STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195584	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allen Oaks Nursing and Rehab Center	909 East 6th Avenue Oakdale, LA 71463

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45213 Based on interview and record review the facility failed to ensure each resident had a comprehensive person-centered care plan developed and implemented to meet his or her goals and address the resident's medical, physical, mental, and psychosocial needs for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting right non-dominant side, Other Muscle Spasms, Major Depressive Disorder, Insomnia, and Type 2 Diabetes Mellitus. Review of Resident #2's Admission/OSA MDS with an ARD of 07/24/2024 revealed a BIMS score of 15, indicating intact cognition. Resident #2's MDS revealed she required extensive assistance with 2 plus persons for bed mobility, transfers, and toilet use. Review of Resident #2's Care Plan with a Target Date of 10/18/2024 revealed in part . History of Drug Abuse. Date initiated 07/22/2024. Intervention: Resident noted to be lethargic, slurred speech, unable to perform ADL's at her normal capacity, found to have container of synthetic THC gummies, container taken to the nurses' station. Date initiated 08/22/2024. Interview on 09/03/2024 at 2:31 p.m. with S6 LPN MDS revealed Resident #2 had a history of drug abuse on admission. S6 LPN MDS confirmed Resident #2's Care Plan should have had interventions in place other than the intervention initiated on 08/22/2024.

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: 195584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Allen Oaks Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 East 6th Avenue Oakdale, LA 71463	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45213 Based on interview and record review, the facility failed to ensure services were provided to meet professional standards of quality for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents by providing Resident #2 with THC gummies without consulting the resident's physician. Findings: Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Non-Dominant Side, Other Muscle Spasms, Major Depressive Disorder, Insomnia, and Type 2 Diabetes Mellitus. Review of Resident #2's Admission/OSA MDS with an ARD of 07/24/2024 revealed a BIMS score of 15, indicating intact cognition. Resident #2's MDS revealed she required extensive assistance with 2 plus persons for bed mobility, transfers, and toilet use. Review of Resident #2's Care Plan with a Target Date of 10/18/2024 revealed in part . History of Drug Abuse. Intervention: Resident #2 noted to be lethargic, slurred speech, unable to perform ADL's at her normal capacity, found to have container of synthetic THC gummies, container taken to the nurses' station. Diagnosis of Depression. Interventions: 08/22/2024 Resident #2 reported suicidal ideations to nurse, PEC per Psychiatrist to inpatient psych hospital. Administer medications as ordered. Consult to see Psychiatrist for medication management. Encourage Resident #2 to express feelings (anger, sadness, guilt) and come up with alternative ways to handle feelings. Monitor for any signs and symptoms of depression: feelings of guilt, helplessness, or hopelessness, poor concentration, sleep disturbances, lethargy, appetite loss or weight gain, anhedonia, loss of mood reactivity, and thoughts of death. Mood and behavior monitored every shift. Review of Resident #2's Progress Notes revealed in part . 08/22/2024 12:00 a.m. Resident remains up in wheelchair in room .her speech is slurred, and she appeared to be intoxicated, staff .finds gummies in an opened container, with a few missing .she has torn the room up, items on the floor, food, and other items, when Resident #2 came back in, she was asked what else did she have beside the prescribed medicine that she received at facility, she replied nothing . By: S4 LPN 08/23/2024 3:01 p.m. On 08/22/2024 at 10:21 a.m., I was notified by nursing staff that Resident #2 was verbalizing threats to harm herself and that she was being sent out to the local ER for psychiatric evaluation . On 08/23/2024 at 10:07 a.m. I spoke with S2 DON on the phone. S2 DON stated .Resident #2 asked him to pick up some THC gummies from the gas station earlier this week and he did so. I was not notified until after this occurred. I did not give an order for them .I told him that he shouldn't have given Resident #2 gummies . By: Physician Review of a Disciplinary Warning Notice for S2 DON dated 08/26/2024 revealed in part . (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This is a record showing S2 DON and S1 ADM had a meeting regarding that THC gummies will no longer be