STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195619	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy Care Center	906 Cherry Street Mamou, LA 70554

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on record review and interview the facility failed to ensure a resident's right to formulate an advanced directive was properly reflected in the resident's medical record for 1 (#38) of 1 resident reviewed for advance directives. The facility failed to ensure all medical records consistently reflected the resident's wishes to be a DNR (Do Not Resuscitate) code status. Findings: Review of the facility's policy dated 01/15/2025 titled, Advance Directives read in part . Policy statement: Advance Directives will be respected in accordance with state law and facility policy. 8. The plan of care for each resident will be consistent with his or her documented treatment preference and/or advance directives. Review of Resident #68's medical record revealed an admitted [DATE] with diagnoses that included: Cerebrovascular Disease, Dysphagia following Cerebral Infarction, Generalized Anxiety Disorder, Bipolar Disorder, and Chronic Systolic Heart Failure. Review of Resident #68's electronic record dashboard/orders revealed the resident was a Full Code status. Review of Resident #68's 03/2025 physician's orders revealed the code status as DNR. Review for Resident #68's care plan with the next review date of 06/24/2025 revealed the code status as DNR. Interview on 03/26/2025 at 10:40 a.m., with S11 LPN revealed she would look at the resident's dashboard/orders in their electronic record to determine their advance directive during a code. Interview on 03/26/2025 at 11:00 a.m., with S2 DON revealed the staff should look at the dashboard/orders of the resident's chart and determine their code status. S2 DON confirmed that Resident #68's electronic record and care plan had inconsistent data regarding advance directives and should be updated to reflect the corrected code status of DNR, but was not.

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: 195619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Savoy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Cherry Street Mamou, LA 70554	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 47004 Based on interview, observation, and record review the facility failed to ensure residents' rights to be free from verbal abuse and psychosocial harm by staff (Resident #15), resident to resident physical abuse (Resident #51 and #6); and protect a resident's right to be free from neglect (Resident #68), for 4 (Residents #6, #15, #51, and #68) of 4 residents (#6, #15, #51, and #68) reviewed for abuse and neglect. This deficient practice resulted in an Immediate Jeopardy situation for Resident #15 on 02/16/2025, when S4 CNA yelled at Resident #15 You stupid piece of sh*t. You're going to do what I say, and you're going to get in bed! Resident #15, who is cognitively intact, stated the incident hurt her feelings, made her cry, and she was fearful of S4 CNA. The Immediate Jeopardy continued on 02/21/2025 at approximately 3:28 p.m., when Resident #25 hit Resident #51 in the face with a box of cookies. Resident #51 stated this made her mad. The Immediate Jeopardy continued on 03/08/2025 at approximately 4:20 p.m., when Resident #25 (who exhibited aggressive and angry behavior on day of the incident), pulled Resident #6's hair. The Immediate Jeopardy continued on 03/25/2025 at 2:25 p.m., when S6 CNA was observed to willfully transfer Resident #68 without the required 2 person physical assist with mechanical lift; although she was knowledgeable that 2 person assist with mechanical lift was required of Care. The deficient practice has the likelihood to affect all other residents who reside in the facility. S1 Administrator was notified of the deficient practice at the Immediate Jeopardy level on 03/27/2025 at 5:56 p.m. Findings: Review of a facility policy on 03/26/2025 at 12:39 p.m., titled Abuse Prevention, with revision date of 03/21/2012, read in part . Each resident shall remain free from harm. Abuse - the ill treatment or disregard of an individual, whether purposeful, or due to carelessness, inattentiveness or omission of the perpetrator Emotional Abuse - any threatening behavior or statement directed to a person including, but not limited to ridicule, gestures that subject the person to humiliation or degradation, threatening motions or noises intended to startle or frighten the person. Physical Injury - an act that physically hurts or damages an individual's body where damage is inflicted by external force. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An intentional act of omission by an employee which denies the standard of care and treatment due to an individual as required by law, rules, regulations, policies, procedures, guidelines or care plans. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Physical Abuse - any physical motion of action, e.g. hitting, spitting, slapping, punching, kicking, pinching, directed toward the individual . Threat- any condition or situation that could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals or their death. Verbal Abuse - use of oral, written, or gestured language by which abuse occurs. Includes: Name calling, swearing., taunting, and using derogatory terms to describe persons with disabilities. Psychological Abuse - includes: humiliation, harassment, threats of punishment or deprivation, sexual coercion, and intimidation. If alleged abuse occurs staff will: Take immediate action to protect the individual(s) involved including removal of the alleged abuser. Ensure that any health or psychological needs of the resident are provided for. Notify the DON immediately. Review of a facility policy on 03/25/2025 at 4:16 p.m., titled Abuse and Neglect-Clinical Protocol, with revision date of 01/01/2025, read in part . Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, misappropriation of property or financial abuse, involuntary seclusion, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of a facility policy on 03/26/2025 at 1:30 p.m. titled Resident Rights with revision date of 12/2021, read in part . Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; and to be free from abuse and neglect. Resident #15 Review of Resident #15's medical record revealed she was admitted to the facility on [DATE]. Resident #15 had diagnoses that included in part . Chronic Pain Syndrome, Major Depressive Disorder, Anxiety Disorder, Parkinson's Disease, Spinal Stenosis, and Other Lack of Coordination. Review of Resident #15's Quarterly MDS with ARD of 01/08/2025, revealed a BIMS score of 15 (cognition intact). Resident #15 had range of motion impairment on both sides, and was dependent on staff for toileting, showering/bathing, and dressing. Review of Resident #15's care plan with an initiation date of 12/18/2024, revealed Resident #15 had a problem of impaired physical mobility related to Parkinson's disease. Interventions included in part . 2 person assist, transfer with mechanical lift. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview of Resident #37 during the Resident Council meeting on 03/24/2025 at 1:32 p.m., revealed Resident # 37 stated that S4 CNA made Resident #15 stay in bed, and refused to get Resident #15 up, per Resident #15's request. S4 CNA then yelled at Resident #15. Interview on 03/24/2025 at 3:05 p.m. with Resident #15, revealed on 02/16/2025 she was seated in her wheelchair in her room, and S4 CNA came into her room to put her to bed. Resident #15 said she stated to S4 CNA that she did not want to go to bed, and that S4 CNA then became upset. Resident #15 stated S4 CNA came at me, and I saw her pull a girl's hair once, so I was afraid of her. Resident #15 stated S4 CNA used an ugly tone with her, and she directly reported the incident and how she was afraid of S4 CNA to S1 Administrator on 02/17/2025. Resident #15 reported S1 Administrator asked her if she was afraid of S4 CNA, to which she replied yes. Resident #15 revealed S1 Administrator stated she would take care of the situation, and that S4 CNA would not provide care to her anymore. Resident #15 stated S1 Administrator moved S4 CNA from Hall Y to Hall Z, and S4 CNA had not provided care to her since. Interview on 03/25/2025 at 10:30 a.m. with S5 CNA Supervisor, revealed S2 DON moved S4 CNA from Hall Y to Hall Z last month, but she was unsure why. S5 CNA Supervisor revealed she was unaware of any incident between S4 CNA and Resident #15. S5 CNA Supervisor revealed she was aware that Resident #37 had informed S2 DON that she did not like the way S4 CNA spoke to residents, so she assumed that was why S2 DON moved S4 CNA to a different hall. Interview on 03/25/2025 at 11:30 a.m. with S1 Administrator revealed last month (02/2025), Resident #15 had reported that she was upset that S4 CNA put her back to bed when she (Resident# 15) did not want to go to bed. S1 Administrator stated Resident #15 reported this as a grievance to S2 DON. S1 Administrator revealed Resident #15 had never at any point in time informed her that she was afraid of S4 CNA, and denied Resident #15 reporting any abuse allegations to her. S1 Administrator revealed S2 DON moved S4 CNA's halls due to Resident #15 not wanting S4 CNA to care for her again. Review of a grievance form dated 02/17/2025, revealed Resident #15 filed a written grievance with S2 DON that read in part . Resident #15 stated S4 CNA put her to bed yesterday, although she was not ready to go to bed. She stated she did not care for S4 CNA due to her loud tone of voice. Action taken to resolve concern: In-service done. Statements received. S4 CNA reassigned to accommodate Resident #15 preference. Telephone interview on 03/25/2025 at 3:56 p.m. with S4 CNA revealed on 02/16/2025, she was paged to the nurses station by S13 LPN, and S13 LPN asked her to put Resident #15 to bed, because Resident #15 was not feeling well. S4 CNA stated Resident #15 stated she did not want to go to bed, but she and S15 CNA convinced Resident #15, and they transferred her 2 person assist with mechanical lift to bed. Interview on 03/26/2025 at 3:10 p.m. with Resident #37 (BIMS score of 15-indicating cognition intact), revealed she was fearful of S4 CNA. Resident #37 began to cry and revealed she was fearful because S4 CNA screamed and cursed at Resident #15. Resident #37 revealed on 02/16/2025, she could hear S4 CNA screaming at Resident #15 from the nursing station, so she went down the hall to Resident #15's room and witnessed S4 CNA yelling and cursing at Resident #15. