

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	

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)
<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to provide services that met professional standards for 1 (#1) of 3 (#1, #2 and #3) sample residents reviewed for impaired cognition and at risk of elopement. S3LPN (licensed practical nurse) failed to implement elopement precautions for Resident #1 when the admission elopement screening completed by S3LPN indicated Resident #1 was at high risk of elopement. The deficient practice resulted in an Immediate Jeopardy on 06/06/2025 at approximately 5:55 p.m. when Resident #1, a severely cognitively impaired resident who was ambulatory, was unsupervised and eloped from the facility. Resident #1 was found to be an elopement risk upon admission to the facility on [DATE] when S3LPN (licensed practical nurse) completed an elopement risk assessment. S3LPN failed to implement elopement precautions for Resident #1 including notifying the physician and responsible party, placement of a wander guard, and updating the care plan to reflect Resident #1 was an elopement risk. Resident #1 exited through the front door of the facility after following visitors out the door. At 8:09 p.m. police found Resident #1 approximately 2 miles from the facility and returned her to the facility. Resident #1 crossed a four lane divided highway to get to where she was located. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Non-Compliance citation. Findings: Review of the facility's Elopement/Wandering - Residents at Risk policy with latest review date 01/2023 revealed in part: Purpose is to identify residents who are incapable of adequately protecting themselves when they leave the premises without necessary supervision to do so. To implement the appropriate protective measures to help guard against a resident wandering/elopement from the facility. Review of Resident #1's records revealed an admit date of 05/28/2025 with diagnoses including but not limited to vascular dementia, spinal stenosis, lumbar region without neurogenic claudication, muscle weakness, depression, unspecified pain, restlessness and agitation. Review of Resident #1's Internal Medicine History and Physical dated 06/03/2025 revealed an (HPI) history of present illness of worsening dementia unable to care for self. Review of Resident #1's admission MDS (Minimum Data Set) assessment reference date 06/09/2025 revealed in part, Resident #1 had a BIMS (Brief Interview Mental Status) score 07 indicating severe cognitive impairment, wandering behavior, antipsychotic and antidepressant medications. Review of resident #1's Admission/readmission Nursing Screening dated 05/28/2025 completed by S3LPN revealed Resident #1 was at risk for elopement. Further review revealed elopement precautions to be implemented included physician notified of risk of elopement, resident representative notified of risk of elopement, care plan in place for at risk for elopement, security bracelet in place. Review of Resident #1's record failed to reveal S3LPN implemented elopement precautions as indicated in the screening. Review of Resident #1's progress noted dated 06/06/2025 at 9:20 p.m. S3LPN documented Resident #1's daughter came to the facility around 6:05 p.m. and writer told her that her mom was in her room waiting for her. Resident #1's daughter came back to nurse's station and stated Resident wasn't in the room or her bathroom. Writer went down hall and had south CNA's check every room and code (W) announcement was made for staff to do head count and then we checked all rooms. Resident #1 was not in building DON, Administrator and other staff members were called immediately. Staff started to search outside in the parking lots in parked vehicles, some employees got in their vehicles and drove around the neighborhood, others checked in the new building and surrounding areas. Police notified at approximately 6:51 p.m. Resident #1 was found by the police at 8:09 p.m. Resident #1 was accompanied by her family daughter, son-in-law, police and administrative staff. During an interview on 06/17/2025 at 2:40 p.m. S5CNA (certified nursing assistant) reported she had last seen Resident #1 around 5:30 p.m. when she escorted her to her room. During an interview on 06/17/2025 at 10:00 a.m. S2DON (director of nursing) reported the Elopement admission screening was completed by S3LPN. S2DON reported she had talked to S3LPN and asked her why she did not inform her Resident #1 was a high risk for elopement. S2DON reported S3LPN reported she did not think Resident #1 was at risk for elopement at the time of admission to the facility. During an interview on 06/17/2025 at 2:15 p.m. S2DON reported the admission Elopement Screenings can be completed by the floor nurses or the MDS Nurse. S2DON reported all nurses had been in-serviced on completing the elopement screenings correctly and steps to take if a resident was found at a high risk for elopement which included to notify the resident's physician, get an order to place a wander guard on the resident, and then notify her. S2DON reported the root cause of Resident #1's elopement was S3LPN not implementing the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Validation of Past Noncompliance:</p> <p>The facility corrective actions were confirmed through onsite interviews, observations and record reviews.</p> <p>Review of the facility's documentation of drills regarding missing residents, Code (W) Drills, revealed drills were done on 06/06/2025, 06/07/2025, and 06/10/2025.</p> <p>Review of the in-service sign in records on elopement policy, recognizing elopement risks and wandering behaviors, and conducting regular checks and assessments dated 06/06/2025 and 06/07/2025 revealed attendance of all the facility's staff including Housekeeping, LPNs, CNAs, Dietary, Laundry, Drivers, [NAME] Clerk, RN (registered nurse), Baylor Program Nurses, [NAME] help, and Activities.