STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195496	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseview Nursing and Rehabilitation Center	3405 Mansfield Road Shreveport, LA 71103

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure a resident was free from neglect during ADL (activities of daily living) care. The facility failed to ensure S4 CNA (Certified Nursing Assistant) asked for assistance for a two person assist before providing incontinence care which resulted in a fall with injuries for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed for neglect.The deficient practice resulted in an immediate jeopardy for Resident #1 on 07/25/2025 at approximately 10:30 a.m. when Resident #1 fell out of the right side of the bed during incontinent care when S4 CNA (Certified Nursing Assistant) failed to ensure a two person assist was used during incontinent care to prevent Resident #1 from falling out of the bed. S4 CNA did not ask for assistance before providing ADL care and Resident #1 fell from the bed resulting in multiple injuries. Resident #1 was sent to a local hospital on [DATE] at 10:47 a.m. via stretcher and was admitted due to his injuries. Review of the hospital records dated 07/25/2025 revealed Resident #1 was diagnosed to have a questionable non-displaced fracture to the right maxillary wall, non-displaced right posterior 12th rib fracture, and a remote T(thoracic)5 vertebral body compression fracture.The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation.Findings:Abuse and Neglect Policy with a revision date of 04/02/2025.Purpose: The purpose of the Abuse/Neglect policy is to comply with the seven - step approach to abuse and neglect detection and prevention:1). Screening 2.) Training 3.) Prevention 4.) Identification 5). Investigation 6.) Protection 7.) Reporting and ResponsePolicy: It is the policy of the facility that each resident will be free from abuse. This facility will not condone any form of resident abuse or neglect. Each resident residing in this facility has the right to be free from verbal, sexual, mental and physical abuse, including .Each resident has the right to be free from mistreatment, neglect, and misappropriation of property.Definition: Abuse and neglect exist in many forms and to varying degrees. G. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.I. Serious Bodily Injury: The term serious bodily injury is defined as any injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. Review of Resident #1's medical record revealed an initial admission date of 03/27/2024 with diagnoses, which included in part, ataxia following other non-traumatic intracranial hemorrhage, essential tremor, muscle wasting and atrophy of left lower leg and right lower leg, weakness, contracture of muscle, multiple sites and aphasia. Review of Resident #1's Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated BIMS (Brief Interview of Mental Status) could not be completed due to resident was rarely/never understood. Further review of the Quarterly MDS assessment revealed Resident #1 had upper and lower extremity impairments to both sides, dependent with eating, oral hygiene, toileting hygiene, and shower/bathe self. Resident #1 was dependent for mobility in rolling left and right. Resident #1 was always incontinent of bowel and bladder and dependent on staff for ADL care. Further review revealed Resident #1 did not return to the facility after his hospitalization on 07/25/2025. Review of Resident #1's comprehensive care plan revealed in part, Resident #1 was at high risk for fall related to neurocognitive disorder and required total care with bedbound status. Further review of the comprehensive care plan revealed Resident #1 had an ADL deficit and required two person assist with all ADLs and transfers.Review of the facility's Incident Log for the past 3 months revealed Resident #1 had a witnessed fall on 07/25/2025.Review of S4 CNAs signed witness statement (undated) revealed: I went to Resident #1's room to check and see was he wet. He was soaked in pee and bowel movement. I looked on the hall to see if there were available aides. I didn't see any so I decided to change Resident #1. His bed was soaked with urine so I had to change, I grabbed my linen to put on his bed. I turned him and put the linen on the bed. I grabbed my pamper and pad. Resident #1 moved a little and hit the floor. I didn't have any time to catch him.Review of Resident #1's nurse's notes dated 07/25/2025 at 11:44 a.m. revealed S3 LPN (Licensed Practical Nurse) was called to Resident #1's room. Upon entering the room, Resident #1 was lying flat and face first on the floor to the right side of the bed between the air unit and bed. S3 LPN was informed by S4 CNA that while she was performing incontinent care and went to turn Resident #1, Resident #1 rolled off the bed to the floor. Redness was noted to the left cheek, left side of forehead, right cheek, right upper back, both knees, right lower leg and back of head. The ambulance was

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow a resident's plan of care for 1 (#1) of 3 (#1, #2, #3) sampled residents. Findings:Review of Resident #1's medical record revealed an initial admission date of 03/27/2024 with diagnoses, which included in part, ataxia following other non-traumatic intracranial hemorrhage, essential tremor, muscle wasting and atrophy of left lower leg and right lower leg, weakness, contracture of muscle, multiple sites and aphasia. Review of Resident #1's Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated BIMS (Brief Interview of Mental Status) could not be completed due to resident was rarely/never understood. Further review of the Quarterly MDS assessment revealed Resident #1 had upper and lower extremity impairments to both sides, dependent with eating, oral hygiene, toileting hygiene, and shower/bathe self. Resident #1 was dependent for mobility in rolling left and right. Resident #1 was always incontinent of bowel and bladder and dependent on staff for ADL (Activities of Daily Living) care. Review of Resident #1's comprehensive care plan revealed in part, Resident #1 was at high risk for fall related to neurocognitive disorder and required total care with bedbound status. Further review of the comprehensive care plan revealed Resident #1 had an ADL deficit and required two person assist with all ADLs and transfers.Review of S4 CNAs (Certified Nursing Assistant) signed witness statement (undated) revealed: I went to Resident #1's room to check and see was he wet. He was soaked in pee and bowel movement. I looked on the hall to see if there were available aides. I didn't see any so I decided to change Resident #1. His bed was soaked with urine so I had to change, I grabbed my linen to put on his bed. I turned him and put the linen on the bed. I grabbed my pamper and pad. Resident #1 moved a little and hit the floor. I didn't have any time to catch him.Review of Resident #1's nurse's notes dated 07/25/2025 at 11:44 a.m. revealed S3 LPN (Licensed Practical Nurse) was called to Resident #1's room. Upon entering the room, Resident #1 was lying flat and face first on the floor to the right side of the bed between the air unit and bed. S3 LPN was informed by S4 CNA that while she was performing incontinent care and went to turn Resident #1, Resident #1 rolled off the bed to the floor. During an interview on 08/13/2025 at 1:20 p.m. S5 CNA Supervisor reported S4 CNA had experience working with Resident #1 and knew Resident #1 was a two person assist with all ADL care and should have asked for assistance before providing ADL care to Resident #1. During an interview on 08/12/2025 at 11:18 a.m. S2 DON (Director of Nursing) confirmed there was a sign above Resident #1's bed notifying staff Resident #1 was a two person assist with all ADLs. S2 DON confirmed S4 CNA did not follow the wall care plan on 07/25/2025 and use one person assist and should have used two person assist during ADL care for Resident #1.