STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195512	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on interviews and record reviews, the facility failed to promote and facilitate residents' self-determination through support of the residents' choice about aspects of his or her life in the facility which were significant to the resident for 3 (#42, #48, and #52) of 24 residents reviewed in the initial pool. The facility failed to ensure residents had rights as evidenced by: 1. Staff did not allow Resident #42 to visit Resident #48; 2. Staff did not allow Resident #48 out of his room; and 3. Staff did not wear gloves at Resident #52's request. Findings: Review of the facility's undated policy titled, Resident Rights revealed the following: 1. Resident Rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 5. Respect and dignity. The resident has a right to be treated with respect and dignity, including: c. The right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. 6. Self Determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. 1. Resident #42 (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #42's Clinical Records revealed she was admitted to the facility on [DATE] with diagnoses which included, Depression, Anxiety, and Muscle Wasting. A review of Resident #42's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/2024 revealed Resident #42 had a Brief Interview for Mental Status (BIMS) of 14, which indicated Resident #42 was cognitively intact. On 10/09/2024 at 3:28 p.m., an interview was conducted with Resident #42. She stated she visited Resident #48 in his room frequently. Resident #42 stated on 09/24/2024, S13LPN did not allow her to visit Resident #48 and told her to go back to her room. On 10/09/2024 at 3:53 p.m., an interview was conducted with S13LPN. She stated she told Resident #42 she could not go into Resident #48's room on 09/24/2024. She further stated on 10/05/2024 she told Resident #42 and #48, get in Resident #48's room or get off the hall. 2. Resident #48 A review of Resident #48's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses which included, Depressive Disorder, Anxiety Disorder, and Mental Disorder. A review of Resident #48's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/20/2024 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) of 11, which indicated Resident #48 was mildly cognitively impaired. On 10/10/2024 at 2:26 p.m., an interview was conducted with Resident #48. He stated on 10/05/2024, S13LPN told him to get in his room or off the hall. On 10/09/2024 at 3:53 p.m., an interview was conducted with S13LPN. She stated on 10/05/2024 she told Resident #48, get in your room or get off the hall, and should not have. 3. Resident #52 A review of Resident #52's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included, Acquired Absence of Right Leg Above the Knee, Acquired Absence of Left Leg Above the Knee and Adjustment Disorder. A review of Resident #52's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. On 10/09/2024 at 3:53 p.m., an interview was conducted with S13LPN. She stated when she was assigned to Resident #52, he requested she wore gloves for medication pass. S13LPN confirmed she did not wear gloves for the medication pass and Resident #52 refused his medication. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 2:40 p.m., an interview was conducted with S1ADM. He confirmed residents had the right to visit other residents, be on the hall if they choose to, and to request staff to wear gloves for medication pass.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on record reviews and interview, the facility failed to notify the physician when a resident had aggressive behaviors toward staff and other residents for 1(#52) of 6 (#18, #26, #42, #51, #52, and #111) residents reviewed for behaviors. Findings: A review of the facility's undated policy, Change in a Resident's Condition or Status revealed the following: 1. The nurse supervisor/Charge Nurse will notify the resident's attending physician or on call physician when there has been: a. An accident or incident involving the resident; d. A significant change in the resident's physical/emotional/mental condition. A review of Resident #52's Clinical Records revealed he was admitted to the facility on [DATE] and diagnosed with Adjustment Disorder, Unspecified. A review of Resident #52's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. A review of Resident #52's Clinical Record revealed no documentation his psychiatric NP was notified of his aggressive behaviors toward other residents and staff beginning 08/15/2024 through 10/08/2024. Review of Resident #52's Psychiatric NP Notes revealed the following: Date: 08/15/2024 Diagnosis: Adjustment disorder, Unspecified. Staff reports improved behaviors. Date: 09/17/2024 Diagnosis: Adjustment disorder, Unspecified. Staff reports no behavior issues. On 10/08/2024 at 3:43 p.m., an interview was conducted with S1ADM. He confirmed Resident #52 had aggressive behaviors with multiple staff and residents. He stated he was not aware if S22NP had been notified but due to his aggressive behaviors he was issued a 30 day discharge. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She confirmed Resident #52 had aggressive behaviors with multiple staff and residents. She further stated S22NP was made aware of his behaviors. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 10/10/2024 at 4:06 p.m., an interview was conducted with S22NP. She stated she was not aware Resident #52 was having behaviors and should have been made aware. She confirmed she was not aware of Resident #52 threatening staff.

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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 - Some	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** 43868 Based on interviews and record reviews, the facility failed to ensure each resident remained free from verbal and mental abuse for 3 (#42, #46, and #52) of 7 (#18, #26, #42, #46, #51, #52, and #111) residents reviewed for abuse. The facility failed to prevent: 1. S4CNA and S5CNA from yelling, cursing, and pointing at Resident #52 while surrounding the wheelchair and preventing the resident from getting away; and 2. S6CNA from yelling and cursing at Resident #52 in the hall; and 3. S13LPN from intimidating and threatening Resident #42; and 4. S6CNA from following and verbally threatened Resident #46 in her room. This deficient practice resulted in an Immediate Jeopardy situation for Resident #52 on 09/04/2024, when multiple staff witnessed S4CNA and S5CNA curse, yell, and point in Resident #52's face. Resident #52 reported he no longer felt safe in the facility. It continued on 09/14/2024, when Resident #46 witnessed and reported to S1ADM, S6CNA yelled and cursed at Resident #52 in the hallway. It continued on 09/23/2024, when Resident #42 reported S13LPN stood in front of her wheelchair, pointed and demanded she get off the hall. Resident #42 reported she felt intimidated by S13LPN. It continued on 09/24/2024 when S6CNA followed Resident #46 to her room, yelled, pointed her finger and threatened Resident #46. Resident #46 reported she felt threatened by S6CNA. S1ADM did not remove S4CNA, S5CNA, S6CNA and S13LPN from resident care, provide additional training or complete any monitoring following each individual incident. S1ADM was notified of the Immediate Jeopardy situation on 10/09/2024 at 9:35 a.m. The Immediate Jeopardy was removed on 10/10/2024 at 12:33 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. This deficient practice continued at a potential for more than minimal harm for the other 59 residents residing in the facility. Findings: Review of the facility's undated policy titled Abuse, Neglect and Exploitation revealed the following, in part: Policy: 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Definitions: Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. 