STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195504	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Oaks Nursing & Rehabilitation Center	110 Maple Street Wisner, LA 71378

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record review and interviews, the facility failed to ensure a resident's right to be free from physical abuse by staff CNA (Certified Nursing Assistant) for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed for abuse. The Immediate Jeopardy situation began on 06/08/2024, around approximately 3:40 p.m., when S4CNA physically abused resident #1. S4CNA and S5CNA were providing care to resident #1 when resident #1 hollered and pointed his finger at S4CNA. S4CNA bent resident #1's finger on left hand back, bent his left foot back, and slapped resident in the chest. S6Licensed Practical Nurse (LPN) entered resident #1's room and observed resident #1 and S4CNA arguing. She then witnessed when the resident pointed his finger at S4CNA and S4CNA grabbed both of the resident's hands and held them down on the bed. After the abuse incident occurred on 06/08/2024, S4CNA continued to work her shift on 06/08/2024 and also worked double shifts on 06/09/2024 and 06/10/2024. The facility did not initiate quality assurance or performance improvement (QAPI) for ongoing monitoring for abuse after the incident was discovered on 06/11/2024 and the facility did not interview other residents to ensure there were no other reports of suspected abuse. The continuation of abuse had the likelihood to affect the other 58 residents in the facility. S1Administrator and S2Director of Nursing (DON) were notified of the Immediate Jeopardy on 07/02/2024 at 5:53 p.m. The Immediate Jeopardy was removed on 07/03/2024 at 1:19 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Review of the Abuse/Neglect Prevention Program Investigation with revision date of 09/08/2021 revealed, in part: Policy Statement: Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals, and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Abuse/Neglect Investigation, Protection, and Reporting: 1. Any person who witnesses or has knowledge of any act or suspected act of abuse/neglect, mistreatment, exploitation, or identifies an injury of unknown source will notify his/her supervisor immediately, and 2. The facility representative receiving the report of abuse shall generate an incident report. If the person accused of the alleged violation is an employee and is still on the premises of facility when the allegation is brought to the attention of the supervising staff member, the employee will be suspended immediately until such time that the facility investigation for that employee is complete. If the allegation occurs after routine office hours, the night or weekend staff must not wait for the Administrator or Director of Nursing to address the incident the following day. The supervising staff must ask the employee to leave the premises immediately. Review of the record for resident #1 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, type 2 diabetes mellitus with diabetic polyneuropathy, heart failure, other schizoaffective disorder, major depressive disorder, mood disorder, and other cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Review of resident #1's current care plan, dated 01/09/2023, revealed resident had been resistant to daily care. Interventions included when resident became combative, leave and try to approach the resident later. Review of the state reported incident dated 06/11/2024 revealed resident #1 was physically abused by S4CNA. The facility investigated the incident that occurred on 06/08/2024 by interviewing resident #1, S4CNA, S5CNA, and S6LPN and obtaining statements from each. The facility determined S5CNA witnessed S4CNA bend back resident #1's finger on his left hand, bend back resident's left foot, and slap the resident in the chest. S5CNA used the call light to call for help and S6LPN entered the resident's room and observed resident #1 and S4CNA arguing. Resident #1 pointed at S4CNA and S4CNA grabbed resident's finger and pushed both of the resident's hands down on the bed. S6LPN told S4CNA to leave the room, and had to block the door to keep S4CNA from reentering the resident's room. S4CNA was terminated on 06/11/2024 because the allegation of physical abuse was substantiated. S5CNA and S6LPN were counselled regarding witnessing abuse to resident #1 by S4CNA and not reporting incident immediately to S1Administrator or S2DON. Review of the facility's Incident Report for resident #1 dated 06/11/2024 at 7:00 a.m., revealed S5CNA reported to S3Assistant Director of Nursing (ADON) that during care for resident #1 on 06/08/2024, resident became combative, cursed, and pointed his finger in S4CNA's face. S4CNA pushed resident #1's finger back and resident kicked S4CNA twice in the stomach. S4CNA then slapped resident in the chest, slapped resident in his right eye, and bent his toes back. Purple bruising around the right eye of resident #1 was identified on 06/11/2024. Review of the Personnel Action form dated 06/11/2024 revealed S4CNA was terminated on 06/11/2024. (continued on next page)

