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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 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Care Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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 ensure a resident received adequate assistance to prevent accidents for 1 (#1) of 3 residents reviewed for transfers by failing to follow Resident #1's plan of care. The deficient practice resulted in actual harm for Resident #1 on 04/08/2026 when Resident #1 was transferred from a wheelchair to a bed without utilization of a mechanical lift. Resident #1's care plan indicated she was totally dependent in transferring with the use of a mechanical lift and two person assist. S4CNA reported Resident #1, sitting in her wheelchair, wrapped her arms around CNA's waist area, S4CNA put her arms under Resident #1's arms, lifted Resident #1 and transferred Resident #1 to her bed. S4CNA and S3LPN reported during the transfer, Resident #1's arms popped and Resident #1 complained of pain. Resident #1 was transferred to a local hospital related to bilateral arm pain. Review of Resident #1's hospital record revealed in part, Resident #1 was admitted with acute left clavicle fracture and acute right humerus 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:Review of Resident #1's facility medical record revealed an admit date of 05/01/2025 with diagnoses including, but not limited to, end stage renal disease with dependency on renal dialysis, other specified disorders of bone density and structure, chronic pain, and osteoarthritis.Further review of Resident #1's facility medical record revealed Resident #1 was transferred to local hospital on [DATE] and had not returned to the facility. Review of Resident #1's annual MDS assessment with ARD of 04/08/2026 revealed in part, Resident #1 had a BIMS score of 15 indicating intact cognition. Further review of Resident #1's MDS dated [DATE] revealed Resident #1 was totally dependent with chair/bed transfers. Review of Resident #1's quarterly MDS assessment with ARD of 01/14/2026 revealed in part, Resident #1 had a BIMS score of 15 indicating intact cognition and was totally dependent with chair/bed transfers. Review of Resident #1's care plan initiated 05/01/2025 revealed in part, Resident #1 was totally dependent in transferring with the use of a mechanical lift and two person assist. Review of Resident #1's progress notes dated 04/08/2026, revealed in part, Resident #1 was receiving staff assist with changing of clothes, an audible pop was heard by staff from Resident #1's right and left shoulder, and Resident #1 complained of pain. Further review of Resident #1's progress notes dated 04/08/2026 revealed in part, Resident #1's doctor was notified, x-ray of right and left shoulder were ordered, and resident was transferred to local emergency room at Resident #1's family request. Review of Resident #1's bilateral upper extremity x-rays performed in the facility on 04/08/2026 revealed in part, acute fracture of the left midclavicle and acute fracture of right humerus. Review of Resident #1's hospital record revealed in part, an admission date of 04/08/2026 with diagnoses including, but not limited to, acute mildly displaced left distal clavicular fracture and acute mildly displaced fracture of the right proximal humeral diaphysis. Review of Resident #1's hospital record revealed Resident #1 reported the injury occurred while facility staff were assisting her with changing clothes while Resident #1 was in the mechanical lift. Further review of Resident #1's hospital record revealed Resident #1 was admitted for the need of new nursing home placement and pain management. Review of the facility's (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident Report with discovered date of 04/09/2026 for Resident #1 revealed, in part, S3LPN and S4CNA did not utilize a mechanical lift during Resident #1's transfer from a wheelchair to Resident #1's bed which resulted in fractures to both of Resident #1's upper extremities. During an interview on 04/21/2026 at 12:15 p.m., S2DON reported the facility had not received x-ray results at the time Resident #1's family requested Resident #1 be sent to a local emergency room. S2DON reported the facility received Resident #1's x-ray results indicating Resident #1 had a fracture to both upper extremities after Resident #1 was transferred to a local hospital for further evaluation. During a telephone interview on 04/22/2026 at 3:58 p.m., S3LPN reported S4CNA was in Resident #1's room assisting Resident #1. S3LPN reported Resident #1 needed assistance with transferring from the wheelchair to the bed. S3LPN reported the mechanical lift was rolled into Resident #1's room and S4CNA reported Resident #1 did not want to use the lift. S3LPN reported S4CNA proceeded to reach under Resident #1's arms and transferred Resident #1 from the wheelchair to the bed without the use of the lift. S3LPN reported during the transfer a pop was heard and resident complained of pain in her arms. S3LPN confirmed it was reported at first the incident occurred during a change of Resident #1's clothing. During a telephone interview on 04/23/2026 at 2:45 p.m., S4CNA reported being aware Resident #1 required the use of a mechanical lift for transfers. S4CNA reported on 04/08/2026 Resident #1 had returned from dialysis and was needing assistance with transfer from wheelchair to bed. S4CNA reported Resident #1 wrapped her arms around CNA's waist area, CNA put her arms under Resident #1's arms, lifted Resident #1 and transferred Resident #1 to Resident #1's bed. S4CNA reported during the transfer, Resident #1's arms popped and Resident #1 complained of pain. S4CNA confirmed it was reported at first the injury occurred while staff were assisting Resident #1 with a change of clothing. During an interview on 04/22/2026 at 2:13 p.m., S1Administrator confirmed Resident #1's incident occurred on 04/08/2026. S1Administrator reported no abuse or neglect was suspected at time of incident because Resident #1, S3LPN, and S4CNA had all reported the incident occurred while staff were assisting