STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195635	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0580

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47546

Based on record review and interviews, the facility failed to ensure a resident's physician was notified of significant changes that required treatment to be altered for 1(#1) of 3 (#1, #2, and #3) residents reviewed for falls with injury. The facility failed to ensure nursing staff notified the physician when Resident #1 fell , had new onset complaints of pain, and required increased assistance with transfer.

The deficient practice resulted in an Immediate Jeopardy situation for Resident #1, a cognitively impaired resident, beginning on 01/02/2025 at 5:00 a.m., when S7CNA failed to report Resident #1 fell during transfer, hitting his wheelchair. From 01/02/2025 at 5:00 a.m. through 01/03/2025 at 7:30 a.m., Resident #1 had multiple complaints of new onset pain and required increased assistance with transfers from staff. Staff did not report the pain or decline in status to the physician during this time for new interventions or treatment. On 01/03/2025, x-ray results revealed the resident had a displaced comminuted intertrochanteric femur fracture that extended through the greater and lesser tuberosities. Resident #1 was then transferred to the hospital on 01/03/2025 where he received 4 mg of morphine and was diagnosed with a Left femur fracture requiring multimodal pain control and surgical intervention. Due to Resident #1's cognitive impairment he was unable to appropriately communicate the affects the fall and delayed treatment caused him. It can be assumed a reasonable person would have suffered psychosocial harm and severe pain when staff failed to ensure he received treatment of a femur fracture.

S1ADM was notified of the Immediate Jeopardy situation on 02/06/2025 at 6:10 p.m.

The Immediate Jeopardy was removed on 02/07/2025 at 5:59 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit.

This deficient practice continued at the potential for more than minimal harm for all cognitively impaired residents with communication deficits.

Findings:

Cross Reference: F697, F600

Review of the facility's Policy titled, Falls, undated revealed the following:

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Capital Oaks Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 4100 North Blvd Baton Rouge, LA 70806	