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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	An interview on 07/01/2024 at 1:05 p.m. with resident #1 revealed on 06/08/2024 he was lying in his bed sleeping when S5CNA came into his room with S4CNA. He heard staff talking to one another and he pointed at S4CNA and told her to leave his room. Resident #1 reported S4CNA bent his finger back and started hitting him in the chest and his eye and his foot. Resident reported S6LPN came into the room and made S4CNA leave the room. Resident reported S4CNA had not been back in his room and she was fired. An interview on 07/01/2024 at 1:20 p.m. with S2DON revealed she was notified on 06/11/2024 by S3ADON of the incident that occurred on 06/08/2024 between resident #1 and S4CNA. S2DON was unsure if S4CNA had been sent home after the incident on 06/08/2024. An interview on 07/01/2024 at 1:30 p.m. with S3ADON revealed S5CNA notified her on 06/11/2024 about the incident that occurred on 06/08/2024 between resident #1 and S4CNA. S3ADON reported she assessed the resident and found a purplish bruise to the resident's right eye on 06/11/2024. During a telephone interview on 07/01/2024 at 1:50 p.m., S4CNA reported that on 06/08/2024 she went into resident #1's room with S5CNA to provide care and S5CNA was discussing with the resident that he needed to try to go to the bathroom, instead of using his brief. S4CNA reported resident #1 started cursing and pointing at her and told her to get out of his room. S4CNA reported resident #1 kicked her in the stomach and in the breast, and she reported she grabbed the resident's hands to calm him down. S4CNA reported S5CNA used the call light to call for help and S6LPN came into the room. S4CNA told S6LPN that resident #1 kicked her for no reason because he didn't like her. S4CNA reported she was told to leave the room, and reported she did not slap the resident in the chest, grab his finger, or hit/bend his toes. S4CNA confirmed she worked the rest of her shift on 06/08/2024 and also worked double shifts on 06/09/2024 and 06/10/2024, and confirmed she was terminated on 06/11/2024. During a telephone interview on 07/01/2024 at 3:10 p.m., with S5CNA revealed that on 06/08/2024 she and S4CNA went to resident #1's room to provide care. She reported she told the resident he needed to start getting up to use the bathroom since he has been going to therapy, and S4CNA repeated the need for resident #1 to get up to use the bathroom. S5CNA reported resident #1 became very upset and cursed, hollered and pointed his finger at S4CNA telling her to get out of his room. S5CNA reported S4CNA bent the resident's finger back, and resident #1 kicked S4CNA in the stomach 2 times, then S4CNA bent resident's foot back and slapped the resident in the chest. S5CNA reported she used the call light to call for help. S5CNA reported S6LPN came into the room and resident #1 and S4CNA were still arguing. S5CNA reported she notified S6LPN regarding S4CNA bending resident's finger back, slapping him in the chest, and bending back resident's foot. During a telephone interview, on 07/01/2024 at 2:10 p.m., with S6LPN revealed that S5CNA called her to resident #1's room on 06/08/2024. S6LPN reported when she entered resident #1's room, S4CNA and resident #1 were arguing and resident #1 pointed his finger at S4CNA and S4CNA grabbed the resident's finger and pushed both of his hands down on the bed. S6LPN reported she made S4CNA leave the resident's room, then she asked resident #1 and S5CNA what had happened. S6LPN reported that resident #1 and S5CNA notified her that S4CNA had bent resident #1's finger back, slapped him in the chest, and bent his toes back. S6LPN reported S4CNA was very upset and she tried to get back into the resident's room. S6LPN reported she spoke with S4CNA later in the hall and S4CNA reported the resident kicked her twice for no reason. S6LPN confirmed she did not notify S1Administrator or S2DON about the physical abuse that occurred between resident #1 and S4CNA. S6LPN confirmed she did not send S4CNA home, but let her work on another hall for the rest of her shift on 06/08/2024. (continued on next page)