</p> <p>Review of the facility's Elopement Policy Quiz revealed every employee was quizzed on elopement after the in-services.</p> <p>Reviewed the nursing in-service from 06/07/2025 on the implementation of the Elopement Risk Screening and steps to take if a resident was found to be a high risk for elopement was attended by all nurses.</p> <p>Observation on 06/16/2025 at 8:00 a.m. revealed on surveyor's arrival to the facility a sign posted on the front door entrance that stated do not hold the door open for anyone unless they are with you. Further observation revealed the front doors were locked and staff had to wait and use a code to let anyone in or out of the facility.</p> <p>Observation on 06/16/2025 at 2:30 p.m. revealed Resident #1 was in therapy with a wander guard secured on her left ankle.</p> <p>Observation on 06/17/2025 at 9:30 a.m. revealed Resident #1 moving about in her room. She was clean and neatly dressed, the room was clean and not cluttered. The wander guard was secure on her left ankle.</p> <p>During an interview on 06/17/2025 at 12:00 p.m. S7Maintenance reported he checked the wander guard system and facility doors the night after the elopement and no repairs were needed. He further reported he checked the wander guard system weekly to ensure proper functioning.</p> <p>During an interview on 06/17/2025 at 12:10 p.m. S10CNA reported she had the elopement training when she was hired and again since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:20 p.m. S8CNA reported she had been trained on the facility's elopement policy when she was hired and again recently since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:30 p.m. S9CNA reported she had the elopement training when she was hired and had the training again since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:40 p.m. S5CNA reported she had elopement training when she was hired and had it again right after Resident #1 eloped.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 06/17/2025 at 2:40 p.m. revealed an elopement drill done by the facility. S5CNA, S8CNA and S9CNA were on the south hall one at each exit door. An overhead announcement was made for a CODE (W) and to do a head count of all the residents.</p> <p>During an interview on 06/17/2025 at 3:10 p.m. S3LPN reported she had been re-trained on the facility's elopement policy and the admission elopement screening including when to implement the elopement precautions.</p> <p>Review of the facility's records for the five residents with wander guards revealed the elopement assessment had been completed during admission and they had been re-assessed since Resident #1's elopement and they were completed correctly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility administration failed to have an adequate system in place to ensure adequate supervision for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed for impaired cognition and at risk of elopement. The deficient practice resulted in an Immediate Jeopardy on 06/06/2025 at approximately 5:55 p.m. when Resident #1, a severely cognitively impaired resident who was ambulatory, was unsupervised and eloped from the facility. Resident #1 was found to be an elopement risk upon admission to the facility on [DATE] when S3LPN (licensed practical nurse) completed an elopement risk assessment. S3LPN failed to implement elopement precautions for Resident #1 including notifying the physician and responsible party, placement of a wander guard, and updating the care plan to reflect Resident #1 was an elopement risk. Resident #1 exited through the front door of the facility after following visitors out the door. At 8:09 p.m. police found Resident #1 approximately 2 miles from the facility and returned her to the facility. Resident #1 crossed a four lane divided highway to get to where she was located. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be Past Noncompliance citation. Findings: Review of the facility's Elopement/Wandering - Residents at Risk policy with latest review date 01/2023 revealed in part: Purpose is to identify residents who are incapable of adequately protecting themselves when they leave the premises without necessary supervision to do so. To implement the appropriate protective measures to help guard against a resident wandering/elopement from the facility. Review of Resident #1's records revealed an admit date of 05/28/2025 with diagnoses including but not limited to vascular dementia, muscle weakness, depression, unspecified pain, restlessness and agitation. Review of Resident #1's Internal Medicine History and Physical dated 06/03/2025 revealed an (HPI) history of present illness of worsening dementia unable to care for self. Review of Resident #1's admission MDS (Minimum Data Set) assessment reference date 06/09/2025 revealed in part, Resident #1 had a BIMS (Brief Interview Mental Status) score 07 indicating severe cognitive impairment, wandering behavior, antipsychotic and antidepressant medications. Review of Resident #1's Baseline Care Plan and Summary dated 05/28/2025 revealed in part: A problem of cognitive loss. Interventions was orient as needed to person, place and time. Introduce self. Approach in a calm manner. Explain what you intend to do while providing care. Observe for non-verbal cues. Review of resident #1's Admission/readmission Nursing Screening date 05/28/2025 completed by S3LPN (licensed practical nurse) revealed Resident #1 was at risk for elopement. Further review revealed elopement precautions to be implemented included physician notified of risk of elopement, resident representative notified of risk of