STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195489	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviere DE Soleil Community Care Center	7408 Hwy 1 Mansura, LA 71350

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure medications and wound care products were stored in accordance with currently accepted professional principles. The facility failed to ensure:1. Treatment carts were free from expired wound care products and medications; and2. Prescription medication had a pharmacy label and was stored in original packaging.A review of the facility policy titled Storage of Medication, revised [DATE], revealed in part. The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.A review of facility policy titled Labeling of Medication Containers, revised [DATE], revealed in part. All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. 2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. Labels for individual resident medications include all necessary information, such as: a. the resident's name. b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; e. The prescription number (if applicable); f. The date the medication was dispensed; i. directions for use.1.On [DATE] at 12:06 p.m., observation of Cart A with S6 Treatment RN revealed the following:- Ten Petroleum Gauze dressings with expiration date of 08/2024.- Five 6-inch x 6-inch Extra absorbent adhesive pads with an expiration date of [DATE].- One 8-inch x 10-inch Silicone Super Absorbent Dressing with an expiration date of [DATE].- Ten Excel Silicone Superabsorbent dressings with an expiration date of [DATE]. - Eight Excel Silicone Superabsorbent dressings with an expiration date of [DATE].On [DATE] at 12:10 p.m., S6 Treatment RN confirmed the above listed wound care products stocked on Cart A were expired, and should not have been. On [DATE] at 12:15 p.m., observation of Cart B with S6 Treatment RN revealed one 473 ml bottle of Dakin's Solution Half Strength with an expiration date of [DATE]. S6 Treatment RN confirmed that the Dakin's Solution Half Strength stocked on Cart B was expired, and should not have been.2.On [DATE] at 12:50 p.m., observation of Cart C with S7 RN revealed one tube of Diclofenac Sodium Topical Gel 1% without the original product box and pharmacy label. The tube of medication read in part . RX Only, indicating the medication was a prescription, and USE DOSING CARD INSIDE CARTON. S7 RN confirmed that the prescription medication should have been stored in the original packaging for proper storage and dosing, but was not. S7 RN confirmed the prescription medication should have had a pharmacy label, and did not. In an interview on [DATE] at 2:03 p.m., S1 DON confirmed expired items were present on facility treatment and medication carts and should not have been. S1 DON confirmed that the prescription medication Diclofenac Sodium Topical Gel 1% should have been stored in the original product packaging for proper storage and dosing, and was not. S1 DON confirmed that the prescription medication Diclofenac Sodium Topical Gel 1% should have had a pharmacy label, and did not

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received services in the facility with reasonable accommodation of resident needs for 1 (Resident #44) of 4 (Resident #44, Resident #48, Resident #87, and Resident #90) resident's reviewed for accidents. The facility failed to ensure Resident #44 had a call light in reach in order to call for assistance. The total sample size was 41. Findings:Review of the facility's current policy titled Call light/Call Pager Systems with effective date of 09/09/2022 read in part. To provide a means of communication to staff for notification of resident needs and a system of communication of staff in the facility; including emergency notifications. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.Review of Resident #44's medical record revealed an admission date of 04/15/2024. Resident #44 had diagnoses that included in part . Hemiplegia affecting Left Non-dominant Side, Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery, Generalized Muscle Weakness, Unsteadiness on Feet, and Repeated Falls.Review of Resident #44's Quarterly MDS with ARD of 08/13/2025 revealed Resident had a BIMS of 09, indicating moderate cognitive impairment. Resident #44 had upper and lower extremity range of motion impairment on one side. Resident #44 required substantial/maximal assistance from staff for chair/bed to chair transfers.Review of Resident #44's Comprehensive Person Centered Care Plan revealed in part.I am at risk for falls related to hemiplegia affecting left non dominant side and generalized weakness. Interventions: Follow facility fall protocol. I need a safe environment with a working and reachable call light. I will have my call light within reach.Review of Resident #44's Fall Risk Evaluation Report dated 08/12/2025 revealed Resident #44 was determined at risk for falls. Review of Resident #44's Departmental Progress Notes revealed in part.09/07/2025 9:38 a.m. S9 LPN documented in part; Front desk notified this nurse that resident's daughter called and said her mom was on the floor and needed help. Resident was trying to elevate legs in recliner, due to chair being too close to the wall, resident slid out of chair on the floor.09/07/2025 9:40 a.m. S9 LPN documented in part; Post Fall Evaluation- Bedside call light on when Resident was found: No.Interview on 09/08/2025 at 10:35 a.m. with Resident #44 revealed on 09/07/2025 she had a fall when she slipped out of her recliner. Resident #44 stated she did not have her call light by her, so she had to call her daughter from her cellphone to get help off of the floor.Observation on 09/09/2025 at 9:05 a.m. of Resident #44 revealed she was sitting up in her wheelchair that was located in the middle of her room. Resident #44's call light was not within reach of resident and was observed hanging on the wall, on the call light box, on the left side of her bed. Resident #44 stated she could not reach her call light, and that staff forgot to give it to her when they got her out of bed and into her wheelchair this morning.Interview on 09/09/2025 at 9:19 a.m. with S4 LPN confirmed Resident #44 had a fall on 09/07/2025 when she slipped out of her recliner, and no injury had occurred. Observation of Resident #44's room with S4 LPN confirmed resident's call light was not in reach of resident, but should be.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure that residents with an order for psychotropic medication were not subjected to chemical restraints for 1 (#75) of the 5 residents (#4, #5, #12, #38, #75) reviewed for unnecessary medications. The facility failed to:1. Ensure as needed or PRN (pro re nata) orders for a psychotropic medication were limited to 14 days for Resident #75.Findings:Resident #75Review of the facility's policy titled, Psychotropic and Antipsychotic Medications and Non-pharmaceutical Intervention, Revision #5, with an effective date of 01/25, reveals in part under the section heading, PRN Psychotropic Medications.if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.Review of Resident #75's medical record revealed a readmission date of 05/09/2022 with diagnoses that included, in part, Parkinson's Disease with dyskinesia, without mention of fluctuations; Psychotic Disorder with delusions due to known physiological condition; Bipolar Disorder, current episode mixed, severe, with psychotic features; General Anxiety Disorder; Major Depressive Disorder; and Muscle Weakness.Review of Resident #75's current medication orders revealed in part, an order for as needed or PRN Trazodone HCl Oral Tablet 50 MG (milligram) (a medication given to treat major depressive disorder) with directions to Give 1 tablet by mouth every 24 hours as needed for Anxiety/Depression/Insomnia/Paranoia related to psychotic disorder with delusions due to known physiological condition; Bipolar Disorder, Current Episode Mixed, Severe, with Psychotic Features; Major Depressive Disorder, Recurrent, Unspecified Take at bedtime. The order had a start date of 03/25/2025 with no end date indicated.Review of the 05/27/2025 Gradual Dose Reduction initiated by the pharmacist and signed on 06/23/2025 by the physician, revealed the following, in part.7. Trazodone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth every 24 hours as needed for Anxiety/Depression/Insomnia/Paranoia. Take at bedtime. (Please provide a specific duration/stop date)8. (PRN Psychotropic: is limited to 14 days and requires the prescriber to evaluate the resident prior to extending the order; if extending, document the rationale for the extended time period in the medical record and indicate a specific duration).Review of Resident #75's medical record revealed there was no rationale provided for the continuation of the as needed Trazodone by the attending physician or prescribing practitioner to extend the orders past 14 days.On 09/10/2025 at 12:45 p.m., S1 DON was notified about the PRN psychotropic medication for Resident #75, and she confirmed that the PRN psychotropic medication was not limited to 14 days.