

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 07/17/2025
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)
F 0600 Level of Harm - Minimal harm or potential for 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

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect a resident's right to be free from physical abuse by another resident for 2 (#22 and #101) of 3 (#9, #22, and #101) residents reviewed for abuse. Findings: Review of the facility's manual with a revision date of 04/03/2025 and titled Abuse-Neglect Prevention Manual, revealed the following, in part:iii. Physical abuse includes hitting, slapping. Resident #22Review of Resident #22's Clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #22's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. On 07/14/2025 at 1:26 p.m., an interview was conducted with Resident #22. Resident #22 stated he got into an altercation with Resident #101 about two weeks ago. He stated he was unable to recall the exact date. Resident #22 stated he was going to his seat in the dining room, and Resident #101 cut him off. Resident #22 stated he grabbed the back of Resident #101's wheelchair, and Resident #101 backhanded him to the side of the face. Resident #22 stated he then hit Resident #101 in the face. Resident #22 stated S7CNA separated them. Resident #22 stated Resident #101 then got up from his wheelchair, walked to him, and tried to hit him while his back was turned. Resident #22 stated he hit Resident #101 in the lower jaw, and Resident #101 went and sat back down in his chair. Review of Resident #22's Nurse's Notes and Care Plan revealed no documentation of the aforementioned altercation. Resident #101Review of Resident #101's Clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #101's Quarterly MDS with an ARD of 05/02/2025 revealed a BIMS score of 11, which indicated moderately impaired cognition. On 07/16/2025 at 8:42 a.m., an interview was conducted with Resident #101. Resident #101 stated he got into a fight with Resident #22. Resident #101 stated Resident #22 hit him first behind the head on the right side so Resident #101 stated he retaliated. Resident #101 stated the incident happened in the dining room at dinnertime and staff were around. Review of Resident #101's Nurse's Notes and Care Plan revealed no documentation of the aforementioned altercation. On 07/15/2025 at 1:51 p.m., an interview was conducted with S7CNA. S7CNA confirmed she witnessed a physical altercation between Residents #22 and #101 about a month ago in the dining room. S7CNA stated the trays were delivered, she turned around, and Residents #22 and #101 were punching each other. S7CNA stated she told the residents to stop and broke them up. S7CNA stated she placed Resident #101 into his wheelchair and went to get the nurse. S7CNA stated she was unable to recall the exact day the altercation occurred nor the nurse she reported to. S7CNA confirmed the residents hitting each other was physical abuse. On 07/16/2025 at 11:25 a.m., an interview was conducted with S5LPN. S5LPN stated Resident #101 reported he had hit Resident #22 on the evening shift. S5LPN stated she was unable to recall the exact date, but it was around 06/19/2025. S5LPN confirmed Resident #101 hitting Resident #22 was an allegation of resident to resident physical abuse. On 07/16/2025 at 1:22 p.m., an interview was conducted with S2DON. S2DON denied staff reporting a physical altercation between Residents #22 and #101. S2DON confirmed residents hitting each other was physical abuse. S2DON confirmed she would expect staff to report if two residents were involved in a physical altercation. On 07/16/2025 at 1:45 p.m., an interview was conducted with S1ADM. S1ADM stated staff did not report an incident between Residents #22 and #101. S1ADM confirmed residents punching or hitting each other was physical abuse. He confirmed the incident should have been reported to him immediately.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure an incident involving abuse was reported to the facility administrator and State Agency in accordance with the mandated reporting guidelines for 2 (#22 and #101) of 3 (#9, #22, and #101) residents sampled for abuse. Findings: Review of the facility's manual with a revision date of 04/03/2025 and titled Abuse-Neglect Prevention Manual revealed the following, in part:iii. Physical abuse includes hitting, slapping, pinching.5. Investigation and Protection: in the event that any evidence involving abuse.the issue will be reported immediately to the administrator or his designee of the facility, who will immediately notify corporate office and the appropriate state officials per