

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/06/2024
NAME OF PROVIDER OR SUPPLIER  Deridder Retirement & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1420 Blankenship Dr Deridder, LA 70634	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773</b></p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's right to be free from sexual abuse by another resident for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for abuse. The facility failed to protect Resident #1 from being sexually abused by Resident #2.</p> <p>This deficient practice resulted in an immediate jeopardy situation on 11/22/2024 at 7:50 a.m., when Resident #2, who was cognitively intact, and had a history of inappropriate sexual behaviors entered the room of a cognitively impaired resident (Resident #1), and was found with his mouth on her mouth and his hand in her brief.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's Investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>Review of the facility's undated policy on 12/04/2024 titled Abuse Prevention and Investigation revealed in part .Residents have the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of property, exploitation and any physical or chemical restraints not required to treat the resident medical symptoms. Residents will not be subjected to abuse by anyone. Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse is non-consensual if the resident either appears to want the contact to occur, but lacks the cognitive ability to consent or does not want the contact to occur.</p> <p>Resident #1</p> <p>Review of Resident #1's medical record revealed an admitted [DATE], with the following diagnoses: Cerebral Palsy, Encephalopathy, Aphasia, Dysphagia, Unspecified Convulsions, and Major Depressive Disorder.</p> <p>Review of Resident #1's Quarterly MDS with an ARD of 10/07/2024 revealed a BIMS score of 99, indicating Resident #1 was unable to complete assessment due to impaired cognition and is total care, dependent on staff for all activities of daily living.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's care plan with a review date of 01/06/2025 revealed a communication impairment with a diagnosis Aphasia related to Cerebral Palsy. Interventions included in part .ask direct yes and no questions, anticipate and meet needs, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed.</p> <p>Resident #2</p> <p>Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included: Malignant Neoplasm of upper left lung, Cognitive Communication Deficit, Paranoid Schizophrenia, Major Depressive Disorder, Hypertensive Heart Disease, Other Anxiety Disorders, and Other Sexual Disorders.</p> <p>Review of Resident #2's Quarterly MDS with an ARD of 08/26/2024 revealed a BIMS score of 15, indicating intact cognition. Resident #2 required staff physical assist with transfers, locomotion on/off unit, toileting, dressing, and personal hygiene.</p> <p>Review of Resident #2's care plan with a review date of 02/20/2025 revealed the following problems in part . The resident has a behavior problem related to inappropriate sexual behavior towards others: Interventions included in part . Monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. Document behavior, potential causes, and notify MD.</p> <p>04/10/2024- Resident asked facility staff if she wanted private time with him, redirected resident and notified NP related sexual behaviors</p> <p>06/24/2024-facility staff witnessed Resident #2 sitting in his wheelchair outside a female resident room telling her he loved her and wanted to have sex with her. Redirected resident brought to front lobby. Notified MD with new medication ordered: Zyprexa 10mg daily.</p> <p>09/08/2024- Resident approached female resident and attempted to touch inappropriately. Targeted resident blocked attempts until facility staff intervened. Resident not easily redirected and placed 1:1 at this time. Notified MD and Psych NP, inpatient psych services for behavioral management requested for medication review and changes for better control of impulses. Remained 1:1 until leaving facility on 09/09/2024.</p> <p>11/22/24- Resident was found in another resident's room kissing her with his hand under the cover. Staff immediately place resident on 1:1 supervision, MD/RP notified, Resident admitted to inpatient psychiatric facility on 11/22/2024.</p> <p>Observation of facility video footage on 12/03/2024 at 9:30 a.m. revealed on 11/22/2024 at 7:43 a.m. Resident #2 was observed propelling himself of out his room and sitting in his doorway in his wheelchair until 7:45 a.m. Resident #2 then propelled himself out of the room towards the nurses station. At 7:47:40 a.m. Resident #2 was observed propelling himself into Resident #1's room. At 7:50:32 a.m., S3 CNA was observed walking into Resident #1's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 12/03/2024 at 9:50 a.m. with S3 CNA revealed while working the morning shift of 11/22/2024 she observed Resident #2 in Resident #1's room. S3 CNA stated she walked into Resident #1's room immediately and observed Resident #2 sitting in his wheelchair with his mouth on Resident #1's mouth and his hand in her brief. S3 CNA stated she removed Resident #2 from Resident #1's room and immediately notified management staff.</p> <p>Interview on 12/03/2024 at 12:31p.m. with S2 DON revealed she was notified of the incident immediately after it occurred on 11/22/2024. S2 DON stated staff immediately placed Resident #2 on 1:1 supervision, a body audit was conducted on Resident #1 and all cognitively impaired residents in the facility, and an abuse questionnaire was completed on all cognitively intact residents. S2 DON revealed an inservice for all staff on abuse was initiated within an hour of the incident and the Medical Director came to the facility and assessed Resident #1 and Resident #2. The Medical Director signed a Physicians Emergency Certificate, and Resident #2 was sent to a local hospital on 11/22/2024.