STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195506	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Toledo Retirement and Rehabilitation Center	1009 N Obrie Street Zwolle, LA 71486

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 - Minimal harm or potential for actual harm 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** 44844 Based on interview and record review the facility failed to ensure a resident's right to be free from resident to resident physical abuse for 1 (Resident #3) of 2 (Resident #3 and Resident #180) sampled residents. The facility failed to ensure Resident #3 was not physically abused by Resident #180. Findings: Review of the facility's undated policy titled Abuse Prevention and Investigation revealed in part .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse, and certain resident to resident altercations. Findings: Resident #3 Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses that included: Other Cerebrovascular Disease, Delusional Disorder, Unspecified Convulsions, Unspecified Psychosis, Peripheral Vascular Disease, Major Depressive Disorder, Anxiety Disorder and Epilepsy Unspecified. Review of Resident #3's Annual MDS with an ARD of 09/25/2024, revealed a BIMS score of 15, indicating intact cognition. The MDS revealed Resident #3 required set-up or clean-up assistance with eating and bathing. Independent with: oral hygiene, toileting, dressing, personal hygiene, transfers and ambulation. Resident #180 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #180's medical record revealed he was admitted to the facility on [DATE], with diagnoses that included: Schizoaffective Disorder Bipolar type, Generalized Anxiety Disorder, Depression, Major Depressive Disorder, Alcohol Dependence, Sleep Terrors, and Secondary Parkinsonism Unspecified. Review of Resident #180's Quarterly MDS with an ARD of 06/17/2024, revealed a BIMS score of 15, indicating intact cognition. The MDS revealed Resident #180 required supervision or touching assistance with eating, oral hygiene, and bathing. Resident #180 was independent with sit to stand and chair/bed to chair transfer. Resident #180 used a manual wheelchair for mobility. Review of Resident #180's Care Plan with a revision date of 06/25/2024, read in part . 1. Behavior: Socially inappropriate: Agitation and Aggression with interventions that included: Monitor resident's whereabouts every 30 minutes, remove from public area when behavior is unacceptable. 2. On 06/10/2024 Resident #180 noted to be easily annoyed with staff . when asked to repeat himself, Resident #180 hollered You're just stupid, also stated to nurse who offered PRN medicine f**k you, I'll beat the f**k out of you, and you'll get raped too. 3. On 06/14/2024 Resident #180 noted to be agitated and rambling incoherent words and requesting his roommate be moved. Review of a facility Incident Report dated 06/20/2024 at 4:50 p.m., revealed in part .Resident #3 reported to S5 LPN that Resident #180 struck him in the face and abdomen. Resident #3 revealed that Resident #180 was propelling himself down the hallway when he (Resident #180), motioned for him to come there. Resident #3 who was ambulatory, walked over to Resident #180, and bent down to hear what Resident #180 was trying to tell him. At this point Resident #180 struck Resident #3 in the face and abdomen with a closed fist. Resident #3 immediately backed away and reported the incident to the nurse. Slight redness was noted to left side of Resident #3's face. No other injuries. Interview on 12/10/2024 at 9:46 a.m. with S2 DON, revealed on 06/20/2024 at 4:50 p.m., Resident #180 punched Resident #3 in the face and stomach with his fist for no reason. S2 DON revealed Resident #3 reported the incident to S5 LPN immediately after it happened. S2 DON revealed Resident #3 had a mark on his face, and no other injuries. During the interview, S2 DON stated on 05/24/2024, Resident #180 exhibited escalation in behaviors, that included verbal threats of violence, throwing objects within his room and at staff, and exhibiting paranoid delusions such as believing the physician was threat to their safety. Resident #180 was sent to the ER, received Ativan (an anti-anxiety medication) in the ER, and was sent back to the facility on [DATE], because he did not meet PEC requirements after receiving the Ativan. Upon return to the facility on [DATE], Resident #180 continued with behaviors, and was sent to an