Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on record review and interviews, the facility failed to notify the responsible party for 1 (#1) of 3 (#1, #2, #3) residents sampled for an incident that involved suspected sexual abuse. Findings: A review of the facility's policy titled, Abuse: Definition: 3. Sexual Abuse: non-consensual sexual contact of any kind revised 06/01/2017 that read: Procedure - Patient grievances system for patient abuse: 1. anyone who receives or witnesses an incident of patient abuse or neglect must report the incident to the immediate supervisor who in turn reports to Social Services Director/Director of Nurses (SSD/DON) and administrator. This does not say anything about notifying the responsible party. Review of the facility Incident and Accident report dated 04/27/2024 at 3:40 p.m., read in part: Resident #1 was at the medication cart when the nurse was passing medications. When the nurse began to gather supplies to obtain blood sugar, Resident #1 wandered into Resident #2's room. The nurse went into Resident #2's room and it appeared that Resident #2 was attempting to remove Resident #1's elastic pants. Resident #1's brief was in place and secure with approximately six inches of her brief exposed. Resident #2 was fully clothed, and Resident #1 was immediately removed from Resident #2's room. A record review revealed Resident #1 was admitted to the facility on [DATE] with current diagnosis of Dementia with psychotic disturbance, Schizoaffective disorder, Major depressive disorder, Anxiety disorder, Neurocognitive disorder with Lewy bodies. Her cognition was severely impaired. Resident's responsible party was her daughter. A record review of Resident #1's nurses notes dated 04/27/2024 did not reveal that Resident #1's responsible party had been notified of the incident on 04/27/2024. Review of the facility document titled Disciplinary Meeting Counseling Form dated 4/29/2024 written by S1ADM (Administrator) read in part: S3LPN (Licensed Practical Nurse) educated and counseled on notifying DON or administrator immediately following attempted sexual or inappropriate acts between residents. Medical Director and family must also be notified. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2024 at 1:50 p.m., an interview was conducted with S3LPN who stated that she was preparing medications and Resident #1 was with S4CNA (Certified Nursing Assistant). She added that when S4CNA went to tend to another resident, Resident #1 was walking in the hallway on the unit. She stated that when she went to give a resident their medication, she observed Resident #1 inside of Resident #2's room. She stated that Resident #2 was standing by his privacy curtain, and behind Resident #1. She added that Resident #2 had his hands on Resident #1's pants, and appeared as though he was attempting to take her pants down. S3LPN stated she immediately intervened and took Resident #1 to her room. She stated that she notified the doctor and the responsible party for Resident #1. On 05/14/2024 at 11:36 p.m., a phone interview was conducted with Resident #1's responsible party. Resident #1's responsible party stated that she was notified on Monday 04/29/2024 by S2DON about the incident that occurred on 04/27/2024. On 05/14/2024 at 1:30 p.m., an interview was conducted with S2DON who confirmed that S3LPN had not informed Resident #1's responsible party, and that she had completed the notification of the incident on 04/29/2024.

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NAME OF PROVIDER OR SUPPLIER: Oak Lane Wellness & Rehabilitative Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1400 W Magnolia Eunice, LA 70535	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on record review, video review, and interview, the facility failed immediately implement safeguards to protect a resident without the capacity to consent to sexual activity from sexual abuse for 1 (#1) of 3 (#1, #2, #3) sampled residents when Resident #2 had non-consensual sexual contact with Resident #1. This deficient practice had the potential to affect 3 female residents who resided on the dementia care unit. Findings: Review of the facility's Policy and Procedure titled, Abuse read in part sexual abuse is nonconsensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to: A. unwanted intimate touching of any kind especially of breast or perineal area. B. all types of sexual assault or battery, such as rape, sodomy and coerced nudity. If you suspect any type of abuse, the Director of Nursing (DON) must be notified immediately or the administrator to determine next step. The facility will conduct an investigation and protect a resident from nonconsensual sexual relation anytime there is reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. Resident #1 Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses which included: Dementia with psychotic disturbances, Schizoaffective disorder, Major depressive disorder, Anxiety disorder, and Neurocognitive disorder with Lewy bodies. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 02, which indicated severe cognitive impairment. Review of Resident #1's Care Plan dated 02/13/2023 revealed in part . wanders in and out of others room, wanders aimlessly. Intervention -if resident is wandering in a potentially unsafe area or situation, redirect to a safer area and reassess regularly. Resident #2 Review of Resident #2's medical record revealed an admitted [DATE] with diagnosis that included vascular Dementia with agitation, Major depressive disorder, and Post-traumatic headache. Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Resident #2's care plan dated 02/01/2024 revealed in part .risk for unstable mood and behavior; inappropriate sexual behavior with staff. Interventions: report decline in mood and changes in behavior to medical doctor. Provide privacy as needed when resident noted to masturbate under bed covers. Redirect and change direction of conversation when resident noted to inappropriately stare at staff, tell nurse that she is pretty and I love you. Redirect and educate resident that touching staffs' crotch is unacceptable and inappropriate. Remind him that staff are in no way romantically involved.

