STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195497	A. Building B. Wing	12/10/2025

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.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interviews, the facility failed to refer a resident with newly evident or possible severe mental disorder, intellectual disability, or a related condition to the appropriate state agency for a Level II PASARR evaluation for 1 (#10) of 1 resident reviewed for PASARR. Findings: Review of Resident #10's medical record revealed a readmission date of 11/15/2023 with a diagnosis of dementia without behavioral disturbance. Further review of Resident #10's diagnoses revealed in part, a diagnosis of Bipolar Disorder with a diagnosis date of 02/04/2025. Review of Resident #10's Level I PASARR screen and determination record dated 03/27/2023 revealed Resident #10 was not suspected to have or had ever been diagnosed with a mental illness. Further review of Resident #10's medical record failed to reveal documented evidence a Level II PASARR was completed after Resident #10 was diagnosed with Bipolar Disorder. During an interview on 12/09/2025 at 12:30 p.m., S3DON confirmed the facility did not have a Level II PASARR for Resident #10. During an interview on 12/09/2025 at 1:52 p.m., S6admission Coordinator confirmed the facility did not have a Level II PASARR for Resident #10.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to develop an individualized comprehensive care plan for 1 (#59) out of 41 total sampled residents reviewed. The facility failed to develop a problem and approach for Resident #59's limited range of motion, restorative care and application of splint/brace.Findings:Review of Resident #59's medical record revealed an admit date of 05/28/2025 with the following diagnoses, in part: injury of radial nerve at wrist and hand level of right and lesion of radial nerve right upper limb. Review of Resident #59's comprehensive care plan failed to reveal problems and approaches for limited range of motion, restorative care and application of splint/brace. Review of Resident #59's hospital records revealed, in part: general medicine progress note with a date of service of 11/23/2025. Further review revealed evaluated by physician and recommend arm splinting to avoid contracture. During an interview on 12/09/2025 at 12:35 p.m. S10 Restorative Aide reported she placed Resident #59's right hand splint/brace on every day for 1 hour as instructed by therapy. During an interview on 12/10/25 at 10:00 a.m. S9 Rehab Director reported Resident #59 was receiving therapy for positioning and passive range of motion. S9 Rehab Director further reported once Resident #59 returned from the hospital, was re-evaluated, a splint was ordered and the restorative aide was instructed on splint application to right hand/wrist. During an interview on 12/10/2025 at 10:05 a.m. S11 Care Plan Nurse acknowledged Resident #59 was not care planned for limited range of motion, restorative care and application of splint/brace.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interviews the facility failed to maintain, store, prepare, distribute, and serve food under sanitary conditions. The facility failed to ensure all staff entering the kitchen wore a hair restraint that covered all hair including hair nets and beard covers. Findings:Review of facility policy Employee Work Practices revised 05/18 revealed in part:Food service employees shall follow sanitary practices to prevent the spread of food borne illness.2. Proper work attire:ii. Wears a clean hat or other hair restraint (e.g. hair net, hat, surgical cap and /or beard restraint) in the food production area. The restraint must cover all hair and prevent the hair from contacting exposed food. Observation on 12/08/2025 at 8:00 a.m. revealed S16 Dietary staff in the kitchen area without a beard or mustache cover in place. Observation on 12/08/2025 at 11:30 a.m. revealed S15 Dietary staff in the kitchen area without a mustache cover in place. During an interview on 12/08/2025 at 11:35 a.m. S14 Dietary Manager confirmed kitchen staff should have facial hair covered and did not. Observation on 12/08/2025 at 11:50 a.m. revealed S1 Administrator walk into kitchen area without a hair or beard cover in place. During an interview on 12/08/2025 at 11:50 a.m. S1 Administrator confirmed a hair and beard cover should be worn when entering the kitchen. Observation on 12/09/2025 at 8:00 a.m. revealed S12 Dietary staff in the kitchen without a beard cover. During an interview on 12/09/2025 at 8:05 a.m. S13 [NAME] confirmed all kitchen staff should have a hair/beard cover on and did not.