inpatient psyche facility for admission on 05/25/2024 to 06/06/2024. Resident #180 continued on every 30 minute monitoring after return to the facility on [DATE], with no other interventions put in place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/10/2024 at 2:20 p.m. with Resident #3, revealed on 06/20/2024, Resident #180 called him over to his wheelchair, and when he bent down to listen, Resident #180 hit him in the face (left side) and his stomach. Resident #3 revealed he then walked away from Resident #180, and went in the dining room and reported the incident to S5 LPN. Resident #3 revealed he had a red spot on his left cheek, but the skin did not break. Resident #3 revealed the hit was painful at the time it happened. Resident #3 revealed he did not see Resident #180 again after this altercation. Interview on 12/10/2024 at 2:30 p.m. with S7 CNA, revealed he had provided care for Resident #180 when he was at the facility. S7 CNA revealed Resident #180 had a history of being verbally abusive to other residents and staff. Interview on 12/10/2024 at 3:05 p.m. with S5 LPN, revealed on 06/20/2024 close to supper time, Resident #3 came into the dining room and reported to her that Resident #180 had punched him in the face and stomach. S5 LPN revealed Resident #3's left cheek was red, but the skin was not broken. Interview on 12/10/2024 at 9:10 a.m. with S2 DON confirmed Resident #3 was a victim of resident to resident physical abuse by Resident #180 on 06/20/2024.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 38894 Based on record review and interview, the facility failed to transmit a quarterly resident assessment within 14 days of completion for 1 (Resident #14) of 15 records reviewed. Findings: On 12/10/2024, Resident #14's Quarterly MDS was reviewed with an ARD of 11/09/2024. The MDS was noted as export ready. Interview on 12/11/2024 at 8:31 a.m. with S3MDS Nurse confirmed that Resident #14's MDS was late being submitted. She stated she was not sure why. S3MDS Nurse exported Resident #14 Quarterly MDS with an ARD of 11/09/2024 during this interview.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096 Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion was provided equipment to prevent further decrease in range of motion for 1 (#17) of 3 (#2, #13, and #17) residents reviewed for limited range of motion in a total facility census of 27 residents. Findings: Observation of Resident #17 on 12/09/2024 at 10:25 a.m. revealed the resident was sitting in a wheelchair. Contracture noted to left hand with no palm guard present. Resident #17 stated that staff use to place something in her hand and had not been putting anything in there lately. Observation of Resident #17 on 12/10/2024 at 8:57 a.m. revealed no palm guard noted to left hand. Resident #17 stated no one put the palm guard on unless therapy does. A review of Resident #17's medical record revealed an admitted [DATE] with diagnoses that include cerebral infarction, contracture of muscle, muscle wasting and atrophy left hand; contracture of left hand, and muscle weakness. A review of Resident #17's Quarterly MDS with an ARD of 10/14/2024 revealed a BIMS of 15. Resident is cognitively intact. Resident does not reject care. Resident has impairment on one side for upper extremity. A review of Resident #17's physician orders with a start date of 09/25/2024 revealed orders for left hand palm guard q day on at 7:00 a.m. off at 11:00 a.m., monitor skin before and after each wear every day shift for contracture management and to prevent skin breakdown related to contracture, left hand. Resident to wear left upper extremity palm guard x 4 hours daily for contracture management and to prevent skin breakdown per OT recommendations with an order date of 09/23/2024. A review of Resident #17's care task revealed the nurse was to monitor that the resident wears LUE palm guard x4 hours daily for contracture management and to prevent skin breakdown. A review of progress notes from 12/9/2024 and 12/10/2024 revealed no refusal of resident in regards to wearing the palm guard. Interview with S8 CNA on 12/10/2024 at 10:35 a.m. revealed that she did not see a palm guard on Resident #17 today. Observation and interview with S9 LPN and S2 DON on 12/10/2024 at 10:20 a.m. revealed that Resident #17 did not have her palm guard on and that it should have been in on between the hours of 7:00 a.m. and 11:00 a.m. according to the physician's order.