Resident #1 with a change of clothing. S1Administrator reported the facility received an email from Resident #1's daughter on the afternoon of 04/09/2026 which eluded to abuse and prompted the facility to launch an investigation. S1Administrator reported during the facility's investigation, S1Administrator watched facility camera footage and observed S3LPN bring a mechanical lift into Resident #1's room and 45 seconds later, S3LPN was observed bringing the mechanical lift out of Resident #1's room. S1Administrator reported he presented the question to S3LPN and S4CNA if 45 seconds was enough time to transfer a resident using a mechanical lift and both S3LPN and S4CNA reported it was not enough time. S1Administrator reported S3LPN and S4CNA both admitted to not using the lift during Resident #1's transfer from wheelchair to bed. S1Administrator reported both S3LPN & S4CNA reported the incident with Resident #1 did not occur during change of clothing but instead occurred during transfer from wheelchair to bed without use of mechanical lift as Resident #1 was care planned for. S1Administrator reported S3LPN and S4CNA were both terminated on 04/10/2026 as a result of the facility's investigation into the incident with Resident #1. During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. The facility implemented the following actions to correct the deficient practice beginning on 04/09/2026 with a completion of 04/17/2026: 1. Residents with a BIMS score of 7 or greater were interviewed by facility staff and questioned whether their transfer plan of care was being followed. Residents care planned for use of lift were asked if a lift was used. Completed 04/10/2026.2. On 04/10/2026 a quality assurance meeting was held. It was determined Resident #1 had received an acute fracture proximal humerus with mild malalignment and acute fracture of left midclavicular during a transfer other than what Resident #1 was assessed/care planned for (mechanical lift). It was further determined any resident that is assessed/care planned for mechanical lift could be affected.3. Process/Systems Involved: Lift policy, incident reporting, and documentation. In-service on lift policy conducted by DON/designee (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	beginning 04/09/2026, have all direct care staff read and sign lifting acknowledgment form. DON/designee will do random direct observations of transfer to ensure transferred according to assessed/care planned mechanical lift beginning 04/11/2026. 4. Education/Training plan must begin immediately on 04/09/2026 and capture staff prior to starting next shift: In-service on Lifting policy, lift acknowledgment form, mechanical lift policy, documentation policy, incident reporting and investigation policy, and prevention of neglect in-services done/to be done with direct care staff. 5. Monitoring of Implemented Actions: Starting 04/11/2026, random sample of direct observation to ensure proper mechanical lift is being used at a minimum of 3 times per week for 3 months or until complete compliance is achieved. DON/designee will review CNA documentation of lift/transfer at a minimum of 3 times per week to ensure what was observed is documented properly for 3 months or until complete compliance is achieved. DON/designee will review nurse documentation of random sample of incidents to ensure documentation is supported after investigation at a minimum of 3 times per week for 3 months or until complete compliance is achieved. Review of facility's action plan revealed the following documentation: 1. Starting 04/09/2026 and completed 04/10/2026, residents with a BIMS score of 7 or greater were interviewed by DON/designee and asked if there had been any problems with staff not following their lift status or if staff had transferred them without following their assigned transfer/lift plan of care. Residents interviewed reported transfer plan of care had been followed. 2. DON/designee performed in-service covering documentation/documentation policy and all documentation in a resident's record must be truthful and factual occurred on: 04/09/2026, 04/10/2026, 04/11/2026, 04/14/2026, and 04/15/2026 ensuring all nursing staff received in-service.3. In-service covering neglect prevention and response occurred on: 04/10/2026, 04/11/2026, 04/13/2026, 04/14/2026, and 04/15/2026 ensuring all nursing staff received in-service.4. In-service covering facility lift policy, mechanical lift policy and staff in attendance signed lifting policy acknowledgement form on: 04/09/2026, 04/10/2026, 04/11/2026, and 04/14/2026 ensuring all nursing staff received in-service.5. In-service covering facility incident investigation & reporting, definitions of abuse & neglect, and immediate notification to administrator with any reports or discovery of abuse, neglect, etc occurred on: 04/09/2026, 04/10/2026, 04/14/2026 ensuring all nursing staff received in-service and Neglect Competency quiz administered afterwards.6. In-service covering facility's Resident Rights policy occurred on: 04/10/2026, 04/13/2026 ensuring all nursing staff received in-service.7. Direct observations of mechanical lift usage by DON/designee occurred on:a. On 04/11/2026 DON/designee observed 5 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed.b. On 04/12/2026 DON/designee observed 5 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed.c. On 04/13/2026 DON/designee observed 5 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed.d. On 04/14/2026 DON/designee observed 5 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed.e. On 04/17/2026 DON/designee observed 5 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed.f. On 04/20/2026 DON/designee observed 4 Residents be transferred and observation revealed all transfers were performed following residents' POC task and documentation supported transfer performed. Review of facility's documentation revealed facility's monitoring was ongoing. Further review of facility's documentation revealed facility had reported S3LPN to State Board of Licensed Practical Nurse Examiners on 04/10/2026 and S4CNA to the Louisiana Certified Nurse Aide Registry on 04/13/2026.