STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195136	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Progressive Care Center	2715 Albert L. Bicknell Dr Shreveport, LA 71103

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708 Based on record reviews and interviews the facility failed to ensure appropriate care and services consistent with professional standards of practice were implemented for 1 of 1 resident (# 19) reviewed for dialysis. The facility failed to ensure Resident #19's dialysis access site was assessed and monitored every shift. Findings: Review of the facility's Monitor Dialysis Site policy dated 12/15/2023 revealed in part: I. The nurse will ensure that the dialysis access site (e.g. [exempli gratia for example] AV [Arteriovenous] shunt or graft) is checked every shift. The nurse will check for a bruit and palpating for a thrill . II. The site will also be monitored every shift for signs and symptoms of infection . Review of Resident #19's medical record revealed an admitted [DATE] with a re-admission on 08/05/2024 with diagnoses which included, but not limited to, end stage renal disease, chronic kidney disease, and dependence on renal dialysis. Review of Resident #19's current physician's orders revealed an order dated 01/03/2025 for outpatient hemodialysis on Monday, Wednesday, and Friday. Further review of Resident #19's current physician's orders revealed an order for 01/13/2025 to remove dialysis dressing to left upper arm at bedtime on Monday, Wednesday, and Friday. Review of Resident #19's medical record failed to reveal documentation Resident #19's dialysis access site was assessed and monitored every shift. During an interview on 02/25/2025 at 11:22 a.m. S13 LPN (Licensed Practical Nurse) reported Resident #19's dialysis access site was in her left upper arm. S13 LPN reviewed Resident #19's medical record and confirmed there was no documentation Resident #19's dialysis access site was assessed and monitored every shift. (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: 195136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Progressive Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 Albert L. Bicknell Dr Shreveport, LA 71103	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/2025 at 12:04 p.m. S2 DON (Director of Nursing) confirmed dialysis access sites should be assessed and monitored every shift. S2 DON reviewed Resident #19's medical record and confirmed there was no documentation Resident #19's dialysis access site was assessed and monitored every shift.

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NAME OF PROVIDER OR SUPPLIER: Progressive Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2715 Albert L. Bicknell Dr Shreveport, LA 71103	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115 Based on record reviews, observations, and interviews the facility failed to ensure, prior to installation and use of bed rails, residents were assessed for the risk of entrapment, a consent was obtained from the resident or resident's representative, and residents had a physician order and care plan for use of bed rails for 7 (#7, #26, #27, #28. #148, #149, #196) out of 7 (#7, #26, #27, #28. #148, #149, #196) residents reviewed for bed rails. Findings: Review of the facility's Proper use of Side Rails dated 08/28/2017 (approved on 09/14/2017) revealed in part: Purpose: It is the policy of _____ that _____ utilize these guidelines to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. Procedure: Physical restrains are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: the definition of restraints is based on the functional status of the resident and not on the device; therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.) 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. bed mobility; and b. ability to change positions, transfer to and from bed or chair, and to stand and toilet. 4. The use of side rails as an assistive device will be addressed in the resident care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. Resident #7 Review of Resident #7's medical record revealed an initial admitted [DATE] with diagnoses including, but not limited to chronic obstructive pulmonary disease and morbid obesity. Review of Resident #7's most recent MDS (Minimum Data Set) assessment dated [DATE] revealed Resident #7 had a BIMS (Brief Interview for Mental Status) of 15 indicating intact cognition. Further Review of Resident #7's most recent MDS revealed Resident #7 required extensive assistance with bed mobility and transfers. Review of Resident #7's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #7's comprehensive care plan failed to reveal Resident #7 was care planned for use of bed rails as an assistive device. Review of Resident #7's physician orders failed to reveal an order for the use of bed rails. An observation 02/24/2025 at 9:00 a.m. revealed Resident #7 was awake in bed with bilateral upper quarter bed rails in use. An observation