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	02/24/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide adequate supervision to prevent accidents and ensure the residents' environment remained free of hazards for 1 (#1) of 4 sampled residents reviewed for facility transportation. The facility failed to:1. Ensure Resident #1 was properly secured with shoulder and lap belt in the facility van,2. Ensure Resident #1 was assessed following a fall on the van, and3. Ensure Resident #1's fall was promptly reported and documented.Findings:Review of Facility's Policy and Procedures, in part revealed:Accident/Incident Reports (undated): Policy: When an accident or incident involving a resident occurs, any witnessing staff will offer immediate assistance. An accident/incident report and the appropriate documentation will be completed by the end of the shift. Questions about what constitutes an accident/incident should be immediately directed to the DON or the shift supervisor. Purpose: To assure appropriate follow-through on all accidents/incidents. To study the cause of accidents and incidents and to give guidance for corrective/preventative action. Procedure: 1. Do not move the resident until a licensed nurse evaluates the resident's condition. 2. Notify the nurse in charge. 3. Licensed Nurse - Administer any necessary first aid .Complete a thorough head to toe assessment of the resident for possible injury, including range of motion. 7. Notify the resident's physician - receive orders for follow-through. 9. Complete an accident/incident report. 10. Note the location and the time of the incident, the names of the witnesses, and the exact circumstances of the incident. 11. Obtain a descriptive statement of incident from the resident involved.Falls (undated): Procedure: 1. Resident will not be moved until a licensed nurse evaluates and has ascertained resident's condition. 2. Notify the nurse in charge. 5. Notify physician for further orders. Follow nursing interventions if required. 8. Fill out incident/accident form.Review of Resident #1's medical records an revealed an admit date of 09/13/2019 with the following diagnoses including in part: type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified glaucoma, acquired absence of left leg below the knee, acquired absence of right leg below the knee and muscle wasting and atrophy not elsewhere classified.Review of Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 15 indicating cognitively intact. Further review revealed impairment on both sides of lower extremities and device used is a wheelchair, Review of Resident #1's comprehensive care plan revealed high risk for falls related to bilateral amputee and wheelchair bound.Review of facility's incident log for the past 4 months failed to reveal an incident dated 01/08/2026 for Resident #1.Review of Resident #1's S7NP notes dated 01/23/2026 revealed in part: .He reports during transport he was not buckled properly and driver had to hit the brakes, and he came out of his secured seat .S7NP discussed transportation incident with S2DON who S4Complainant reported they were aware of the incident, as well as administration . NP was not made aware .During a telephone interview on 02/23/2026 at 11:25 a.m. S4Complainant reported on 01/08/2026 as she rode in the facility transport van with (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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NAME OF PROVIDER OR SUPPLIER Roseview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3405 Mansfield Road Shreveport, LA 71103	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1, S3CNA/Van Driver was speeding and slammed on the brakes causing Resident #1 to fly out of his wheelchair. S4Complainant further reported Resident #1 was initially facing forward in his wheelchair and once he flew out he was on the floor facing the back of the van. S4Complainant reported S3CNA/Van Driver pulled over, they opened the back of the van, used the ramp to get Resident #1 back in his wheelchair which took about 30 minutes and then took him to the doctor's appointment. S4Complainant further reported the chest strap was not in place placed during Resident #1's transport. S4Complainant reported upon arrival back to the facility S3CNA/Van Driver told S1Administrator and S2DON what happened. S4Complainant reported once Resident #1 returned to the facility he was not assessed and had bruises on his nubs.During an interview on 02/23/2026 at 12:45 p.m. S8LPN reported she was not informed Resident #1 had fallen on the van and therefore, an assessment was not completed.During an interview on 02/23/2026 at 1:50 p.m. S5CNA reported on 01/08/2026 she accompanied Resident #1 when he fell on the van. S5CNA further reported after Resident #1's wheelchair was secured, she turned around and noticed his chest strap wasn't on and then S3CNA/Van Driver slammed on the brakes and Resident #1 came out of his wheelchair and fell on the floor. S5CNA reported S3CNA/Van Driver pulled the van over and got him back in his wheelchair. S5CNA further reported the incident should have been reported and S3CNA/Van Driver said she was going to report the incident.During an interview on 02/23/2026 at 3:00 p.m. S3CNA/Van Driver reported on 01/08/2026 Resident #1 fell while being transported to an appointment. Resident #1's