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedure: 1. Resident will not be moved until a Licensed Nurse has ascertained resident's condition. 5. Notify physician for further orders. 8. Fill out accident/incident form Review of the facility's Policy titled, Accident/Incident Reports: Resident, undated revealed the following: Policy: When an accident or incident involving a resident occurs, any witnessing staff will offer immediate assistance. An accident/incident report and the appropriate documentation will be completed by the end of the shift. Purpose: To assure appropriate follow-through on all accidents/incidents. Procedure: 1. Do not move the resident until a Licensed Nurse evaluates the condition. 2. Notify the nurse in charge 7. Notify the resident's physician 9. Complete an accident/incident report. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included, in part, the following: Muscle Wasting and Atrophy, Age Related Osteoporosis, Dementia, Alzheimer's disease, Aphasia, and Cognitive Communication Deficit. Further review revealed Resident #1was diagnosed with a Left Femur Fracture resulting from a fall on 01/02/2025. Review of Resident #1's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2024, indicated the resident had a Brief Interview of Mental Status (BIMS) of 3, which indicated severe cognitive impairment. Further review revealed the resident had no pain. Review of Resident #1's current Care Plan revealed the following interventions: Dated 11/15/2024 - Physical mobility impaired: Transfer assist x 1 Dated 01/02/2025 - X-Ray of Left hip/pelvis and knee Dated 01/02/2025 - Send to local hospital emergency room for eval Dated 01/07/2025 -Transfer status to 2-person assist Review of Resident #1's Imaging Results, dated 01/03/2025, revealed, in part, the following: (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Exam - CT left hip without contrast Findings - Displaced comminuted intertrochanteric femur fracture with surrounding soft tissues swelling. Fracture planes extend through the greater and lesser tuberosities. Review of the local hospital records dated 01/03/2025 revealed the following: admitted : 01/03/2025 Chief complaint: Left hip pain The hip was noted to be outwardly rotated and shortened on x-ray with intertrochanteric left femur fracture. Consulted Orthopedics. Plan: Orthopedic Admit, with surgical plans pending CT results. Multimodal pain control. Further review of hospital record revealed Resident had a Left Femur Intertrochanteric Fracture Surgical Repair procedure performed on 01/05/2025. On 01/29/2025 at 1:38 p.m., an interview was conducted with S7CNA. S7CNA stated on 01/02/2025 at approximately 5:00 a.m. she transferred Resident #1 in his room. She explained during the transfer, the resident began to struggle and she had to lower the resident to the ground. As he was being lowered he hit his left side on the wheelchair. She stated she then called S12CNA into the room and they picked the resident up off the floor placing him back in his wheelchair. She stated she did not report the fall to the nurse or her supervisor. She stated later that day, at 1:15 p.m., Resident #1 complained of pain during transfer into bed. She stated she reported the pain to S4LPN, but did not report the resident fell . S7CNA stated she did not report the fall because Resident #1 did not complain of pain and did not have any obvious injuries. She stated she did not report the fall and should have. On 01/30/2025 at 8:35 a.m., an interview was conducted with S12CNA. S12CNA stated on the morning of 01/02/2025, S7CNA asked her to assist with transferring Resident #1. She stated she walked into Resident #1's room and found him on the floor in front of his wheelchair. She stated she did not know how he ended up on the floor, but she helped S7CNA move him from the floor to his wheelchair and went back to her assigned unit. She stated she did not report that resident was found on the floor to anyone. On 01/30/2025 at 12:24 p.m., an interview was conducted with S4LPN. S4LPN stated on 01/02/2025 at approximately 1:00 p.m. S7CNA notified her Resident #1 complained of pain, but did not report the resident had fallen earlier in the day. She stated if a resident had a fall it should be reported to the nurse or supervisor. She stated she did not administer pain medication or report the new onset of pain to her supervisor or the NP. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/30/2025 at 7:10 a.m., an interview was conducted with S6LPN. S6LPN stated at approximately 4:45 a. m. on 01/02/2025 she heard Resident #1 yell from his room. She stated by the time she got to Resident #1's room he was sitting on the side of his bed. She stated S7CNA was in the room and did not report the resident fell . She did not assess the resident at that time. She stated before Resident #1's injury he was able to stand and would sometimes get into his wheelchair without assistance. She stated Resident #1 did not normally complain of pain. On 01/29/2025 at 2:17 p.m., an interview was conducted with S8CNA. She stated Resident #1 was able to stand, pivot, and transfer with 1 person assistance with transfers before going out to the hospital. On 01/29/2025 at 2:43 p.m., an interview was conducted with S9CNA. She stated before his injury, Resident #1 was able to stand and pivot to the wheelchair with 1 person assistance. She stated on 01/02/2025, she worked the 2:00 p.m.-10:00 p.m. shift. She stated at approximately 2:00 p.m. she went in to change resident's brief. She stated Resident #1 usually stood up to transfer, but did not stand on his own at this time. She stated she had to extensively assist him into his wheelchair, which was not his normal. She stated she did not report the increased need for assistance to anyone. On 01/29/2025 at 3:45 p.m., an interview was conducted with S5LPN. She stated she worked on 01/02/2025 from 2:00 p.m. -10:00 p.m. shift. She stated no one reported Resident #1 fell . She stated on 01/03/2025 at approximately 7:00 a.m., she overheard S10CNA report to S4LPN Resident #1 had complained of leg pain. She said at this time an assessment was done by herself and S4LPN of Resident #1's leg and the resident grimaced when his left leg was moved. She stated the NP was notified and x- ray was ordered. She stated before his injury, Resident #1 was able to stand and pivot with transfers and did not normally complain of pain. On 01/30/2025 at 10:00 a.m., an interview was conducted with S13NP. S13NP stated she was not notified Resident #1 had a fall on 01/02/2025 and should have been. She stated if she had known about the fall and subsequent complaints of pain an x-ray would have been ordered sooner or she would have assessed the resident herself. On 01/30/2025 at 12:29 p.m., an interview was conducted with S3RN. She stated S7CNA did not report to her Resident #1 fell on [DATE]. S3RN stated if a resident had a fall she should be notified so the resident could be assessed by the nurse and the doctor would be notified. She stated Resident #1 did not normally complain of pain. On 01/30/2025 at 12:39 p.m., an interview was conducted with S2DON. S2DON stated she was not aware Resident #1 fell on [DATE]. She stated if a resident fell to the floor the CNA should not move the resident and notify the nurse immediately. The surveyors confirmed the following had been initiated and/or implemented prior to exit: 1. All residents who were identified as cognitively impaired were assessed to see if they showed any signs or symptoms of pain. A thorough review of each of the cognitively impaired residents fall risk assessment was completed by the Clinical Care Coordinators. (continued on next page)

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	195635	A. Building B. Wing	02/07/2025