allowed at the nursing home . Interview on 08/27/2024 11:07 a.m. with S1 ADM revealed Resident #2 was depressed about being in a nursing home after having a massive stroke and her boyfriend recently broke up with her. S1 ADM revealed when S2 DON talked to Resident #2, she asked him to get her marijuana and S2 DON told her he could not. S1 ADM reported S2 DON asked her if he could get THC gummies for Resident #2 and she told him he could. S1 ADM revealed S2 DON bought THC-P gummies and gave the can of 10 gummies to Resident #2. S1 ADM revealed she did not consider the complications of allowing S2 DON to purchase THC gummies, and confirmed she should have called the doctor prior to allowing the S2 DON to purchase the gummies for Resident #2. Interview on 08/27/2024 at 2:53 p.m. with S2 DON revealed on 08/20/2024 he heard and saw Resident #2 crying on the patio. S2 DON revealed he went out to speak with Resident #2 and when he asked her what was wrong, she said Nothing, It's Nothing. S2 DON reported Resident #2 then asked him for a marijuana joint and he told her he could not do that, but he could see about getting her THC gummies. S2 DON revealed he spoke to S1 ADM and S1 ADM told him it was legal and he could get it for Resident #2. S2 DON revealed Resident #2 asked about the THC gummies on 08/21/2024 and he went that afternoon and got them for her. S2 DON reported he got a container that had 10 gummies and gave Resident #2 the whole container. Interview on 08/29/2024 at 1:58 p.m. with S2 DON confirmed he did not call Resident #2's physician prior to buying the THC gummies and giving them to her, but he should have. Telephone interview on 08/30/2024 at 9:07 a.m. with S4 LPN revealed during her medication pass on 08/21/2024, staff notified her Resident #2 voiced she wanted to kill herself and those around her. S4 LPN revealed she could not recall the time or name of the staff. S4 LPN reported she told the staff to monitor Resident #2 when she went into her room. S4 LPN revealed she could not recall if she notified the Resident #2's physician. S4 LPN revealed when passing Resident #2's room she saw it was in disarray and she went in. S4 LPN reported she found food on the floor and some blue THC gummies in a tin can with 8 gummies remaining in the can. Interview on 08/30/2024 at 12:55 p.m. with Resident #2's physician revealed he heard S2 DON had given Resident #2 THC gummies, he said he was not notified, and would have never agreed to it. He revealed he was never made aware Resident #2 was asking staff about marijuana, nor did any staff speak to him about THC gummies, until after they were given to Resident #2 and she was in the hospital. Interview on 09/03/2024 at 3:00 p.m. with Resident #2 revealed she just returned to the facility today after being treated at a behavioral hospital. Resident #2 reported she does not recall exactly what happened on 08/21/2024 or what she said to staff because she was in and out of it. Resident #2 reported she just knows she was very depressed. Resident #2 revealed she had taken THC gummies in the past prior to being admitted to the facility. Resident #2 reported the THC gummies that were purchased by S2 DON were stronger and she did not like the way they made her feel.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45213 Based on interview and record review, the facility failed to ensure a resident who displays or is diagnosed with a mental disorder received appropriate treatment and services to correct the assessed problem and to attain the highest practicable mental and psychosocial well-being for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of a facility policy titled Change in a Resident's Condition or Status dated 12/2016 read in part . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc). 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): d. significant change in the resident's physical, emotional, mental condition . Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Non-Dominant Side, Other Muscle Spasms, Major Depressive Disorder, Insomnia, and Type 2 Diabetes Mellitus. Review of Resident #2's Admission/OSA MDS with an ARD of 07/24/2024 revealed a BIMS score of 15, indicating intact cognition. Resident #2's MDS revealed she required extensive assistance with 2 plus persons for bed mobility, transfers, and toilet use. Review of Resident #2's Care Plan with a Target Date of 10/18/2024 revealed in part . History of Drug Abuse. Intervention: Resident #2 noted to be lethargic, slurred speech, unable to perform ADL's at her normal capacity, found to have container of synthetic THC gummies, container taken to the nurses' station. Diagnosis of Depression. Interventions: 08/22/2024 Resident #2 reported suicidal ideations to nurse, PEC per Psychiatrist to inpatient psych hospital. Administer medications as ordered. Consult to see Psychiatrist for medication management. Encourage Resident #2 to express feelings (anger, sadness, guilt) and come up with alternative ways to handle feelings. Monitor for any signs and symptoms of depression: feelings of guilt, helplessness, or hopelessness, poor concentration, sleep disturbances, lethargy, appetite loss or weight gain, anhedonia, loss of mood reactivity, and thoughts of death. Mood and behavior monitored every shift. Review of Resident #2's Progress Notes revealed in part . 