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Observation and Interview on 03/26/2025 at 3:20 p.m. with Resident #15 revealed, Resident #37 and a visitor were in the room Resident #15 stated S4 CNA yelled at her and said You stupid piece of sh*t, you're going to do what I say, and you're going to get in that bed! Resident #37 stated at that time that she heard S4 CNA yell at Resident #15 and say, You stupid piece of sh*t, you're going do what I say, and you're going to get in that bed! Resident #15 began to cry during the interview, and stated yes that is exactly what S4 CNA said to me! I don't like to use profanity, she hurt my feelings. The visitor stated that he has heard S4 CNA tell other residents on several occasions to Shut up and get in your room! Interview on 03/27/2025 at 8:43 a.m. with Resident #15 revealed she informed S1 Administrator of her exact concerns with S4 CNA, and reported to S1 Administrator that S4 CNA yelled and used profanity at her, made her go to bed, and grabbed her ankle and arm. Resident #15 stated S1 Administrator revealed she would take care of things. Resident #15 stated S4 CNA made me afraid and I just want to forget the whole incident, because it made me question if I made the right choice in moving here. Resident #15 stated she has often thought about going home since the incident with S4 CNA. Resident #51 Review of Resident #51's medical record, revealed Resident #51 was admitted to facility on 03/27/2024. Resident #51 had diagnoses that included in part . Bipolar Disorder, Paranoid Schizophrenia, Chronic Kidney Disease, Pain, and Major Depressive Disorder. Review of Resident #51's Annual MDS with an ARD of 12/18/2024 revealed a BIMS score of 15 (cognition intact). Review of Resident #51's Departmental Progress Notes revealed in part . On 02/21/2025 at 3:28 p.m., S16 LPN documented: CNA reported that Resident #25 hit Resident #51 in the face with a box a cookies. Neuro started, and Resident to Resident altercation in progress. Resident #51's husband made aware of altercation. Interview on 03/27/2025 at 8:32 a.m. with Resident #51, revealed sometime last month (unknown date), Resident #25 came into the dining room acting mad, and hit her in the face with a box of cookies. Resident #51 stated that made me mad and upset me, but she did not hurt me. She's just mean! Telephone interview on 03/28/2025 at 11:53 a.m. with Resident #51's RP confirmed the facility had called him last month to inform him another Resident had hit Resident #51 with a box of cookies. Interview with S16 LPN was unsuccessful. Interview on 03/27/2025 at 11:00 a.m. with S2 DON, revealed she was not aware of the resident to resident altercation between Resident #25 and Resident #51 on 02/21/2025. Resident #6 Review of Resident #6's medical record, revealed Resident #6 was admitted to facility on 10/14/2024. Resident #6 had diagnoses that included in part . Depression, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #6's Quarterly MDS with an ARD of 01/22/2025, revealed a BIMS score of 6 (severe cognitive impairment). Review of Resident #6's Departmental Progress Notes revealed in part . On 03/08/2025 at 4:39 p.m., S12 LPN documented: Resident #25 had a disagreement with Resident #6, and pulled Resident #6's hair. Telephone interview on 03/26/2025 at 12:31 p.m. with S14 CNA, revealed she worked the 2:00 p.m. - 10:00 p.m. shift on 03/08/2025 on Hall Y. S14 CNA stated she was working in another resident's room, and Resident #46's RP came to the room to tell her that Resident #25 and Resident #6 were fighting. S14 CNA stated that she did not witness the incident, but Resident #46's RP did, and she immediately reported the incident to S12 LPN. Resident #25 Review of Resident #25's medical record revealed Resident #25 was admitted to the facility on [DATE]. Resident #25 had diagnoses that included in part . Traumatic Subarachnoid Hemorrhage, General Anxiety Disorder, Bipolar Disorder, Depression, and Anxiety. Review of Resident #25's Quarterly MDS with an ARD 02/20/2025, revealed a BIMS score of 00 (severe cognitive impairment). Review of Resident #25's Care Plan with a problem initiation date of 12/24/2024, revealed in part . Potential for verbally aggressive behaviors due to a history of delusions and verbal aggression secondary to Bipolar disorder; Depressed Severe, with psychotic features; Depression; Anxiety Disorder. Interventions: 02/21/2025, Resident got into an altercation with another resident. S2 DON contacted psychiatrist, a medication review was done, and medication adjustment was ordered. Psychiatrist made aware of resident being manic. Review of Resident #25's Departmental Progress Notes revealed in part . On 02/21/2025 at 3:37 p.m., S16 LPN documented: CNA reported that Resident #25 hit Resident #51 in the face with a box a cookies. Resident to Resident altercation in progress. Resident #51's husband made aware of altercation. On 03/08/2025 at 4:39 p.m., S12 LPN documented: Resident #25 had a disagreement with Resident #6, and pulled Resident #6's hair. Interview on 03/25/2025 at 10:30 a.m. with S5 CNA Supervisor, revealed last month Resident #25 had aggressive behaviors. S5 CNA Supervisor stated there was an incident between Resident #25 and Resident #6 one day last month (date unknown). Resident #25 became mad and aggressive, and pulled her best friend's hair (Resident #6). S5 CNA Supervisor stated Resident #6 became very upset and told Resident #25 What's the matter with you? Don't do that! and went to her room crying. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON, confirmed last month Resident #25 had pulled Resident #6's hair. S2 DON stated she did not see this incident as resident to resident abuse, so the facility had not performed an abuse investigation. S1 Administrator confirmed the facility had not reported the resident to resident abuse to SIMS. S1 Administrator stated she was not aware of the details of situation, so she would have to look into it. Interview on 03/26/2025 at 3:50 p.m. revealed Resident #50 (BIMS score of 15 indicating cognition intact), stated on 03/08/2025, Resident #25 attempted to hit him right before she hit Resident #6. Resident #50 stated he told Resident #25 Don't hit me, and she left him alone and he went to his room. During interview Resident #46's RP revealed he visited daily, and stated on 03/08/2025 he saw Resident #25 hit Resident #6 in the head, and he went and told a CNA what was going on. 46773 Resident #68 Review of Resident #68's medical records revealed an admitted [DATE], with diagnoses that included: Cerebrovascular Disease, Dysphagia following Cerebral Infarction, Generalized Anxiety Disorder, Bipolar Disorder, and Chronic Systolic Heart Failure. Review of Resident #68's Care plan with review date of 06/04/2025 revealed Resident #68's transfer status required a lift with 2-person physical assist, and extensive assistance with bed mobility. Review of Resident #68's Quarterly MDS with an ARD of 03/05/2025, revealed a BIMS of 14, indicating intact cognition, and the resident's chair/bed-to-chair transfer status as dependent on staff to complete the activity. Observation on 03/25/2025 at 2:25 p.m., revealed S6 CNA transferred Resident #68 from the bed to his wheelchair, without another staff member present, and without the use of a mechanical lift. Interview on 03/25/2025 at 2:57 p.m. with S3 ADON, revealed Resident #68's transfer status is 2-person lift according to his care plan. S3 ADON revealed that all staff should access a resident's transfer status prior to transfer by looking at the residents' POC in the kiosk on the hall. S3 ADON confirmed mechanical lift was documented in Resident #68's POC for transfer status. Interview on 03/25/2025 at 3:02 p.m. with S9 CNA revealed she was able to determine a resident's transfer status by the presence of a leaf on his or her door, and if there was a lifter pad underneath the resident. S9 CNA stated that she transferred Resident #68 by herself, and did not use a lift when she transferred Resident #68 by herself. S9 CNA stated she had transferred other residents with a lift, by herself at times, if she was unable to find staff to help. Interview on 03/25/2025 at 3:08 p.m. with Resident #68 revealed he was transferred by 1 staff member, without a lift, from the bed to the wheelchair. Resident #68 was unable to tell the surveyor which CNAs transferred him without the lift. He stated that when he was first admitted , a lift was used during transfers; however 2 person assistance with a lift had not been used in a while. Resident #68 was unable to say exactly how long the lift and 2 person assist had not been used for transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/26/2025 at 9:25 a.m. with S7 CNA revealed she has been trained to look in the kiosk for transfer status, but stated she was unaware that Resident #68 was a 2-person assist with lift. S7 CNA revealed if she were to call a nurse to come assist her, they would come help, but she does not always call for help. Interview on 03/26/2025 at 9:30 a.m. with S8 CNA revealed she had been trained to look in the kiosk to determine a resident's transfer status. S8 CNA stated she did not believe Resident #68 was a 2-person assist. S8 CNA stated there are times that she had to get residents up alone with the lifts, because there was no one else on the halls. Interview on 03/26/2025 at 9:40 a.m. with S6 CNA revealed she transferred Resident #68 by herself without a lift because she was unaware that he required a lift. S6 CNA stated she could find the residents transfer status on the kiosk located on the hall to determine transfer status, but did not look at the Kiosk for Resident #68's transfer