

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2025
NAME OF PROVIDER OR SUPPLIER  River Oaks Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  3612 Baker Blvd Baker, LA 70714	

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 - Actual harm</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**</b> 39121</p> <p>Based on interviews and record reviews, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 (#3 and #6) of 6 (#1, #2, #3, #4, #5, and #6) residents reviewed for abuse. The facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. Resident #3 was free from physical abuse by Resident #4; and</li> <li>2. Resident #6 was free from physical abuse by Resident #5.</li> </ol> <p>This deficient practice resulted in an actual physical harm on 02/23/2025 when Resident #4, a severely cognitively impaired resident, pushed Resident #3, a severely cognitively impaired resident, onto the floor in the hallway causing Resident #3 to sustain a left eyebrow laceration. Resident #3 was sent to the local emergency room (ER) where he received 9 sutures to his left eyebrow.</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 policy titled Abuse/Neglect Policy Statement dated 09/2024 revealed the following, in part:</p> <p>Each resident residing in this facility has the right to be free from physical abuse.</p> <p>Residents must not be subjected to abuse by anyone, including but not limited to, other residents.</p> <p>Abuse and Neglect Reporting Definitions</p> <ol style="list-style-type: none"> <li>1. Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</li> <li>5. Physical Abuse - includes hitting, slapping, pinching, and kicking.</li> </ol> <ol style="list-style-type: none"> <li>1.</li> </ol> <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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3</p> <p>Review of Resident #3's clinical record revealed an admitted to the facility of 06/24/2024 with diagnoses, which included Vascular Dementia, Sequelae of Cerebral Infarction, and Bipolar Disorder.</p> <p>Review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/18/2025 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 3, which indicated severe cognitive impairment.</p> <p>Review of Resident #3's current Care Plan revealed the following, in part:</p> <p>Risk for altered skin integrity/pressure ulcers 02/23/2025 - in altercation with another resident after wandering into that resident's room, end result laceration above left brow, new order send to ER for Evaluation; 02/23/2025 - return from ER 9 sutures to left brow, no complaint of pain noted; 02/26/2025 -redness bruising swelling noted to left eyebrow</p> <p>Interventions: 02/23/2025 immediate separation from other resident; Neuro checks as ordered; Send to ER as ordered; Unit change to keep both residents separated; Monitor sutures to left brow, report any changes to Medical Doctor (MD)</p> <p>Review of Resident #3's current Physician's Orders revealed the following, in part:</p> <p>02/24/2025 Left forehead: Monitor dissolvable sutures and area for signs and symptoms of infection until resolved. every day shift</p> <p>08/01/2024 Visual check for resident's location every 1 hour every shift</p> <p>Review of Resident #3's Incident Report dated 02/23/2025 revealed the following, in part:</p> <p>Around 10:45 a.m. S5LPN was called to the unit. Resident #3 was observed on floor with blood coming from area above his eyebrow. Resident #3 was crying and frightened. Certified Nursing Assistant (CNA) stated Resident #4 hit Resident #3 because Resident #3 wandered into Resident #4's room.</p> <p>Immediate Action Taken</p> <p>Charge nurse attempted to stop bleeding. Resident #3 was sent out to a local hospital via ambulance for evaluation and treatment.</p> <p>Injury Type: Laceration</p> <p>Injury Location: Face</p> <p>Review of Resident #3's Hospital records with a date of service 02/23/2025 revealed the following, in part:</p> <p>Laceration Repair: 02/23/2025 at 7:15 p.m.