on 02/26/2025 at 7:40 a.m. revealed Resident #7 sitting upright in bed with bilateral upper and lower quarter bed rails in use. During an interview on 02/26/2025 at 7:40 a.m. Resident #7 reported she used the lower bed rails for mobility and not the upper bed rails. During an interview on 02/26/2025 at 7:45 a.m. S4 ADON (Assistant Director of Nursing) acknowledged Resident #7 had both upper and lower bilateral bed rails in use. Resident #26 Review of Resident #26's medical record revealed an initial admitted [DATE] with diagnoses including, but not limited to hemiplegia following other cerebrovascular disease affecting the left non-dominant side, aphasia following unspecified cerebrovascular disease, unspecified dementia, and anxiety disorder. Review of Resident #26's most recent MDS assessment dated [DATE] revealed Resident #26 had a BIMS of 05 indicating severely impaired cognition. Further review of the most recent MDS revealed Resident #26 required extensive assist with bed mobility and transfers. Review of Resident #26's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's comprehensive care plan failed to reveal Resident #26 was care planned for use of bed rails as an assistive device. Review of Resident #26's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 8:25 a.m. revealed Resident #26 was resting in bed with bilateral upper bed rails in use. An observation on 02/25/2025 at 8:40 a.m. revealed Resident #26 was awake in bed with bilateral upper and lower bed rails in use. During an interview on 02/26/2025 at 7:50 a.m. S7 CNA (Certified Nursing Assistant) confirmed Resident #26's bilateral upper and lower bed rails were used most of the time. Resident #27 Review of Resident #27's medical record revealed an initial admitted [DATE] with diagnoses including, but not limited to, acute pain not elsewhere classified, fusion of spine-lumbar region, other spondylosis lumbar region, generalized muscle weakness, unspecified lack of coordination, bed confinement status, other reduced mobility, and history of falling. Review of Resident #27's most recent MDS assessment dated [DATE] revealed Resident #27 had a BIMS of 14 indicating intact cognition. Further Review of Resident #27's most recent MDS revealed Resident #27 required extensive assistance with bed mobility and transfers. Review of Resident #27's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #27's comprehensive care plan failed to reveal Resident #27 was care planned for use of bed rails as an assistive device. Review of Resident #27's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 9:32 a.m. revealed Resident #27 had bilateral upper quarter bed rails in use. During an interview on 02/24/2025 at 9:32 a.m. Resident #27 reported he required assistance to transfer out of bed and utilized the bed rails for bed mobility. An observation on 02/25/2025 at 2:10 p.m. revealed Resident #27 sitting in a wheelchair next to the bed which had bilateral upper bed rails in use. An observation on 02/26/2025 at 7:45 a.m. revealed Resident #27 resting in bed with bilateral upper quarter bed rails in use as well as bilateral lower quarter bed rails in use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2025 at 7:47 a.m. S9 CNA reported Resident #27 required assistance to get out of bed and utilized bilateral upper quarter bed rails for bed mobility. S9 CNA acknowledged bilateral upper and lower quarter bed rails were in use. During an interview on 02/26/2025 at 7:50 a.m. S10 LPN (Licensed Practical Nurse) reported Resident #27 required assistance to get out of bed and utilized bilateral upper quarter bed rails for bed mobility. S10 LPN reported lower quarter bed rails should not be utilized. Resident #28 Review of Resident #28's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, atherosclerotic heart disease of native coronary artery, and polyosteoarthritis unspecified. Review of Resident #28's MDS assessment dated [DATE] revealed Resident #28 had a BIMS score of 11, which indicated a moderate cognitive impairment. Further Review of Resident #28's MDS revealed Resident #28 required extensive assistance with bed mobility and transfers. Review of Resident #28's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #28's comprehensive care plan failed to reveal Resident #28 was care planned for use of bed rails as an assistive device. Review of Resident #28's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 11:33 a.m. revealed Resident #28 in bed with the bed rails up on each side of upper bed and bed rail up on left side of lower bed. During an interview on 02/24/2025 at 11:33 a.m. Resident #28 reported he liked having his bed rails up to help him move in bed. An observation on 02/25/2025 at 07:58 a.m. revealed Resident #28 was in bed with bed rails up on each side of upper bed and one bed rail up on left side of lower bed. During an interview on 02/26/2025 at 7:55 a.m. S11 LPN reported Resident #28 would request his bed rails to be up. Resident #148 Review