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. All staff were trained by the Administrator, DON, or designee to report any observed or verbalized pain or any change of condition immediately to a nurse or an administrative team member. The nurse or an administrative nurse will follow the standing or PRN orders and will follow up with their MD (Started 01/03/2025). 3. Nursing staff were trained by DON or designee on proper pivot transfers for one-person assist residents. Training emphasized that if a resident is combative, staff should not transfer the resident alone and should seek assistance (Started 01/03/2025). 3. Staff were educated by administrator, DON, or designee on the corporate policy for identifying and reporting incidents and accidents. The in-service also included the reporting process of when an incident/accident occurs (Started 01/06/2025). 4. Staff were educated by administrator, DON, or designee that covered definitions and examples of abuse and neglect. (Started 01/06/2025). 5. Nursing Staff were educated on identifying high fall risk residents, using assistive device markers and wall indicators - Falling Star Program (Started 01/06/2025). 6. All nurses were in-serviced to ensure a proper pain assessment was completed when a resident reports or shows any signs of pain to a staff member (Started 02/03/2025). 7. Monitoring was implemented on 01/06/2025 to assess and observe one-person pivot transfers conducted by the DON or designee 3 times a week for 6 weeks and monthly thereafter for 3 months (Started 01/06/2025). 8. Monitoring was implemented to assess resident pain with interviews of a random sample of nurses 3 times a week for 6 weeks and monthly thereafter including a specific section asking residents about pain during transfers (Started 01/30/2025). 9. Evaluation of staff knowledge, using a questionnaire, on handling incidents and accidents. Random audits conducted on 10 staff members per week for 6 weeks, followed by periodic checks (Started 02/06/2025). 10. Daily huddles with administrative staff in random facility sections asking nurses and CNAs about any observations of pain or incidents that occurred during their shift. These huddles started on 02/07/2025 and will be conducted daily for 2 weeks, then monthly thereafter for 3 months. As of 02/07/2025, the facility asserts the likelihood for serious harm to any recipient no longer exists.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47546 Based on interviews and record reviews, the facility failed to ensure a resident's right to be free from neglect for 1 (Resident #1) of 3 (Residents #1, #2, and #3) sampled residents. The facility failed to ensure Resident #1 received needed services and treatment when CNA staff neglected to report a fall, which resulted in a left femur fracture. The deficient practice resulted in an Immediate Jeopardy situation for Resident #1, a cognitively impaired resident, beginning on 01/02/2025 at 5:00 a.m., when S7CNA failed to report Resident #1 fell during transfer, hitting his wheelchair. From 01/02/2025 at 5:00 a.m. through 01/03/2025 at 7:30 a.m., Resident #1 had multiple complaints of new onset pain and required increased assistance with transfers from staff. Staff did not report the pain or decline in status to the physician during this time for new interventions or treatment. On 01/03/2025, x-ray results revealed the resident left femur fracture. Resident #1 was transferred to the hospital on 01/03/2025 where he received 4 mg of morphine and was diagnosed with a Left femur fracture requiring surgical intervention. Due to Resident #1's cognitive impairment he was unable to appropriately communicate the affects the fall and delayed treatment caused him. It can be assumed a reasonable person would have suffered psychosocial harm and severe pain when staff failed to ensure he received treatment of a femur fracture. S1ADM was notified of the Immediate Jeopardy situation on 02/06/2025 at 6:10 p.m. The Immediate Jeopardy was removed on 02/07/2025 at 5:59 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit. This deficient practice continued at the potential for more than minimal harm for all residents residing in the facility. Findings: Cross Reference: F697 and F580 Review of the facility's policy, Abuse/Neglect Policy Statement, dated 12/11/2018 revealed the following, in part: The facility will not condone any form of resident neglect Each resident has the right to be free from neglect. Abuse/Neglect Reporting Definitions 9. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish . Identification: Possible indicators of Potential Abuse and Neglect (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Injuries of unknown origin 3. Changes in the behavior pattern of the resident 6. New onset of physical concern (pain) 23. Complaints of pain or injury that have not been addressed by facility staff 26. Medical conditions that have not been addressed by nursing personnel .evaluations based on the individual's needs 27. Inability of the resident to access medical personnel Review of the facility's undated policy, Falls, revealed the following, in part: Policy: To provide emergency care. Procedure 1. Resident will not be moved until a Licensed Nurse has ascertained resident's condition. 2. Assess resident for any abnormalities: i.e., a. deformed, discolored or painful body parts c. Vitals 3. Ascertain extent and type of injury. 4. Make resident as comfortable as condition permits 5. Notify physician for further orders. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included, in part, the following: Muscle Wasting and Atrophy, Age Related Osteoporosis, Dementia, Alzheimer's Disease, Aphasia, and Cognitive Communication Deficit. Further review revealed Resident #1 was diagnosed with a Left Femur Fracture resulting from a fall on 01/02/2025. Review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2024, revealed a Brief Interview of Mental Status (BIMS) of 3, which indicated severe cognitive impairment. Further review revealed no indication Resident #1 had pain upon assessment completion. Review of Resident #1's current Care Plan revealed the resident had impaired cognition and communication related to Alzheimer's Disease and Expressive Aphasia. Further review of Resident #1's Care Plan revealed the following interventions: Start date: 01/02/2025 - X-Ray of L hip/pelvis and knee (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start date: 01/02/2025 - Send to local hospital emergency room for eval Review of Resident #1's January 2025 Medication Administration Record (MAR) revealed the following: X-ray left hip, femur, and knee for complaint of increased of pain to area for left hip/leg pain - Start date 01/03/2025 Review of Resident #1's Imaging Results, dated 01/03/2025, revealed, in part, the following: a CT without contrast of the left hip was performed which showed a Displaced comminuted intertrochanteric femur fracture with surrounding soft tissues swelling. Fracture planes extend through the greater and lesser tuberosities and mild degenerative change. Review of Resident #1's local hospital record notes revealed an admitted [DATE] at 2:38 p.m. Resident's chief complaint was hip pain with a pain score of 4. Resident was administered 4 mg of Morphine at 5:00 p. m. Resident was admitted to the hospital on the same day with a Left femur fracture. Orthopedics was consulted and surgery was performed on 01/04/2025 to surgically repair a Left Femur Fracture. On 01/30/2025 at 12:37 p.m., an interview was conducted with S11SW. She stated she was responsible for completing BIMS assessments. She stated Resident #1 was able to respond to limited questions. She stated he was oriented to person only and could not identify the month and year. She stated he was not able to recall events that occurred 5 minutes ago. On 01/29/2025 at 1:38 p.m., an interview was conducted with S7CNA. She stated, on 01/02/2025 at approximately 5:00 a.m., she transferred Resident #1 in his room. She explained during the transfer, the resident began to struggle and she