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interviews the facility failed to develop a post-discharge plan of care for 1 (#116) of 4 resident reviewed for closed records.Review of the facility's Discharge, Transfer and Planning Policy (Latest revision date 08/25, Latest Review Date 09/25) revealed in part: Discharge PlanningDischarge planning shall be initiated by the Social Service Director/Designee with anticipated discharges and on all skilled level care admissions documented in the resident's clinical record. Anticipated means the discharge was not due to an emergency (hospitalization for acute condition) or death.The community shall develop and implement an effective discharge planning process. The discharge plan shall focus on the residents' discharge goals and the preparation of residents to be active partners for post discharge care. The discharge plan shall include an effective transition to post-discharge care, and the reduction of factors leading to preventable readmissions. The interdisciplinary team shall- Ensure the discharge needs of each resident are identified and result in the development of a discharge plan. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. Communities must update a resident's comprehensive care plan and discharge plan appropriately in response to information received from referrals to local contact agencies or other appropriate entities.Review of the closed record for resident #116 revealed an admission date of 10/22/2025 with a discharge date of 11/03/2025. Diagnoses upon admission included displaced fracture of medial condyle of left tibia, other lack of coordination, generalized muscle weakness, unspecified osteoarthritis, depression and anxiety.Review of the facility nurse progress notes dated 11/03/2025 at 10:53 a.m. revealed resident #116 left AMA with family.Further review of resident #116's closed record revealed a nurse's progress note dated 10/28/2025 resident #116 went out of the facility to an orthopedic appointment and returned with new orders to start PT with Home Health PT when stable. RTC in 4 weeks. X-ray of the left knee 3 views.Review of resident #116's records failed to reveal documented evidence resident #116 had been assisted with an effective discharge plan that included assistance with making an appointment for Home Health and a return appointment for the orthopedic clinic in 4 weeks with an X-ray of the left knee.During an interview on 12/09/2025 at 4:25 p.m. S3 DON reported resident #116 voiced she did not like being at the facility from the time she was admitted . S3 DON reported there was no documentation made to reveal the dislike resident #116 expressed by being admitted to the facility and her plans to leave.Review of resident #116's Comprehensive Plan of Care failed to reveal a focus on discharge are any interventions.During an interview on 12/10/2025 at 2:15 p.m. S6 admission Coordinator reported resident #116's nurse came and reported resident #116 was packing preparing to leave the facility. S6 admission Coordinator reported she spoke with Resident #116 and persuaded resident to remain at the facility a few more days. S6 admission Coordinator reported a discharge was not completed for Resident #116. S6 admission Coordinator reported the Social Worker that would have completed the discharge process, making the appointments for resident #116 to have Home Health PT and everything was no longer employed at this facility.During an interview on 12/10/2025 at 2:30 p.m. S3 DON reported there is no documented evidence resident #116 was assisted by their previous Social Service Worker with the discharge planning process that included the new orders from the orthopedic clinic dated 10/28/2025.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview the facility failed to ensure the plan of care had been revised for 1(#7) resident out of a total of 41 residents reviewed for plan of care. The facility failed to revise a resident's plan of care for code status change.Findings:Review of Resident #7's physician orders revealed in part an order dated 10/30/2025 DNR (Do Not Resuscitate) Do Not call 911. Call Hospice with any questions or concerns. Review of Resident #7's comprehensive care plan revealed Resident #7's code status as Full Code initiated 06/26/2025.During an interview on 12/09/2025 at 2:00 p.m. S1 Corporate Nurse reviewed Resident #7's physician orders and comprehensive care plan and confirmed Resident #7's code status had not been updated from Full code to DNR status and should have been.