was completed. Observations, interviews, and record review, revealed monitoring had begun as mentioned above in the POR with no further issues identified.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343 Based on video observation, interviews and record review, the facility failed to ensure alleged violations involving neglect were reported to the state agency within 2 hours after the allegations of neglect were made for Resident #1, Resident #3, and all other residents residing all Hall A. Findings: Cross reference: F600 Review of the facility's Abuse/Neglect Prevention Program policy, revised [DATE], revealed the following in part: Each resident has the right to be free from mistreatment, neglect, and misappropriation of property. 9. Neglect: failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. In the event of any evidence involving neglect, an occurrence will be reported immediately to the Administrator or his or her designee of the facility, who will immediately notify corporate office and the appropriate state officials per state guidelines. Review of the facility's Mandated Reporting Flowsheet, revised [DATE], revealed the following in part: Does the incident or allegation involve abuse, with or without serious bodily harm, or neglect, exploitation, injury of unknown source or other reportable incident that results in serious bodily harm (an injury involving extreme physical pain, involving substantial risk of death; requiring medical intervention)? If yes, report immediately to the administrator and to law enforcement as applicable, but not later than 2 hours to the State Survey Agency. Resident #1 Review of the facility's self-reported incident dated [DATE] revealed the following: Events Entered: [DATE] at 9:43 a.m. Occurred and Discovered: [DATE] at 2:45 a.m. Type of injury: Blank Incident description: Initial investigation: The fall of Resident #1 was reported to S2ADM at 4:01 a.m. Developing Issues: While investigating the incident involving the resident, it came to light that a vendor working on the floors may have impeded making rounds every 2 hours. Review of Resident #1's Nurses' Note dated [DATE] revealed the following, in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:42 a.m.: Upon doing rounds aide walked into room and found resident unresponsive on fall mat. Nurse was immediately called to room upon entering room nurse noticed resident on her fall mat in a kneeling position facing the bed. Unable to obtain pulse or blood pressure upon assessment. Initiated CPR immediately. 911 notified. At 2:53 a.m., Coroner's office notified. Signed by: S5LPN. Resident #3 Review of Resident #3's Nurses Note dated [DATE] revealed the following, in part: On [DATE] at 2:53 a.m.: Upon doing rounds aide found Resident #3 lying down on the floor, nurse was immediately called to the room. Signed by: S5LPN. Review of the CNA Daily Assignment Sheet from 10:00 p.m. to 6:00 a.m. dated [DATE] revealed the following, in part: S7CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] S8CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] S6CNA was assigned to care for the residents residing on Hall A Rooms ,d+[DATE] On [DATE] at 2:04 p.m., a review of the facility's video surveillance footage of Hall A, dated [DATE] from 12:00 a.m. until approximately 4:45 a.m., was conducted with S2ADM. Prior to reviewing the footage, S2ADM stated he did not have access to any surveillance footage prior to [DATE] at 12:00 a.m. The surveillance footage revealed from 12:00 a.m. to approximately 2:35 a.m., staff neglected to provide any care and services to any resident's residing on Hall A. At 12:35 a.m., a call light was observed to be on in Hall A, which indicated a resident was calling for assistance. S2ADM confirmed the above review of the facility footage revealed no staff rounded on or provided care to any resident on Hall A from 12:00 a.m., on [DATE] until approximately 2:37 a.m. On [DATE] at 11:58 a.m., an interview was conducted with S6CNA. She stated she worked the 10:00 p.m. to 6:00 a.m. shift on [DATE] and was assigned to provide care for Resident #1 and Resident #3, as well as the residents in Rooms ,d+[DATE] on Hall A. She stated on [DATE], she was not able to provide care to her assigned residents on Hall A from 10:00 p.m. to 2:30 a.m., due to floor maintenance. On [DATE] at 3:29 p.m., an interview was conducted with S5LPN. S5LPN stated she was assigned to provide care for Resident #1, #3, and all of the residents on Hall A on [DATE] and worked the 10:00 p.m. to 6:00 a.m. shift. She stated on the night of [DATE] she did not provide care to her assigned residents on Hall A from 10:00 p.m. until 2:30 a.m. due to floor maintenance. On [DATE] at 10:58 a.m., an interview was conducted with S8CNA. S8CNA stated she worked the 10:00 p. m. to 6:00 a.m., shift on [DATE], and was assigned to Rooms ,d+[DATE] on Hall A. She stated on [DATE], she did not go to any of the resident's rooms or provide care for the residents on Hall A due to floor maintenance from 10:00 p.m. until 2:30 a.m. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:20 p.m., an interview was conducted with S7CNA. She stated she worked the 10:00 p.m. to 6:00 a.m., shift on [DATE], and was assigned to Rooms ,d+[DATE] on Hall A. She stated she did not perform visual checks every two hours or provide care for her assigned residents from 10:00 p.m. until 2:30 a.m. On [DATE] at 4:36 p.m., an interview was conducted with S2ADM. He stated on [DATE] at approximately 4:00 a.m., S5LPN made him aware the floor vendor impeded care by not allowing nursing staff to perform visual checks on residents on Hall A from 10:00 p.m. until approximately 2:30 a.m. He confirmed no residents residing on Hall A received care from 10:00 p.m. through 2:30 a.m. on [DATE]. He confirmed any allegations of neglect should be reported to the State Survey Agency within 2 hours. He confirmed he submitted the incident to the State Survey Agency on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195471	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Manor Nursing and Rehab Ctr, LLC	9919 Jefferson Hwy. Baton Rouge, LA 70809