1. A review of Resident #52's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Acquired Absence of Right Leg Above the Knee, Acquired Absence of Left Leg Above the Knee and Adjustment Disorder. A review of Resident #52's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. On 10/07/2024 at 8:35 a.m., an interview was conducted with Resident #52. He stated a few weeks ago he asked S4CNA to empty his urinal and she told him he could do it himself. S4CNA told him, tell your mammy to empty it. Resident #52 responded by saying S4CNA could drink it, then S4CNA responded tell that b**** to empty it. He stated he and S4CNA continued verbally arguing. He stated he attempted to call S2DON but she did not answer the call, so he rolled his wheelchair to S2DON's office. He said when he got to S2DON's office, S4CNA and S5CNA were standing in front of S2DON's door and stopped him from entering. He stated S4CNA and S5CNA continued to yell and curse at him while he was outside of S2DON's office door. He stated S2DON was in her office and told S4CNA and S5CNA to just ignore him and he would go away. He stated he was angry, overwhelmed and felt intimidated. He stated S17SW intervened, and brought him outside to calm down. On 10/08/2024 at 10:15 a.m., an interview was conducted with S17SW. She stated on 09/04/2024 at approximately 5:30 p.m., she saw Resident #52 in the doorway of S2DON's office in his wheelchair. She reported S5CNA was standing in front of Resident #52 and S4CNA was standing behind Resident #52 preventing him from entering S2DON's office. She stated Resident #52, S4CNA, and S5CNA yelled and cursed at each other at the same time so loudly she did not know what they said only heard cursing back and forth. She stated S5CNA pointed her finger in Resident #52's face. She stated S2DON was in her office, could see and hear the altercation, and did not intervene. She stated she intervened, removed Resident #52, and brought him to the outside patio. She stated Resident #52 was upset and angry and she sat with him until he calmed down. She stated yelling, cursing and pointing a finger at a residents face is abuse and she reported it to S1ADM on the next day. She stated on 09/05/2024, she recommended S1ADM provide training on de-escalation and S1ADM responded, training was not needed because Resident #52 cursed at his staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/08/2024 at 11:08 a.m., an interview was conducted with S18LPN. She stated on 09/04/2024, she saw Resident #52 in the doorway of S2DON's office in his wheelchair. She reported S5CNA was standing in front of Resident #52 and S4CNA was standing behind Resident #52 preventing him from entering S2DON's office. She stated Resident #52, S4CNA and S5CNA yelled and cursed at each other at the same time so loudly she did not know what they said only heard cursing back and forth. She stated S5CNA pointed her finger in Resident #52's face and told him he was capable of emptying his urinal. She stated S2DON was in her office, could see and hear the altercation, and did not intervene. She stated she intervened and assisted S17SW with removing Resident #52, and bringing him to the outside patio. She stated yelling, cursing and pointing a finger at a residents face is abuse. She stated staff should not have treated Resident #52 in that manner and S4CNA, S5CNA continued to provide care at the facility. On 10/08/2024 at 11:16 a.m., an interview was conducted with S19CNA. She stated on 09/04/2024, she saw Resident #52 in the doorway of S2DON's office in his wheelchair. She reported S5CNA was standing in front of Resident #52 and S4CNA was standing behind Resident #52 preventing him from entering S2DON's office. She stated Resident #52, S4CNA and S5CNA yelled and cursed at each other at the same time so loudly she did not know what they said only heard cursing back and forth. She stated S5CNA pointed her finger in Resident #52's face and told him he was capable of emptying his urinal. She stated S2DON was in her office, could see and hear the altercation, and did not intervene. On 10/09/2024 at 4:20 p.m., an interview was conducted with S26OMB. She stated Resident #52 reported to her that he asked S4CNA to empty his urinal and she told him, Tell your mammy to do it and they argued back and forth. She stated Resident #52 reported he felt vulnerable because he does not have any legs and he did not feel safe at the facility after the incident. On 10/09/2024 at 4:30 p.m., an interview was conducted with S4CNA. She stated on 09/04/2024, Resident #52 told her to empty his urinal and make his bed immediately. She denied arguing, yelling or cursing at Resident #52. She stated 09/07/2024 was the last day she provided care to Resident #52, but continued to provide care to other residents in the facility until 09/24/2024. She stated her last abuse training was in June 2024. On 10/09/2024 at 4:35 p.m., an interview was conducted with S5CNA. She stated she was never assigned to Resident #52 but would help S4CNA with his care. She stated on 09/04/2024, Resident #52 told S4CNA to empty his urinal and make his bed immediately. She denied arguing, yelling or cursing at Resident #52. She stated she provided care to other residents in the facility until she was moved to another facility on 09/26/2024, with a plan to return to the facility when Resident #52 was discharged . She stated her last abuse training was in June 2024. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She stated on 09/04/2024, Resident #52 asked S4CNA to empty his urinal and she told him he could do it himself. She stated Resident #52 rolled his wheelchair to the doorway of her office, parked his wheelchair, and yelled and cursed at her and S4CNA. S2DON stated she did not hear the 2 CNAs yell or curse at the resident. She stated staff cursing and pointing a finger at a resident was abuse. She confirmed S4CNA continued to provide care to residents in the facility until 09/24/2024 and S5CNA continued to provide care to residents in the facility until 09/26/2024 when S1ADM removed them. She confirmed no additional education was provided to staff on de-escalation for residents with behaviors or monitoring completed following the incident on 09/04/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #52 reported on 09/25/2024, he asked S4CNA on 09/05/2024 to empty his urinal. Resident #52 reported S4CNA refused to empty his urinal, yelled and cursed at her. S1ADM explained Resident #52 had aggressive behaviors, which included, yelling and cursing with other residents and staff. He stated S4CNA and S5CNA triggered Resident #52's behaviors so they were moved to another facility on 09/24/2024 and 09/26/2024, with a plan to return when Resident #52 was discharged . He stated S4CNA was not assigned to Resident #52 after 09/07/2024 but did provide care to other residents at the facility until 09/24/2024. He confirmed no additional education was provided to staff on de-escalation for residents with behaviors or monitoring completed following the incident on 09/04/2024. 2. On 10/08/2024 at 9:31 a.m., an interview was conducted with S20LPN. She stated on 09/14/2024 she witnessed S6CNA yell and curse at Resident #52 but could not remember exactly what was said. She confirmed arguing, yelling and cursing with a resident was abuse and she reported it to administration. She further stated she had witnessed multiple staff curse at Resident #52 and some of those employees still worked at the facility even after notifying administration of the abuse. On 10/08/2024 at 9:54 a.m., an interview was conducted with S21CNA. She stated on 09/14/2024, she witnessed S6CNA curse and argue with Resident #52 but could not remember exactly what was said. She stated S1ADM was made aware of the incident. She confirmed cursing at a resident was abuse. On 10/08/2024 at 11:45 p.m., an interview was conducted with Resident #46, a cognitively intact resident. She stated on 09/14/2024, she was in the hall and witnessed S6CNA yell and curse at Resident #52. She stated S6CNA told Resident #52, F*** you. She stated she reported the incident immediately to S1ADM. She stated S6CNA continued to provide care at the facility on her hall until 09/24/2024, when S6CNA threatened her. On 10/09/2024 at 2:01 p.m., an interview was attempted with S6CNA, unable to leave a message. On 10/09/2024 at 4:45 p.m., an interview was attempted with S6CNA, unable to leave a message. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 approached him on 09/14/2024 and notified him of the incident with Resident #52 and S6CNA. He stated S6CNA was not removed from the facility and continued to provide care to Resident #46 and Resident #52 until S6CNA was removed on 09/26/2024. He stated on 09/24/2024, S6CNA was involved in another incident with Resident #46 and S6CNA was terminated but not related to the allegation. He confirmed no additional education was provided to staff on de-escalation for residents with behaviors. He confirmed the last abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. 