status. Interview on 03/26/2025 at 5:10 p.m. with S2 DON, revealed that when a resident's POC was entered into the electronic system, it then fired to the kiosk located on the halls for the CNAs to view. S2 DON stated that staff were to look at the kiosk prior to caring for residents to determine their transfer status. S2 DON confirmed that Resident #68 was care planned as a 2-person lift, and should not have been transferred without another staff member present and without the use of a lift. An interview on 03/27/2025 at 3:06 p.m. with S20 CNA, revealed she has been trained by the facility that all residents who require a bed lift for transfers should always have 2 CNAs operating the lift. S20 CNA stated she has transferred lift residents by herself often because other CNAs were busy, and residents were ready to go to bed and don't want to wait. S20 CNA stated she recently transferred Resident #11 on 03/25/2025 by herself on Hall Y on the 2:00 p.m. to 10:00 p.m. shift. The Immediate Jeopardy was removed on 03/28/2025 at 6:04 p.m. as confirmed by onsite verification through observations, interviews and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to survey exit that included the following: The facility identified 4 instances of abuse/neglect in the facility: 1. Staff to Resident verbal and emotional abuse on 02/16/2025, when S4 CNA verbally and emotionally abused Resident #15; 2. Resident to Resident abuse on 02/21/2025, when Resident #25 physically abused Resident #51; 3. Resident to Resident abuse on 03/08/2025, when Resident #25 physically abused Resident #6; and 4. Neglect, when S6 CNA neglected Resident #68. These instances have the ability to affect all residents that reside in the facility. The facility implemented the following actions to remove the immediacy: On 03/27/2025 S4 CNA was placed on administrative leave pending thorough investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 03/27/2025 at 5:56 p.m. all current staff in the facility were in-serviced on the facility's Abuse and Neglect Policy and Procedure. On 03/27/2025 Monitoring tool initiated for S5 CNA Supervisor or designee to complete the lift protocol monitoring tool 4 times a week for 4 weeks, then twice per week for 2 weeks to ensure compliance with lift protocol and mechanical lifts for residents who require 2 person transfer. On 03/27/2025 Monitoring tool initiated for every 15 minute and every 30 minute checks for Resident #6, Resident #15, Resident #25, and Resident #51, and shall be turned into S2 DON daily for review. On 03/27/2025 S2 DON completed a monitoring tool to ensure all allegations for abuse and neglect were properly and thoroughly investigated. The daily monitoring tool was to include any allegation of abuse and neglect was reported to S2 DON and S1 Administrator, and SIMS reporting was completed. Monitoring to be completed daily for 30days, then 3 times weekly for 2 weeks to ensure compliance is sustained. On 03/27/2025 monitoring tool initiated for review of the nurses notes from the prior day in the weekly morning stand up meeting with IDT team. Any findings/allegations shall be reported to S1 Administrator immediately. On 03/28/2025 at 6:00 a.m. all on coming staff was in-serviced on the facility's Abuse and Neglect Policy and Procedure. On 03/28/2025 at 2:00 p.m. there was a mandatory all staff meeting on the facility's Abuse and Neglect Policy and Procedure which addressed the required components to include reporting protocols and 2 hour timeline in which to report alleged incidents into SIMS. Staff member who had not received in-service would be required to receive in-service prior to beginning their scheduled shift. On 03/28/2025 S6 CNA was in serviced on the policy and procedure for patients requiring mechanical lift. Return demonstration for S6 CNA was required. Visual return demonstration was observed by S2 DON. Resident #68 was discharged home on 03/27/2025 at 2:30p.m. On 03/28/2025 Interviews were conducted with Resident #15, Resident #6, Resident #25, and Resident #51 to ensure freedom of abuse/neglect. Resident #15 shall continue to be on every 30 minute checks indefinitely. Resident #6 was placed on every 30 minute checks indefinitely. Resident #25 had every 15 minutes checks for 24 hours, then every 30 minute checks indefinitely. Resident #51 was placed on every 30 minute checks for two weeks. Resident #68 was discharged from the facility on 03/27/2025 at 2:30 p.m. On 03/28/2025 Resident #25's psychiatrist was informed of resident's behaviors. No new orders were given. The above allegations and monitoring was added to the facility's QAPI, and shall be discussed monthly for the next 3 months. Facility completion date 03/28/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Savoy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Cherry Street Mamou, LA 70554	

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004 Based on interview and record review the facility failed to ensure that all alleged violations involving verbal, sexual, physical,and/or mental abuse, are reported immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse, or not later than 24 hours if the events that cause the allegation do not involve abuse in accordance with State law through established procedures, for 3 (#6, # 15, and #51) of 3 (#6, # 15, #51) residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy situation on 02/16/2025, when S4 CNA yelled and cursed Resident #15, and made her go to bed; on 02/21/2025 at approximately 3:28 p.m., when Resident #25 hit Resident #51 in the face with a box of cookies; and on 03/08/2025 at approximately 4:20 p.m., when Resident #25 pulled Resident #6's hair. The facility failed to report the above staff to resident verbal abuse, and resident to resident abuse, to the State Agency. The deficient practice has the likelihood to affect all other residents who reside in the facility. S1 Administrator was notified of the deficient practice at the Immediate Jeopardy level on 03/27/2025 at 5:56 p.m. Findings: Resident #15 Review of Resident #15's medical record revealed she was admitted to the facility on [DATE]. Resident #15 had diagnoses that included in part . Chronic Pain Syndrome, Major Depressive Disorder, Anxiety Disorder, Parkinson's Disease, Spinal Stenosis, and Other Lack of Coordination. Review of Resident #15's Quarterly MDS with ARD of 01/08/2025, revealed a BIMS score of 15 (cognition intact). Resident #15 had range of motion impairment on both sides, and was dependent on staff for toileting, showering/bathing, and dressing. Review of Resident #15's care plan with an initiation date of 12/18/2024, revealed Resident #15 had a problem of impaired physical mobility related to Parkinson's disease. Interventions included in part . 2 person assist, transfer with mechanical lift. Interview of Resident #37 during the Resident Council meeting on 03/24/2025 at 1:32 p.m., revealed. Resident # 37 stated that S4 CNA made Resident #15 stay in bed and refused to get Resident #15 up, per Resident #15's request. S4 CNA then yelled at Resident #15. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/24/2025 at 3:05 p.m. with Resident #15, revealed on 02/16/2025 she was seated in her wheelchair in her room, and S4 CNA came into her room to put her to bed. Resident #15 said she stated to S4 CNA that she did not want to go to bed, and that S4 CNA then became upset. Resident #15 stated S4 CNA came at me, and I saw her pull a girl's hair once, so I was afraid of her. Resident #15 stated S4 CNA used an ugly tone with her. Resident #15 stated she directly reported the incident, and how she was afraid of S4 CNA to S1 Administrator on 02/17/2025. Resident #15 reported S1 Administrator asked her if she was afraid of S4 CNA, to which she replied yes. Resident #15 revealed S1 Administrator stated she would take care of the situation, and that S4 CNA would not provide care to her anymore. Resident #15 stated S1 Administrator moved S4 CNA from Hall Y to Hall Z, and S4 CNA had not provided care to her since. Review of Resident #15's medical record revealed no evidence that the alleged staff to resident abuse of Resident #15 by S4 CNA had been reported to the State Agency. Interview on 03/25/2025 at 11:30 a.m. with S1 Administrator, revealed last month Resident #15 reported that she was upset that S4 CNA put her back to bed when she (Resident# 15) did not want to go to bed. S1 Administrator stated Resident #15 reported this as a grievance to S2 DON. S1 Administrator revealed Resident #15 had never at any point in time informed her that she was afraid of S4 CNA, and denied Resident #15 reporting any abuse allegations to her. S1 Administrator revealed S2 DON moved S4 CNA to another hall due to Resident #15 not wanting S4 CNA to care for her again. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON confirmed there was no SIMS or facility incident report related to the allegations. S1 Administrator stated that the facility had completed a written grievance; however, S1 Administrator was unable to state how the facility addressed Resident #15's grievance. Telephone interview on 03/25/2025 at 3:56 p.m. with S4 CNA, revealed she was paged to the nurses station by S13 LPN on 02/16/2025, and S13 LPN asked her to put Resident #15 to bed, because Resident #15 was not feeling well. S4 CNA stated Resident #15 stated she did not want to go to bed, but she and S15 CNA convinced Resident #15, and they transferred her 2 person assist with a mechanical lift to bed. Interview on 03/26/2025 at 3:10 p.m. with Resident #37 (BIMS score of 15-indicating cognition intact), revealed she was fearful of S4 CNA. Resident #37 began to cry and revealed she was fearful because S4 CNA screamed and cursed at Resident #15. Resident #37 revealed on 02/16/2025, she heard S4 CNA screaming at Resident #15 from the nursing station, so she went down the hall to Resident #15's room, and witnessed S4 CNA yelling and cursing at Resident #15. Observation and Interview on 03/26/2025 at 3:20 p.m. with Resident #15 and Resident #37 revealed Resident #15 stated S4 CNA yelled at her on 02/16/2025, and said You stupid piece of sh*t, you're going to do what I say, and you're going to get in that bed! Resident #37 stated at that time that she heard S4 CNA yell at Resident #15 and say, You stupid piece of sh*t, you're going do what I say, and you're going to get in that bed! Resident #15 began to cry during the interview, and stated yes that is exactly what S4 CNA said to me! I don't like to use profanity, she hurt my feelings. