

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/08/2025
NAME OF PROVIDER OR SUPPLIER  Desoto Retirement & Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  635 Schley Street Mansfield, LA 71052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, observations, and interviews the facility failed to protect resident's right to be free from verbal abuse by a staff member for 1 (Resident #2) of 3 sampled residents. 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. Findings: Review of the facility's Abuse Prevention and Intervention Policy (undated) revealed 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, 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. Review of Resident #2's medical record revealed an admit date of 09/23/2025 with diagnoses that included but not limited to cerebral infarction of right middle cerebral artery, cerebral vascular accident affecting left non-dominant side, peripheral vascular disease, type 2 diabetes mellitus, hypertensive heart disease, chronic obstructive pulmonary disease, unspecified acute kidney failure, urinary tract infection-site not specified, generalized anxiety disorder, recurrent major depressive disorder, chronic peripheral venous insufficiency, chronic pain syndrome, restless leg syndrome, other abnormalities of gait and mobility, unspecified lack of coordination, generalized muscle weakness, muscle wasting and atrophy, cognitive communication deficit, other symbolic dysfunctions, and unspecified dementia with other behavioral disturbance. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had a Brief Interview for Mental Status score of 13 which indicated Resident #2 was cognitively intact. Further review of Resident #2's MDS Assessment revealed Resident #2 had impairment in functional range of motion to upper and lower extremities on one side of her body and required partial to moderate assist with bed mobility and transfers. Review of Resident #2's comprehensive care plan revealed a problem of receiver of verbal abuse revised 11/18/2025. Resident #2's care plan goals included resident will be free from any type of abuse through next review. Resident #2 care plan interventions included: monitor for any psychosocial trauma responses such as increased sadness, crying, loss of appetite; monitor for any type of abuse; and staff in-services provided per protocol. Review of the facility's Self-Reported Incident Management System (SIMS) reports revealed a report initiated 11/07/2025 in part, as follows: Occurred: 10/30/2025 Discovered: 10/31/2025 Victim: Resident #2 Accused: S5 Certified Nursing Assistant (CNA) Allegation: Verbal Abuse-unsubstantiated Protective Actions: Suspended Pending Outcome S5 CNA was immediately suspended on 10/31/2025 pending investigation. On 10/31/25 the facility initiated the following: Life satisfaction rounds were implemented on Resident #2 and residents who resided on the secured unit with Resident #2; Hourly nurse rounds on the secure unit were implemented; Statements were obtained from S5 CNA and other staff; In-service training was implemented to staff regarding abuse and customer service; and Life satisfaction rounds continued on 8 residents a week for 8 weeks then randomly. During an interview on 12/02/2025 at 11:40 a.m. with S1 Administrator, S3 Corporate Nurse, and S4 Director of Nursing (DON), S3 Corporate Nurse reported S2 Former Administrator and S4 DON initiated investigation into incident following observation of video involving Resident #2 and S5 CNA that Resident #2's family showed them. S3 Corporate Nurse indicated S4 DON had not viewed the full video. S3 Corporate Nurse reported S2 Former Administrator was terminated as a result of how this incident was handled. S1 Administrator reported he relieved S2 Former Administrator on 11/11/2025 following her termination. S1 Administrator reported on his arrival to the facility he begin speaking with Resident #2's family and the Ombudsman and indicated in speaking with them he realized he did not have all the information related to the incident. S1 Administrator requested the full video from family. S1 Administrator reported after he received and viewed the full video he filed a police report, reopened the SIMS investigation, suspended S5 CNA again, and S5 CNA was terminated following substantiation of verbal abuse. Review of the signed undated statement provided by S5 CNA revealed in part: S5 CNA wrote she entered Resident #2's room at 10:30 p.m. to find Resident #2 was on the mattress on the floor and was wet and dirty. S5 CNA wrote she was upset because Resident #2 was left like that. S5 CNA wrote she was not particularly talking to Resident #2 but was referring to the condition she was in and said I'm sick of this f***ing s***t every night I just got to work. S5 CNA wrote she recalled telling Resident #2 to get on her knees so she could get back in bed. S5</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record reviews and interviews the facility failed to complete required reporting to the State Survey Agency in accordance with State law in a timely manner for 1 (Resident #2) of 2 sampled residents who required reporting to be submitted. The facility failed to report an allegation of verbal abuse from a staff member to Resident #2 within 2 hours after the allegation was made. Findings: Review of the facility's Abuse Prevention and Intervention Policy (undated) revealed 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, 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: 2. The facility has designated the Administrator as the Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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. Review of the facility's Self-Reported Incident Management System (SIMS) reports for the past 6 months revealed the following SIMS: Allegation: Verbal Abuse Entered: 11/07/2025 3:49 p.m. Occurred: 10/30/2025 Discovered: 10/31/2025 4:47 p.m. Report due date: 11/18/2025 Victim: Resident #2 Accused: S5 Certified Nursing Assistant (CNA) Incident Description (in part): Resident #2's sister presented the facility with video recording of S5 CNA repeatedly told Resident #2 come on Resident #2, get your a** up'. S2 Former Administrator and S4 Director of Nursing (DON) assured Resident #2's sister that S5 CNA did act in an unprofessional manner and was not providing quality customer service. At this time an investigation was initiated and S5 CNA was suspended pending investigation to rule out abuse. Observation on 12/02/2025 at 4:50p.m. of the video including audio regarding Resident #2 and S5 CNA with S1 Administrator revealed a 7 minute video in part as follows: Video segment dated 10/30/2025 at 10:23:30 p.m. revealed in part: S5 CNA entered the room and made a loud statement get you're a** up off the floor got piss all over everything, as soon as I walk in the door there is s**t going on, makes no d***sense. S5 CNA turned toward the door talking to someone I don't wanna hear nothing S5 CNA continued talking loudly telling Resident #2 to grab onto the bed grab bar and get on her knees. A hand came in view reaching toward the grab bar. During an interview on 12/03/2025 at 1:49 p.m. S4 DON reported the abuse coordinator for the facility was the administrator and the administrator entered SIMS reports in the system. S4 DON reported S2 Former Administrator was terminated on 11/10/2025. S4 DON reported she and S2 Former Administrator were made aware of the verbal abuse allegation incident between S5 CNA and Resident #2 by Resident #2's sister on 10/31/2025. S4 DON acknowledged the SIMS report was not entered into the system and reported until 11/07/2025 and should have been entered and reported on 10/31/2025 within 2 hours of the allegation being made.</p>		