elopement, care plan in place for at risk for elopement, security bracelet in place. Review of Resident #1's record failed to reveal S3LPN implemented elopement precautions as indicated in the screening. Review of Resident #1's progress noted dated 06/06/2025 at 9:20 p.m. S3LPN documented Resident #1's daughter came to the facility around 6:05 p.m. and writer told her that her mom was in her room waiting for her. Resident #1's daughter came back to nurse's station and stated Resident wasn't in the room or her bathroom. Writer went down hall and had south CNA's check every room and code (W) announcement was made for staff to do head count and then we checked all rooms. Resident #1 was not in building DON, Administrator and other staff members were called immediately. Staff started to search outside in the parking lots in parked vehicles, some employees got in their vehicles and drove around the neighborhood, others checked in the new building and surrounding areas. Police notified at approximately 6:51 p.m. Resident #1 was found by the police at 8:09 p.m. Resident #1 was accompanied by her family daughter, son-in-law, police and administrative staff. During an interview on 06/17/2025 at 2:40 p.m. S5CNA (certified nursing assistant) reported she had last seen Resident #1 around 5:30 p.m. when she escorted her to her room. During an interview on 06/17/2025 at 10:00 a.m. S2DON (director of nursing) reported the Elopement admission Screening was completed by S3LPN. S2DON reported when she was notified of Resident #1's elopement she immediately went to the facility. S2DON reported when she arrived to the facility's parking lot she called the police and the police reported they were on the phone with Resident #1's daughter. S2DON reported she talked to S3LPN and asked her why she did not inform her Resident #1 was a high risk for elopement. S2DON reported S3LPN responded she did not think Resident #1 was at risk for elopement at the time of admission to the facility. During an interview on 06/17/2025 at 10:15 a.m. Resident #1's daughter reported she arrived at the facility around 6:05 p.m. on 06/06/2025. Resident #1's daughter reported when</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Validation of Past Noncompliance:</p> <p>The facility corrective actions were confirmed through onsite interviews, observations and record reviews.</p> <p>Review of the facility's documentation of drills regarding missing residents, Code (W) Drills, revealed drills were done on 06/06/2025, 06/07/2025, and 06/10/2025.</p> <p>Review of the in-service sign in records on elopement policy, recognizing elopement risks and wandering behaviors, and conducting regular checks and assessments dated 06/06/2025 and 06/07/2025 revealed attendance of all the facility's staff including Housekeeping, LPNs, CNAs, Dietary, Laundry, Drivers, [NAME] Clerk, RN (registered nurse), Baylor Program Nurses, [NAME] help, and Activities.</p> <p>Review of the facility's Elopement Policy Quiz revealed every employee was quizzed on elopement after the in-services.</p> <p>Reviewed the nursing in-service from 06/07/2025 on the implementation of the Elopement Risk Screening and steps to take if a resident was found to be a high risk for elopement was attended by all nurses.</p> <p>Observation on 06/16/2025 at 8:00 a.m. revealed on surveyor's arrival to the facility a sign posted on the front door entrance that stated do not hold the door open for anyone unless they are with you. Further observation revealed the front doors were locked and staff had to wait and use a code to let anyone in or out of the facility.</p> <p>Observation on 06/16/2025 at 2:30 p.m. revealed Resident #1 was in therapy with a wander guard secured on her left ankle.</p> <p>Observation on 06/17/2025 at 9:30 a.m. revealed Resident #1 moving about in her room. She was clean and neatly dressed, the room was clean and not cluttered. The wander guard was secure on her left ankle.</p> <p>During an interview on 06/17/2025 at 12:00 p.m. S7Maintenance reported he checked the wander guard system and facility doors the night after the elopement and no repairs were needed. He further reported he checked the wander guard system weekly to ensure proper functioning.</p> <p>During an interview on 06/17/2025 at 12:10 p.m. S10CNA reported she had the elopement training when she was hired and again since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:20 p.m. S8CNA reported she had been trained on the facility's elopement policy when she was hired and again recently since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:30 p.m. S9CNA reported she had the elopement training when she was hired and had the training again since Resident #1 eloped.</p> <p>During an interview on 06/17/2025 at 2:40 p.m. S5CNA reported she had elopement training when she was hired and had it again right after Resident #1 eloped.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Riverview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4820 Medical Drive Bossier City, LA 71112	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 06/17/2025 at 2:40 p.m. revealed an elopement drill done by the facility. S5CNA, S8CNA and S9CNA were on the south hall one at each exit door. An overhead announcement was made for a CODE (W) and to do a head count of all the residents.</p> <p>During an interview on 06/17/2025 at 3:10 p.m. S3LPN reported she had been re-trained on the facility's elopement policy and the admission elopement screening including when to implement the elopement precautions.</p> <p>Review of the facility's records for the five residents with wander guards revealed the elopement assessment had been completed during admission and they had been re-assessed since Resident #1's elopement and they were completed correctly.</p>		