had to lower the resident to the ground. She stated, as he was being lowered he hit his left side on the wheelchair. She stated she called S12CNA into the room and they picked the resident up off the floor placing him back in his wheelchair. She stated after getting the resident into his wheelchair, he did not complain of pain or show nonverbal signs of pain, and there were no visible injuries. She stated Resident #1 did fall to the floor and she did not report the fall to the nurse or her supervisor. She stated later that day, at 1:15 p.m., she transferred the resident into bed and the resident complained of pain. She stated she reported the pain to S4LPN, but did not report the resident fell . On 01/30/2025 at 8:35 a.m., an interview was conducted with S12CNA. She stated on the morning of 01/02/2025, S7CNA asked for help with transferring Resident #1. She stated when she walked into the room Resident #1 was on the floor in front of the wheelchair with his legs straight out in front of him. She stated he did not complain of any pain. She stated she helped S7CNA move him to his wheelchair and went back to her assigned unit. She did not know how resident ended up on the floor and she did not report the resident was found on the floor. On 01/29/2025 at 2:17 p.m., an interview was conducted with S8CNA. She stated around lunch time on 01/02/2025, she assisted S7CNA with transferring Resident #1 from his bed to the wheelchair. She stated, during the transfer, Resident #1 cried out in pain when his left leg was moved. She stated she was not aware of Resident #1 having a fall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/29/2025 at 2:43 p.m., an interview was conducted with S9CNA. She stated on 01/02/2025 at approximately 2:00 p.m., she went into Resident #1's room to change his brief. She stated the resident had been lying on his right side and did not want to roll to his back. She stated she asked Resident #1 what was wrong and he responded my leg. She stated she continued to change the resident's brief, sat him up on the side of his bed, and transferred him into his wheelchair. She stated prior to the Left Femur Fracture, Resident #1 was able to stand and pivot for transfers, but on this day he did not stand on his own. She stated she had to extensively assist him into the wheelchair, and this was not his normal. She stated she was not aware of Resident #1 having a fall. On 01/29/2025 at 3:45 p.m., an interview was conducted with S5LPN. She stated on 01/02/2025 she worked the evening shift on Resident #1's hall. She stated she did not receive a report or a fall regarding Resident #1 during her shift on 01/02/2025 by the CNA staff. She stated before his Left Femur Fracture, Resident #1 was able to stand and pivot with transfers and did not normally complain of pain. On 01/30/2025 at 8:52 a.m., an interview was conducted with S10CNA. She stated on 01/03/2025, she and S7CNA were bringing Resident #1 back to his room via wheelchair, when Resident #1 complained of leg pain. She stated before his injury, Resident #1 was able to get himself out of his wheelchair and onto the sofa without assistance. She stated she was not aware of Resident #1 having a fall. On 01/30/2025 at 12:24 p.m., an interview was conducted with S4LPN. She stated at approximately 1:00 p. m. on 01/02/2025, S7CNA notified her Resident #1 had complained of pain. She stated the CNA did not notify her that the resident had fallen earlier in the day. She stated on 01/03/2025 at approximately 7:00 a.m. Resident #1 was in his wheelchair being pushed through the dining room. She stated she and S5LPN overheard S10CNA state Resident #1 could not stand on his leg and he had complained of pain. She stated she and S5LPN completed an assessment on Resident #1 by moving his left leg. She stated when the left leg was moved, Resident #1 grimaced. She stated the charge nurse and Nurse Practitioner (NP) were notified, x-ray was ordered, and Tylenol was given. She stated Resident #1 was oriented to self only. She stated due to his cognitive impairment, he was only capable of reporting pain he currently felt, not pain from an earlier time. She stated Resident #1 did not normally complain of pain and this was a new complaint for him. On 01/30/2025 at 12:29 p.m., an interview was conducted with S3RN. She stated on 01/02/2025 S8CNA called the nurse's station and informed her of Resident #1's complaint of pain but did not report the resident had fallen earlier in the day. S3RN stated Resident #1 was oriented to self only and could not answer questions appropriately. She stated he would not be able to communicate pain unless he was feeling pain at that moment. She stated Resident #1 did not normally complain of pain. She stated a cognitively impaired resident's pain assessment would include the following; asking verbally, moving resident and observing for grimacing, and speaking with staff that reported the pain for more information. She stated she would expect a reasonable person with a fracture to express pain with movement or manipulation. On 01/30/2025 at 12:39 p.m., an interview was conducted with S2DON. She confirmed she was not aware Resident #1 had a fall on 01/02/2025. She stated a cognitively impaired resident's pain assessment would include the following: observing for grimaces and checking for limited range of motion. She stated Resident #1 would not be able to communicate pain unless he was currently experiencing pain. She stated if a resident had fallen to the floor, expressed pain, and no report of fall was made she would consider this neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/29/2025 at 3:00 p.m. an interview was conducted with S1ADM. He stated he was not aware Resident #1 had a fall to the floor on 01/02/2025. He stated a CNA withholding information about a resident's fall that would delay necessary care would be classified as neglect. The surveyors confirmed the following had been initiated and/or implemented prior to exit: 1. All staff were in-serviced on resident pain and change of condition reporting (Conducted on 01/03/2025) 2. Nursing staff were in-serviced on proper transfers (Conducted on 01/03/2025) 3. All staff were in-serviced on abuse and neglect policies (Conducted on 01/06/2025) including different types of abuse and neglect and how they can occur in the facility and corporate policies identifying, preventing, and reporting abuse or neglect. 4. In-service conducted on incident and accident reporting including definitions and reinforcement of the need for immediate documentation and notification of supervisory staff. 5. Daily huddles performed with CNAs and nurses, randomly picking a section of the building and asking if any reported falls or if any issues of abuse/neglect have been reported. (Started 02/07/2025 and to continue for 2 weeks and randomly thereafter. 6. QA monitoring of one person assist transfers and assessment of pain and reporting of falls. An administrative nurse or designee will randomly monitor transfers 3 times a week for 6 weeks and monthly thereafter (Implemented on 01/06/2025). 7. Implementation of a questionnaire regarding abuse and neglect: A questionnaire will be implemented randomly monitoring all staff members of their knowledge of abuse/neglect. Ten staff members will be randomly selected and questioned weekly for six weeks. The questionnaire will bring up specific types of abuse/neglect and if the staff members know and understand what they are. Random checks will continue after the initial six-week period to ensure continued compliance (Implemented on 02/06/2025) 8. Incident and accident Questionnaire - A questionnaire will be implemented randomly monitoring staff members for their knowledge of incident and accident reports. The questionnaire gives specific examples of what to do if a resident is on the floor and how to report those instances to administration (Implemented on 02/06/2025) As of 02/07/2025, the facility asserts the likelihood for serious harm to any recipient no longer exists.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