</p> <p>Location: Left Eyebrow</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Length: 3 centimeter (cm) Depth: 1 millimeter</p> <p>Number of Sutures: 9</p> <p>Review of Resident #3's Psychiatric Nurse Practitioner noted dated 02/24/2025 revealed the following, in part:</p> <p>Chief complaint/nature of presenting problem: Assault from another resident. Pushed, unwitnessed fall with laceration .evaluation this morning in bed sleeping, then resident noted ambulating up and down hallways, zero distress is noted.</p> <p>Plan: Bipolar Affective disorder, current episode severity unspecified: No medication other than Paxil at present- Recent altercation - no behaviors now other than pulling at dressings over left eye.</p> <p>Resident #4</p> <p>Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Paranoid Schizophrenia.</p> <p>Review of Resident #4's Optional State Assessment (OSA) MDS with an ARD of 02/19/2025 revealed a BIMS of 1, which indicated severe cognitive impairment.</p> <p>Review of Resident #4's Incident Report dated 02/23/2025 revealed the following, in part:</p> <p>Around 10:45 a.m., S5LPN was called to the unit. Resident #4 was observed to be standing over Resident #3 with fist balled up, cursing, and telling resident, I told you, I will kill you. It appeared Resident #4 had made physical contact with Resident #3. CNA stated Resident #4 had hit Resident #3 because he wandered into his room.</p> <p>Review of Resident #4's current Care Plan revealed the following:</p> <p>Focus: The resident is physically aggressive with others. 02/23/2025-Noted with physical aggression toward another resident. New orders to send to a local emergency room (ER) for Psychiatric evaluation. 02/24/2025-admitted to a Behavioral Health Unit.</p> <p>Interventions: 02/23/2025- 1:1 supervision with resident until transported to behavior for Physician's Emergency Certificate (PEC); PEC to a local hospital's behavioral unit; Send to a local hospital for psychiatric evaluation; Psychiatric/Psychogeriatric consult as needed.</p> <p>On 03/03/2025 at 2:08 p.m., 03/03/2025 at 2:42 p.m., and 03/05/2025 at 11:05 a.m., unsuccessful attempts were made to interview Resident #3's responsible party.</p> <p>On 03/03/2025 at 11:01 a.m., an interview was conducted with Resident #3. Resident #3 had a scabbed laceration in his left eyebrow. Resident #3 stated he did not know what happened to his eyebrow.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/05/2025 at 10:20 a.m., an observation and interview was conducted with Resident #4 about the incident with Resident #3. Resident #4 became agitated, his body became tense and he was speaking in a loud voice. With exaggerated hand movements, Resident #4 began shouting, It was a little accident. I don't want to talk about it. Leave. Getting on my nerves.</p> <p>On 03/03/2025 at 3:00 p.m., an interview was conducted with S5LPN. S5LPN confirmed she worked on 02/23/2025 when Resident #3 and Resident #4 had the incident but did not witness it. S5LPN stated she observed Resident #3 visibly shaken, crying, and bleeding from his left eyebrow in the hallway after the incident. S5LPN stated she observed Resident #4 was standing with his fists balled up, stated he would punch or hit him, and stated, I swear to God I will kill him. S5LPN stated Resident #3 and Resident #4 were separated. S5LPN stated the charge nurse stayed with Resident #3 until he was sent to the hospital for the treatment of his behaviors. S5LPN stated Resident #4 was sent to the hospital for behaviors. S5LPN stated Resident #3 has been moved to a different hall.</p> <p>On 03/05/2025 at 9:34 a.m., an interview was conducted with S13CNA. S13CNA stated Resident #3 would wander the halls after his meals and staff would redirect him to his room or the dining room. S13CNA stated once Resident #3 was brought to his room, he usually stayed there. S13CNA stated she received abuse training a week ago. S13CNA was knowledgeable on the types of abuse. S13CNA defined physical abuse as fighting and touching. S13CNA stated she would report abuse to the nurse or the supervisor immediately.