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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	An interview on 07/01/2024 at 4:05 p.m. with S7CNA revealed she heard the commotion going on in resident #1's room on 06/08/2024 and went to see what had happened. S7CNA reported she did not witness any abuse, but she assisted with pulling S4CNA out of the resident #1's room. An interview on 07/02/2024 at 8:15 a.m. with S2DON reported the facility did not initiate QAPI for ongoing monitoring for abuse after the incident was discovered on 06/11/2024. S2DON further reported the facility did not interview other residents in the facility to ensure there were no other reports of suspected abuse. Review of the Employee Timecard for S4CNA revealed she was clocked in and out for the remainder of the weekend, as follows: -06/08/2024 in at 3:27 p.m. and out at 4:25 a.m. -06/09/2024 in at 3:16 p.m. and out at 5:36 a.m. -06/10/2024 in at 3:22 p.m. and out at 11:34 p.m. Surveyor alerted S2DON on 07/02/2024 at 8:15 a.m. that S4CNA was not sent home on 06/08/2024 after the incident occurred, and S4CNA also worked on 06/09/2024 and 06/10/2024 per review of S4CNA's timecard. S2DON confirmed S4CNA should have been sent home immediately per the facility's policy on abuse/neglect, and should not have been allowed to work on 06/09/2024 and 06/10/2024. S2DON confirmed S4CNA was terminated on 06/11/2024 for physical abuse to resident #1.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record reviews and interviews, the facility failed to ensure staff reported physical abuse of a resident to administration immediately and failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act within 24 hours to one or more law enforcement entities for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed for abuse. The Immediate Jeopardy situation began on 06/08/2024, around approximately 3:40 p.m., as a result of resident #1 being physically abused on 06/08/2024 by S4Certified Nursing Assistant (CNA) and witnessed by S5CNA and S6LPN (Licensed Practical Nurse). The physical abuse of resident #1 was not reported immediately to S1Administration or S2Director of Nursing (DON) on 06/08/2024 by S4CNA, S5CNA or S6LPN. S1Administrator and S2DON were notified of the Immediate Jeopardy on 07/02/2024 at 5:53 p.m. The Immediate Jeopardy was removed on 07/03/2024 at 1:19 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Review of the Abuse/Neglect Prevention Program Investigation with revision date of 09/08/2021 revealed, in part: Abuse/Neglect Investigation, Protection, and Reporting: 1. Any person who witnesses or has knowledge of any act or suspected act of abuse/neglect, mistreatment, exploitation, or identifies an injury of unknown source will notify his/her supervisor immediately, and 2. The facility representative receiving the report of abuse shall generate an incident report. If the person accused of the alleged violation is an employee and is still on the premises of facility when the allegation is brought to the attention of the supervising staff member, the employee will be suspended immediately until such time that the facility investigation for that employee is complete. If the allegation occurs after routine office hours, the night or weekend staff must not wait for the Administrator or Director of Nursing to address the incident the following day. The supervising staff must ask the employee to leave the premises immediately. Guidance for Mandated Reporting for Allegations of Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Reportable Incidents: II. Additional Incidents: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	J. The Nursing Facility is responsible for reporting suspicious or actual criminal activity against a resident both to Health Standards Section and one or more law enforcement entities in which the facility is located. Review of the record for resident #1 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease with acute exacerbation, type 2 diabetes mellitus with diabetic polyneuropathy, heart failure, other schizoaffective disorder, major depressive disorder, mood disorder, other cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Review of resident #1's current care plan dated 01/09/2023 revealed resident had been resistant to daily care. Interventions included when resident became combative, leave and try to approach the resident later. Review of the facility's Incident Report for resident #1 dated 06/11/2024 at 7:00 a.m. revealed S5CNA reported to S3Assistant Director of Nursing (ADON) that during care for resident #1 on 06/08/2024, resident became combative, cursed, and pointed his finger in S4CNA's face. S4CNA pushed resident's finger back and resident #1 kicked S4CNA twice in the stomach. S4CNA then slapped resident in the chest, slapped resident in his right eye, and bent his toes back. Purple bruising around the right eye of resident #1 was identified on 06/11/2024. An interview on 07/01/2024 at 1:05 p.m. with resident #1 revealed on 06/08/2024 he was lying in his bed sleeping when S5CNA came into his room with S4CNA. He heard staff talking to one another and he pointed at S4CNA and told her to leave his room. Resident #1 reported S4CNA bent his finger back and started hitting him in the chest and his eye and his foot. Resident reported S6LPN came into the room and made S4CNA leave the room. Resident reported S4CNA had not been back in his room and she was fired. An interview on 07/01/2024 at 1:20 p.m. with S2DON revealed she was notified on 06/11/2024 by S3ADON of the incident that occurred on 06/08/2024 between resident #1 and S4CNA. S2DON was unsure if S4CNA had been sent home on 06/08/2024. An interview on 07/01/2024 at 1:30 p.m. with S3ADON revealed S5CNA notified her on 06/11/2024 about the incident that occurred on 06/08/2024 between resident #1 and S4CNA. S3ADON reported she assessed the resident and found a purplish bruise to the resident's right eye on 06/11/2024. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 07/01/2024 at 1:50 p.m., S4CNA reported on 06/08/2024 she went into resident #1's room with S5CNA to provide care and S5CNA was discussing with the resident that he needed to try to go to the bathroom, instead of using his brief. S4CNA reported resident #1 started cursing and pointing at her and told her to get out of his room. S4CNA reported resident #1 kicked her in the stomach and in the breast, and she reported she grabbed the resident's hands to calm him down. S4CNA reported S5CNA used the call light to call for help and S6LPN came into the room. S4CNA told S6LPN resident #1 kicked her for no reason because he didn't like her. S4CNA reported she was told to leave the room, and reported she did not slap the resident in the chest, grab his finger, or hit/bend his toes. S4CNA confirmed she worked the rest of her shift on 06/08/2024 and also worked double shifts on 06/09/2024 and 06/10/2024, and confirmed she was terminated on 06/11/2024. S4CNA confirmed she did not notify S1Administrator or S2DON immediately when she was accused of physical abuse to resident #1 on 06/08/2024. During a telephone interview on 07/01/2024 at 3:10 p.m., S5CNA revealed on 06/08/2024 she and S4CNA went to resident #1's room to provide care. She reported she told the resident he needed to start getting up to use the bathroom since he has been going to therapy. S4CNA repeated the need for resident #1 to get up to use the bathroom also. S5CNA reported resident #1 became very upset and cursed, hollered and pointed his finger at S4CNA telling her to get out of his room. S5CNA reported S4CNA bent the resident's finger back, and resident #1 kicked S4CNA in the stomach 2 times. S4CNA then bent resident #1's foot back and slapped the resident in the chest. S5CNA reported she used the call light to call for help. S5CNA reported S6LPN came into the room and resident #1 and S4CNA were still arguing. During a telephone interview on 07/01/2024 at 2:10 p.m., S6LPN revealed that S5CNA called her to resident #1's room on 06/08/2024. S6LPN reported when she entered resident #1's room, S4CNA and resident #1 were arguing and resident #1 pointed his finger at S4CNA and S4CNA grabbed the resident's finger and pushed both of his hands down on the bed. S6LPN reported she made S4CNA leave the resident's room, then she asked resident #1 and S5CNA what had happened. S6LPN reported that resident #1 and S5CNA notified her that S4CNA had bent resident #1's finger back, slapped him in the chest, and bent his toes back. S6LPN reported S4CNA was very upset and she tried to get back into the resident's room. S6LPN reported she spoke with S4CNA later in the hall and S4CNA reported the resident kicked her twice for no reason. S6LPN confirmed she did not notify S1Administrator or S2DON about the physical abuse that occurred between resident #1 and S4CNA. S6LPN confirmed she did not send S4CNA home, but let her work on another hall for the rest of her shift on 06/08/2024. S6LPN confirmed she was counselled on 06/11/2024 for not notifying S2DON or S1Administrator on 06/08/2024 when resident #1 was physically abused by S4CNA. An interview on 07/02/2024 at 11:55 a.m. with S5CNA confirmed she did not notify S2DON or S1Administrator of physical abuse of resident #1 on 06/08/2024 by S4CNA. Review of the Employee Timecard for S4CNA revealed she was clocked in and out for the remainder of the weekend, as follows: -06/08/2024 in at 3:27 p.m. and out at 4:25 a.m. -06/09/2024 in at 3:16 p.m. and out at 5:36 a.m. -06/10/2024 in at 3:22 p.m. and out at 11:34 p.m. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor alerted S2DON on 07/02/2024 at 8:15 a.m. that S4CNA was not sent home on 06/08/2024 after the incident occurred, and S4CNA also worked on 06/09/2024 and 06/10/2024 per review of S4CNA's timecard. S2DON confirmed S4CNA should have been sent home immediately per the facility's policy on abuse, and should not have been allowed to work on 06/09/2024 or 06/10/2024. S2DON confirmed S4CNA was terminated on 06/11/2024 for physical abuse to resident #1. S2DON confirmed that S4CNA, S5CNA, and S6LPN failed to follow the facility's abuse policy and procedure by not reporting abuse immediately to S2DON or S1Administrator on 06/08/2024 when S4CNA physically abused resident #1. An interview on 07/08/2024 at 1:00 p.m. with S1Administrator confirmed the facility did not notify a law enforcement entity within 24 hours of becoming aware of the physical abuse of resident #1 by S4CNA that occurred on 06/08/2024.