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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 - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47546

Based on interviews and record review, the facility failed to ensure alleged violations involving neglect were reported immediately to the Administrator and a law enforcement entity within 2 hours after the allegations of neglect were made to the state agency for 1 (Resident #1) of 3 (Resident #1, #2, and #3) residents reviewed for neglect.

Findings:

Cross reference: F600

Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE]

Review of the facility's self-reported incident dated 01/03/2025 revealed the following:

Type of incident: Injury of Unknown Origin - On 01/03/2025 at approximately 2:45 p.m. it was reported to the administrator Resident #1 had a left Femur Fracture. Resident #1 complained of pain at approximately 7:30 a.m. on 01/03/2025. Nurse assessed resident, x-ray was ordered, and resident was sent to local emergency room after receiving x-ray results. No documented falls had been reported for this resident in recent history. Further review of the report revealed S7CNA was suspended pending investigation and then terminated for failure to report the incident that would have explained how the fracture occurred. The report stated S7CNA did not divulge the incident until she was questioned during the investigation. S7CNA did not reveal Resident #1 fell to the floor in the facility's investigation process.

Allegation Finding: Unsubstantiated

Further review revealed no revision or new reports entered after this date.

Review of the facility's investigation report dated 01/03/2025 revealed on the morning of 01/02/2025 Resident #1 was being transferred by S7CNA when he had trouble with pivoting and went to the wheelchair and landed on his left side. S7CNA stated in the facility interview Resident #1 hit the wheelchair kind of hard on his left side. Further review of facility investigation revealed S7CNA did not reveal Resident #1 hit the floor.