3. A review of Resident #42's Clinical Records revealed Resident #42 was admitted to the facility on 01/16/2024 with diagnoses which included, Depression, Anxiety, and Muscle Wasting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #42's MDS with an ARD of 08/07/2024 revealed Resident #42 had a BIMS of 14, which indicated Resident #42 was cognitively intact. A review of Resident #42's grievance, dated 09/23/2024, revealed the following: Statement of concern: Resident #42 stated S13LPN displayed poor customer service and asked Resident #42 to leave the hall and return to her room. Investigation: Resident #48 was witness Conclusion: S13LPN educated on customer service and residents right to be invited to other rooms. On 10/09/2024 at 3:28 p.m., an interview was conducted with Resident #42. She stated she and Resident #48 were friends and she visited Resident #48's room frequently. She stated on 09/22/2024, she was in her wheelchair, rolling down the hall, when S13LPN stopped her, stood in front of her wheelchair and stated, Get off my hall, you're not allowed over here in a stern voice. She stated on the same day after leaving the smoking patio and going back to her room, she heard S13LPN call her white trash. Resident #42 stated she felt intimidated and threatened by S13LPN and reported the incident to S1ADM on 09/23/2024. She stated again on 10/05/2024, S13LPN told her to get in Resident #48's room or get off the hall in a stern voice. On 10/10/2024 at 2:26 p.m., an interview was conducted with Resident #48, a mildly cognitively impaired resident. He stated on 09/22/2024, he witnessed S13LPN stand in front of Resident #42's wheelchair and tell her You can't come down this hall in a stern voice. He stated again on 10/05/2024, S13LPN told him and Resident #42 to get in Resident #48's room or get off the hall in a stern voice. On 10/09/2024 at 3:53 p.m., an interview was conducted with S13LPN. She stated Resident #42 was loud, made too much noise on the hall and always visited Resident #48 on her hall. She stated on 09/22/2024 she told Resident #42 she could not go down the hall. She stated on 10/05/2024, Resident #42 was again visiting Resident #48 on her hall. She stated she told them either to get in Resident #48's room or get off the hall. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He said on 09/23/2024 Resident #42 reported that on 09/22/2024, S13LPN stopped her, stood in front of her wheelchair and stated, Get off my hall, you're not allowed over here in a stern voice. He confirmed Resident #42 should not have been stopped and been allowed to visit Resident #48. He stated he did not report it because it was a customer service issue and not abuse. He stated he was made aware of the 10/05/2024 incident by the state surveyor on 10/09/2024. He confirmed S13LPN was not removed from the facility after 09/22/2024 and provided care at the facility when another incident occurred on 10/05/2024. He confirmed abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. 4. A review of Resident #46's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, Depression and Weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195512	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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 - Some	A review of Resident #46's MDS, with an ARD of 07/11/2024, revealed Resident #46 had a BIMS of 15, which indicated Resident #46 was cognitively intact. A review of Resident #46's grievance, dated 09/24/2024, revealed the following: Statement of concern: Resident #46 stated S6CNA approached her and asked, If you have something to say, say it to me Investigation: S6CNA confirmed Resident #46's statement Conclusion: S6CNA terminated On 10/08/2024 at 11:45 a.m., an interview was conducted with Resident #46. She stated on 09/24/2024, she and Resident #52 were talking in the hall. She stated when she finished talking with Resident #52, she went to her room, and S6CNA followed her to her room, stood in the doorway and yelled while shaking and pointing her finger toward her, if you have something to say, say it to my face. She stated she felt threatened by S6CNA and reported this to S1ADM the same day. On 10/09/2024 at 2:01 p.m., an interview was attempted with S6CNA, unable to leave a message. On 10/09/2024 at 4:45 p.m., an interview was attempted with S6CNA, unable to leave a message. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 notified him of the incident with S6CNA on 09/24/2024. He stated he did not report it because it was a customer service issue and not abuse. He confirmed abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. F-600 Plan of Removal 1. On 10/09/2024 Residents #46 and #52 were re-assessed for any signs of psychosocial harm. Both residents declined any need for counseling or psychosocial services. All interviewable residents were assessed for signs of abuse or allegations of being mistreated by Administrator/SSD/Designee on 10/9/24. Beginning on 10/07/2024 and completing on 10/10/2024 any non-interviewable residents were assessed by a weekly body audit and daily skin checks. Any abnormal findings will be documented by licensed staff and the Administrator/DON will be notified. 2. S4CNA no longer works in the facility as of 09/24/2024. S5CNA no longer works in facility as of 09/25/2024. S6CNA no longer works in facility as of 09/26/2024. 3. All staff will be re-trained on verbal abuse including yelling, cursing, threatening residents as well as immediately reporting verbal abuse to the Administrator if it is witnessed. The Corporate Office retrained Administrator/Designee initially on 10/09/2024 at 12:45pm. Administrator/Designee began retraining facility staff on 10/09/2024. After retraining, staff will be tested for competency / understanding. No staff member will be allowed to work a shift without receiving re-training and successfully completing a competency test. All staff will receive abuse training on hire and at least annually, including training on verbal abuse. (continued on next page)

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Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. On 10/09/2024 Administrator/ DON/ or SSD will interview 5 random residents weekly with BIMS above 8 to ensure no allegations of abuse for 8 weeks and randomly thereafter. As of 10/09/2024, the facility asserts the likelihood for serious harm to any recipient no longer exists.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	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** 43133 Based on interviews and record reviews, the facility failed to ensure all alleged violations of abuse were reported to the state survey agency. The facility failed to: 1. Ensure allegations of verbal and physical abuse were reported to the State Survey Agency, immediately but not later than 2 hours after the allegation was made for 5 (#35, #42, #46, #51, and #52) of 19 sampled residents reviewed for abuse; and 2. Report the results of the investigations within 5 working days with appropriate corrective actions implemented for 5 (#35, #42, #46, #51, and #52) of 19 sampled residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy situation on 09/04/2024 when multiple staff witnessed S4CNA and S5CNA curse, yell, and point in Resident #52's face. It continued on 09/14/2024, when Resident #46 witnessed and reported to S1ADM, S6CNA yelled and cursed at Resident #52 in the hallway. It continued on 09/23/2024, when Resident #42 reported S13LPN stood in front of her wheelchair, pointed and demanded she get off the hall. It continued on 09/24/2024 when S6CNA followed Resident #46 to her room, yelled, pointed her finger and threatened Resident #46. S1ADM did not report, investigate, report investigation findings or initiate any corrective actions for any of the above abuse allegations. S1ADM was notified of the Immediate Jeopardy Situation on 10/09/2024 at 1:53 p.m. The Immediate Jeopardy was removed on 10/10/2024 at 12:33 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit. This deficient practice continued at a potential for more than minimal harm for the other 59 residents residing in the facility. Cross Reference F600. Findings: Review of the facility's undated policy titled, Abuse Neglect and Exploitation revealed the following, in part: Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: b. Establish policies and procedures to investigate any such allegations VII. Reporting/Response (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 - Many Note: The nursing home is disputing this citation.	A. The facility will have written procedures that include 1. Reporting of all alleged violations to the Administrator, state agency, and all other required agencies within specified time frames: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . 1. Resident #52 A review of Resident #52's Clinical Record revealed he was admitted to the facility on [DATE]. A review of Resident #52's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. A review of the facility's Self-Reported Incidents dated 09/25/2024 revealed the following: Incident Occurred: 09/05/2024 at 2:00 p.m. Incident Discovered: 09/25/2024 at 12:30 p.m. Incident Reported on: 09/25/2024 12:33 p.m. Incident Description: Resident #52 reported to S1ADM, S4CNA and S5CNA were asked to empty his urinal and refused. CNAs responded to Resident #52 that he capable of emptying his own urinal. Resident #52 alleged CNAs told him, tell your mammy to do it, yeah tell that b**** to do it. On 10/08/2024 at 10:15 a.m., an interview was conducted with S17SW. She stated on 09/04/2024 at approximately 5:30 p.m., she saw Resident #52 in the doorway of S2DON's office where S4CNA and S5CNA yelled, cursed, pointed their finger, and argued with Resident #52. She confirmed yelling, cursing, and pointing your finger at a residents face was abuse and she reported it to S1ADM on 09/05/2024. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She stated staff cursing and pointing a finger at a resident was abuse and should be reported to administration immediately. She stated S1ADM was responsible for reporting to the State Agency. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated if staff witnessed Resident #52, S4CNA and S5CNA yell, argue and curse it should have been reported to him immediately. He stated the incident involving S4CNA, S5CNA, and Resident #52 was not reported to him until 09/25/2024. He stated any allegation of abuse should be reported to him immediately. He stated he was responsible for reporting the allegation to State Agency within 2 hours. A review of the facility's Self-Reported Incidents dated 09/24/2024 revealed the following: Incident Occurred: 09/14/2024 at 9:00 a.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 - Many Note: The nursing home is disputing this citation.	Incident Discovered: 09/24/2024 at 2:30 p.m. Incident Reported on: 09/25/2024 4:00 p.m. Incident Description: Resident #46 reported S6CNA and Resident #52 cursed and yelled at each other in the hall. On 10/08/2024 at 9:31 a.m., an interview was conducted with S20LPN. She stated on 09/14/2024 she witnessed S6CNA yell and curse at Resident #52. She confirmed arguing, yelling and cursing with a resident was abuse and she reported it to administration on 09/14/2024. On 10/08/2024 at 11:45 p.m., an interview was conducted with Resident #46, a cognitively intact resident. She stated on 09/14/2024, she was in the hall and witnessed S6CNA yell and curse at Resident #52. She stated S6CNA told Resident #52, F*** you. She stated she contacted S1ADM and reported the incident immediately. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 approached him on 09/14/2024 and notified him of the incident with S6CNA. He confirmed he did not report the allegation of abuse or conduct an investigation until 09/24/2024. Resident #42 A review of Resident #42's Clinical Record revealed Resident #42 was admitted to the facility on [DATE]. A review of Resident #42's Quarterly MDS with an ARD of 08/07/2024 revealed Resident #42 had a BIMS of 14, which indicated Resident #42 was cognitively intact. A review of the facility's Self-Reported Incidents dated September 2024 revealed no entries for the 09/22/2024 incident with Resident #42 and S13LPN. On 10/09/2024 at 3:28 p.m., an interview was conducted with Resident #42. She stated she and Resident #48 were friends and she visited Resident #48's room frequently. She stated on 09/22/2024, she was in her wheelchair, rolling down the hall, S13LPN stopped her, stood in front of her wheelchair and stated, Get off my hall, you're not allowed over here in a stern voice. Resident #42 stated she felt intimidated and threatened by S13LPN and reported the incident to S1ADM on 09/23/2024. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #42 notified him of the incident with S13LPN on 09/23/2024 and he completed a grievance. He confirmed he did not report or investigate the incident because it was a customer service issue. Resident #46 A review of Resident #46's Clinical Record revealed she was admitted to the facility on [DATE]. A review of Resident #46's Admission MDS, with an ARD of 07/11/2024, revealed Resident #46 had a BIMS of 15, which indicated Resident #46 was cognitively intact. (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 - Many Note: The nursing home is disputing this citation.	A review of Resident #46's grievance, dated 09/24/2024, revealed the following: Statement of concern: Resident #46 stated S6CNA approached her and asked, If you have something to say, say it to me A review of the facility's Self-Reported Incidents revealed no entries for the 09/24/2024 incident with Resident #46 and S6CNA. On 10/08/2024 at 11:45 a.m., an interview was conducted with Resident #46. She stated on 09/24/2024, she and Resident #52 were talking in the hall. She stated when she finished talking with Resident #52, she went to her room, and S6CNA followed her to her room, stood in the doorway and yelled while shaking and pointing her finger toward her, if you have something to say, say it to my face. She stated she felt threatened by S6CNA and reported this to S1ADM the same day. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 notified him of the incident with S6CNA on 09/24/2024. He confirmed he did not report or investigate the incident. Resident #35 A review of Resident #35's Clinical Record revealed he was admitted to the facility on [DATE]. A review of Resident #35's Admission MDS with an ARD of 09/20/2024, revealed Resident #35 had a BIMS of 15, which indicated Resident #35 was cognitively intact. Resident #51 A review of Resident #51's Clinical Record revealed she was admitted to the facility on [DATE]. A review of Resident #51's Admission MDS with an ARD of 07/11/2024, revealed Resident #51 had a BIMS of 15, which indicated Resident #51 was cognitively intact. A review of the facility's Self-Reported Incidents dated October 2024 revealed no entries for the 10/02/2024 incident with Resident #35 and #51. On 10/08/2024 at 9:15 a.m., an interview was conducted with Resident #51. He stated about one week ago Resident #35 yelled at him and pushed him against the wall. He stated he reported it to S11LPN. On 10/08/2024 at 9:30 a.m., an interview was conducted with S11LPN. She stated on 10/02/2024 at approximately 10:00 a.m., she heard yelling as Resident #35 entered his shared room with Resident #51. S11LPN stated when she went into the room, Resident #51 told her Resident #35 grabbed him by the wrist and pushed him against the dresser. She stated she reported the incident on 10/02/2024 to S1ADM and S2DON immediately. On 10/09/2024 at 12:45 p.m., an interview was conducted with S1ADM. He stated he was aware of the incident on 10/02/2024 between Resident #35 and #51. He stated he did not feel that this incident rose to the reportable level, therefore he did not investigate or report. (continued on next page)

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	195512	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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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 - Many Note: The nursing home is disputing this citation.	2. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She stated S1ADM was responsible for investigating abuse allegations. She confirmed no corrective actions were placed for any of the above incidents. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated he was responsible for conducting an investigation and reporting the investigation findings within 5 days following any allegations of abuse. He stated the following employees were not removed following the above incidents and continued to provide care to residents: S4CNA, S5CNA, S6CNA, and S13LPN. He confirmed he did not conduct an investigation or place any corrective actions for any of the above incidents. F609 Plan of Removal 1. On 10/9/24 Administrator has opened SIMS reports for all cited incidents. 2. All interviewable residents were assessed for signs of abuse or allegations of being mistreated by Administrator/ SSI)/ Designee on 10/9/24. Beginning on 10/7/24 and completing on 10/10/24 any non-interviewable residents were assessed by a weekly body audit and daily skin checks. Any abnormal findings will be documented by licensed staff and the Administrator/ DON will be notified. 3. Administrator will receive 1:1 education by Regional Administrator on 10/9/2024 on requirement of reporting allegations of verbal abuse to state survey agency within 2 hours. Administrator will be tested for understanding / competency. All staff will be re-trained by the Administrator on reporting abuse allegations in a timely manner. After retraining, staff will be tested for competency / understanding. No staff member will be allowed to work a shift without receiving re-training and successfully completing a competency test. All staff will receive abuse training on hire and at least annually, including training on reporting abuse allegations in a timely manner. 4. Beginning on 10/9/24, the Regional Administrator or Regional Nurse will review all allegations of abuse at least weekly for 8 weeks then randomly for an additional 8 weeks to ensure the reporting requirement is met. As of 10/9/24, the facility asserts the likelihood for serious harm to any recipient no longer exists. 43868 47546