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/27/2025 at 8:43 a.m. with Resident #15, revealed she informed S1 Administrator of her exact concerns with S4 CNA, and reported to S1 Administrator that S4 CNA yelled and used profanity at her, made her go to bed, and grabbed her ankle and arm. Resident #15 stated S1 Administrator revealed she would take care of things. Resident #15 stated S4 CNA made me afraid and I just want to forget the whole incident, because it made me question if I made the right choice in moving here. Resident #15 stated she has often thought about going home since the incident with S4 CNA. Resident #25 Review of Resident #25's medical record revealed Resident #25 was admitted to the facility on [DATE]. Resident #25 had diagnoses that included in part . Traumatic Subarachnoid Hemorrhage, General Anxiety Disorder, Bipolar Disorder, Weakness, Generalized Muscle Weakness, Depression, and Anxiety. Review of Resident #25's Quarterly MDS with an ARD 02/20/2025, revealed Resident #25 had a BIMS score of 00 (severe cognitive impairment). Review of Resident #25's Care Plan with a problem initiation date of 12/24/2024, revealed in part . Potential for verbally aggressive behaviors due to a history of delusions and verbal aggression secondary to Bipolar disorder; Depressed Severe, with psychotic features; Depression; Anxiety Disorder. Interventions: 02/21/2025, Resident got into an altercation with another resident. S2 DON contacted psychiatrist, a medication review was done, and medication adjustment was ordered. Psychiatrist made aware of resident being manic. Review of Resident #25's Departmental Progress Notes revealed in part . On 02/21/2025 at 3:37 p.m., S16 LPN documented: CNA reported that Resident #25 hit Resident #51 in the face with a box a cookies. Resident to Resident altercation in progress. Resident #51's husband made aware of altercation. On 03/08/2025 at 4:39 p.m., S12 LPN documented: Resident #25 had a disagreement with Resident #6, and pulled Resident #6's hair. Interview on 03/25/2025 at 10:30 a.m. with S5 CNA Supervisor, revealed there was an incident between Resident #25 and Resident #6 one day last month (date unknown). Resident #25 became mad and aggressive, and pulled Resident #6's hair. S5 CNA Supervisor stated Resident #6 became very upset and told Resident #25 What's the matter with you? Don't do that! and went to her room crying. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON, confirmed last month Resident #25 pulled Resident #6's hair. S2 DON stated she did not see this incident as resident to resident abuse, and confirmed the facility had not reported the resident to resident abuse to the State Agency. Resident #51 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #51's medical record, revealed Resident #51 was admitted to facility on 03/27/2024. Resident #51 had diagnoses that included in part . Bipolar Disorder, Paranoid Schizophrenia, Chronic Kidney Disease, Pain, and Major Depressive Disorder. Review of Resident #51's Annual MDS with an ARD of 12/18/2024 revealed a BIMS score of 15 (cognition intact). Review of Resident #51's Departmental Progress Notes revealed in part . On 02/21/2025 at 3:28 p.m., S16 LPN documented: CNA reported that Resident #25 hit Resident #51 in the face with a box a cookies. Resident to Resident altercation in progress. Resident #51's husband made aware of altercation. Interview on 03/27/2025 at 8:32 a.m. with Resident #51, revealed sometime last month (unknown date), Resident #25 came into the dining room acting mad, and hit her in the face with a box of cookies. Resident #51 stated that made me mad and upset me, but she did not hurt me. She's just mean! Telephone interview on 03/28/2025 at 11:53 a.m. with Resident #51's RP confirmed the facility had called him last month to inform him another Resident had hit Resident #51 with a box of cookies. S16 LPN was unavailable for interview at time of survey. Interview on 03/27/2025 at 11:00 a.m. with S2 DON, revealed the incident was not reported to the State Agency because she was not aware of the resident to resident altercation between Resident #25 and Resident #51 on 02/21/2025. Resident #6 Review of Resident #6's medical record, revealed Resident #6 was admitted to facility on 10/14/2024. Resident #6 had diagnoses that included in part . Depression, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Review of Resident #6's Quarterly MDS with an ARD of 01/22/2025, revealed a BIMS score of 6 (severe cognitive impairment). Review of Resident #6's Departmental Progress Notes revealed in part . On 03/08/2025 at 4:39 p.m., S12 LPN documented: Resident #25 had a disagreement with Resident #6, and pulled Resident #6's hair. Telephone interview on 03/26/2025 at 12:31 p.m. with S14 CNA, revealed she worked the 2:00 p.m. - 10:00 p.m. shift on 03/08/2025 on Hall Y. S14 CNA stated she was working in another resident's room, and Resident #46's RP came to the room to tell her that Resident #25 and Resident #6 were fighting. S14 CNA stated that she did not witness the incident, but Resident #46's RP did, and she immediately reported the incident to S12 LPN. Interview on 03/24/2025 at 1:04 p.m. with S1 Administrator confirmed the facility had no reportable incidents, and no submission to the State Agency since last survey on 06/12/2024. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Immediate Jeopardy was removed on 03/28/2025 at 6:04 p.m. as confirmed by onsite verification through observations, interviews and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to survey exit that included the following: The facility identified 4 instances of abuse/neglect in the facility: 1. Staff to Resident verbal and emotional abuse on 02/16/2025, when S4 CNA verbally and emotionally abused Resident #15; 2. Resident to Resident abuse on 02/21/2025, when Resident #25 physically abused Resident #51; 3. Resident to Resident abuse on 03/08/2025, when Resident #25 physically abused Resident #6; and These instances have the ability to affect all residents that reside in the facility. The facility implemented the following actions to remove the immediacy: On 03/27/2025 at 5:56 p.m. all current staff in the facility were in-serviced on the facility's Abuse and Neglect Policy and Procedure. On 03/27/2025 S2 DON completed a monitoring tool to ensure all allegations for abuse and neglect were properly and thoroughly investigated. The daily monitoring tool was to include any allegation of abuse and neglect was reported to S2 DON and S1 Administrator, and SIMS reporting was completed. Monitoring to be completed daily for 30days, then 3 times weekly for 2 weeks to ensure compliance is sustained. On 03/28/2025 at 6:00 a.m. all on coming staff was in-serviced on the facility's Abuse and Neglect Policy and Procedure. On 03/28/2025 at 2:00 p.m. there was a mandatory all staff meeting on the facility's Abuse and Neglect Policy and Procedure which addressed the required components to include reporting protocols and 2 hour timeline in which to report alleged incidents into SIMS. Staff member who had not received in-service would be required to receive in-service prior to beginning their scheduled shift. The above allegations and monitoring was added to the facility's QAPI, and shall be discussed monthly for the next 3 months. Facility completion date 03/28/2025.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004 Based on interview and record review the facility failed to ensure allegations of verbal, physical, and/or mental abuse, were thoroughly investigated for 3 (Resident #6, Resident # 15, and Resident #51) of 3 (Resident #6, Resident # 15, and Resident #51) residents reviewed for abuse. This deficient practice resulted in an Immediate Jeopardy situation for Resident #15 on 02/16/2025, when S4 CNA yelled at Resident #15 You stupid piece of sh*t. You're going to do what I say, and you're going to get in bed! Resident #15, who is cognitively intact, stated the incident hurt her feelings, made her cry, and she was fearful of S4 CNA. The Immediate Jeopardy continued on 02/21/2025 at approximately 3:28 p.m., when Resident #25 hit Resident #51 in the face with a box of cookies. Resident #51 stated this made her mad. The Immediate Jeopardy continued on 03/08/2025 at approximately 4:20 p.m., when Resident #25 (who exhibited aggressive and angry behavior on day of incident), pulled Resident #6's hair. S1 Administrator was notified of the deficient practice at the Immediate Jeopardy level on 03/27/2025 at 5:56 p.m. Findings: Review of a facility policy on 03/26/2025 at 12:39 p.m. titled Abuse Prevention with revision date of 03/21/2012 read in part . Each resident shall remain free from harm. Should an employee and/or resident report suspected abuse the following should occur: The incident will be immediately reported to the charge nurse. The charge nurse will immediately contact the Director of Nursing. The charge nurse will then complete an incident report. The DON and/or Administrator will conduct an investigation per policy and federal/state guidelines. Investigation: The Administrator with the assistance of the DON and in their absence the ADON, and Social Services will begin the investigation process for all incidents that require investigation as soon as the following situations are identified: Abuse - the ill treatment or disregard of an individual, whether purposeful, or due to carelessness, inattentiveness or omission of the perpetrator. May also include domestic, institutional, self-abuse and self-neglect. Emotional Abuse - any threatening behavior or statement directed to a person including, but not limited to ridicule, gestures that subject the person to humiliation or degradation, threatening motions or noises intended to startle or frighten the person. Physical Injury - an act that physically hurts or damages an individual's body where damage is inflicted by external force. