

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Cypress at Lake Providence		STREET ADDRESS, CITY, STATE, ZIP CODE 5976 US-65 North Lake Providence, LA 71254	

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 - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from verbal abuse by S6Certified Nursing Aide (CNA) for 1 (#5) of 3 (#1, #3, and #5) sampled residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of the facility's Freedom from Abuse, Neglect, and Exploitation, revised 03/2023, revealed the following, in part:</p> <p>Purpose:</p> <p>To keep residents free from abuse, neglect, and corporal punishment of any kind by any person.</p> <p>Policy:</p> <p>The facility will provide a safe resident environment and protect residents from abuse. The facility will keep residents free from abuse, neglect, misappropriation of resident property, and exploitation. This includes freedom from verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms. This protection extends to abuse by staff, consultants, contractors, volunteers, students, and visitors (collectively staff).</p> <p>Guidelines:</p> <p>4. Staff to resident abuse:</p> <p>a. Staff are expected to be in control of their behavior, are to behave professionally, and understand how to work with the facility population. For example, striking a combative resident is not considered appropriate.</p> <p>b. A knee-jerk or reflexive reaction is not acceptable.</p> <p>c. In determining abuse, willful (deliberate) action (not inadvertent or accidental) will be considered regardless of whether the individual intended to inflict injury or harm.</p> <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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Retaliation by staff is abuse, regardless of whether harm was intended.</p> <p>Types of Abuse:</p> <p>3. Mental and Verbal Abuse</p> <p>a. Verbal and nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.</p> <p>b. Verbal abuse may be considered to be a type of mental abuse.</p> <p>c. Verbal abuse may be oral, written, or gestured communication or sounds to residents within hearing distance regardless of the residents' ability to comprehend.</p> <p>Review of the record for resident #5 revealed an admitted [DATE] with diagnoses including anoxic brain damage, other intracranial injury without loss of consciousness, cervical root disorders, mild protein calorie malnutrition, major depressive disorder, generalized anxiety disorder, attention deficit hyperactivity disorder, delusional disorders, psychotic disorder with delusions due to known physiological condition, pain, and impulse disorder.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 99 indicating unable to determine cognitive function. Further review of the MDS revealed the resident required moderate to maximal assistance with activities of daily living.</p> <p>Review of the resident's current care plan revealed the resident had aggressive behaviors and had one on one care 24 hours per day.</p> <p>Review of the facility's investigation dated 04/18/2025 revealed S2Director of Nursing (DON) notified S1Administrator at 5:00 p.m. that S5Agency Licensed Practical Nurse (LPN) overheard S6CNA raise his voice and use inappropriate language to resident #5. S6CNA notified S5Agency LPN that resident #5 had grabbed him with her nails and it was painful.</p> <p>Interview on 04/22/2025 at 9:10 a.m. with S5Agency LPN revealed on 04/18/2025 about 10:00 a.m. she overheard someone raise their voice and say b let me go. She turned around and it was S6CNA that had said this to resident #5. S6CNA told S5Agency LPN that resident #5 had grabbed his wrist and it was painful. S5Agency LPN reported that S6CNA immediately apologized.</p> <p>Interview on 04/22/2025 at 10:08 a.m. with S6CNA reported he was working one on one with resident #5 on 04/18/2025. S6CNA reported that around 9:00 a.m. to 10:00 a.m. resident #5 grabbed his wrist and her nails dug into him and he pulled his arm back. S6CNA reported he did not remember cussing at resident #5, but he was in pain. S6CNA reported that resident #5 had a history of hitting, pinching, and grabbing staff. S6CNA acknowledged he reported this to the nurse that was on the hall. S6CNA reported he has worked with resident #5 for 2 years.</p> <p>(continued on next page)</p>		

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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>Interview on 04/22/2025 at 11:05 a.m. with S2DON revealed she was notified on 04/18/2025 about 2:30 p.m. by S5Agency LPN that S5Agency LPN overheard S6CNA say b let me go to resident #5. S2DON revealed she removed S6CNA from caring for resident #5 on 04/18/2025 at approximately 1:00 p.m., however S2DON revealed she was not aware of the allegation of verbal abuse by S6CNA to resident #5 until approximately 2:30 p.m.</p> <p>An interview on 04/22/2025 at 1:20 p.m. with S1Administrator confirmed that he was notified on 04/18/2025 by S2DON at 5:00 p.m. that S5Agency LPN overheard S6CNA cuss at resident #5. S1Administrator confirmed that S6CNA was suspended while the incident was under investigation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40238</p> <p>Based on record reviews and interviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to the State Survey Agency in accordance with State law for 2 (#1, #5) of 4 (#1, #3, #5, #6) residents investigated for possible abuse or neglect.</p> <p>The failed practice was evidenced by the facility failing to report: 1.) an injury of unknown source to the State Survey Agency within 2 hours of the incident which involved resident #1 and 2.) abuse to the administrator and State Survey Agency within 2 hours of an incident involving resident #5.