On 01/29/2025 at 1:38 p.m., an interview was conducted with S7CNA. She stated, on 01/02/2025 at approximately 5:00 a.m., she transferred Resident #1 in his room. She explained during the transfer, the resident began to struggle and she had to lower the resident to the floor. She stated, as he was being lowered he hit his left side on the wheelchair. She stated she called S12CNA into the room and they picked the resident up off the floor placing him back in his wheelchair. She stated Resident #1 did fall to the floor and she did not report the fall to the nurse or her supervisor. She stated she should have reported this incident to her supervisor and she did not.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195635	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/2025 at 8:35 a.m., an interview was conducted with S12CNA. She stated on the morning of 01/02/2025, S7CNA asked for help with transferring Resident #1. She stated when she walked into the room Resident #1 was on the floor in front of the wheelchair with his legs straight out in front of him. She stated she helped S7CNA move him to his wheelchair and went back to her assigned unit. She did not know how resident ended up on the floor and she did not report to anyone the resident was found on the floor. On 02/07/2025 at 6:22 p.m., an interview was conducted with S2DON. She confirmed she became aware on 01/30/2025 Resident #1 had fallen to the floor. She stated no new facility self-reported incident or revision of original facility self-reported incident had been completed after discovering Resident #1 had fallen to the floor. She further stated if a resident had fallen to the floor and no report of the fall was made she would consider this neglect. On 02/07/2025 at 6:16 p.m., an interview was conducted with S1ADM. S1ADM stated he reported an injury of unknown origin when Resident #1 was diagnosed with a left Femur Fracture on 01/03/2025. He explained, staff never reported to him Resident #1 fell on [DATE]. He confirmed he was made aware on 01/30/2025 that Resident #1 fell to the floor on 01/02/2025 during transfer with S7CNA. He further confirmed S7CNA did not report the fall even after the resident began complaining of pain. He stated a CNA withholding information about a resident's fall that would delay necessary care would be classified as neglect. He confirmed he did not submit a new facility incident report nor update the original report when he became aware of the fall. He further confirmed he did not report the incident to the appropriate law enforcement entity within the mandated timeframe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47546 Based on interviews and record review, the facility failed to provide pain management consistent with professional standards of practice for a cognitively impaired resident, following a fall, for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for pain. Nursing staff failed to assess and treat Resident #1 after multiple complaints of new onset pain. The deficient practice resulted in an Immediate Jeopardy situation for Resident #1, a cognitively impaired resident, beginning on 01/02/2025 at 5:00 a.m., when S7CNA failed to report Resident #1 fell during transfer, hitting his wheelchair. From 01/02/2025 at 5:00 a.m. through 01/03/2025 at 7:30 a.m., Resident #1 had multiple complaints of new onset pain and required increased assistance with transfers from staff. Staff did not report the pain or decline in status to the physician during this time for new interventions or treatment. On 01/03/2025, x-ray results revealed the resident had a displaced comminuted intertrochanteric femur fracture that extended through the greater and lesser tuberosities. Resident #1 was transferred to the hospital where he received 4 mg of morphine and was diagnosed with a Left femur fracture requiring multimodal pain control and surgical intervention. Resident #1 was not treated or appropriately assessed for pain even though he reported pain multiple times to staff. Due to Resident #1's cognitive impairment he was unable to appropriately communicate the affects the fall and delayed treatment caused him. It can be assumed a reasonable person would have suffered psychosocial harm and severe pain when staff failed to ensure he received treatment of a femur fracture. S1ADM was notified of the Immediate Jeopardy Situation on 02/07/2025 at 3:10 p.m. The Immediate Jeopardy was removed on 02/07/2025 at 6:37 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal prior to the survey exit. This deficient practice continued at the potential for more than minimal harm for all cognitively impaired residents, with communication deficits, experiencing pain. Findings: Cross Reference: F580 and F600 Review of the facility's undated policy, Falls revealed the following, in part: Policy: To provide emergency care. Procedure 1. Resident will not be moved until a Licensed Nurse has ascertained resident's condition. 2. Assess resident for any abnormalities: i.e., a. deformed, discolored or painful body parts (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Capital Oaks Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 4100 North Blvd, Baton Rouge, LA 70806	

