STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195561	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Nursing & Rehabilitation Center LLC	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)
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. (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
	195561	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Nursing & Rehabilitation Center LLC	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect the residents' right to be free from physical abuse by another resident for 1 (#2) of 6 residents reviewed for abuse. The facility failed to ensure Resident #2 was free from physical abuse by Resident #1. This deficient practice resulted in actual physical harm on 10/28/2025 for Resident #2 when Resident #1 hit Resident #2 in the face with a chair. Resident #2 obtained an Acute right orbital floor and anterior orbital rim fractures with no signs of entrapment, acute fracture of the anterior and posterolateral wall of the right maxillary sinus, and a comminuted fracture of the nasal bone with recommended surgical repair. 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 policy titled Abuse/Neglect Policy with a revised date of 04/03/2025, revealed the following, in part:Policy: It is the policy of the facility that each resident will be free from abuse. DefinitionsA. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.iii. Physical Abuse - includes hitting, slapping, pinching, and kicking. Review of the facility census revealed Resident #1 and Resident #2 shared a room beginning in April 2025. Review of Resident #1 and #2's incident reports dated 07/18/2025 through 10/27/2025 revealed no physical altercations. Resident #2Review of Resident #2's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Schizophrenia, Bipolar Disorder, Cognitive Communication Deficit, and Primary Bilateral Open Angle Glaucoma. Review of Resident #2's Quarterly MDS with an ARD of 02/19/2025 revealed a BIMS of 15, which indicated he was cognitively intact. Review of Resident #2's current Care Plan revealed the resident had a potential for verbal aggression related to Depression, Bipolar Disorder, and Schizophrenia. On 10/28/2025, Resident #2 was verbally aggressive with Resident #1 which resulted in a physical altercation. Resident #2 sustained bruising and a skin tear to right eye. Staff immediately separated the 2 residents, implemented 1:1 supervision for both residents, began neurological assessments and skin treatments for Resident #2, and placed Resident #2 in a new room. Resident #2 refused to go to the Emergency Room. An x-ray of the right facial bone was completed in the facility and revealed a sinus fracture. Resident #2 agreed to go to emergency room with much encouragement. Review of Resident #2's Hospital records with a date of service of 10/28/2025 revealed a CT of the Head without Contrast was completed with results of an Acute right orbital floor and anterior orbital rim fractures with no signs of entrapment, acute fracture of the anterior and posterolateral wall of the right maxillary sinus, and comminuted fractures of the nasal bone. Review of the Emergency Department Provider Notes dated 10/28/2025 revealed Resident #2 complained of pain to face, reported blurry vision at baseline, and no vision changes following incident. Review of the Hospital Ophthalmology Consult Note dated 10/29/2025 revealed the following in part:Assessment/Plan:1. Primary Open Angle Glaucoma-Denies pain currently; exam within normal limits in terms of trauma. No evidence of traumatic injury to anterior or posterior eye structures.2. Orbital Fracture Right Eye- no evidence of entrapment on imaging; extraocular muscles intact; Follow up with ENT/OMFS/Plastics for repair outpatient. Review of Resident #2's care plan, updated upon return from the hospital on [DATE] revealed the resident was discharged from the hospital due to refusing interventions. Resident #2 refused to cease smoking upon return to the facility when taken off droplet isolation. On 11/03/2025 an intervention was added for the resident to be seen by the Psychiatric MD on the next physician's round. Review of Resident #2's current Physician's Orders dated 10/31/2025 revealed the following, in part:Tylenol 325 mg by mouth every 4 hours as needed for pain per standing order for 7 days. Review of Resident #2's MAR revealed Tylenol 325 mg for pain had not been administered by the facility since the incident on 10/28/2025 or since his discharge from the hospital on [DATE]. Review of Resident #2's Nurses' Notes dated 10/31/2025-11/06/2025 revealed documentation Resident #2 was assessed by a nurse at least daily for pain and denied pain. Further review of Resident #2's Nurses' Notes revealed the following, in part:10/30/2025 at 1:46 p.m., a call was received from the hospital social worker who said Resident #2 refused to have scheduled surgery. S3DON and family were notified. Will continue to follow-up. 10/31/2025 at 9:09 p.m. Resident #2 returned to facility at 8:50 p.m. Resident #2 was alert x3, PERRL, with facial bruising was noted to right side eyes, cheeks and forehead. Resident #2 had 2 butterfly bandages to upper eyebrow. Resident #2 denied pain or shortness of breath. Resident #2 denied SOB. Follow up with OMFS scheduled for 11/12/2025 with tentative surgery plans for