</p> <p>Findings:</p> <p>Policy/Procedure</p> <p>Review of abuse policy with a revision date of 05/15/2023 revealed the following in part:</p> <p>Response to Allegations and Suspicions</p> <ol style="list-style-type: none"> 1. Allegations may be verbal or in writing and will be reported to the administrator of the facility and other officials as required. 2. Report any reasonable suspicion of a crime against a resident that involves serious bodily injury immediately, but not later than (2) hours after forming the suspicion. 3. In the absence of abuse or serious bodily injury, reporting is required not later than 24-hours after forming the suspicion. <p>Investigation:</p> <ol style="list-style-type: none"> 1. The facility Administrator/designee will conduct thorough investigations of alleged violations and report the findings to the State agency within 5 working days of the allegation. 2. The facility will immediately protect the resident from further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. <p>This includes:</p> <ol style="list-style-type: none"> a. Removing employee/s from duty when an allegation has been made until the investigation has been completed and a determination has been made. b. Separating involved residents to protect the alleged victim. <p>Resident #1</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 - Some</p>	<p>Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, paranoid schizophrenia, conversion disorder with seizures or convulsions, acute kidney failure, adjustment disorder with anxiety, pain, abnormal posture, muscle spasm, and lack of coordination.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 00 indicating unable to determine cognitive functioning.</p> <p>Review of accident/incident reports revealed a report involving resident #1 dated 03/21/2025. The report acknowledged resident #1 was found in his bed with a small laceration to the back of his head on 03/21/2025 at 7:05 p.m. Resident #1 was sent to a hospital and received two sutures to the back of his head. The incident category was reported as an injury of unknown origin. The report recorded the incident was reported to the State Survey Agency on 03/22/2025 at 4:39 p.m.</p> <p>On 04/22/2025 at 1:02 p.m., an observation and attempted interview with resident #1 was conducted in his room. Resident #1 could not answer simple yes or no questions verbally or with body gestures. Resident #1 could not report any information related to the laceration to the back of his head that occurred on 03/21/2025.</p> <p>On 04/23/2025 at 1:10 p.m., a telephone interview was conducted with S8Certified Nursing Aide (CNA). S8CNA reported she was in the hallway outside of resident #1's room on 03/21/2025 around 7:00 p.m., when she heard a loud noise in the room. S8CNA reported the room door was closed and resident #1 and resident #7 (roommate) were the only people in the room. S8CNA reported she discovered resident #1 in his bed with a laceration to the back of the head. She reported resident #1 was lying on his side facing the wall and resident #7 was standing beside resident #1's bed. S8CNA reported resident #7 responded he didn't know when S8CNA asked resident #7 what happened.</p> <p>On 04/23/2025 at 1:15 p.m., an interview with S2Director of Nursing (DON) revealed their investigation could not determine how resident #1 obtained the laceration to the back of his head. S2DON reported resident #7 consistently reported he did not know what happened and denied injuring resident #1.</p> <p>On 04/23/2025 at 1:52 p.m., an interview with S9Licensed Practical Nurse (LPN) confirmed she was working the evening of 03/21/2025. She reported there was no blood observed anywhere in in resident #1's room other than to the back of his head and on the cover where his head was laying. S9LPN reported resident #7 was in close proximity to resident #1's bed. S9LPN reported resident #7 did not have any blood on him. S9LPN reported resident #7 reported he did not know what happened to resident #1 and denied making physical contact with him. S9LPN reported there was no physical evidence or admission that could prove resident #7 injured resident #1. S9LPN reported resident #7 had short term memory loss that seemed to have worsened in the past few months.</p> <p>On 04/23/2025 at 4:05p.m., an interview with S4Corporate Registered Nurse confirmed the facility failed to ensure allegations involving an injury of unknown source was reported to the State Survey Agency within 2 hours of the incident on 03/21/2025 involving resident #1.</p> <p>43405</p> <p>Resident #5</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 - Some</p>	<p>Review of the record revealed an admitted [DATE] with diagnoses including anoxic brain damage, other intracranial injury without loss of consciousness, cervical root disorders, mild protein calorie malnutrition, major depressive disorder, generalized anxiety disorder, attention deficit hyperactivity disorder, delusional disorders, psychotic disorder with delusions due to known physiological condition, pain, and impulse disorder.</p> <p>Review of the Annual MDS assessment dated [DATE] revealed a BIMS score of 99 which indicated unable to determine cognitive function. Further review of the MDS revealed the resident required moderate to maximal assistance with activities of daily living.</p> <p>Review of the resident's current care plan revealed the resident had aggressive behaviors and had one on one care 24 hours per day.