Risk for wandering. Interventions - census check every one hours. Observe for wandering behaviors and redirect as needed.

Review of S5LPN (Licensed Practical Nurse) nurses notes dated 04/08/2024 at 8:30 a.m., read in part .CNA (Certified Nursing Assistant) informed S5LPN that while taking Resident #2's vital signs, he quickly put his hand to grab her crotch. S5LPN further documented that before the CNA could complete the task, Resident #2 attempted to grab CNA's crotch again.

Review of the facility's document Multidisciplinary Progress Note by a psychiatrist from the day program Resident #2 attended dated 04/16/2024 read in part .Resident #2 was experiencing maladaptive behavior such as grabbing his nurse's crotch on several occasions. Resident #2 should be closely observed for any further incidents as such behavior could be impulse control issues.

On 04/24/2024, the psychiatrist wrote that S5LPN reported Resident #2 was experiencing increased sexual preoccupation. S5LPN reported when the aide (CNA) asked Resident #2 if she could help him with anything, he stated, you can get in this bed and let me stick it in. S5LPN also reported that on the same morning, a different aide went in to assist the resident with getting dressed for the day. The aide asked Resident #2 to take his pajamas off while she looked for his jeans inside his closet. Resident #2 then began to repeat, like this, like this. When the aide turned around, Resident #2 was observed naked, holding his private area in his hands, and laughing.

Review of Electronic Treatment Administration Record (ETAR) dated 04/2024 read in part .census check every 1 hours. Further review of the ETAR did not reveal any behavior monitoring.

Review of the facility, Incident and Accident Report dated 04/27/2024 at 3:31 p.m., prepared by S3LPN read in part Resident #1 was at the medication cart with S3LPN while she was administering medication. When S3LPN began to gather supplies, Resident #1 wandered into Resident #2's room. When S3LPN went into Resident #2's room, she observed Resident #1 standing by the privacy curtain inside of Resident #2's room. Resident #2 attempted to remove Resident #1's elastic pants. The nurse observed the resident's pants had been moved down approximately six inches with Resident #1's incontinent brief exposed.

