STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195558	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Oaks Nursing & Rehabilitation Center	1524 Glen Oaks Place Shreveport, LA 71103

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on record review and interview, the facility failed to protect the resident's right to be free of verbal abuse and psychosocial harm by facility staff for 1 (#1) of 3 (#1, #2, #3) sampled residents. The actual harm resulted for resident #1 who was cognitively impaired with communication deficits on 04/23/2024 when S3CNA (certified nursing assistant) verbally abused resident #1 by telling resident #1, I will hit you in your m__f__ face, during resident #1's whirlpool bath. Resident #1 was agitated during the bath and did not want his hair washed by S3CNA. It can be determined that any reasonable person would have experienced psychosocial harm as a result of the verbal abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility. The facility implemented corrective actions which were completed prior to the Stage Agency's Investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility's Abuse Policy dated March 2016 revealed the following: The facility will not condone any form of resident abuse or neglect. Each resident residing in this facility has the right to be free from verbal, sexual, mental and physical abuse including corporal punishment. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, facility members or legal guardians, friends or other individuals. Verbal Abuse is the use of oral, written or gestured language 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. Additionally, threats of corporal punishment to control behavior are considered verbal abuse. Review of resident #1's electronic health record revealed an admitted [DATE] with a diagnosis of but not limited to: cerebral vascular accident with right sided hemiplegia, aphasia, apraxia, dysphasia, diabetes, bipolar disease and hypertension. (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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(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 - Actual harm Residents Affected - Few	Review of resident #1's Quarterly Minimum Data Set, dated dated dated [DATE] revealed resident #1 was assessed to have a BIMS (brief mental status interview) score of 00 indicating cognitive deficits and an inability to complete the interview. Review of resident #1's comprehensive care plan revealed: Behavior: socially inappropriate /disruptive behavior, resident is unable to communicate and grunts and makes hand gestures, refuses medications and nasal swabs: do not argue with resident, do not challenge content of behaviors, assist in selection of appropriate coping mechanisms, allow resident the opportunity to make choices, and participate in care. Impaired Cognition related to diagnosis of CVA (cerebral vascular accident): approach in a calm manner, ask simple direct questions, calmly talk with resident and offer reassurance prior to care, provide consistent caregivers, and provide cueing with decision making. Review of the facility's investigative documentation revealed the following: On 04/23/2024 it was reported that S3CNA was assisting resident #1 in the whirlpool. During this time, resident #1 became frustrated and allegedly attempted to get the S3CNA to leave him alone. In response, S3CNA verbally threatened to hit resident #1. S5LPN (licensed practical nurse) on the nearby hall heard the commotion and entered the whirlpool room and told S3CNA to step away from the resident while he was upset. To protect the resident, S3CNA placed on administrative leave pending the determination of the investigative team. During an interview on 05/20/2024 at 8:30 a.m. resident #1 was able to make gestures to communicate about the incident. When asked, has anyone been verbally aggressive with you, resident #1 nodded head indicating yes. When asked if it was a staff member, resident #1 nodded head indicating yes. When asked if this happened while in the whirlpool, resident #1 nodded head indicating yes. Resident #1 became visibly agitated and upset and attempted to verbally explain but only was able to say, Ah man, ah man. When asked if S3CNA verbally threatened to hit him resident #1 again nodded his head indicating yes and was tearful and visibly agitated. During a phone interview on 05/20/2024 at 12:03 p.m. S5LPN reported standing on the hall across from the whirlpool room on 04/23/2024 when S5LPN heard resident #1 yelling and grunting in the whirlpool room. S5LPN reported when she looked inside the whirlpool room resident #1 was flailing his arms and gesturing because resident #1 did not want S3CNA to wash his hair. S5 LPN further reported S3CNA was aggravated and told resident #1, don't try to hit me, I'll hit you in your mo__f__ing face. S5LPN reported S3CNA was immediately told to come out of the whirlpool and leave resident #1 alone. S3CNA left the whirlpool room and did not return. During an interview on 05/16/2024 at 12:21p.m. S6CNA reported, I was near the whirlpool room (on 04/23/2024) and I heard someone in the whirlpool room say, I'll hit you in your mo_f__ing face. S6CNA also reported S5LPN was present and heard the verbal abuse also. S5LPN told S3CNA to come out the whirlpool room because the resident #1 was agitated and S3CNA left the whirlpool room. During an interview on 05/16/2024 at 12:34 p.m. S4LPN reported hearing resident #1 on 04/23/2024 mumbling and trying to talk loudly, S4LPN looked over into the whirlpool room and I saw resident #1 pointing toward the door trying to tell S3CNA to leave out of the whirlpool room. S5LPN told S3CNA to leave out of the whirlpool. S3CNA left the whirlpool room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/20/2024 at 12:00 p.m. S2 DON (Director of Nurses) reported on 04/24/2024 resident #1 came to her office and tried to tell her something. Resident #1 was very agitated, visibly upset and was gesturing and pointing at the whirlpool room and his head. S2 DON reported she had difficulty understanding what resident #1 was trying to tell her due to his aphasia until S6CNA came and told her that resident #1 was trying to tell S2DON about what had happened in the whirlpool room on the day before. S2 DON reported that S6CNA told her S3CNA had verbally threatened resident #1 while bathing him in the whirlpool on 04/23/2024. S2DON reported she immediately notified S1 Administrator and an investigation into the verbal abuse began on 04/24/2024. S2 DON further reported S3CNA was suspended while the investigation was completed. S2 DON reported two staff members confirmed hearing the alleged verbal abuse and S3CNA was terminated on 4/26/2024. During an interview 05/21/2024 at 10:00 a.m. S1 Administrator confirmed being notified of resident #1's allegation of verbal abuse by S3CNA on 04/24/2024. S1 Administrator further confirmed that the investigation confirmed two staff members reported hearing the verbal abuse directed at resident #1 by S3CNA. S3CNA was terminated on 04/26/2024. During the survey, in-service records and QA (Quality Assurance) monitoring records were reviewed, and it was determined that the facility had implemented the following actions to correct the deficient practice. 