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Vitals 3. Ascertain extent and type of injury. 4. Make resident as comfortable as condition permits 5. Notify physician for further orders. Review of the facility's undated policy, Accident/Incident Reports: Resident Purpose: To provide appropriate follow-through on all accidents/incidents. To study the cause of accidents and incidents and to give guidance for corrective/preventive action. Procecure: 1. Do not move the resident until a Licensed Practical Nurse evaluated the condition. 2. Notify the nurse in charge. 3. Licensed Nurse - .Complete a thorough head -to-toe assessment of the resident for possible injury, including range of motion. 6. Make the resident comfortable. 7. Notify the resident's physician-receive orders for follow-through. 10. Note the location and the time of the incident, and the exact circumstances of the incident. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included, in part, the following: Muscle Wasting and Atrophy, Age Related Osteoporosis, Dementia, Alzheimer's disease, Aphasia, and Cognitive Communication Deficit. Further review revealed Resident #1 was diagnosed with a Left Femur Fracture resulting from a fall on 01/02/2025. Review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2024, revealed a Brief Interview of Mental Status (BIMS) of 3, which indicated severe cognitive impairment. Further review revealed no indication Resident #1 had pain upon assessment completion. Review of Resident #1's current Care Plan revealed the resident had impaired cognition and communication related to Alzheimer's Disease and expressive aphasia. Further review revealed the resident had chronic pain. Review of Resident #1's January 2025 Medication Administration Record (MAR) revealed no documentation the resident received medication for the treatment of pain until 01/03/2025 at approximately 7:30 a.m. when Resident #1 was administered Tylenol after S4LPN assessed him to find pain with movement of his left leg. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Capital Oaks Nursing & Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 North Blvd Baton Rouge, LA 70806	