</p> <p>On 03/05/2025 at 10:17 a.m., an interview was conducted with S11CNA. S11CNA stated she did not witness the 02/23/2025 incident between Resident # and Resident #4. S11CNA stated she was in another resident's room and heard yelling and commotion down the hall. S11CNA stated she saw Resident #3 side-lying on the floor in the hall and bleeding from his eyebrow. S11CNA stated Resident #4 was standing over Resident #3 with his fist clenched, yelling for him to get out of his room. S11CNA stated Resident #3 was brought into another room and was provided nursing care until Emergency Medical Services (EMS) arrived. S11CNA stated Resident #3 required stitches. S11CNA denied any changes in Resident #3's behavior after the incident. S11CNA stated an in-service on abuse and neglect was provided after the incident. S11CNA confirmed that the incident between Resident #3 and Resident #4 was physical abuse.</p> <p>On 03/03/2025 at 3:17 p.m., an interview was conducted with S1ADM. S1ADM stated he reviewed the video footage of the incident between Resident #3 and Resident #4 on 02/23/2025. S1ADM stated Resident #3 went into Resident #4's room and Resident #4 pushed Resident #3 out of the room and Resident #3 fell face forward into the hallway. S1ADM stated Resident #3 fell to his knees and hit his left forehead on the floor. S1ADM stated Resident #3 and #4 were placed on 1:1 supervision until they were sent to the hospital. S1ADM stated Resident #3 was sent to the hospital for stitches and returned the same day. S1ADM stated Resident #4 was sent to a psych hospital in excess of a week. S1ADM stated Resident #3 was moved to a different locked unit due to his wandering and to prevent further problems.</p> <p>On 03/05/2025 at 10:32 a.m., an interview was conducted with S3ADON. S3ADON confirmed she responded to the incident with Resident #3 and Resident #4 on 02/23/2025. S3ADON stated staff were assisting Resident #3 when she arrived. S3ADON stated Resident #3's left forehead was bleeding. S3ADON confirmed Resident #3 was sent out to the hospital and received 9 sutures to the laceration. S3ADON stated Resident #4 stated Resident #3 came into his room and he wanted him out and he pushed him out.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>On 03/05/2025 at 12:33 p.m., an interview was conducted with S2DON. S2DON confirmed on the video footage they saw Resident #4 physically push Resident #3 out of the room on 02/23/2025. S2DON confirmed the incident between Resident #3 and Resident #4 was an incident of resident to resident physical abuse. S2DON stated after the 02/23/2025 incident with Resident #3 and #4, staff ensured both residents were safe and separated until they were sent out of the facility. S2DON stated Resident #3 was moved to a different unit. S2DON stated the facility reported the 02/23/2025 incident between Resident #3 and #4 to the State Agency, notified the police, and opened a Quality Assurance and Performance Improvement (QAPI) on resident to resident altercations. S2DON stated staff were educated on abuse and received an abuse quiz. S2DON stated cognitive residents were also interviewed regarding abuse - abuse by staff and other residents, and were encouraged to report. S2DON stated Residents with BIMS less than 10 were assessed for any concerns related to abuse and behavioral changes - depression or being withdrawn. S2DON stated she has completed monitoring randomly on 3 cognitively impaired residents 3 three times a week. S2DON stated monitoring will continue until compliance is met.</p> <p>2.</p> <p>Resident #6</p> <p>Review of Resident #6's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease and Dementia.</p> <p>Review of Resident #6's Quarterly MDS with ARD of 11/05/2024 revealed the provider assessed the resident has having a BIMS of 7, which indicated cognitive impairment.</p> <p>On 03/05/2025 multiple attempts were made to contact Resident #6's Responsible Party with no answer.</p> <p>On 03/05/2025 at 10:00 a.m., an attempt to interview Resident #6 revealed he was unable to answer any historical questions regarding the incident on 02/14/2025.</p> <p>Resident #5</p> <p>Review of Resident # 5's Clinical Record revealed he was admitted to the facility on [DATE] with Diagnoses which included Chronic Kidney Disease and Chronic Schizoaffective Disorders.