1. On 04/24/2024 at 3:30pm Verbal abuse allegation brought to the S2DONs' attention by resident #1 and S6CNA. S1Administrator notified and investigation begin. S3CNA temporarily suspended during investigation. 2. Statements obtained from staff member present during altercation confirmed S3CNA's verbal abuse of resident #1. S3CNA was terminated on 04/26/2024. S3CNA's last day of work was 04/24/2024. 3. S5LPN's employment was terminated on 04/25/2024 after learning that S5LPN witnessed S3CNA's verbal abuse of resident #1 and failed to report it to the supervisor immediately. 4. On 04/25/2024 S2 DON and S7ADON (assistant director of nurses), interviewed all residents on A hall and Short B hall, (the residents that S3CNA were assigned to). All residents were asked if they had been abused in any way by S3CNA or any other staff member. 5. An all staff in-service was done on 04/25/2024 regarding abuse and neglect, the procedure for reporting abuse allegations upon discovery and the de-escalation of difficult or angry residents. 6. QA (quality assurance) monitoring began on 04/24/2024 by nursing administration. S2DON or her designee will review each incident/grievance for suspected abuse. This monitoring will occur with each incident/grievance for the next 6 weeks, or until compliance is maintained. Any type of suspicious events will be investigated following our Abuse and Neglect procedure. Daily rounds by the administrator, social worker, DON and ADON will be done on all residents in the facility focusing on abuse indefinitely. The results of the daily rounds and the QA monitoring will be discussed in the facility's daily QA and corrective actions implemented weekly if indicated. 7. Date of Compliance 04/26/2024 when S3CNA was terminated.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36665 Based on record review and interview the facility failed to ensure an allegation of verbal abuse by staff was reported immediately to the facility administrator and to the State Survey Agency no later than 2 hours after the allegation was made, for 1 (#1) of 3 (#1, #2, #3) residents reviewed for abuse. Findings: Review of the facility's Abuse/Neglect Prevention program dated March 2016 revealed, in part, the following: Reporting: Any person who witnesses or has knowledge of any act or suspected act of abuse/neglect, mistreatment, exploitation, or identifies an injury of unknown source will notify his or her supervisor immediately. Reporting requirements: Facility must report to State Survey Agency any incidents and allegations of abuse, neglect, exploitation, misappropriation of resident property and/or injuries of unknown source immediately, but no later than 2 hours after the allegation is made, if the event that caused the allegation involves abuse or results in bodily harm. Review of resident #1's electronic health record revealed an admitted [DATE] with a diagnosis of but not limited to: cerebral vascular accident with right sided hemiplegia, aphasia, apraxia, dysphasia, diabetes, bipolar disease and hypertension. Review of resident #1's Quarterly Minimum Data Set, dated dated dated [DATE] revealed resident #1 was assessed to have a BIMS (brief mental status interview) score of 00 indicating cognitive deficits and an inability to complete the interview. Review of the facility's investigative documentation revealed the following: On 04/23/2024 it was reported that S3CNA (certified nursing assistant) was assisting resident #1 in the whirlpool. During this time, resident #1 became frustrated and allegedly attempted to get the S3CNA to leave him alone. In response, S3CNA verbally threatened to hit resident #1. S5LPN (licensed practical nurse) on the nearby hall heard the commotion and entered the whirlpool room and told S3CNA to step away from the resident while he was upset. To protect the resident, S3CNA was placed on administrative leave pending the determination of the investigative team. (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 - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 05/20/2024 at 12:03 p.m. S5LPN reported standing on the hall across from the whirlpool room when S5LPN heard resident #1 yelling and grunting in the whirlpool room. S5LPN reported when she looked inside the whirlpool room resident #1 was flailing his arms and gesturing because resident #1 did not want S3CNA to wash his hair. S5 LPN further reported S3CNA was aggravated and told resident #1, don't try to hit me, I'll hit you in your mo__f__ing face. S5LPN reported S3CNA was immediately told to come out of the whirlpool and leave him resident #1 alone. S3CNA left the whirlpool room and did not return. S5LPN confirmed she did not report this incident to S2DON (director of nurses) or S1 Administrator because she did not want to get S3 CNA in any trouble. During an interview on 05/20/2024 at 12:00 p.m. S2DON confirmed S5LPN did not follow the facility policy and notify her supervisor immediately when S3CNA verbally abused resident #1. S2DON also confirmed that she notified S1Administrator of resident #1's allegation of abuse on 04/24/2024 the day after the incident. Review of the Health Standards Incident Report revealed S1Administrator reported the incident to the State Survey Agency on 04/25/2024 at 1:20 p.m. S1Administrator failed to report the allegation of abuse involving resident #1 on 04/24/2024 when he was made aware by S2DON to the State Survey Agency within two hours. During an interview on 05/21/2024 at 10:00 a.m. S1Administrator confirmed he did not report resident #1's allegation of verbal abuse to the State Survey Agency within the 2 hour window.