state guidelines.1. Any person who has knowledge of any act or suspected act of abuse. will notify his/her supervisor immediately.Internal Reporting a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator or his designee of the facility. Findings: Review of Facility Reported Incidents from 06/14/2025 to 07/14/2025 revealed no incidents had been reported to the state agency for Residents #22 and #101. Resident #22Review of Resident #22's Clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #22's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/2025 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. On 07/14/2025 at 1:26 p.m., an interview was conducted with Resident #22. Resident #22 stated he got into an altercation with Resident #101 about two weeks ago. He stated he was unable to recall the exact date. Resident #22 stated he was going to his seat in the dining room, and Resident #101 cut him off. Resident #22 stated he grabbed the back of Resident #101's wheelchair, and Resident #101 backhanded him to the side of the face. Resident #22 stated he then hit Resident #101 in the face. Resident #22 stated S7CNA separated them. Resident #22 stated Resident #101 then got up from his wheelchair, walked to him, and tried to hit him while his back was turned. Resident #22 stated he hit Resident #101 in the lower jaw, and Resident #101 went and sat back down in his chair. Review of Resident #22's Nurse's Notes and Care Plan revealed no documentation of the aforementioned altercation. Resident #101Review of Resident #101's Clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #101's Quarterly MDS with an ARD of 05/02/2025 revealed a BIMS score of 11, which indicated moderately impaired cognition. On 07/16/2025 at 8:42 a.m., an interview was conducted with Resident #101. Resident #101 stated he got into a fight with Resident #22. Resident #101 stated Resident #22 hit him first behind the head on the right side. Resident #101 stated he retaliated. Resident #101 stated the incident happened in the dining room at dinnertime and staff were around. Resident #101 stated he reported the incident but could not recall who he reported it to. Review of Resident #101's Nurse's Notes and Care Plan revealed no documentation of the aforementioned altercation. On 07/15/2025 at 1:51 p.m., an interview was conducted with S7CNA. S7CNA confirmed she witnessed a physical altercation between Residents #22 and #101 about a month ago in the dining room. S7CNA stated the trays were delivered, she turned around, and Residents #22 and #101 were punching each other. S7CNA stated she told the residents to stop and broke them up. S7CNA stated she placed Resident #101 into his wheelchair and went to get the nurse. S7CNA stated she was unable to recall the exact day the altercation occurred nor the nurse she reported to. S7CNA confirmed the residents hitting each other was physical abuse. On 07/16/2025 at 11:25 a.m., an interview was conducted with S5LPN. S5LPN stated Resident #101 reported he had hit Resident #22 on the evening shift. S5LPN stated she was unable to recall the exact date, but it was around 06/19/2025. S5LPN stated Resident #101 told her he had reported the incident to a nurse already, but did not tell her which nurse. S5LPN confirmed Resident #101 hitting Resident #22 was an allegation of resident to resident physical abuse. On 07/16/2025 at 1:22 p.m., an interview was conducted with S2DON. S2DON denied staff reporting a physical altercation between Residents #22 and #101. S2DON confirmed residents hitting each other was physical abuse. S2DON confirmed she would expect staff to report if two residents were involved in a physical altercation. On 07/16/2025 at 1:45 p.m., an interview was conducted with S1ADM. S1ADM stated staff did not report an incident between Residents #22 and #101. S1ADM confirmed residents punching or hitting each other was physical abuse. He confirmed the incident should have been reported to him immediately.