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 Based on record review and interviews, the facility failed to ensure a resident's assessment accurately reflected the Discharge Status for 1 (#62) of 24 residents reviewed in the final sample. Findings: Review of Resident #62's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #62's Discharge MDS, with an ARD of 08/24/2024, indicated, in part, the following; Section A: discharge date : 08/24/2024. Discharge Status: 1. Home/Community. Review of Resident #62's Nurses Notes revealed, in part, a note written on 08/24/2024 at 11:38 p.m. by S8LPN indicating Resident #62 was transferred to a local hospital by ambulance. On 10/09/2024 at 10:55 a.m., an interview was conducted with S7RN. She confirmed she was responsible for entering MDS Assessments for the facility. She reviewed Resident #62's Discharge MDS and Nurses Notes dated 08/24/2024. She confirmed the resident was discharged to the hospital, not home/community and the MDS was coded inaccurately. On 10/09/2024 at 11:07 a.m., an interview was conducted with S2DON. She reviewed Resident #62's Discharge MDS and Nurses Notes dated 08/24/2024. She confirmed the resident was discharged to the hospital, not home/community and the MDS was coded inaccurately.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on record reviews and interviews, the facility failed to ensure the resident's care plan was reviewed and revised for 2 (#5 and #52) of 19 sampled residents reviewed for care plans. The facility failed to ensure: 1. Resident #5's transfer status was documented on his care plan; and 2. Resident #52's care plan was reviewed and revised for behaviors. Findings: Review of the facility's undated policy titled Care Plans - Comprehensive revealed, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 8. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs. 10. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 13. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 1. Review of Resident #5's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses, which included: Cerebral Palsy, Muscle Weakness, History of Falling, and Unspecified Lack of Coordination. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's most recent MDS, with ARD of 09/04/2024, revealed Resident #5 had a BIMS of 15, indicating he was cognitively intact. Further review of MDS Section GG revealed Resident #5 was dependent on staff for the following: Chair/bed-to-chair transfer, upper and lower body dressing, Personal hygiene, rolling left and right, and sit to lying. Review of Resident #5's Care Plan revealed the following, in part: Date: 05/10/2022 Resident Problem: ADLs: Requires assistance for ADLs Further review revealed there were no interventions noted for Resident #5's transfer status. 2. Review of Resident #52's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses, which included: Adjustment Disorder, Unspecified. Review of Resident #52's most recent MDS, with ARD of 08/05/2024, revealed Resident #52 had a BIMS of 15, indicating he was cognitively intact. Review of Resident #52's Care Plan revealed the following, in part: Date: 06/24/2024 Resident Problem: Behavior: Verbally aggressive behavior. Further review revealed there were no updated interventions noted for Resident #5's behavior/s. An interview was conducted on 10/10/2024 at 2:10 p.m. with S7RN and S16LPN. Both stated they were responsible for MDS and review and revision of care plans. S7RN stated she was not aware Resident #52 had behaviors. S7RN further stated Resident #5 required 2 person mechanical lift transfers. S7RN confirmed Resident #5 was not care planned for 2 person mechanical lift transfers, and Resident #52 had not had any behavior interventions updated, and should have. An interview was conducted on 10/10/2024 at 2:23 p.m. with S3CRN. S3CRN confirmed a resident's transfer status should be included in their care plan, and interventions should have be updated for Resident #52's behaviors. 47546

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43133 Based on record review and interviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 (#28) of 19 residents reviewed in the final sample. The facility failed to ensure Resident #28 received her required HIV medication. Findings: Review of Resident #28's clinical record revealed she was admitted to the facility on [DATE] with diagnoses, which included HIV. Review of Resident #28's discharge instructions from a local rehabilitation center dated 06/19/2024 revealed an order for Bictegravir/Emtricitabine/Alafenamide 50mg/200mg/25mg one tablet by mouth daily. Review of Resident #28's MAR dated 06/10/2024-10/10/2024 revealed no documentation of Bictegravir/Emtricitabine/Alafenamide 50mg/200mg/25mg one tablet by mouth daily. On 10/10/2024 at 2:02 p.m., an interview was conducted with S8LPN. She stated Resident #28 had a diagnosis of HIV. She stated Resident #28's HIV medication was discontinued. She stated she discontinued the medication after the clinic visit. She reviewed Resident #28's orders and confirmed she did not see an order to discontinue HIV medication. On 10/10/2024 at 2:04 p.m., an interview was conducted with S2DON. She stated Resident #28 was readmitted to the facility from a rehabilitation center. She stated she was responsible for inputting admission orders. She stated she was unaware of discharge orders from local rehabilitation facility. She confirmed HIV medication for Resident #28 was not reordered. On 10/10/2024 at 2:30 p.m., a telephone interview was conducted with S12NP. He stated he was unaware of HIV medications for Resident #28. He reviewed the medication list and confirmed there was no order for HIV medication. On 10/10/2024 at 4:42 p.m., an interview was conducted with S13CRN. She reviewed Resident #28's physician orders along with the rehabilitation facility's discharge instructions dated 06/19/2024 and confirmed an order for the following HIV medication, Bictegravir/Emtricitabine/Alafenamide 50mg/200mg/25mg one tablet by mouth daily 2and further confirmed the medication was not reordered and should have been.

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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** 47546 Based on interviews and record reviews, the facility failed to ensure residents remained free of accidents by failing to ensure residents were transferred with proper transfer assistance and devices for 1 (#5) of 19 sampled residents reviewed for accidents. Findings: Review of the facility's undated policy titled, Safe Resident Handling/Transfers revealed the following: Policy: It is the policy of this facility to ensure residents are handled and transferred safely to prevent or minimize risks for injury, and provide and promote a safe, secure, and comfortable experience for the resident, while keeping the employees safe, in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized, dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 26. Two staff members must be utilized when transferring residents with a mechanical lift. Review of Resident #5's Clinical Records revealed he was admitted to the facility on [DATE] with diagnoses, which included: Cerebral Palsy, Muscle Weakness, History of Falling, and Unspecified Lack of Coordination. Review of Resident #5's most recent MDS, with ARD of 09/04/2024, revealed Resident #5 had a BIMS of 15 indicating he was cognitively intact. Further review of MDS Section GG revealed Resident #5 was dependent on staff for the following: chair/bed-to-chair transfers, upper and lower body dressing, personal hygiene, rolling left and right, and sit to lying. Review of Resident #5's Care Plan revealed the following: Date: 05/10/2022 Resident Problem: ADLs: Requires assistance for all ADLs Further review revealed no interventions were documented for Resident #5's transfer status. Review of Resident #5's Nursing Progress Notes dated 10/06/2024 to 10/07/2024 revealed the following, in part: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/06/2024 at 10:50 a.m., Mobile x-ray ordered for Resident #5 related to complaint of bilateral lower extremity pain, onset from previous night. -signed S20LPN. On 10/07/2024 at 7:21 a.m., Late entry from 10/6/2024 at 5:30 a.m.