</p> <p>Review of Resident #5's Annual MDS with ARD of 12/04/2024, revealed a BIMS of 15, which indicated the resident was cognitively intact.</p> <p>Review of Resident #5's Care Plan, updated 02/14/2025 revealed, in part:</p> <p>Mood State: Mood disorder related to diagnosis of Schizoaffective Disorder. 02/14/2025 - Resident's roommate reported that he was hit by this resident, aggressive with staff, PEC for behavioral hospital in house evaluation.</p> <p>Interventions: assess for changes in mood status, assess for effectiveness of medication therapy, monitor for side effects of psychoactive therapy, (02/14/2025) remove from room immediately, send to behavioral hospital per PEC, 02/28/2025) room change upon return to facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's incident report, dated 2/14/2025 revealed the following, in part: at approximately 7:00 a.m. S12CNA heard a noise coming from Resident #5 and Resident #6's room. S12CNA went to the room and witnessed Resident #5 hitting Resident # 6.</p> <p>On 03/05/2025 three attempts were made to contact S12CNA, she was unavailable.</p> <p>On 03/05/2025 at 9:00 a.m., an interview was conducted with Resident #5. He stated he was sent out to the hospital on 02/14/2025 for hitting his roommate, Resident #6.</p> <p>On 03/05/2025 at 9:10 a.m., an interview was conducted with S4LPN. She stated on 02/14/2025 S12CNA summoned her to Resident #6's room. S4LPN stated S12CNA told her Resident #5 was hitting Resident #6. S4LPN stated they were separated and Resident #6 was brought to the nurse's station for 1:1 observation. S4LPN stated Resident #6 was examined and did not have any injury. S4LPN stated Resident #5 was placed on 1:1 observation until he was transferred to the behavioral hospital for evaluation. S4LPN stated Resident #5 hitting Resident #6 was resident to resident abuse.</p> <p>On 03/05/2025 at 10:15 a.m., an interview was conducted with S2DON. S2DON stated on 02/14/2025 Resident #5 and Resident #6 were involved in an altercation. She stated S12CNA witnessed Resident #5 hitting Resident #6. S2DON stated Resident #6 did not have any injuries and was placed on 1:1 observation. S2DON stated Resident #5 was placed on 1:1 observation until admitted to the psychiatric hospital for evaluation and treatment. She confirmed Resident #5 was moved to another room upon return to the facility. S2DON confirmed on 02/14/2025 In-Service Training was conducted with all staff by S1ADM on Abuse and Neglect and Redirection of Residents with Aggressive Behaviors. S2DON confirmed Resident #5 hitting Resident #6 was abuse.</p> <p>On 03/05/2025 at 3:10 p.m., an interview was conducted with S1ADM. He confirmed the incident on 02/23/2025 between Residents #3 and #4 was an incident of resident to resident abuse. He confirmed the incident on 02/14/2025 between Residents #5 and #6 were incidents of resident to resident abuse.</p> <p>The facility had implemented the following corrective actions to correct the deficient practice:</p> <p>Plan of Correction:</p> <p>Resident to Resident Altercation/Abuse Allegation</p> <p>On 02/14/2025 at 9:28 a.m. an altercation occurred between 2 residents. Resident #5 and Resident #6. S12CNA was making rounds on the hall when she heard Resident #5 yelling out. When she entered Resident #5's room she witnessed Resident #5 hitting Resident #6. She immediately intervened and separated the 2 residents and notified the nurse. Resident #5 was placed on 1:1 supervision. The NP (Nurse Practitioner) assessed Resident #6 and no injuries were found. Resident #5 remained on 1:1 supervision until the ambulance arrived at approximately 4:00 p.m.</p> <p>On 02/14/2025, the Administrator and Director of Nursing held an in-service with the nursing staff and reviewed the following areas:</p> <p>1-Abuse/Neglect, Reporting Abuse/Neglect to Immediate Supervisor, Administrator Director of Nursing, Assistant Director of Nursing, Charge Nurse, Weekend Registered Nurse, Floor Nurse.</p> <p>(continued on next page)</p>		

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