Review of S3LPN's undated witness statement read in part . During rounds Resident #1 was going into other residents' rooms. She removed Resident #1 from the room and positioned the resident near the medication cart where she was working. While gathering supplies to check Resident #1's blood sugar, Resident #1 wandered off and went into Resident #2's room. S3LPN observed Resident #1 inside of Resident #2's room near the privacy curtain. Resident #2 was standing behind Resident #1 with Resident #1's pants pulled down approximately six inches. Resident #2 stated, I'm sorry, I won't do it again.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the video footage provided by the facility revealed Resident #1 wandered into Resident #2's room at approximately 3:29 p.m. S3LPN was observed at the medication cart on the hall, gathering supplies with her back towards the residents on the hall. In the same minute Resident #1 was observed entering Resident #2's room. At 3:30 p.m., Resident #2 was observed standing in his doorway looking up and down the hall while touching his private area. S3LPN was still at the medication cart, continuing to gather supplies and thumb through medication cards. S3LPN had her back turned to Resident #2 who was staring at her while she was at the medication cart. Resident #2 was observed going back inside of his room at 3:31 p.m. S3LPN then walked away from her medication cart and was no longer visible on camera. Resident #1 remained in Resident #2's room at this time. A few seconds later, S3LPN returned to the medication cart then began to walk down the hallway in the direction of Resident #2's room. While walking down the hallway, S3LPN looked into Resident #2's room before entering. After entering Resident #2's room at 3:32 p.m., S3LPN was observed exiting Resident #2's room with Resident #1. At that time the video ended. On 05/13/2024 at 1:30 p.m., an interview was conducted with S2DON who stated the facility was aware Resident #2 was experiencing increased sexual behaviors like grabbing at CNA's crotches and buttocks. She added that the facility was also aware of the inappropriate conversations Resident #2 had with the staff like telling one CNA to get in the bed so he could stick it in, standing in the room naked, and holding his private area while laughing. S2DON confirmed that on 04/29/2024 staff observed Resident #2 masturbating under the covers inside of his room. The resident was care planned for his behaviors towards staff, but the facility did not have a plan in place to protect the female residents on the dementia unit who could be at risk. S2DON stated they did not think that Resident #2 would do something like that with another resident in reference to the incident involving Resident #1. S2DON stated Resident #1 had a BIMS score of 02 and did not have the capacity to understand what was going on. She confirmed the facility failed to implement safeguards to prevent sexual abuse for Resident #1 and ensure the safety of the three vulnerable female residents who resided on the memory care unit with Resident #2. On 05/13/2024 at 1:50 p.m., an interview was conducted with S3LPN who stated she worked at the facility for two months and that working in the dementia care unit was not her normal assignment. She stated she was not made aware that Resident #2 had a history of sexually inappropriate behaviors toward staff nor was she aware that Residents #1 and #2 needed close monitoring. She added that no special interventions were implement except to complete a census check on all residents every hour. S3LPN stated on the day of the incident with Resident #1, she was at the medication cart gathering supplies for medication administration. She stated that prior to the incident Resident #1 was with the CNA, but the CNA had to tend to another resident inside of their room, so she had Resident #1 was stand at the medication cart with her. She added that in gathering the supplies, she did not pay close attention to the resident at that time. S3LPN stated she left her cart to pass medications on the dementia unit and on two other halls. When she returned to the hall, she observed Resident #1 inside Resident #2's room. She entered the room and observed Resident #2 standing behind Resident #1 near his privacy curtain. Resident #1's pants were observed pulled down about six inches and it appeared as if Resident #2 was attempting to pull Resident #1's pants down. She stated that she immediately removed Resident #1 from Resident #2's room and took the resident back to her own room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 10:45 a.m., an interview was conducted with S5LPN who stated she was aware Resident #2 grabbed at the CNAs' crotch and made inappropriate conversations with staff. She stated she monitored all the residents on the dementia care unit every hour and that there were no specific interventions in place to monitor Resident #2's sexual behaviors towards residents. She added that she did not think Resident #2 would have done anything like that to another resident. On 05/14/2024 at 11:00 a.m., a phone interview was conducted with S6LPN who stated that she was aware of the inappropriate behavior Resident #2 had with staff. She stated did not monitor or document Resident #2's behaviors. No other interventions were initiated to protect the female residents on the dementia unit. Nurses were required to complete one hour census checks on all residents. She also stated she did not think Resident #2 would have done anything sexual to another resident. On 05/14/2024 at 11:36 a.m., a phone interview was conducted with Resident #1's responsible party who stated that she had not informed her dad (Resident #1's husband) about the incident because he would be irate. The responsible party stated the facility needed to do a better job of monitoring the residents on the dementia unit. She stated if her mom had the mental capacity to understand what happened to her, she would have been upset. She stated her mother did not like anyone to take her clothes off.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41419 Based on record review and interviews, the facility failed to ensure alleged violation of sexual abuse were reported immediately, but not later than 24 hours after the allegation was made to the State Survey Agency for 1 (#1) out of 3 (#1, #2, #3) sampled residents. This had the potential to effect a census of 78 residents. Findings: A review of the facility's policy titled Unusual Occurrence Reporting revised date 12/2007 read in part Policy Interpretation and Implementation: 1. Our facility will report the following events to appropriate agencies: g. Allegations of abuse, neglect and misappropriation of resident property. H. Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. 2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations. A review of the facility's policy and procedure titled Abuse: Definition: 3 . Sexual Abuse: non-consensual sexual contact of any kind revised date 06/01/2017, read: Procedure - Patient grievances system for patient abuse: 1. Anyone who receives or witnesses an incident of patient abuse or neglect must report the incident to the immediate supervisor who in turn reports to Social Services Director/Director of Nursing (SSD/DON) and Administrator. Review of Resident #1's medical record revealed she was admitted to facility on 02/13/2023 with diagnoses that included in part: Dementia with psychotic disturbance, Schizoaffective disorder, Major depressive disorder, Anxiety disorder, Neurocognitive disorder with Lewy bodies. A review of a Statewide Incident Management System (SIMS) report for Resident #1 revealed the report was entered on 04/29/2024 at 10:41 a.m. Further review revealed the incident occurred on 04/27/2024 at 3:32 p. m. A review of the facility's document titled Disciplinary Meeting Counseling Form by S1ADM dated 04/29/2024 and signed by S2DON read in part .S2DON failed to report suspected sexual misconduct to administrator within 24 hours of occurrence resulting in late reporting to appropriate agencies. On 05/14/2024 at 1:30 p.m., an interview was conducted with S2DON (Director of Nursing) who confirmed that she did not notify S1ADM (Administrator) about the incident that occurred on 04/27/2024 until 04/29/2024. She stated that S1ADM should have been notified immediately.