</p> <p>Review of the facility's investigation dated 04/18/2025 revealed S2DON notified S1Administrator at 5:00 p. m. that S5Agency LPN overheard S6CNA raise his voice and use inappropriate language to resident #5. S6CNA notified S5Agency LPN that resident #5 had grabbed him with her nails and it was painful.</p> <p>Interview on 04/22/2025 at 9:10 a.m. with S5Agency LPN revealed on 04/18/2025 about 10:00 a.m. she overheard someone raise their voice and say b let me go. She turned around and it was S6CNA that had said this to resident #5. S6CNA told S5Agency LPN that resident #5 had grabbed his wrist and it was painful. S5Agency LPN reported that S6CNA immediately apologized. S5Agency LPN reported she failed to notify S2DON immediately but no later than 2 hours when she overheard S6CNA cuss at resident #5.</p> <p>Interview on 04/22/2025 at 10:08 a.m. with S6CNA reported he was working one on one with the resident #5 on 04/18/2025. S6CNA reported that around 9:00 a.m. to 10:00 a.m. resident #5 grabbed his wrist and her nails dug into him and he pulled his arm back. S6CNA reported he did not remember cussing at resident #5, but he was in pain. S6CNA reported that resident #5 had a history of hitting, pinching, and grabbing staff. S6CNA acknowledged he reported this to the agency nurse that was on the hall.</p> <p>Interview on 04/22/2025 at 11:05 a.m. with S2DON revealed she was notified by S5Agency LPN on 04/18/2025 about 2:30 p.m. that S5Agency LPN overheard S6CNA say b let me go to resident #5. S2DON reported that she notified S1Administrator of this on 04/18/2025 around 5:00 p.m. S2DON confirmed that S5Agency LPN failed to notify her immediately when she overheard S6CNA cuss at resident #5. S2DON further acknowledged she failed to report this to S1Administrator until 04/18/2025 at 5:00 p.m.</p> <p>An interview on 04/22/2025 at 1:20 p.m. with S1Administrator confirmed that he was notified by S2DON on 04/18/2025 at 5:00 p.m. that S5Agency LPN overheard S6CNA cuss at resident #5. S1Administrator confirmed that S5Agency LPN failed to report immediately or within 2 hours of her overhearing S6CNA cussing at resident #5. S1Administrator confirmed S2DON failed to report immediately or within 2 hours of an allegation of verbal abuse to S1Administrator. S1Administrator confirmed he failed to submit a report to the State Survey Agency immediately or within 2 hours of an allegation of verbal abuse by S6CNA.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405</p> <p>Based on interviews and record review, the facility failed to ensure residents recieved the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management for 1 (#4) of 2 (#3, #4) sampled residents reviewed for pain management.</p> <p>Findings:</p> <p>Review of the record revealed an admitted [DATE] with diagnoses including paresthesia of skin, morbid obesity, bipolar disorder, hypertension, cellulitis of groin, lumbar radiculopathy, sleep apnea, aggressive behavior, open fracture of first lumbar vertebra, stenosis of lateral recess of lumbar spine, prolapsed lumbar intervertebral disc, and secondary kyphosis.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact.</p> <p>Review of the April 2025 Physician's Orders revealed an order dated 02/27/2025 for Oxycodone-Acetaminophen oral tablet 10-325 milligrams (mg) give 1 tablet by mouth (po) every 8 hours (hrs) as needed (prn) pain.</p> <p>Review of the March 2025 Medication Administration Record (MAR) revealed the following:</p> <p>March 2025- Oxycodone-Acetaminophen 10-325 mg 1 tablet po every 8 hrs prn pain was administered 45 times.</p> <p>Review of the April 2025 MAR revealed Oxycodone-Acetaminophen 10-325 mg was not administered from 04/01/2025 through 04/03/2025.</p> <p>Review of the Controlled Drug Record for resident #4 revealed resident's Oxycodone-Acetaminophen 10-325 mg was not available for resident #4 from 03/31/2025 through 04/03/2025.</p> <p>Review of the resident's current care plan revealed the following: resident has pain- interventions included administer analgesia as per orders, give 1/2 hour before treatments or care, and anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>Review of the nurse's note dated 04/03/2025 at 9:59 a.m. revealed resident was agitated and upset about his pain medicine and proceeded to fuss at the nurse about the pain medicine. Nurse offered resident #4 Tylenol and ibuprofen and he refused. Nurse assured him that he will have to wait until pharmacy deliver his meds. Nurse tried to use non-pharmacological method of distraction but resident was still upset. Nurse stated I told him he's fussing at me over something I have no control of and have to continue to pass meds he then states yeah you always say that I then turned to leave out the room and he yelled out and f . you I then left out the room</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 04/21/2025 at 2:40 p.m. with S7Licensed Practical Nurse (LPN) revealed that she has been working at the facility for a little over a month and she provided care to resident #4. S7LPN confirmed resident #4 did run out of his pain medication since she had been working at the facility but was unsure of the dates.</p> <p>On 04/20/2025 at 4:20 p.m., an interview with resident#4 was conducted in the privacy of his room. Resident#4 reported he was without his as needed (prn) pain medication from 03/31/2025 through 04/03/2025.</p> <p>On 04/22/2025 at 10:35 a.m. S2Director of Nursing (DON) and S4Corporate Registered Nurse (RN) confirmed resident #4 did not have his prn Oxycodone-Acetaminophen 10-325 mg available from 03/31/2025 through 04/03/2025.</p>		