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to provide respiratory care consistent with professional standards for 2 (Resident #42 and Resident #70) of 3 (Resident #24, Resident #42, and Resident #70) sampled residents reviewed for respiratory care. The facility failed to ensure physician orders were followed for oxygen administration for Residents #42 and #70, and that oxygen equipment was stored appropriately for Resident #70.Findings: Review of the facility's undated policy titled, “Oxygen Administration,” read in part…Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Resident #42 Review of Resident #42's medical record revealed an admit date of 08/23/2024 with a re-entry date of 08/06/2025 with diagnoses that included in part .Heart Failure, Chronic Respiratory Failure with Hypoxia, and Pleural Effusion in Other Conditions. Review of Resident #42's 09/2025 Physician orders revealed the following orders in part .07/14/2025 Oxygen: Oxygen at 2 liters/nasal cannula. Review of Resident #42's Significant Change MDS with an ARD of 08/12/2025 revealed a BIMS summary score of 15 indicating intact cognition. Resident #42 required oxygen therapy. Observation on 09/08/2025 at 10:48 a.m. revealed Resident #42 lying in bed awake and alert with oxygen infusing via nasal cannula. Resident #42 stated he required continuous oxygen at 2liters/minute. Oxygen concentrator observed with oxygen set at 3 liters/minute. Observation on 09/08/2025 at 3:46 p.m., revealed Resident #42 lying in bed asleep wearing a nasal cannula with oxygen infusing at 3 liters/minute via oxygen concentrator. Observation on 09/09/2025 at 8:27 a.m., revealed Resident #42 lying in bed asleep on room air. Nasal cannula observed next to Resident #42. Oxygen concentrator observed on and oxygen infusing at 3 liters/minute. Interview on 09/09/2025 at 8:31 a.m., with S3 LPN revealed Resident #42 wore oxygen continuously and staff made frequent rounds on Resident #42. S3 LPN stated Resident #42 was originally on 3 liters/minute and requested to have his oxygen down to 2 liters/minute. S3 LPN revealed Resident #42 was ordered oxygen at 2liters/minute. S3 LPN stated all staff are required to follow the physician orders for oxygen administration and that Resident #42 should currently be on 2 liters/minute. S3 LPN observed Resident #42's oxygen concentrator and confirmed that the oxygen concentrator was set at 3 liters/minute and should have been on 2 liters/minute. Resident #70 Review of Resident #70's medical record revealed an admission date of 07/24/2020. Resident #70 had diagnoses that included in part… Chronic Respiratory Failure with Hypoxia, and COPD (Chronic Obstructive Pulmonary Disease). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70's Quarterly MDS with ARD of 07/09/2025 revealed the resident had a BIMS of 08, indicating moderate cognitive impairment. Resident #70 was not coded for refusals of care. Resident#70 received oxygen therapy. Review of Resident #70's current 09/2025 physician orders revealed in part… Order date: 07/14/2024: Oxygen every shift at 2L/NC, may remove for bathing and ADL care. Order date: 04/24/2023: Ensure resident has continuous oxygen in place at all times. Every 4 hours for low oxygen saturation. Order Date: 04/09/2025: Respiratory Therapy 7 days a week, 2 times a day for 15 minutes. Review of Resident #70's Comprehensive Person Centered Care Plan revealed in part… I am currently receiving respiratory therapy services related to diagnoses of: COPD, Chronic Respiratory Failure with Hypoxia, and Pneumonia. Interventions: Oxygen Settings: Administer Oxygen as ordered by the MD. I am high risk for falls related to history of falls, poor balance, increased weakness, and diagnosis of dementia. Interventions: Nurse to ensure oxygen is in place while resident is in bed. Nurses are educated to ensure resident has continuous oxygen in place at all times due to increased confusion from oxygen deprivation. Observation on 09/08/2025 at 10:42 a.m. of Resident #70 revealed her nasal cannula oxygen tubing was lying uncovered and draped over the first