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An intentional act of omission by an employee which denies the standard of care and treatment due to an individual as required by law, rules, regulations, policies, procedures, guidelines or care plans. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Physical Abuse - any physical motion of action, e.g. hitting, spitting, slapping, punching, kicking, pinching, directed toward the individual. It included use of corporal punishment as well as the use of restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment or correction. Threat- any condition or situation that could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals or their death. Verbal Abuse - use of oral, written, or gestured language by which abuse occurs. Includes: Name calling, swearing., taunting, and using derogatory terms to describe persons with disabilities. Psychological Abuse - includes: humiliation, harassment, threats of punishment or deprivation, sexual coercion, and intimidation. If alleged abuse occurs staff will: Take immediate action to protect the individual(s) involved including removal of the alleged abuser. Ensure that any health or psychological needs of the resident are provided for. Notify the DON immediately. Resident #15 Review of Resident #15's medical record revealed she was admitted to the facility on [DATE]. Resident #15 had diagnoses that included in part . Chronic Pain Syndrome, Major Depressive Disorder, Anxiety Disorder, Parkinson's Disease, Spinal Stenosis, and Other Lack of Coordination. Review of Resident #15's Quarterly MDS with ARD of 01/08/2025, revealed a BIMS score of 15 (cognition intact). Resident #15 had range of motion impairment on both sides, and was dependent on staff for toileting, showering/bathing, and dressing. Review of Resident #15's care plan with an initiation date of 12/18/2024, revealed Resident #15 had a problem of impaired physical mobility related to Parkinson's disease. Interventions included in part . 2 person assist, transfer with mechanical lift. Interview on 03/24/2025 at 3:05 p.m. with Resident #15, revealed on 02/16/2025 she was seated in her wheelchair in her room, and S4 CNA came into her room to put her to bed. Resident #15 said she stated to S4 CNA that she did not want to go to bed, and that S4 CNA then became upset. Resident #15 stated S4 CNA came at me, and I saw her pull a girl's hair once, so I was afraid of her. Resident #15 stated S4 CNA used an ugly tone with her, and she directly reported the incident and how she was afraid of S4 CNA to S1 Administrator on 02/17/2025. Resident #15 reported S1 Administrator asked her if she was afraid of S4 CNA, to which she replied yes. Resident #15 revealed S1 Administrator stated she would take care of the situation, and that S4 CNA would not provide care to her anymore. Resident #15 stated S1 Administrator moved S4 CNA from Hall Y to Hall Z, and had not provided care to her since. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/25/2025 at 11:30 a.m. with S1 Administrator, revealed last month (02/2025), Resident #15 reported that she was upset that S4 CNA put her back to bed when she (Resident# 15) did not want to go to bed. S1 Administrator stated Resident #15 reported this as a grievance to S2 DON. S1 Administrator revealed Resident #15 had never at any point in time informed her that she was afraid of S4 CNA, and denied Resident #15 reporting any abuse allegations to her. S1 Administrator revealed S2 DON moved S4 CNA's halls due to Resident #15 not wanting S4 CNA to care for her again. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON confirmed the facility had not investigated staff to resident verbal and emotional abuse that occurred for Resident #15 by S4 CNA on 02/16/2025, because they did not consider the incident as an abuse allegation, and so they did not investigate it as such. S2 DON confirmed the facility had not performed monitoring of S4 CNA, and had not interviewed any other resident following Resident #15's allegations of verbal abuse by S4 CNA. Telephone interview on 03/25/2025 at 3:56 p.m. with S4 CNA revealed on 02/16/2025, she was paged to the nurses station by S13 LPN, and S13 LPN asked her to put Resident #15 to bed, because Resident #15 was not feeling well. S4 CNA stated Resident #15 stated she did not want to go to bed, but she and S15 CNA convinced Resident #15, and they transferred her 2 person assist with mechanical lift to bed. Observation and Interview on 03/26/2025 at 3:20 p.m. with Resident #15 and Resident #37 revealed Resident #15 stated S4 CNA yelled at her on 02/16/2025, and said You stupid piece of sh*t, you're going to do what I say, and you're going to get in that bed! Resident #37 stated at that time that she heard S4 CNA yell at Resident #15 and say, You stupid piece of sh*t, you're going do what I say, and you're going to get in that bed! Resident #15 began to cry during the interview, and stated yes that is exactly what S4 CNA said to me! I don't like to use profanity, she hurt my feelings. Interview on 03/27/2025 at 8:43 a.m. with Resident #15 revealed she informed S1 Administrator of her exact concerns with S4 CNA, and reported to S1 Administrator that S4 CNA yelled and used profanity at her, made her go to bed, and grabbed her ankle and arm. Resident #15 stated S1 Administrator revealed she would take care of things. Resident #15 stated S4 CNA made me afraid and I just want to forget the whole incident, because it made me question if I made the right choice in moving here. Resident #15 stated she has often thought about going home since the incident with S4 CNA. Resident #51 Review of Resident #51's medical record, revealed Resident #51 was admitted to facility on 03/27/2024. Resident #51 had diagnoses that included in part . Bipolar Disorder, Paranoid Schizophrenia, Chronic Kidney Disease, Pain, and Major Depressive Disorder. Review of Resident #51's Annual MDS with an ARD of 12/18/2024 revealed a BIMS score of 15 (cognition intact). Review of Resident #51's Departmental Progress Notes revealed in part . On 02/21/2025 at 3:28 p.m., S16 LPN documented: CNA reported that Resident #25 hit Resident #51 in the face with a box a cookies. Resident to Resident altercation in progress. Resident #51's husband made aware of altercation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/27/2025 at 8:32 a.m. with Resident #51, revealed sometime last month (unknown date), Resident #25 came into the dining room acting mad, and hit her in the face with a box of cookies. Resident #51 stated that made me mad and upset me, but she did not hurt me. She's just mean! Telephone interview on 03/28/2025 at 11:53 a.m. with Resident #51's RP, confirmed the facility had called him last month to inform him another Resident had hit Resident #51 with a box of cookies. Interview on 03/27/2025 at 11:00 a.m. with S2 DON revealed she was aware of an incident between Resident #25 and Resident #51 that occurred sometime last month. S2 DON stated she was told by staff that Resident #25 and Resident #51 was arguing over a cookie, but was not informed of Resident #25 hitting Resident #51. S2 DON confirmed she did not further investigate the resident to resident abuse on 02/21/2025 when Resident #25 hit Resident #51 in the face with a box of cookies, but should have. Resident #6 Review of Resident #6's medical record, revealed Resident #6 was admitted to facility on 10/14/2024. Resident #6 had diagnoses that included in part . Depression, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Review of Resident #6's Quarterly MDS with an ARD of 01/22/2025, revealed a BIMS score of 6 (severe cognitive impairment). Review of Resident #6's Departmental Progress Notes revealed in part . On 03/08/2025 at 4:39 p.m., S12 LPN documented: Resident #25 had a disagreement with Resident #6, and pulled Resident #6's hair. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON confirmed last month (02/2025), Resident #25 pulled Resident #6's hair. S2 DON stated she did not see this incident as resident to resident abuse, so the facility had not performed an abuse investigation. Telephone interview on 03/26/2025 at 12:31 p.m. with S14 CNA, revealed she worked the 2:00 p.m. - 10:00 p.m. shift on 03/08/2025 on Hall Y. S14 CNA stated she was working in another resident's room, and Resident #46's RP came to the room to tell her that Resident #25 and Resident #6 were fighting. S14 CNA stated that she did not witness the incident, but Resident #46's RP did, and she immediately reported the incident to S12 LPN. Interview on 03/26/2025 at 12:53 p.m. with S2 DON revealed on 03/08/2025 she spoke to S12 LPN about the documented disagreement between Resident #25 and Resident #6. S2 DON stated S12 LPN informed her that she observed the two residents playing in each other's hair. S2 DON confirmed she did not interview any other staff, and that no one had reported a physical altercation between Resident #25 and Resident #6 to her, so she did not investigate further, but should have. The Immediate Jeopardy was removed on 03/28/2025 at 6:04 p.m. after it was verified through observation, interview and record review that the facility submitted and implemented a Plan of Removal that included the following: The facility identified 3 instances of abuse/neglect in the facility: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Savoy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Cherry Street Mamou, LA 70554	