- resident complained of pain to left knee. States CNA fell (lean) on his leg last evening. Resident requested pain medication-signed S13LPN. On 10/07/2024 at 7:33 a.m., Spoke with S12NP who gave order to send to Emergency Department for evaluation and treatment of leg fracture. - signed S11LPN. On 10/07/2024 at 4:10 p.m. Resident #5 returned from emergency room . Resident #5 diagnosed with Plateau Fracture of Left Knee, immobilizer intact and in place- signed S24LPN. On 10/08/24 at 9:22 a.m., an interview was conducted with S11LPN. She stated Resident #5 informed her S14CNA was transferring him without assistance and fell on top of him on 10/05/2024. On 10/08/2024 at 10:00 a.m., an interview was conducted with Resident #5. He stated S14CNA transferred him back into bed, without assistance, and fell on his leg on the night of 10/05/2024. On 10/08/24 at 11:39 a.m., a telephone interview was conducted with S25CNA. She stated on 10/05/2024 at approximately 5:30 a.m. Resident #5 informed her S14CNA fell on him. Resident #5 reported his leg was hurting and he needed medication for pain. On 10/08/24 at 12:00 p.m., an interview was conducted with S20LPN. Resident #5 informed her while his brief was being changed, S14CNA fell on him. She stated Resident #5 was a 2 person mechanical lift transfer. On 10/09/24 at 09:00 a.m., an interview was conducted with S14CNA. She stated on 10/5/2024 at approximately 8:30 p.m. she went into Resident #5's room and transferred him into his bed by herself using the mechanical lift. She further stated she was short and did have to reach across resident in order to turn him and may have leaned on Resident #5's leg. S14CNA stated she was aware Resident #5 was a 2 person mechanical lift transfer. On 10/09/2024 at 12:42 p.m., an interview was conducted with S2DON. S2DON confirmed all mechanical lift transfers should be performed by two nursing staff in order to ensure resident safety. On 10/10/2024 at 4:40 p.m., an interview was conducted with S3CRN. S3CRN confirmed all mechanical lift transfers should be performed by two nursing staff in order to ensure resident safety and to prevent accidents. S3CRN confirmed it was unacceptable for one staff member to perform mechanical lift transfers.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47546 Based on interviews and record reviews, the facility failed to ensure nursing staff had the appropriate competencies and skills sets to provide nursing and related services to ensure resident safety, as determined by resident assessments and individual plans of care. The facility failed to ensure: 1. All nursing staff were competent to implement a resident's assessed transfer needs for 1 (#5) of 19 sampled residents reviewed for transfer status. This deficient practice had the potential to affect 14 residents residing in the facility who required mechanical lift transfers. Findings: Review of the facility's undated policy titled, Safe Resident Handling/Transfers revealed the following: Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury, and provide and promote a safe, secure and comfortable experience for the resident, while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized, dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 26. Two staff members must be utilized when transferring residents with a mechanical lift. Review of Resident #5's Clinical Records revealed he was admitted on [DATE] with diagnoses, which included: Cerebral Palsy, Cognitive Communication Deficit, Muscle Weakness, History of Falling, and Unspecified Lack of Coordination. Review of Resident #5's most recent MDS (Minimum Data Set), with ARD (Assessment Reference Date) of 09/04/2024, revealed Resident #5 had a BIMS (Brief Interview of Mental Status) of 15, indicating Resident #5 was cognitively intact. Review of Resident #5's Care Plan revealed he required assistance for all ADLs. Further review revealed there was no documentation of the amount of assistance, supervision, and/or assistive devices required for Resident #5's transfers. On 10/08/24 at 11:55 a.m., an interview was conducted with S23TD. S23TD confirmed Resident #5 had been assessed and required a 2 person assist mechanical lift transfer. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 09:00 a.m., an interview was conducted with S14CNA. She stated on 10/5/2024 at approximately 8:30 p.m. she went into Resident #5's room and transferred him into his bed by herself using the mechanical lift, while S15CNA stood in the doorway spotting her. S14CNA stated she was aware of Resident #5's 2 person assist mechanical lift transfer status. On 10/09/2024 at 10:24 a.m., an interview was conducted with S15CNA. She confirmed she was standing in Resident #5's door on 10/05/2024, while S14CNA transferred Resident #5 independently using the mechanical lift. S15CNA stated she was aware of Resident #5's 2 person assist mechanical lift transfer status On 10/09/2024 at 12:42 p.m., an interview was conducted with S2DON, she confirmed 2 nursing staff should perform all mechanical lift transfers. On 10/10/2024 at 4:40 p.m., an interview was conducted with S3CRN. S3CRN confirmed 2 nursing staff should perform all mechanical lift transfers. S3CRN confirmed it was unacceptable for one staff member to perform mechanical lift transfers.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on interviews and record review the facility failed to ensure direct care staff had appropriate competencies and skills to assure resident safety and maintain the highest practicable physical, mental, and psychological well-being of each resident. The facility failed to ensure all direct care staff had competency training in crisis prevention interventions (CPI) for a resident (Resident #52) who displayed aggressive threatening behaviors. The deficient practice had the potential to effect all 59 residents that resided in the facility. Findings: A review of Resident #52's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Adjustment Disorder. A review of Resident #52's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. A review of Resident #52's Psychiatric NP Notes, dated 09/17/2024 revealed the following, in part: Diagnosis: Adjustment disorder. A review of Resident #52's NP Progress Notes, dated 09/04/2024 revealed the following, in part: Confrontational with staff, Aggressive behaviors. On 10/08/2024 at 9:31 a.m., an interview was conducted with S20LPN. She stated Resident #52 had behaviors and was aggressive with staff. She further stated she had not received behavior health training, which included CPI, upon hire. On 10/09/2024 at 4:25 p.m., an interview was conducted with S4CNA. She stated Resident #52 had behaviors and was aggressive with staff. She further stated she had not received behavior health training, which included CPI, upon hire. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She confirmed Resident #52 had behaviors and was aggressive with staff. S2DON confirmed the facility had not provided direct care staff with behavior health training, which included CPI. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated the facility was aware of Resident #52's diagnosis of Adjustment Disorder on admit. S1ADM confirmed Resident #52 had behaviors and was aggressive with staff. S1ADM confirmed the facility had not provided direct care staff with behavior health training, which included CPI. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 10/10/2024 at 4:06 p.m., an interview was conducted with S22NP. She confirmed staff needed CPI training before providing care to Resident #52 due to his diagnosis of Adjustment Disorder.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43133 Based on interviews and record review, the facility failed to employ staff with appropriate competencies and skills sets to carry out the functions of the food and nutrition service by failing to have a certified dietary manager on staff. This deficient practice had the potential to affect the 56 residents who consumed food from the kitchen. Findings: On 10/09/2024 at 1:10 p.m., an interview was conducted with S9DM. He stated he was hired one month ago. S9DM stated he had not received a dietary manager certification. On 10/09/2024 at 1:30 p.m., an interview was conducted with S10RD. She stated she was hired by the facility as a Consultant Dietitian and worked 20 hours per week. S10RD stated she was not a full-time employee at the facility. On 10/09/2024 at 11:22 a.m., an interview was conducted with S1ADM. He stated S9DM was hired one month ago. S1ADM confirmed S9DM did not have a dietary manager certification and should have.