wheelchair was buckled down on the bottom in the front and back but the chest strap was not placed across him. S3CNA/Van Driver further reported they were coming to a light, she put on the brakes and the next thing she knew Resident #1 was on the floor sitting on his butt. S3CNA/Van Driver reported it is the van driver's responsibility to strap the resident in and the CNA goes behind and checks. S3CNA/Van Driver reported after Resident #1 fell she pulled over and they put him back in his wheelchair. S3CNA/Van Driver reported once they returned to the facility S2DON and S1Administrator were notified. S3CNA/Van Driver acknowledged she did not call the fall in to the facility when it happened and should have.During an interview on 02/24/2026 at 8:20 a.m. S6Corporate Nurse reported S3CNA/Van Driver should have pulled over, called the facility so the nurse could go and assess Resident #1 before moving him and proceeding to the appointment. S6Corporate Nurse confirmed the facility should have documented the incident.During an interview on 02/24/2026 at 8:35 a.m. S2DON reported on 01/08/2026 S3CNA/Van Driver returned from dropping off Resident #1 for an appointment and reported there was an incident on the van. S2DON further reported S3CNA/Van Driver indicated Resident #1 was taken to his appointment. S2 DON further reported S3CNA/Van Driver told her she was stopping at a red light and Resident #1 slid out of the wheelchair. S2DON indicated S3CNA/Van Driver reported the chest strap and a lap safety belt that hook into each other was not on Resident #1 when he fell out of the wheelchair. S2DON further reported S3CNA/Van Driver should have pulled over, called the facility so Resident #1 could be assessed for injuries before moving him. S2DON acknowledged an incident report should have written and was not. S2DON further acknowledged Resident #1's nurse was not notified the day of the incident and should have been.During an interview on 02/24/2026 at 12:30 p.m. S2 DON reported the van driver was responsible for securing a resident and resident's wheelchair in the van for transport.During an interview on 02/24/2026 at 1:30 p.m. Resident #1 reported on 01/08/2026 he was being transported to the eye doctor by S3CNA/Van Driver and S5CNA and S4Complainant were also on the van. Resident #1 further reported the back and front straps were placed on the wheelchair but when they started to put on the chest strap across his chest it didn't work. Resident #1 reported they didn't tell anyone the strap was not working and left to go to doctor's office anyway with no chest strap in place. S3CNA/Van Driver was driving and stepped hard on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the brakes causing Resident #1 to fall forward and onto the floor. S3CNA/Van Driver pulled over and S3CNA/Van Driver, S5CNA and S4Complainant tried to help him up but he was too heavy so they took his wheelchair out of the van and lined it up on the ramp so he could scoot into wheelchair. Resident #1 reported once settled in his wheelchair S5CNA and S4Complainant realized the chest strap didn't work because it was not snapped in and attached. Resident #1 further reported they proceeded to the appointment without the strap across his chest or lap. Resident #1 reported once he returned to the facility no one came to check on him and ask if he was okay.During an interview on 02/24/2026 at 3:05 p.m. S1Administrator reported S3CNA/Van Driver reported on 01/08/2026 Resident #1 slid out of his wheelchair on the van and he crawled back into his wheelchair. S1Administrator further reported he looked at the van and was informed the staff did not use the strap across the chest and should have. S1Administrator acknowledged an incident report should have be written.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, the facility failed to ensure the daily van safety checklist was accurately documented for 1 (#1) of 3 (#1, #2, #3) residents reviewed for transport. Findings:Review of facility's daily van safety checklist revealed, in part: Must be used for every transport - whether leaving the facility or returning to facility. Was shoulder and lap seat belt secured correctly on the resident? Were seatbelts and wheelchair straps re-checked after initial strapping? Report any unsafe condition to the Administrator (i.e. equipment failure, van maintenance issue, etc.) If No, corrective action.Review of facility's daily van checklist dated 01/08/2026 revealed S3CNA/Van Driver transported Resident #1 and all questions answered yes (Was shoulder and lap seat belt secured correctly on the resident?), Unsafe conditions NA.During an interview on 02/24/2026 at 3:05 p.m. S1Administrator reported staff on the van did not use the strap across the chest of Resident #1 during transport on 01/08/2026 and should have. While reviewing the daily van safety checklist, S1Administrator confirmed S3CNA/Van Driver's documentation was inaccurate. Further review revealed the shoulder and lap belt was documented as secured and was not contributing to the incident on 01/08/2026.During an interview on 02/24/2026 at 3:25 p.m. S3CNA/Van Driver reported the daily van safety checklist dated 01/08/2026 should have been checked no for the question: was shoulder and lap seat belt secured correctly on resident? at the time of Resident #1's transport in the van.