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	1. Staff to Resident verbal and emotional abuse on 02/16/2025, when S4 CNA verbally and emotionally abused Resident #15; 2. Resident to Resident abuse on 02/21/2025, when Resident #25 physically abused Resident #51; 3. Resident to Resident abuse on 03/08/2025, when Resident #25 physically abused Resident #6. These instances have the ability to affect all residents that reside in the facility. The facility implemented the following actions to remove the immediacy: On 03/27/2025 at 5:56 p.m. all current staff in the facility were in-serviced on the facility's Abuse and Neglect Policy and Procedure. On 03/27/2025 S2 DON completed a monitoring tool to ensure all allegations for abuse and neglect were properly and thoroughly investigated. The daily monitoring tool was to include any allegation of abuse and neglect was reported to S2 DON and S1 Administrator, and SIMS reporting was completed. Monitoring to be completed daily for 30days, then 3 times weekly for 2 weeks to ensure compliance is sustained. On 03/27/2025 monitoring tool initiated for review of the nurses notes from the prior day in the weekly morning stand up meeting with IDT team. Any findings/allegations shall be reported to S1 Administrator immediately. On 03/28/2025 at 2:00 p.m. there was a mandatory all staff meeting to discuss Abuse and Neglect Policy and Procedure, Lifting protocols, and the facility's Use of Mechanical Lift. In-service included monitoring for a reporting resident to resident abuse, staff to resident abuse, and neglect. In addition, reporting and investigation requirements of all alleged incidents of abuse and neglect. The facility shall thoroughly investigate any and all allegations of abuse and neglect to prevent the likelihood of further incidents of abuse and neglect. The above allegations and monitoring was added to the facility's QAPI, and shall be discussed monthly for the next 3 months. Facility completion date 03/28/2025.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy Care Center	906 Cherry Street Mamou, LA 70554

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on record review and interview, the facility failed to ensure residents identified with Mental Disorder and/or Intellectual Disability had an accurately completed PASARR (Pre-admission Screening and Resident Review) Level I and/or Level II for 1(#23) resident of 2(#23 and #26) residents reviewed for PASARR screening. Findings: Review of the facility's undated policy titled, PASARR Policy read in part .If during the residents stay, their condition warrants having an inpatient psychiatric hospitalization or becomes diagnosed with a serious mental illness, a Level 2 screening should be done. Review of Resident #23's medical record revealed an admitted [DATE] with diagnoses read in part Benign Neoplasm of Stomach , Chronic Kidney Disease, and Bipolar Disorder, Current Episode Severe with Psychotic Features (01/19/2023). Review of Resident #23's medical record revealed a Level 1 pre-screening was provided for Resident #23 prior to admission on 12/01/2022, which indicated a Level 2 screening is not necessary due to no diagnoses of mental illness. Review of Resident #23's medical record revealed a psychiatric evaluation completed on 01/03/2023, which indicated Resident #23 has persistent symptoms of depression and delusions with diagnostic impression of Bipolar Disorder. Review of Resident #23's electronic record revealed a diagnosis of Bipolar disorder with a start date of 01/19/2023. Interview on 03/26/2025 at 09:50 a.m. with S2 DON revealed if a resident is admitted to the facility with a Level 1 PASARR and they received a new serious mental illness that a Level 2 screening would be required. S2 DON revealed Resident #23 was admitted with a Level 1 without any mental condition and received a diagnosis of Bipolar Disorder after being admitted to the facility. S2 DON confirmed that a Level 2 screening should have been completed for Resident #23 after the mental illness diagnosis, but had not been done.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51503 Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan to meet the needs of 3 (#34, #36, and #37) residents of 34 sampled residents. The facility failed to ensure Resident #34's and Resident #36's fall interventions were implemented, and failed to ensure 2 person physical assistance was used for bed mobility and toileting for Resident #37. Findings: Review of an undated facility policy titled, Care Plans Comprehensive read the following part .1. The interdisciplinary team will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, dietary and psychosocial needs and maximize the resident's highest level of functioning. Resident #34 Review of Resident #34's medical record revealed an admitted [DATE], with diagnoses that included in part . Chronic Kidney Disease, Stage 4 (Severe), Atrial Fibrillation, Pulmonary Fibrosis, and History of Falling. Review of Resident #34's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/16/2024 revealed a BIMS (Brief Interview of Mental Status) score of 13, which indicated intact cognition. Resident #34 had a history of falls in the last month and required limited assistance with one person physical assistance for bed mobility, transfers, and toilet use. Review of Resident #34's physician orders revealed an order for a fall mat on the floor next to her bed per the family's request every 12 hours with a start date of 12/04/2024. Review of Resident #34's care plan revealed in part .Focus: Risk for falls related to history of falls. Interventions: fall mat on the floor next to bed per the family's request with an initial date of 12/05/2024. On 03/24/2025 at 9:39 a.m., observed Resident #34 in the bed with the right side of the bed against the wall. No fall mat observed on the left side of the bed. On 03/25/2025 at 9:05 a.m., observed Resident #34 asleep in the bed with no fall mat on the bedside floor. On 03/26/2025 at 8:54 a.m., observed Resident #34 in the bed with no fall mat on the bedside floor. In an interview and record review on 03/26/2025 at 2:31 p.m., S12 LPN revealed that Resident #34 should have had a fall mat at the bedside per the physician's orders. S12 LPN confirmed that Resident #34 did not have a fall mat on the floor at her bedside and should have. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 03/26/2025 at 2:58 p.m., S2 DON revealed that Resident #34 had active physician's orders started on 12/04/2024 for a fall mat next to her bed. S2 DON revealed Resident #34's fall risk care plan had a fall intervention to place a fall mat at the resident's bedside. S2 DON confirmed Resident #34 should have had a fall mat on the floor next to her bed, but did not. Resident #36 Review of Resident #36's medical record revealed an admitted [DATE], with diagnoses that included in part . Paroxysmal Atrial Fibrillation, Personal History of Transient Ischemic Attack (TIA), Cerebral Infarction Without Residual Deficits, and Seizures. Review of Resident #36's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 02/20/2025 revealed a BIMS (Brief Interview of Mental Status) score of 14, which indicated intact cognition. Resident #36 had two or more falls since admission to the facility and required total dependence with two person physical assistance for bed mobility, transfers, and toilet use. Review of Resident #36's care plan revealed in part .Focus: Risk for falls characterized by history of fall/injury, and multiple risk factors related to unsteady gait. Interventions: Fall mat to the resident's bedside with an initial date of 02/18/2025. On 03/24/2025 at 10:55 a.m., observed Resident #36 in the bed with a black fall mat propped up against the wall, which was located behind the resident's bed. On 03/25/2025 at 2:14 p.m., observed Resident #36 asleep in the bed with a black fall mat propped up against the wall, which was located behind the resident's bed. On 03/26/2025 at 8:40 a.m., observed Resident #36 sitting on the side of her bed with a black fall mat propped up against the wall, which was located behind the resident's bed. In an interview and record review on 03/26/2025 at 10:04 a.m., S2 DON revealed Resident #36 had a fall on 02/16/2025 and the fall risk intervention was to place a fall mat at the resident's bedside. S2 DON confirmed that Resident #36's fall mat should not be propped up against the wall located behind the resident's bed. S2 DON confirmed Resident #36's fall mat should be placed on the left of the bedside floor, but was not. Resident #37 Review of Resident 37's's medical records revealed an admitted [DATE] with diagnoses that included: Malignant Neoplasm of Upper Lobe, Left Bronchus or Lung; Neoplastic (Malignant) related Fatigue, Spinal Stenosis, Chronic Systolic (Congestive) Heart Failure, and Chronic Pain. Review of Resident #37's care plan with a revision date of 12/5/2024 revealed Resident #37 required extensive assistance with bed mobility and toileting and requires 2-person physical assist using a lift with transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's Quarterly MDS with ARD of 10/16/2024 revealed a BIMS of 14, which indicated intact cognition. Resident #37 was dependent on staff with bed mobility and required 2 person physical assist. Review of a facility report dated 10/19/2024 revealed in part Resident #37 rolled on her side to be cleaned and rolled out of the bed. No injuries observed. Interview on 03/27/2025 at 12:05 p.m. with Resident #37 revealed 1 one CNA staff rolled her over in bed to provide incontinent care and the resident fell /rolled out of the bed. Several unsuccessful attempts to contact S10 CNA. Interview on 03/27/2025 at 12:19 p.m. with S2 DON, revealed that on 10/19/2024, S10 CNA reported that Resident #37 fell /rolled out of bed when she provided incontinent care alone. Interview on 03/27/2025 at 1:50 p.m. with S2 DON revealed that Resident #37's current care plan required 2 person physical assistance with bed mobility and toileting. S2 DON confirmed S10 CNA provided bed mobility and toileting on 10/19/2024 alone and confirmed S10 CNA failed to follow Resident #37's plan of care at the time of her fall.