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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. 43133 Based on observations and interviews, the facility failed to store food in accordance with professional standards for food service safety. This deficient practice had the potential to affect the 56 residents who consumed food from the kitchen. Findings: On 10/07/2024 at 08:27 a.m., an observation was made of the kitchen food preparation area with S9DM, which revealed the following items: 2-12oz containers of parsley flakes opened and unlabeled. 1-18oz container of celery salt opened and unlabeled. 1-18oz container of ground cinnamon opened and unlabeled. 1-32oz bottle of lemon juice opened and unlabeled. 1 16oz box of brown sugar opened and unlabeled. On 10/07/2024 at 08:32 a.m., an observation was made of the dry storage area, which revealed the following items: 1-50lb bag of white granular sugar opened and unlabeled. 1-25lb bag of brown rice opened and unlabeled. On 10/07/2024 at 8:34 a.m., an interview was conducted with S9DM. He confirmed all opened container should have been labeled with open date and were not. On 10/07/2024 at 9:30 a.m., an interview was conducted with S1ADM. He was notified of the aforementioned findings. S1ADM confirmed opened containers should be labeled with open date.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46981 Based on interviews and record reviews, the facility failed to ensure it was administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to have an effective system in place to: 1. Ensure residents remained free from verbal and mental abuse for 3 (#42, #46, and #52) of 7 (#18, #26, #42, #46, #51, #52, and #111) residents reviewed for abuse; and 2. Ensure allegations of verbal and physical abuse were reported to the State Survey Agency, immediately but not later than 2 hours after the allegation was made for 5 (#35, #42, #46, #51, and #52) of 19 sampled residents reviewed for abuse; and 3. Report the results of the investigations within 5 working days with appropriate corrective actions implemented for 5 (#35, #42, #46, #51, and #52) of 19 sampled residents reviewed for abuse. Cross Reference F600 and F609 This deficient practice resulted in an Immediate Jeopardy situation on 09/04/2024 when multiple staff witnessed S4CNA and S5CNA curse, yell, and point in Resident #52's face. It continued on 09/14/2024, when Resident #46 witnessed and reported to S1ADM, S6CNA yelled and cursed at Resident #52 in the hallway. It continued on 09/23/2024, when Resident #42 reported S13LPN stood in front of her wheelchair, pointed and demanded she get off the hall. It continued on 09/24/2024 when S6CNA followed Resident #46 to her room, yelled, pointed her finger and threatened Resident #46. It continued on 10/02/2024 when Resident #51 reported to staff Resident #35 grabbed him by the wrist and pushed him against the dresser. S1ADM did not report timely, report investigation findings or initiate any corrective actions for any of the above abuse allegations. The facility failed to protect residents from any further abuse following the incidents. S1ADM was notified of the Immediate Jeopardy situation on 10/09/2024 at 1:53 p.m. The Immediate Jeopardy was removed on 10/10/2024 at 12:33 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit. This deficient practice continued at a potential for more than minimal harm for the 59 residents currently residing in the facility. Findings: Review of the facility's undated policy titled, Abuse Neglect and Exploitation revealed the following, in part: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy Statement: 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: Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: b. Establish policies and procedures to investigate any such allegations; and VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State agency, and all other required agencies within specified time frames: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by State agencies. Resident #52 A review of Resident #52's Clinical Record revealed he was admitted on [DATE] with diagnoses which included, Acquired Absence of Right Leg Above Knee, Acquired Absence Of Left Leg Above Knee, And Adjustment Disorder, Unspecified. A review of Resident #52's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #52 was cognitively intact. Review of the facility's Self-Reported Incident Reports, dated 09/05/2024, revealed the following: Occurred: 09/05/2024 at 2:00 p.m. Discovered: 09/25/2024 at 12:30 p.m. Incident Reported on: 09/25/2024 12:33 p.m. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Description: Resident #52 reported to S1ADM S4CNA and S5CNA were asked to empty his urinal. CNA's responded with Resident #52 was capable of emptying his own urinal. Resident #52 became angry and began yelling. Resident #52 alleged CNA's told him, tell your mammy to do it, yea tell that b**** to do it. On 10/08/2024 at 10:15 a.m., an interview was conducted with S17SW. She stated on 09/04/2024 at approximately 5:30 p.m., she saw Resident #52 in the doorway of S2DON's office where S4CNA and S5CNA yelled, cursed, pointed their finger, and argued with Resident #52. She stated S2DON was in her office, could see and hear the altercation, and did not intervene. She confirmed yelling, cursing, and pointing your finger at a residents face was abuse and she reported it to S1ADM on 09/05/2024. On 10/08/2024 at 11:08 a.m., an interview was conducted with S18LPN. She stated on 09/04/2024, she saw Resident #52 in the doorway of S2DON's office in his wheelchair. She stated Resident #52, S4CNA and S5CNA yelled and cursed at each other. She stated S5CNA pointed her finger in Resident #52's face and told him he was capable of emptying his urinal. She stated S2DON was in her office, could see and hear the altercation, and did not intervene. She stated yelling, cursing and pointing a finger at a residents face is abuse. On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She stated on 09/04/2024, Resident #52 asked S4CNA to empty his urinal and she told him he could do it himself. She stated Resident #52 rolled his wheelchair to the doorway of her office, parked his wheelchair, and yelled and cursed at her and S4CNA. S2DON stated she did not hear the 2 CNAs yell or curse at the resident. She stated staff cursing and pointing a finger at a resident was abuse. She confirmed S4CNA continued to provide care to residents in the facility until 09/24/2024 and S5CNA continued to provide care to residents in the facility until 09/26/2024 when S1ADM removed them. She confirmed no additional education was provided to staff on de-escalation for residents with behaviors or monitoring completed following the incident on 09/04/2024. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #52 reported on 09/25/2024, he asked S4CNA on 09/05/2024 to empty his urinal. Resident #52 reported S4CNA refused to empty his urinal, yelled and cursed at her. S1ADM explained Resident #52 had aggressive behaviors, which included, yelling and cursing with other residents and staff. He stated S4CNA and S5CNA triggered Resident #52's behaviors so they were moved to another facility on 09/24/2024 and 09/26/2024, with a plan to return when Resident #52 was discharged . He stated S4CNA was not assigned to Resident #52 after 09/07/2024 but did provide care to other residents at the facility until 09/24/2024. He confirmed no additional education was provided to staff on de-escalation for residents with behaviors or monitoring completed following the incident on 09/04/2024. Review of the facility's Self-Reported Incident Reports dated 09/05/2024 revealed the following: Occurred: 09/14/2024 at 9:00 a.m. Discovered: 09/24/2024 at 2:30 p.m. Description: Resident #46 reported S6CNA and Resident #52 were cursing and yelling at each other in the hall. (continued on next page)