drawer of her nightstand beside her bed. Resident #70 was observed sitting up in her recliner without oxygen therapy being administered. Resident #70 stated she always wore oxygen, and did not know why staff did not give her oxygen back to her when they assisted her out of her bed to her chair this morning. Observation on 09/08/2025 at 3:50 p.m. revealed Resident #70 remained out of bed, sitting in her recliner without oxygen therapy being administered as ordered. Resident #70's nasal cannula oxygen tubing remained uncovered, draped over the first drawer of her nightstand. Interview on 09/08/2025 at 3:57 p.m. with S9 LPN confirmed Resident #70 should be wearing oxygen at 2L per nasal cannula continuously, and if not in use the oxygen tubing should have been stored covered within a bag, but was not. Observation on 09/09/2025 at 9:11 a.m. of Resident #70 revealed she was without oxygen therapy as ordered, and the oxygen tubing was laid uncovered draped over the top of her oxygen concentrator machine. Observation on 09/09/2025 at 4:15 p.m. of Resident #70 revealed she was without oxygen therapy as ordered, and the oxygen tubing was laid uncovered draped over the top of her oxygen concentrator machine. Observation on 09/10/2025 at 8:35 a.m. of Resident #70 revealed she was without oxygen therapy as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/10/2025 at 8:40 a.m. with S3 LPN confirmed Resident #70 was without oxygen therapy as ordered, and confirmed according to physician orders, Resident #70 was to wear oxygen continuously.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. .Based on record review, observation, and interview, the facility failed to ensure an infection prevention and control program was maintained to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections. During a COVID outbreak, the facility failed to ensure:1. Staff performed hand hygiene between residents while preparing and serving lunch trays to residents; and2. Staff donned PPE appropriately while preparing and serving lunch trays to residents.This deficient practice had the potential to affect all 12 residents who resided in Neighborhood X.Findings:On 09/10/2025, a review of the facility's policy titled Infection Control Interim Policy for Coronavirus dated 02/21/2025 revealed in part.Source control options for HCP (health care professional) include.a well-fitting facemask.On 09/10/2025, a review of the facility's policy titled Handwashing/Hand Hygiene revised 08/2015 revealed in part.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.7. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: o. before and after eating or handling food; p. before and after assisting a resident with meals. In an interview on 09/10/2025 at 10:35 a.m., S3 LPN confirmed there were 7 positive cases of COVID at this time in Neighborhood X. Observation in Neighborhood X on 09/10/2025 at 11:30 a.m., revealed S8 CNA wearing a surgical mask covering her mouth and chin, but not covering her nose. S8 CNA filled a glass with water, covered it with plastic wrap, placed the glass on a lunch tray, and then carried the tray to the door of a resident's room. S8 CNA passed the tray to another CNA in the resident's room. S8 CNA then returned to the kitchen counter and repeated these steps twice more without washing or sanitizing her hands. At 11:35 a.m., S8 CNA entered a resident's room. Upon exiting the room, S8 CNA returned to the kitchen counter, without washing or sanitizing her hands. S8 CNA removed plastic wrap from the box and covered the drink for the next resident's lunch tray. S8 CNA then touched the kitchen counter, put her hands in her pockets, then prepared and served lunch trays without sanitizing her hands. In an interview on 09/10/2025 at 11:36 a.m., S8 CNA confirmed her mask was not covering her nose and stated I chew gum so my mask falls down a lot. S8 CNA confirmed she prepped the glasses of water and delivered multiple lunch trays without gelling or washing her hands between trays. S8 CNA stated it gets crazy and I forgot. S8 CNA confirmed she should have sanitized her hands. In an interview on 09/10/2025 at 11:43 a.m., S2 LPN confirmed she was the facility's Infection Preventionist. S2 LPN was notified of the lunch observations on Neighborhood X. S2 LPN acknowledged S8 CNA was not wearing her mask properly and not performing hand hygiene between resident trays, but should have.