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on observation, record review, and interview, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 (#68) of 1 resident reviewed for pressure ulcers. The facility failed to ensure: 1. gloves used during wound care were not contaminated by the bedside table; and 2. gloves were removed and hands were sanitized after cleaning Resident #68's wound. Findings: Review of the facility's undated policy titled Wound Treatment Management read in part .Policy: To promote wound healing of various types of wounds . to provide evidence based treatments in accordance with current standards of practice and physicians orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Review of Resident #68's medical records revealed an admitted [DATE] with diagnoses that include: Pressure Ulcer of Sacral Region, Stage 3, Cerebrovascular Disease, Dysphagia following Cerebral Infarction, Generalized Anxiety Disorder, Bipolar Disorder, and Chronic Systolic Heart Failure. Review of Resident #68's 03/2025 Physician Orders read in part . 03/25/2025 -Stage 3 Pressure ulcer to sacrum - Clean with wound cleanser, apply Santyl and apply collagen dressing, cover with silicone bordered foam dressing, change daily and as needed due to soiling or dislodgment. Observation of wound care for Resident #68 on 03/25/2025 at 9:16 a.m. revealed S17 Treatment nurse removing the gloves from her clean field and placing them on Resident #68's beside table on top of a banana and his belongings. S17 Treatment nurse was observed removing the gloves from the bedside table, donning the gloves, and providing wound care to Resident #68's sacrum pressure ulcer. S17 Treatment Nurse was observed cleaning the wound with a 4x4, discarded soiled 4x4, obtained a new 4x4 from the clean field and cleansed the wound with soiled gloves without discarding gloves and cleansing hands. Interview on 03/25/2025 at 3:35 p.m., S17 Treatment Nurse was notified by this surveyor that she placed clean gloves on the unclean bedside table on top of Resident #68's belongings prior to using them for wound care, and failed to remove soiled gloves and sanitize hands prior to obtaining supplies from the clean field and cleansing the wound. S17 Treatment Nurse confirmed the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773 Based on record review, observation, and interviews, the facility failed to administer a resident's enteral flush per the physician orders for 1(Resident #68) of 1 residents investigated for enteral feedings. Findings: Review of the facility's policy titled, Enteral Nutritional Therapy dated 04/05/2012, read in part Purpose: to provide hydration through a tube inserted into the stomach. If a feeding pump had been ordered .d. Adjust flow rate as prescribed. Review of Resident #68 medical records revealed an admitted [DATE] with diagnoses that include: Cerebrovascular Disease, Dysphagia following Cerebral Infarction, Generalized Anxiety Disorder, Bipolar Disorder, and Chronic Systolic Heart Failure. Review of Resident #68's 03/2025 physician orders revealed an order was started on 02/18/2025 for Glucerna 1.5 cal at 60cc/hour with 35cc/hour H2O flushes, per pump. Review of Resident #68's care plan with the next review date of 06/02/2025 read in part I require tube feeding related to Dysphagia secondary to Cerebrovascular Accident. Interventions: Glucerna 1.5 cal at 60cc/hour/pump with 35cc/hour/pump water flush. Observation on 03/24/2025 at 1:25 p.m. revealed Resident #68's tube feeding of Glucerna 1.5 cal at 60cc/hour with 30cc/hour water flush. Observation on 03/25/2025 at 2:15 p.m. revealed Resident #68's tube feeding of Glucerna 1.5 cal at 60cc/hour with 30cc/hour water flush. Interview on 03/25/2025 at 2:30 p.m. with S3 ADON revealed Resident #68's water flush was set incorrectly at 30 cc/hour and should have been set as ordered at 35cc/hour, but was not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082 Based on record review, observations and interviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure oxygen was administered as ordered by the physician for 1 (#47) of 1 residents reviewed for respiratory care. Findings: Review of the facility's undated policy titled, Oxygen Concentrator revealed the following in part .Policy: The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators. Policy Explanation and Compliance Guidelines: 2. Oxygen is administered under orders of the attending physician, except in the case of an emergency. 4. Use of Concentrator: a. The nurse shall verify physician's orders for the rate of flow and route of administration of oxygen (mask, nasal cannula etc.). Review of Resident #47's medical record revealed an admitted [DATE] with diagnoses that included in part, Cerebrovascular Disease; Shortness of Breath; Anxiety Disorder; Aphagia; Anorexia; and Dysphagia. Review of 03/2025 physician orders for Resident #47 revealed O2 (oxygen) at 2 liters per minute via nasal cannula, continuously every day and night shift for shortness of breath with an order date of 02/25/2025. Review of the Significant Change Minimum Data Set (MDS) with an ARD (Assessment Reference Date) dated 05/28/2025 revealed the resident has a Brief Interview for Mental Status (BIMS) score of 01, which indicated severe cognitive impairment. Resident #47 was dependent on staff with activities of daily living and required oxygen therapy. Review of Resident #47's care plan revealed in part .Shortness of breath related to disease process receiving hospice services, decreased energy, and fatigue. Interventions: Oxygen as ordered. Observation on 03/24/2025 at 12:10 p.m. revealed Resident #47 lying in bed awake with oxygen in progress at 3 liters/minute via nasal cannula per oxygen concentrator. Resident #47 stated she wears oxygen via nasal cannula continuously. Observation on 03/25/2025 at 9:22 a.m. revealed Resident #47 lying in bed with oxygen in progress at 3 liters/minute via nasal cannula. Interview on 03/25/2025 at 10:58 a.m., S11 LPN stated Resident #47 required continuous oxygen at 2 liters per minute via nasal cannula. S11 LPN stated oxygen concentration settings are reviewed under physician orders at each shift. Observation at this time accompanied with S11 LPN revealed Resident #47 lying in bed with oxygen in progress at 3 liters per minute via nasal cannula. S11 LPN confirmed Resident #47's oxygen concentrator was set at 3 liters per minute via nasal cannula and should have been set at 2 liters per minute via nasal cannula according to the physician's order but was not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/25/2025 at 11:03 a.m., S2 DON stated a physician's order is required to titrate oxygen settings. S2 DON confirmed resident #47's oxygen was ordered for 2 liters per minute via nasal cannula and should not have been set at 3 liters per nasal cannula.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47004 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that assure the accurate administering of all drugs to meet the needs of each resident by failing to maintain accurate and complete documentation of controlled substances. Findings: Review of an undated facility policy on 03/27/2025 at 7:05 p.m. titled Drug Administration: Nursing Department Procedures read in part . b. Charting of medications shall be kept current and shall be completed as soon as administration is completed. Observation on 03/25/2025 at 8:48 a.m. of Cart B on Hall Y with S11 LPN revealed she had just completed morning medication pass for all resident's on Hall Y. Observation revealed narcotics were stored within a separate compartment of the cart and had a separate lock with key held by nurse. There was a narcotic log binder stored within the bottom drawer of cart. Record Review of the narcotic record log at time of the above observation for Resident # 37's Gabapentin 300mg capsules revealed a total of 18 capsules documented, with a last entry date of 03/24/2025. Observation of Resident #37's Gabapentin 300mg medication blister pack revealed there were 17 capsules remaining in the pack. Record Review of Resident #37's Morphine 30mg tablet narcotic record log revealed a total of 2 tablets documented, with a last entry date of 03/24/2025. Observation of Resident #37's Morphine 30mg medication blister pack revealed there was 1 tablet remaining in pack. S11 LPN reviewed the narcotic record log sheets and blister packs and stated she forgot to sign out the medications on the log sheet when she administered the medications to Resident #37 this morning. Record Review of Resident #2's narcotic record log for Gabapentin 300mg capsules revealed a total of 44 capsules documented, with a last entry date of 03/24/2025. Observation of Resident #2's Gabapentin 300mg medication blister pack revealed there was 43 capsules remaining in the pack. Interview on 03/25/2025 at 9:08 a.m. with S11 LPN confirmed when she administered Resident #37 and Resident #2's medications this morning, she should have signed them out on the narcotic record log sheet and updated the log with the correct amount remaining in medication packs. S11 LPN confirmed the above medication counts for Resident #37 and Resident #2 were incorrect, and should not be. Interview on 03/25/2025 at 5:00 p.m. with S2 DON confirmed all controlled medications are to be signed off on the narcotic record log sheet as soon as it was administered by the nurse.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 46773 Based on observations and interviews, the facility failed to provide drinks consistent with resident preferences. The facility failed to ensure staff, in Hall X dining room, provided water to 10 residents with their meal during lunchtime. Findings: Observation on 03/24/2025 at 11:11 a.m. revealed staff serving resident lunch trays in Hall X dining room with only juice observed on the lunch tray. No water was observed on the lunch trays or offered to the 10 residents prior to receiving their lunch trays. Interview on 03/24/2025 at 11:12 a.m. with S5 CNA Supervisor revealed that the residents were given juice and milk with their lunch tray, but were not served/offered water with their meal. Observation on 03/25/2025 11:30 a.m. in Hall X dining room revealed the 10 residents were served only milk and juice with their lunch tray and were not offered or provided water. Interview on 03/25/2025 at 2:32 p.m. S5 CNA Supervisor revealed the kitchen does not send water on resident's meal trays and only send juice and Kool-Aid. S5 CNA Supervisor stated only if a resident were to request water with their meal, staff would go get it for them.