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Imaging Results, dated 01/03/2025, revealed, in part, the following: a CT without contrast of the left hip was performed which showed a Displaced comminuted intertrochanteric femur fracture with surrounding soft tissues swelling. Fracture planes extend through the greater and lesser tuberosities and mild degenerative change. Review of Resident #1's local hospital record notes revealed an admitted [DATE] at 2:38 p.m. Resident's chief complaint was hip pain with a pain score of 4. Resident was administered 4 mg of Morphine at 5:00 p. m. Resident was admitted to the hospital on the same day with a Left femur fracture. Orthopedics was consulted and surgery was performed on 01/04/2025 to surgically repair a Left Femur Fracture. On 1/30/2025 at 12:37 p.m., an interview was conducted with S11SW. She stated she was responsible for completing the BIMS assessments on residents. She stated Resident #1 was able to respond to limited questions. She stated he was oriented to person only and could not identify the month and year. She stated he was not able to recall events that occurred 5 minutes ago. On 01/30/2025 at 7:10 a.m., an interview was conducted with S6LPN. She stated at approximately 4:45 a.m. on 01/02/2025, she heard Resident #1 yell from his room. She stated when she got to Resident #1's room he was dressed and sitting on the side of the bed. She stated S7CNA was in the room with the resident and S7CNA said everything was ok. She stated she asked Resident #1 if he was ok and the resident did not respond. She said she did not assess the resident at this time. She stated Resident #1 did not get up on the night of 01/02/2025 and slept. She further stated Resident #1 did not often complain of or show signs of pain. She stated before his injury, Resident #1 was able to stand and would sometimes get into his wheelchair without assistance. On 01/29/2025 at 1:38 p.m., an interview was conducted with S7CNA. She stated, on 01/02/2025 at approximately 5:00 a.m., she transferred Resident #1 in his room. She explained during the transfer, the resident began to struggle and she had to lower the resident to the ground. As he was being lowered he hit his left side on the wheelchair. She stated she called S12CNA into the room and picked the resident up off the floor placing him back in his wheelchair. She stated after getting the resident into his wheelchair, he did not complain of pain or show nonverbal signs of pain, and there were no visible injuries. She stated she did not report the fall to the nurse or her supervisor. She stated later that day, at 1:15 p.m., she transferred the resident into bed and the resident complained of pain. She stated she reported the pain to S4LPN, but did not report the resident fell . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/30/2025 at 12:24 p.m., an interview was conducted with S4LPN. She stated at approximately 1:00 p.m. on 01/02/2025, S7CNA notified her Resident #1 had complained of pain. She confirmed she did not complete a full pain assessment on Resident #1 on 01/02/2025 when the complaint of pain was reported to her. She stated on 01/03/2025 at approximately 7:00 a.m. Resident #1 was in his wheelchair being pushed through the dining room. She stated she and S5LPN overheard S10CNA state Resident #1 could not stand on his leg and he had complained of pain. She stated at that time she and S5LPN completed an assessment on Resident #1 by moving his left leg. She stated when the left leg was moved, Resident #1 grimaced. She stated the charge nurse and NP were notified, x-ray was ordered, and Tylenol was given. She stated Resident #1 was oriented to self only. She stated due to his cognitive impairment, he was only capable of reporting pain he currently felt, not pain from an earlier time. She stated Resident #1 did not normally complain of pain and this was a new complaint for him. She stated a reasonable person with a femur fracture would express pain with incontinent care. She stated a cognitively impaired resident's pain assessment would include the following; asking if they had pain, observe for pain indicators, such as grimacing, pulling away or favoring a certain area. She confirmed on 01/02/2025 she only asked the resident if he was in pain. On 01/29/2025 at 2:17 p.m., an interview was conducted with S8CNA. She stated around lunch time on 01/02/2025, she assisted S7CNA with transferring Resident #1 from his bed to the wheelchair. She stated, during the transfer, Resident #1 cried out in pain when his left leg was moved. She stated she notified S3RN, who then notified S4LPN about the resident's complaint of pain. On 01/29/2025 at 2:43 p.m., an interview was conducted with S9CNA. She stated on 01/02/2025 at approximately 2:00 p.m., she went into Resident #1's room to change his brief. She stated the resident had been lying on his right side and did not want to roll to his back. She stated she asked Resident #1 what was wrong and he responded my leg. She stated she continued to change the resident's brief, sat him up on the side of his bed, and transferred him into his wheelchair. She stated prior to the left femur fracture, Resident #1 was able to stand and pivot for transfers, but on this day he did not stand on his own. She stated she had to extensively assist him into the wheelchair, and this was not his normal. She stated she notified S5LPN that Resident #1 had complained of pain. On 01/29/2025 at 3:45 p.m., an interview was conducted with S5LPN. She stated on 01/02/2025 she worked the evening shift on Resident #1's hall. She stated he did not complain of pain while he was up in his wheelchair, and did not appear to be in pain when she was in his room. She stated she did not receive a report of pain regarding Resident #1 during her shift on 01/02/2025. She stated on 01/03/2025, S9CNA reported the resident had pain. She stated before his left leg fracture, Resident #1 was able to stand and pivot with transfers and did not normally complain of pain. On 01/30/2025 at 8:52 a.m., an interview was conducted with S10CNA. She stated on 01/03/2025 she and S7CNA were bringing Resident #1 back to his room via wheelchair with S8CNA, when Resident #1 complained of leg pain. She stated she reported this to S3RN. She stated before his injury, Resident #1 was able to get himself out of his wheelchair and onto the sofa without assistance. On 01/30/2025 at 10:00 a.m. an interview was conducted with S13NP. S13NP stated she was not notified Resident #1 had a fall on 01/02/2025 and should have been. She further stated she had not been made aware of Resident #1's complaints of pain until 01/03/2025. She stated if she had known about the fall and subsequent complaints of pain she would have ordered an x-ray sooner or waited until she could assess the resident herself. (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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/30/2025 at 12:29 p.m., an interview was conducted with S3RN. She stated on 01/02/2025 S8CNA called the nurse's station and informed her of Resident #1's complaint of pain. She stated she informed S4LPN within minutes. She stated S4LPN went to Resident #1's room, came back and reported to her Resident #1 denied pain. S3RN stated Resident #1 was oriented to self only and could not answer questions appropriately. She stated he would not be able to communicate pain unless he was feeling pain at that moment. She stated Resident #1 did not normally complain of pain. She stated CNA should have reported that resident was having pain in leg while performing transfer or incontinent care. She stated a cognitively impaired resident's pain assessment would include the following; asking verbally, moving resident and observing for grimacing, and speaking with staff that reported the pain for more information. She stated she would expect a reasonable person with a fracture to express pain with movement or manipulation. On 01/30/2025 at 12:39 p.m., an interview was conducted with S2DON. She stated a cognitively impaired resident's pain assessment would include the following: observing for grimaces and checking for limited range of motion. She stated the assessment would be based on who it was and based on the clinical presentation. She stated Resident #1 would not be able to communicate pain unless he was currently experiencing pain. She stated Resident #1 would not be able to communicate pain unless it was current. She further stated Resident #1 would not be able to communicate pain 5 minutes after it had occurred. The surveyors confirmed the following had been initiated and/or implemented prior to exit: 1. All residents who were identified as cognitively impaired were assessed to see if they showed any signs or symptoms of pain. A thorough review of each of the cognitively impaired residents fall risk assessment was completed by the Clinical Care Coordinators. 2. All staff were trained by the Administrator, DON, or designee to report any observed or verbalized pain or any change of condition immediately to a nurse or an administrative team member. The nurse or an administrative nurse will follow the standing or PRN orders and will follow up with their MD (Started 01/03/2025). 3. All nurses were in-serviced to ensure a proper pain assessment was completed when a resident reports or shows any signs of pain to a staff member (Started 02/03/2025). 4. Monitoring was implemented to assess resident pain with interviews of a random sample of nurses 3 times a week for 6 weeks and monthly thereafter including a specific section asking residents about pain during transfers (Started 01/30/2025). 5. Daily huddles with administrative staff in random facility sections asking nurses and CNAs about any observations of pain or incidents that occurred during their shift. These huddles started on 02/07/2025 and will be conducted daily for 2 weeks, then monthly thereafter for 3 months. As of 02/07/2025, the facility asserts the likelihood for serious harm to any recipient no longer exists.