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing for 1 (#59) of 1 resident investigated for pressure ulcers. The facility failed to follow the recommendations of the consulting Wound Care Nurse Practitioner. Findings:Review of Resident #59's medical records revealed an admit date of 05/28/2025, and diagnoses including: lack of coordination, unspecified severe protein-calorie malnutrition, vascular dementia, stage 4 pressure ulcer of sacral region, and enterocolitis due to clostridium difficile.Review of Resident #59's active physician's orders revealed orders including:12/04/2025 - Isolation for Clostridium Difficile12/02/2025 - Clean pressure injury of the sacrum with wound cleaner and apply Urgoclean Ag along with dry dressing daily one time a day for wound care.Review of Resident #59's Wound Care NP progress note dated 12/01/2025 revealed treatment recommendations including: clean Resident #59's Stage 4 sacrococcyx pressure ulcer with wound cleanser, apply Urgoclean Ag and dry dressing, change daily and as needed if dislodged, saturated, or soiled.During an interview on 12/08/2025 at 10:00 a.m., Resident #59's RP reported resident #59's wound had gotten worse and was a big hole. Resident #59's RP further reported the staff weren't changing the wound dressing when it was soiled with feces, and thought that was why the wound wasn't getting any better.Observation on 12/09/2025 at 7:40 a.m. revealed S4 LPN/Wound Care Nurse performed wound care on Resident #59's sacrococcyx pressure ulcer assisted by S4 CNA. On removal of Resident #59's incontinence brief, the resident's sacrococcyx pressure ulcer was observed to have no dressing covering the wound.During an interview on 12/09/2025 at 7:40 a.m., S4 LPN/Wound Care Nurse confirmed Resident #59's wound should have been covered with a dressing and was not. S4 LPN/Wound Care Nurse further confirmed there was no loose dressing in Resident #59's incontinence brief. S4 LPN/Wound Care Nurse reported staff should notify the Wound Care Nurse whenever Resident #59's dressing became soiled or dislodged, and had not. S4 LPN/Wound Care Nurse further reported the staff nurses were responsible for applying a clean dressing to Resident #59's pressure ulcer when it became soiled or dislodged when the Wound Care Nurse was not available. During an interview on 12/09/2025 at 7:45 a.m., S5 CNA reported the CNA's day shift started at 6:00 a.m., and incontinence care with a brief change for Resident #59 had not yet been completed . S5 CNA further reported the dressing to Resident #59's pressure ulcer must have come off before the beginning of the shift and should have been reported to the nurse.

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F 0689 Level of Harm - Minimal harm or potential for 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 review, observations, and interviews, the facility failed to provide an environment that is free from accident hazards with assistive devices to prevent avoidable accidents for 1 (#59) of 2 (#54, #59) residents reviewed for accident hazards. Findings: Review of Resident #59's medical records revealed an admit date of 05/28/2025 with the following diagnoses, in part: cognitive communication deficit, vascular dementia moderate with agitation, restlessness and agitation. Review of Resident #59's MDS assessment dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Review of Resident #59's comprehensive care plan revealed problems and approaches for altered thought processes related to dementia, current safety devices and special equipment date initiated 05/28/2025 for assist rail. Observation on 12/09/2025 at 8:00 a.m. revealed Resident #59 had bilateral quarter metal side rails attached to the upper half of the bed. The rail on the left side of the bed was in the lowered position and the rail to the right side of the bed was in the raised position. Resident #59 was observed using the rail on the right to assist with positioning herself during wound care. Further observation revealed the right side rail was loose and moved toward and away from the mattress, and moved back and forth toward the head and foot of the bed when pulled on. Observation on 12/10/2025 at 7:50 a.m. revealed Resident #59 sitting up in bed with metal side rail on right side of bed tilted inward towards resident. Further observation revealed bilateral quarter metal side rails loose, movable in a back and forth motion, and not secured. Observation on 12/10/2025 at 10:10 a.m. revealed Resident #59's bilateral quarter metal side rails loose, movable in a back and forth motion, and not secured. Observation on 12/10/2025 at 10:15 a.m. accompanied by S3 DON revealed Resident #59's bilateral quarter metal side rails were loose, movable in a back and forth motion and not secured. S3 DON attempted to tighten the side rails but was unsuccessful. During an interview on 12/10/2025 at 10:15 a.m. S3 DON acknowledged the bilateral quarter metal side rails on Resident #59's bed did not fit the bed properly, were loose and not secured.