</p> <p>Interview on 12/03/2024 1:20 p.m. with S1 Administrator revealed after the 11/22/2024 incident occurred with Resident #1 and Resident #2 she began the investigation. S1 Administrator stated the facility immediately placed Resident #2 on 1:1 supervision until he was sent out to the hospital. Body audits were completed for Resident #1 and Resident #2. The Medical Director assessed Resident #1 and Resident #2 on 11/22/2024 with no concerns. All cognitive resident were interviewed and questioned about abuse and a body audit was conducted for all resident with impaired cognition with no notification or signs of abuse. S1 Administrator revealed abuse in-servicing was initiated on 11/22/2024. Resident #1's family was notified and made the decision not to send her to the hospital for evaluation. Local police came out to investigate and determined Resident #1 and Resident #2 would not be fit to stand trial.</p> <p>S1 Administrator revealed that Resident #2 had plans to be discharged from the inpatient behavioral hospital on 12/06/2024, and had been accepted into a different nursing facility with an all male unit.</p> <p>Interview on 12/03/2024 at 3:00 p.m. with S2 DON revealed Resident #1 is cognitively impaired and cannot make decisions, including giving consent on her own. S2 DON confirmed Resident #2 kissed and inappropriately touched Resident #1, but should not have.</p> <p>The facility has implemented the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> <li>1. Resident #2 was removed and immediately placed on 1:1 supervision.</li> <li>2. On 11/22/2024 the Medical Director was notified and made rounds on both residents; Physician Emergency Certificate was signed for Resident #2.</li> <li>3. Body Audits were conducted on Resident #1 and all resident with impaired cognition in the facility with no concerns on 11/22/2024.</li> <li>4. Resident #1's Care Plan was updated to consult with Pastoral Care, Social Services, and Psyche services after the incident.</li> <li>5. All cognitive residents were interviewed and questioned about abuse with no concerns on 11/22/2024.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. Abuse in-servicing was initiated for all staff on 11/22/2024 and was completed on 11/23/2024.</p> <p>7. Resident #2 was sent to a local hospital on 11/22/2024, then transferred to an inpatient behavioral hospital.</p> <p>8. Weekly abuse monitoring for 8 random residents x 8 weeks was initiated on 11/22/2024.</p> <p>9. Administration initiated morning rounds for all residents to questions about abuse on Monday- Friday indefinitely.</p> <p>10. QA on abuse was updated and is being reviewed weekly. QAPI for abuse will be reviewed daily during morning meetings</p> <p>As of 11/23/2024 the past noncompliance was considered to be corrected.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51096</p> <p>Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status by failing to accurately code the Minimum Data Set (MDS) for Behaviors for 1 (#2) of 3 (#1, #2 and #3) sampled residents. The facility failed to accurately capture Resident #2's inappropriate behavior against Resident #3 during the lookback period.</p> <p>Findings:</p> <p>Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included: Malignant Neoplasm of upper left lung, Cognitive Communication Deficit, Paranoid Schizophrenia, Major Depressive Disorder, Hypertensive Heart Disease, Other Anxiety Disorders, and Other Sexual Disorders.</p> <p>Review of Resident #2's Quarterly MDS with an ARD of 08/26/2024 revealed a BIMS score of 15, indicating intact cognition. Resident #2 required staff physical assistance with transfers, locomotion on/off unit, toileting, dressing, and personal hygiene.</p> <p>Review of Resident #2's Discharge MDS with an ARD of 09/09/2024 revealed there were no physical behaviors exhibited that were directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually.) No verbal behaviors exhibited that were directed toward others (threatening others, screaming at others, cursing at others.) No other behaviors exhibited not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).</p> <p>Review of Resident #2's care plan with a review date of 02/20/2025 revealed the following problems in part . The resident has a behavior problem related to inappropriate sexual behavior towards others: Interventions included in part . Monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations. Document behavior, potential causes, and notify MD.</p> <p>Review of the Nurses' notes/incident report revealed the following: 09/08/2024- Resident #2 approached female resident and attempted to touch inappropriately. Targeted resident blocked attempts until facility staff intervened. Resident #2 not easily redirected and placed 1:1 at this time. Notified MD and Psych NP, inpatient psych services for behavioral management requested for medication review and changes for better control of impulses. Remained 1:1 until leaving facility on 09/09/2024. Signed by S2 DON.</p> <p>Interview with S6MDSLPN; S2DON and S1Administrator on 12/04/2024 at 5:31 pm revealed Section E-Behavior on Resident #2's MDS with an ARD of 09/09/2024 was not accurately coded and did not capture the inappropriate behavior that he exhibited toward Resident #3 on 09/08/2024 and it should have.</p>		