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (#3) resident out of a total of 28 sampled residents by failing to ensure Resident #3 was accurately coded for PASRR (Pre-admission Screening and Resident Review). Findings: Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Recurrent Depressive Disorders, Bipolar Disorder, and Post-Traumatic Stress Disorder. Review of Resident #3's Form 142 titled Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification dated 05/22/2024, revealed an approval for admission by the state Level II Authority for a temporary period effective 05/22/2024 through 05/21/2025. Review of Resident #3's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/2025 revealed Section A1500: Preadmission Screening and Resident Review (PASRR) was coded 0-No. Section A1510: Serious Mental Illness was blank. On 07/17/2025 at 12:25 p.m., an interview was conducted with S8MDS. S8MDS verified Resident #3's Form 142 indicated Resident #3 was approved for admission by the state Level II Authority for a temporary period effective 05/22/2024 through 05/21/2025. She reviewed Resident #3's Annual MDS assessment dated [DATE] and confirmed Section A1500 should have been coded as 1-Yes, and was not. On 07/17/2025 at 12:50 p.m., an interview was conducted with S2DON. S2DON reviewed and confirmed Resident #3's Form 142 indicated Resident #3 was approved for admission by the state Level II Authority for a temporary period effective 05/22/2024 through 05/21/2025. She reviewed Resident #3's Annual MDS assessment dated [DATE] and confirmed Section A1500 should have been coded as 1-Yes, and was not.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident with an identified mental health diagnosis was referred for a Preadmission Screening and Resident Review (PASRR) Level II evaluation as required for 2 (#7 and #9) of 4 (#5, #7, #9, and #19) sampled residents reviewed for PASRR Level II. Resident #7</p> <p>Review of the Clinical Record revealed Resident #7 was admitted to the facility on [DATE]. Further review revealed he was diagnosed with Undifferentiated Schizophrenia on 01/09/2023.</p> <p>Review of Resident #7's Form 142 dated 09/22/2014 revealed he did not meet the criteria for PASRR Level II services.</p> <p>On 07/16/2025 at 10:58 a.m., an interview was conducted with S3SSD. She stated she was responsible for submitting Resident Review Forms to OBH. She reviewed Resident #7's Form 142 dated 09/22/2014 and confirmed it was the most recent on file. She then reviewed Resident #7's diagnoses, which included Undifferentiated Schizophrenia with an onset date of 01/09/2023. S3SSD confirmed a Resident Review Form should have been resubmitted and was not.</p> <p>Resident #9Review of the Clinical Record revealed Resident #9 was admitted to the facility on [DATE]. Further review revealed he was diagnosed with Post-Traumatic Stress Disorder (PTSD) and Delusional Disorder upon admission.</p> <p>On 07/17/2025 at 10:10 a.m., an interview was conducted with S3SSD. She stated Resident #9 admitted to the facility on [DATE] with diagnoses of PTSD and Delusional Disorder with a Level I dated 4/8/2025. She stated upon review of the OBH PASSR Level II Request for Resident Review indicated Delusional Disorder was a Tier 2 diagnosis. She confirmed Resident #9 diagnosis of Delusional Disorder should have been captured on the Level I screening form and was not.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and record reviews, the facility failed to store, prepare and distribute food in accordance with professional standards for food service safety as evidenced by failing to: 1. Ensure opened foods were sealed properly; and 2. Ensure expired food items were disposed. This deficient practice had the potential to affect all 130 residents served from the kitchen. Findings: Review of the undated facility policy titled Food Safety and Sanitation Policy and Procedure revealed the following, in part: Food Storage 1. Food that is stored is protected from contamination and growth of any pathogenic organisms. 10. Foods with expiration dates are used prior to the use by date on the package Review of the provider's policy dated 2021 and titled Food Storage Safety revealed the following, in part: Food storage from top to bottom when items are stored in the same refrigerator or freezer - Cooked foods are stored over Raw Poultry. On 07/14/2025 at 10:30 a.m., an initial tour of the kitchen was conducted with S4DM. The following observations were made and confirmed: Freezer a 1 case of uncooked fritter style chicken breasts and 1 plastic bag of raw chicken tenderloins were stored over 1 case of Boston cream pies and 1 case of Philadelphia cheese cakes Refrigerator a 1 1/2 gallon of 100% lactulose free 2% reduced fat milk with an expiration date of 07/08/2025. Refrigerator b1 open and unsealed plastic bag of cheese slices 1 open and unsealed plastic bag of ham 1 open and unsealed plastic bag of bacon On 07/14/2025 at 10:30 a.m., an interview was conducted with S4DM. S4DM confirmed Boston cream pies and Philadelphia cheese cakes should not be stored under raw chicken. S4DM confirmed expired milk should be discarded. S4DM confirmed items stored in the refrigerator should be sealed. On 07/17/2025 at 10:31 a.m., an interview was conducted with S1ADM. S1ADM confirmed items in the kitchen should be stored in a clean, safe way.</p>		