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	195512	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/08/2024 at 11:45 p.m., an interview was conducted with Resident #46, a cognitively intact resident. She stated on 09/14/2024, she was in the hall and witnessed S6CNA yell and curse at Resident #52. She stated S6CNA told Resident #52, F*** you. She stated she reported the incident immediately to S1ADM. She stated S6CNA continued to provide care at the facility on her hall until 09/24/2024, when S6CNA threatened her. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 approached him on 09/14/2024 and notified him of the incident with Resident #52 and S6CNA. He stated S6CNA was not removed from the facility and continued to provide care to Resident #46 and Resident #52 until S6CNA was removed on 09/26/2024. He stated on 09/24/2024, S6CNA was involved in another incident with Resident #46 and S6CNA was terminated but not related to the allegation. He confirmed no additional education was provided to staff on de-escalation for residents with behaviors. He confirmed the last abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. Resident #42 A review of Resident #42's Clinical Record revealed Resident #42 was admitted to the facility on [DATE]. A review of Resident #42's Quarterly MDS with an ARD of 08/07/2024 revealed Resident #42 had a BIMS of 14, which indicated Resident #42 was cognitively intact. A review of the facility's Self-Reported Incidents dated September 2024 revealed no entries for the 09/22/2024 incident with Resident #42 and S13LPN. On 10/09/2024 at 3:28 p.m., an interview was conducted with Resident #42. She stated she and Resident #48 were friends and she visited Resident #48's room frequently. She stated on 09/22/2024, she was in her wheelchair, rolling down the hall, when S13LPN stopped her, stood in front of her wheelchair and stated, Get off my hall, you're not allowed over here in a stern voice. She stated on the same day after leaving the smoking patio and going back to her room, she heard S13LPN call her white trash. Resident #42 stated she felt intimidated and threatened by S13LPN and reported the incident to S1ADM on 09/23/2024. She stated again on 10/05/2024, S13LPN told her to get in Resident #48's room or get off the hall in a stern voice. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He said on 09/23/2024 Resident #42 reported that on 09/22/2024, S13LPN stopped her, stood in front of her wheelchair and stated, Get off my hall, you're not allowed over here in a stern voice. He confirmed Resident #42 should not have been stopped and been allowed to visit Resident #48. He stated he did not report it because it was a customer service issue and not abuse. He stated he was made aware of the 10/05/2024 incident by the state surveyor on 10/09/2024. He confirmed S13LPN was not removed from the facility after 09/22/2024 and provided care at the facility when another incident occurred on 10/05/2024. He confirmed abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. Resident #46 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident #46's Clinical Record revealed she was admitted on [DATE] with diagnoses which included, Depression and Weakness. A review of Resident #46's MDS, with an ARD of 07/11/2024, revealed Resident #46 had a BIMS of 15, which indicated Resident #46 was cognitively intact. On 10/08/2024 at 11:45 a.m., an interview was conducted with Resident #46. She stated on 09/24/2024, she and Resident #52 were talking in the hall. She stated when she finished talking with Resident #52, she went to her room, and S6CNA followed her to her room, stood in the doorway and yelled while shaking and pointing her finger toward her, if you have something to say, say it to my face. She stated she felt threatened by S6CNA and reported this to S1ADM immediately. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated Resident #46 notified him of the incident with S6CNA on 09/24/2024. He stated he did not report it because it was a customer service issue and not abuse. He confirmed abuse training was conducted during the staff meeting on 10/01/2024 but S4CNA, S5CNA, S6CNA and S13LPN did not attend the meeting for the abuse training. Resident #35 A review of Resident #35's Clinical Record revealed he was admitted on [DATE] with diagnoses which included, Unqualified Visual Loss of Left Eye and Depressive Episodes. A review of Resident #35's MDS, with an ARD of 09/20/2024, revealed Resident #35 had a BIMS of 15, which indicated Resident #35 was cognitively intact. Resident #51 A review of Resident #51's Clinical Record revealed he was admitted on [DATE] with diagnoses which included, Depressive Disorder, Anxiety Disorder, and Personal history of other Mental and Behavioral Disorders. A review of Resident #51's MDS, with an ARD of 07/11/2024, revealed Resident #51 had a BIMS of 15, which indicated Resident #51 was cognitively intact. On 10/08/2024 at 9:15 a.m., an interview was conducted with Resident #51. He stated about one week ago Resident #35 yelled at him and pushed him against the wall. On 10/08/2024 at 9:30 a.m., an interview was conducted with S11LPN. She stated on 10/02/2024 at approximately 10:00 a.m., she heard yelling as Resident #35 entered his shared room with Resident #51. She stated when she went into the room, Resident #51 told her Resident #35 grabbed him by the wrist and pushed him against the dresser. She stated she reported the incident on 10/02/2024 to S1ADM and S2DON. On 10/09/2024 at 12:45 p.m., an interview was conducted with S1ADM. He stated he was aware of the incident on 10/02/2024 between Resident #35 and #51. He stated he did not feel that this incident rose to the reportable level, therefore he did not investigate or report. (continued on next page)

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Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/09/2024 at 8:37 a.m., an interview was conducted with S2DON. She stated staff cursing, pointing a finger and intimidating a resident was abuse and should be reported to administration immediately. She stated S1ADM was responsible for reporting to the State Agency. She confirmed no corrective actions were placed for any of the above incidents. On 10/10/2024 at 10:51 a.m., an interview was conducted with S1ADM. He stated any allegation of abuse should be reported to him immediately. He stated he was responsible for reporting within 2 hours and reporting the investigation within 5 days. He stated the following employees were not removed following the above incidents and continued to provide care to residents: S4CNA, S5CNA, S6CNA, and S13LPN. He confirmed he did not report, conduct an investigation, or place any corrective actions for any of the above incidents. Plan of Removal: 1. On 10/09/2024 Residents #46 and #52 were re-assessed for any signs of psychosocial harm. Both residents declined any need for counseling or psychosocial services. S4CNA no longer works in the facility as of 09/24/2024. S5CNA no longer works in facility as of 09/25/2024. S6CNA no longer works in facility as of 09/26/2024. 2. All interviewable residents were assessed for signs of abuse or allegations of being mistreated by Administrator/SSD/Designee on 10/9/24. Beginning on 10/07/2024 and completing on 10/10/2024 any non-interviewable residents were assessed by a weekly body audit and daily skin checks. Any abnormal findings will be documented by licensed staff and the Administrator/DON will be notified. 3. All staff will be re-trained on verbal abuse including yelling, cursing, threatening residents as well as immediately reporting verbal abuse to the Administrator if it is witnessed. The Corporate Office retrained Administrator/Designee initially on 10/09/2024. The Corporate Office retrained the Administrator on verbal abuse on 10/09/2024. Administrator/Designee began retraining facility staff on 10/09/2024. After retraining, staff will be tested for competency / understanding. No staff member will be allowed to work a shift without receiving re-training and successfully completing a competency test. All staff will receive abuse training on hire and at least annually, including training on verbal abuse and reporting abuse allegations in a timely manner. All incidents and accidents and nurses notes will be reviewed by corporate to ensure that any potential incidents have been reported accurately and timely. This will begin on 10/10/2024 and continue for 8 weeks 3x per week then randomly for 8 weeks thereafter. 4. Beginning on 10/09/2024, Administrator/DON/ or SSD will interview 5 random residents weekly for 8 weeks then randomly for an additional 8 weeks with BIMS above 8 to ensure no allegations of abuse. As of 10/09/2024, The Pines Retirement Center of [NAME] asserts the likelihood for serious harm to any recipient no longer exists.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46981 Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infection. The facility failed to ensure S8LPN disinfected the glucometer between resident use for 1 (#1) of 3 (#1, #26, and #55) residents observed during blood glucose monitoring. Findings: Review of the facility's policy titled, Glucometer Disinfection, dated 05/2023, revealed in part, the following: Policy Explanation and Compliance Guidelines: 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use. 2. The glucometers will be disinfected with a wipe pre-saturated with a registered healthcare disinfectant. An observation was made on 10/07/2024 at 9:00 a.m. of S8LPN. S8LPN performed a blood glucose check on Resident #1. S8LPN then wiped the glucometer with an incontinence wipe, without disinfectant, and placed the glucometer in the top drawer of the medication cart. An interview was conducted on 10/07/2024 at 9:02 a.m. with S8LPN. S8LPN confirmed she cleaned the glucometer with an incontinence wipe, without disinfectant, and not a disinfecting wipe. An interview was conducted on 10/07/2024 at 9:35 a.m. with S2DON. S2DON confirmed the glucometer should be cleaned before and after each resident's use with approved disinfecting wipes or cleaning agent.