08/21/2024 6:30 p.m. Resident #2 on the outside on patio, saying she wanted to speak to someone, anyone, staff says that she was just talking about a lot of nothing, until she replied, that she wanted to kill herself and those around her, writer was inside the building .when Resident #2 did come inside passed me .she went to her room, and did not wait nor ask for anything. By: S4 LPN (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/22/2024 12:00 a.m. Resident remains up in wheelchair in room .her speech is slurred, and she appeared to be intoxicated, staff .finds gummies in an opened container, with a few missing .she has torn the room up, items on the floor, food, and other items, when Resident #2 came back in, she was asked what else did she have beside the prescribed medicine that she received at facility, she replied nothing . By: S4 LPN 08/22/2024 9:30 a.m. Resident #2 noted to be agitated this am. Yelling out help me from room. Stated that she wanted to kill herself to the night time nurse. Psychiatrist here on rounds .PEC filled out for transfer to facility for psych evaluation. Send to local hospital for evaluation r/t verbal threats to harm self. By: S5 LPN 08/23/2024 3:01 p.m. On 08/22/2024 at 10:21 a.m., I was notified by nursing staff that Resident #2 was verbalizing threats to harm herself and that she was being sent out to the local ER for psychiatric evaluation . On 08/23/2024 at 10:07 a.m. I spoke with S2 DON on the phone. S2 DON stated .Resident #2 asked him to pick up some THC gummies from the gas station earlier this week and he did so. I was not notified until after this occurred. I did not give an order for them .I told him that he shouldn't have given Resident #2 gummies . By: Physician Review of Resident #2's PEC dated 08/22/2024 at 1:00 p.m. revealed in part .stating she wants to kill herself, not sleeping. Mental condition: depressed, anxious, crying, not sleeping, not cooperative. Suicidal. Dangerous to self. Unwilling. Signed by: Psychiatrist Review of a Disciplinary Warning Notice for S4 LPN Dated 08/23/2024 revealed in part . Resident #2 stated she wanted to kill herself and S4 LPN did not put Resident #2 on one on one or notify the physician . Signed by: S3 ADON and S2 DON Interview on 08/27/2024 11:07 a.m. with S1 ADM revealed Resident #2 was depressed about being in a nursing home after having a massive stroke and her boyfriend recently broke up with her. S1 ADM revealed when S2 DON talked to Resident #2, she asked him to get her marijuana and S2 DON told her he could not. S1 ADM reported S2 DON asked her if he could get THC gummies for Resident #2 and she told him he could. S1 ADM revealed S2 DON bought THC-P gummies and gave the can of 10 gummies to Resident #2. S1 ADM revealed she did not consider the complications of allowing S2 DON to purchase THC gummies, and confirmed she should have called the doctor prior to allowing the S2 DON to purchase the gummies for Resident #2. Interview on 08/27/2024 at 2:53 p.m. with S2 DON revealed on 08/20/2024 he heard and saw Resident #2 crying on the patio. S2 DON revealed he went out to speak with Resident #2 and when he asked her what was wrong, she said Nothing, It's Nothing. S2 DON reported Resident #2 then asked him for a marijuana joint and he told her he could not do that, but he could see about getting her THC gummies. S2 DON revealed he spoke to S1 ADM and S1 ADM told him it was legal and he could get it for Resident #2. S2 DON revealed Resident #2 asked about the THC gummies on 08/21/2024 and he went that afternoon and got them for her. S2 DON reported he got a container that had 10 gummies and gave Resident #2 the whole container. (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/29/2024 at 1:58 p.m. with S2 DON confirmed he did not call Resident #2's physician prior to buying the THC gummies and giving them to her, but he should have. S2 DON revealed it was reported to him on 08/22/2024 that Resident #2 had behaviors the night before of wanting to kill herself and others, and S4 LPN did not follow policy and procedure. S2 DON reported once he found out Resident #2 