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343 Based on observations, interviews, and record review the facility failed to ensure residents were assessed for risk of entrapment from bedrails and informed consents were obtained prior to installation of bedrails for 4 (#1, #3, #R1, and #R2) of 4 sampled residents identified for having bedrails in use. This deficient practice had the potential to affect all 51 residents residing in the facility with bedrails in use. Findings: Resident #1 Review of Resident #1's Clinical Record revealed she was readmitted to the facility on [DATE] and had diagnoses, which included Foot Drop of Right and Left Foot, Muscle Weakness (generalized), Muscle Wasting and Atrophy, Primary Generalized Osteoarthritis, Abnormal Posture, Cognitive Communication Deficit, and Need of Assistance for Personal Care. Further review revealed Resident #1 expired on [DATE]. Review of Resident #1's most recent completed Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #1 was dependent on staff assistance with bed mobility and transfers. Review of Resident #1's current Physician Orders revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning every shift. Review of Resident #1's Medication Administration Record (MAR) dated [DATE] revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning every shift. Review of Resident #1's Clinical Record revealed no documentation of Entrapment Risk Assessments for bedrails. Review of Resident #1's Clinical Record revealed no documentation of informed consent for bedrails. An interview was conducted with S5LPN on [DATE] at 3:29 p.m. She stated anytime Resident #1 was in bed, her mobility bars were in a raised position. Resident #3 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Muscle Wasting, Muscle Weakness and Lack of Coordination. Review of Resident #3's quarterly MDS with an ARD of [DATE] revealed she had a Brief Interview of Mental Status (BIMS) of 15, which indicated she was cognitively intact. Further review revealed she required partial to substantial/max assist with bed mobility and transfers. Review of Resident #3's current Physician Orders revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning, every shift. Review of Resident #3's MAR dated [DATE] revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning, every shift. Review of Resident #3's Clinical Record revealed no documentation of Entrapment Risk Assessments for bedrails prior to [DATE]. Review of Resident #3's Clinical Record revealed no documentation of informed consent for bedrails. An observation was made and interview was conducted with Resident #3 on [DATE] at 3:45p.m. Resident #3's bed had two mobility bars, one on each side of the bed, in an upright position. Resident #3 confirmed she had not signed a consent for bedrails when the bedrails were implemented, and she used the bedrails for mobility. Resident #R1 Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Muscle Weakness and Acute Paralytic Poliomyelitis. Review of Resident #R1's quarterly MDS with an ARD of [DATE] revealed he had a BIMS of 15, which indicated he was cognitively intact. Further review revealed he required substantial/max assist with bed mobility. Review of Resident #R1's current Physician Orders revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning, every shift. Review of Resident #R1's MAR dated [DATE] revealed the following, in part: Start date [DATE]: Mobility bars x2 to assist with bed mobility and repositioning, every shift. Review of Resident #R1's Clinical Record revealed no documentation of Entrapment Risk Assessments for bedrails prior to [DATE]. Review of Resident #R1's Clinical Record revealed no documentation of informed consent for bedrails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation was made and interview was conducted with Resident #R1 on [DATE] at 4:15 p.m. Resident #R1's bed had two mobility bars, one on each side of the bed, in an upright position. Resident #R1 confirmed he had not signed a consent for bedrails when the bedrails were implemented, and he used the bedrail for mobility. Resident #R2 Review of Resident #R2's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Repeated Falls, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, and Other Lack of Coordination. Review of Resident #R2's quarterly MDS with an ARD of [DATE] revealed she had a BIMS of 14, which indicated she was cognitively intact. Further review revealed she required substantial/max assist with bed mobility. Review of Resident #R2's current Physician Orders revealed the following, in part: Start date [DATE]: Mobility rails x2 to assist with bed mobility and repositioning, every shift. Review of Resident #R2's MAR dated [DATE] revealed the following, in part: Start date [DATE]: Mobility rails x2 to assist with bed mobility and repositioning, every shift. Review of Resident #R2's Clinical Record revealed no documentation of Entrapment Risk Assessments for bedrails prior to [DATE]. Review of Resident #R2's Clinical Record revealed no documentation of informed consent for bedrails. An observation was made and interview was conducted with Resident #R2 on [DATE] at 3:29 p.m. Resident #R2's bed had two mobility bars, one on each side of the bed, in an upright position. Resident #R2 confirmed she had not signed a consent for bedrails when the bedrails were implemented, and she used the bedrails for mobility. An interview was conducted with S9CRN on [DATE] at 1:35 p.m. She stated she and another staff member completed entrapment risk assessments. She stated the facility does not obtain consents for bed rails prior to installing them if they are not being used as a restraint. She confirmed they had not obtained informed consents for mobility bars prior to installing them, and no entrapment risk evaluations had been completed prior to [DATE]. An interview was conducted with S3DON on [DATE] at 3:01 p.m. She stated no staff was assigned to perform entrapment risk assessments or obtain informed consents for residents who had mobility bars ordered. She stated informed consents were not obtained to indicate Resident's #1, #3, #R1, and R#2 had given consent for the mobility bars. She stated entrapment risk assessments were not conducted for residents with mobility bars prior to [DATE]. She stated she was unaware consents and entrapment risk assessments should be completed prior to installing mobility bars.