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NAME OF PROVIDER OR SUPPLIER Savoy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Cherry Street Mamou, LA 70554	

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 47004 Based on record review and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 5 (Resident #6, Resident # 15, Resident #25, Resident #51, and Resident #68) of 34 Sampled Residents. The facility failed to: 1. Protect and ensure Resident #15 was free from verbal abuse and psychosocial harm by S4 CNA; 2. Ensure Resident #51 and Resident #6 were free from resident to resident physical abuse by Resident #25; 3. Ensure Resident #68 was free from neglect by S6 CNA; 4. Have an effective system in place to ensure all alleged violations involving abuse and neglect were reported immediately, but not later than 2 hours after the allegation was made for Resident #6, Resident # 15, and Resident #51; and 5. Have an effective system in place to ensure allegations of abuse and neglect were thoroughly investigated for Resident #6, Resident # 15, Resident #51, and Resident #68. This deficient practice resulted in an Immediate Jeopardy situation for Resident #15 on 02/16/2025, when S4 CNA yelled at Resident #15 You stupid piece of sh*t. You're going to do what I say, and you're going to get in bed! Resident #15, who is cognitively intact, stated the incident hurt her feelings, made her cry, and she was fearful of S4 CNA. The Immediate Jeopardy continued on 02/21/2025 at approximately 3:28 p.m., when Resident #25 hit Resident #51 in the face with a box of cookies. Resident #51 stated this made her mad. The Immediate Jeopardy continued on 03/08/2025 at approximately 4:20 p.m., when Resident #25 (who exhibited aggressive and angry behavior on day of the incident), pulled Resident #6's hair. The Immediate Jeopardy continued on 03/25/2025 at 2:25 p.m., when S6 CNA was observed to willfully transfer Resident #68 without the required 2 person physical assist with mechanical lift; although she was knowledgeable that 2 person assist with mechanical lift was required of Care. The deficient practice has the likelihood to affect all other residents who reside in the facility. S1 Administrator was notified of the deficient practice at the Immediate Jeopardy level on 03/27/2025 at 5:56 p.m. Findings: Cross reference F600, F609, and F610. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a facility policy on 03/26/2025 at 12:39 p.m., titled Abuse Prevention, with revision date of 03/21/2012, read in part . Each resident shall remain free from harm. Abuse - the ill treatment or disregard of an individual, whether purposeful, or due to carelessness, inattentiveness or omission of the perpetrator Emotional Abuse - any threatening behavior or statement directed to a person including, but not limited to ridicule, gestures that subject the person to humiliation or degradation, threatening motions or noises intended to startle or frighten the person. Physical Injury - an act that physically hurts or damages an individual's body where damage is inflicted by external force. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An intentional act of omission by an employee which denies the standard of care and treatment due to an individual as required by law, rules, regulations, policies, procedures, guidelines or care plans. Physical Abuse - any physical motion of action, e.g. hitting, spitting, slapping, punching, kicking, pinching, directed toward the individual . Threat- any condition or situation that could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals or their death. Verbal Abuse - use of oral, written, or gestured language by which abuse occurs. Includes: Name calling, swearing., taunting, and using derogatory terms to describe persons with disabilities. Psychological Abuse - includes: humiliation, harassment, threats of punishment or deprivation, sexual coercion, and intimidation. If alleged abuse occurs staff will: Take immediate action to protect the individual(s) involved including removal of the alleged abuser. Ensure that any health or psychological needs of the resident are provided for. Notify the DON immediately. Review of a facility policy on 03/25/2025 at 4:16 p.m., titled Abuse and Neglect-Clinical Protocol, with revision date of 01/01/2025, read in part . Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, misappropriation of property or financial abuse, involuntary seclusion, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a facility policy on 03/26/2025 at 1:30 p.m. titled Resident Rights with revision date of 12/2021, read in part . Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; and to be free from abuse and neglect. Interview on 03/24/2025 at 1:04 p.m. with S1 Administrator confirmed the facility had no reportable incidents, and no submission to the State Agency since last survey on 06/12/2024. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON confirmed the facility had not investigated staff to resident verbal and emotional abuse that occurred for Resident #15 by S4 CNA on 02/16/2025, because they did not consider the incident as an abuse allegation, and so they did not investigate it as such. S2 DON confirmed the facility had not performed monitoring of S4 CNA, and had not interviewed any other resident following Resident #15's allegations of verbal abuse by S4 CNA. Interview on 03/25/2025 at 2:36 p.m. with S1 Administrator and S2 DON, confirmed last month (02/2025), Resident #25 pulled Resident #6's hair. S2 DON stated she did not see this incident as resident to resident abuse, and confirmed the facility had not reported the resident to resident abuse to the State Agency. Interview on 03/25/2025 at 2:57 p.m. with S3 ADON, revealed Resident #68's transfer status is 2-person lift according to his care plan. S3 ADON revealed that all staff should access a resident's transfer status prior to transfer by looking at the residents' POC in the kiosk on the hall. S3 ADON confirmed mechanical lift was documented in Resident #68's POC for transfer status. Interview on 03/26/2025 at 5:10 p.m. with S2 DON, revealed that when a resident's POC was entered into the electronic system, it then fired to the kiosk located on the halls for the CNAs to view. S2 DON stated that staff were to look at the kiosk prior to caring for residents to determine their transfer status. S2 DON confirmed that Resident #68 was care planned as a 2-person lift, and should not have been transferred without another staff member present and without the use of a lift. Interview on 03/27/2025 at 11:00 a.m. with S2 DON revealed she was aware of an incident between Resident #25 and Resident #51 that occurred sometime last month. S2 DON stated she was told by staff that Resident #25 and Resident #51 was arguing over a cookie, but was not informed of Resident #25 hitting Resident #51. S2 DON confirmed she did not further investigate the documented resident to resident abuse on 02/21/2025 when Resident #25 hit Resident #51 in the face with a box of cookies, but should have. S2 DON revealed the incident was not reported to the State Agency because she was not aware of the resident to resident altercation between Resident #25 and Resident #51 on 02/21/2025. The Immediate Jeopardy was removed on 03/28/2025 at 6:04 p.m. after it was verified through observation, interview and record review that the facility submitted and implemented a Plan of Removal that included the following: The facility identified 4 instances of abuse/neglect in the facility: 1. Staff to Resident verbal and emotional abuse on 02/16/2025, when S4 CNA verbally and emotionally abused Resident #15; (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	2. Resident to Resident abuse on 02/21/2025, when Resident #25 physically abused Resident #51; 3. Resident to Resident abuse on 03/08/2025, when Resident #25 physically abused Resident #6; and 4. Neglect, when S6 CNA neglected Resident #68. These instances have the ability to affect all residents that reside in the facility. The facility implemented the following actions to remove the immediacy: On 03/27/2025 in-service was completed with all current staff on shift for abuse and neglect policy and procedure, lifting protocol, and what constitutes abuse and neglect. On 03/27/2025 S4 CNA was placed on administrative leave pending thorough investigation. On 03/27/2025 S6 CNA was in services on proper lifting techniques with proper return demonstration completed. On 03/27/2025 S2 DON completed a monitoring tool to ensure all allegations for abuse and neglect were properly and thoroughly investigated. The daily monitoring tool was to include any allegation of abuse and neglect was reported to S2 DON and S1 Administrator, and SIMS reporting was completed. Monitoring to be completed daily for 30days, then 3 times weekly for 2 weeks to ensure compliance is sustained. On 03/27/2025 Administrative oversight was provided to S1 Administrator and S2 DON by the regional administrator. The regional administrator shall thoroughly investigate all allegations of abuse and neglect to prevent the likelihood of further incidents of abuse. Regional administrator will monitor S1 Administrator weekly by direct observation and onsite oversight weekly for 30 days. On 03/28/2025 at 2:00 p.m. there was a mandatory all staff meeting to discuss Abuse and Neglect Policy and procedure, reportable incidents, lifting protocols, and use of lifters. In-service also included monitoring for and reporting resident to resident abuse, staff to resident abuse, and neglect. The facility shall thoroughly investigate any and all allegations of abuse and neglect to prevent the likelihood of further incidents of abuse. Any staff member not in serviced will be in serviced prior to the beginning of their shift. On 03/28/2025 a monitoring tool was initiated for nurse's notes to be reviewed daily for any alleged cases of abuse and neglect to be investigated as necessary. All alleged cases will be brought to S2 DON and S1 Administrator's attention and investigation and reporting are to be done immediately. On 03/28/2025 the above allegations and monitoring was added to the facility's QAPI, and shall be discussed monthly for the next 3 months. Facility completion date 03/28/2025.