had threatened to kill herself and others, she was immediately placed on 1:1 and he got a PEC from the psychiatrist to send her to a psych facility. S2 DON reported they could not find placement therefore, Resident #2 was sent to a local hospital, and then was eventually transferred to a behavioral hospital. S2 DON reported S4 LPN should have taken immediate action, the physician should have been called, and Resident #2 should have been on 1:1 for close monitoring to ensure her safety as well as others in the facility. Telephone interview on 08/30/2024 at 9:07 a.m. with S4 LPN revealed during her medication pass on 08/21/2024, staff notified her Resident #2 voiced she wanted to kill herself and those around her. S4 LPN revealed she could not recall the time or name of the staff. S4 LPN reported she told the staff to monitor Resident #2 when she went into her room. S4 LPN revealed she could not recall if she notified the Resident #2's physician. S4 LPN revealed when passing Resident #2's room she saw it was in disarray and she went in. S4 LPN reported she found food on the floor and some blue THC gummies in a tin can with 8 gummies remaining in the can. Interview on 08/30/2024 at 12:55 p.m. with Resident #2's physician revealed he was notified by S5 LPN on 08/22/2024 around 10:00 a.m. that Resident #2 was suicidal and was being sent to the local ER. He reported about an hour later, around 11:00 a.m., he received a message from S2 DON saying the resident needed a PEC. He revealed S2 DON told him Resident #2 was suicidal and threatened to kill herself and everyone else at the nursing home. He revealed he was told Resident #2 was already placed on 1:1 and he said he would write the PEC. He reported he wrote the PEC and S2 DON came by his clinic and picked it up. He revealed he found out that the psychiatrist had gone to see Resident #2 and had also written a PEC for Resident #2 and was helping with trying to find placement at an inpatient psychiatric hospital. He revealed he was made aware by S1 ADM and S3 ADON on 08/29/2024 that Resident #2 was suicidal on 08/21/2024 and he was not notified by staff until 08/22/2024. He reported Resident #2 should have gone straight to the local ER if she was suicidal and threatening to harm others. He revealed he heard S2 DON had given Resident #2 THC gummies, he said he was not notified, and would have never agreed to it. He revealed he was never made aware Resident #2 was asking staff about marijuana, nor did any staff speak to him about THC gummies, until after they were given to Resident #2 and she was in the hospital. Interview on 08/30/2024 at 2:11 p.m. with S5 LPN revealed on 08/22/2024 S4 LPN informed her during report for her 6:00 a.m. to 6:00 p.m. shift, THC gummies were found in Resident #2's purse. S5 LPN revealed Resident #2 woke up screaming and hollering for S3 ADON because S4 LPN had called S3 ADON on the 6:00 p.m. to 6:00 a.m. shift to let her know about Resident #2's behaviors. S5 LPN reported the psychiatrist saw Resident #2 and wrote a PEC. S5 LPN revealed Resident #2 went out around 2:00 p.m. to the local ER. S5 LPN reported she was not instructed to have staff sit 1:1 with Resident #2. S5 LPN reported from 6:00 a.m. to around 2:00 p.m. when Resident #2 went to the hospital, whenever she went in the room to provide care, Resident #2 was alone. S5 LPN revealed when the psychiatrist came, she woke up and starting screaming, and then was screaming again right before she went to the hospital. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/2024 at 11:04 a.m. with S3 ADON revealed Resident #2 reported to staff on 08/21/2024 around 6:20 p.m. that she wanted to kill herself and others. S3 ADON reported Resident #2's physician was not notified until around 9:30 a.m. to 10:00 a.m. the following morning on 08/22/2024. S3 ADON reported she got a call at around 12:30 a.m. on 08/22/2024 notifying her Resident #2 was yelling out, they found THC gummies in her room, and her room was a mess. S3 ADON reported they did not tell her Resident #2 voiced wanting to kill herself and others. S3 ADON confirmed the resident was not placed on 1:1, but should have been. Interview on 09/03/2024 at 3:00 p.m. with Resident #2 revealed she just returned to the facility today after being treated at a behavioral hospital. Resident #2 reported she does not recall exactly what happened on 08/21/2024 or what she said to staff because she was in and out of it. Resident #2 reported she just knows she was very depressed. Resident #2 revealed she had taken THC gummies in the past prior to being admitted to the facility. Resident #2 reported the THC gummies that were purchased by S2 DON were stronger and she did not like the way they made her feel.