of Resident #148's medical record revealed an initial admitted [DATE] with diagnoses including, but not limited to, other chronic pain, heart failure unspecified, and presence of cardiac pacemaker. During an interview on 02/26/2025 at 9:35 a.m. S8 SSD (Social Services Director) reported Resident #148's BIMS interview had been completed and Resident #148 had a BIMS score of 11, which indicated a moderate cognitive impairment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #148's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #148's comprehensive care plan revealed Resident #148 required extensive to maximum assistance with mobility and transfers. Further review of Resident #148's comprehensive care plan failed to reveal Resident #148 was care planned for use of bed rails as an assistive device. Review of Resident #148's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 11:46 a.m. revealed Resident #148 lying on her back in bed, with bed rails up on each side of upper and lower bed. During an interview on 02/26/2025 at 07:50 a.m. S12 CNA reported Resident #148 would request to have all her bed rails up and would use the bed rails to reposition when in bed. Resident #149 Review of Resident #149's medical record revealed an admitted [DATE] with diagnoses including, but not limited to non-displaced fracture of upper end left humerus and history of falling. During an interview on 02/26/2025 at 8:32 a.m. S8 SSD reported Resident #149's BIMS interview had been completed yesterday and Resident #149 had a BIMS score of 06, which indicated severe cognitive impairment. Review of Resident #149's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #149's comprehensive care plan revealed Resident #149 required extensive to maximum assistance with mobility and transfers. Further review of Resident #149's comprehensive care plan failed to reveal Resident #149 was care planned for use of bed rails as an assistive device. Review of Resident #149's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 12:36 p.m. revealed Resident #149 with bed rails up on each side of upper bed. During an interview on 02/24/2025 at 12:36 p.m. Resident #149 reported she liked having the bed rails up to help her move in bed. An observation on 02/25/2025 at 07:53 a.m. revealed Resident #149 was lying in bed with bed rails up on each side of upper bed. During an interview on 02/26/2025 at 07:50 a.m. S12 CNA reported Resident #149 would request her bed rails to be elevated and used them for bed mobility. Resident #196 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #196's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, malignant neoplasm of cerebellum, malignant neoplasm of brain stem, and cerebral edema. Review of Resident #196's most recent MDS dated [DATE] revealed Resident #196 had a BIMS of 11 indicating moderately impaired cognition. Further review of Resident #196's MDS revealed Resident #196 required limited to extensive assistance with mobility. Review of Resident #196's medical record failed to reveal an entrapment risk assessment was completed and an informed consent was obtained from the resident or resident's representative prior to installation and use of bed rails. Review of Resident #196's comprehensive care plan failed to reveal Resident #196 was care planned for use of bed rails as an assistive device. Review of Resident #196's physician orders failed to reveal an order for the use of bed rails. An observation on 02/24/2025 at 9:50 a.m. revealed Resident #196 had bilateral upper quarter bed rails and bilateral lower quarter bed rails in use. During an interview on 02/24/2025 at 9:50 a.m. Resident #196 reported he required assistance to transfer out of bed and utilized the bed rails for bed mobility. An observation on 02/25/2025 at 2:12 p.m. revealed Resident #196 sitting in a wheelchair next to the left side of the bed which had bilateral upper quarter bed rails and the right lower quarter bed rail in use. An observation on 02/26/2025 at 7:45 a.m. revealed Resident #196 resting in bed with bilateral upper quarter bed rails and the left lower quarter bed rail in use. During an interview on 02/26/2025 at 7:47 a.m. S9 CNA reported Resident #196 required assistance to get out of bed and utilized bilateral upper quarter bed rails for bed mobility. S9 CNA acknowledged bilateral upper and lower left quarter bed rails were in use. During an interview on 02/26/2025 at 7:50 a.m. S10 LPN reported Resident #196 required assistance to get out of bed and utilized bilateral upper quarter bed rails for bed mobility. S10 LPN reported lower quarter bed rails should not be utilized. During an interview on 02/26/2025 at 8:35 a.m. S6 MDS and S1 Administrator reviewed Resident #7, #26, #27, #28, #148, #149, and #196's records and confirmed that prior to installation and use of bed rails, the residents were not assessed for the risk of entrapment from bed rails, a consent was not obtained from the residents or residents' representative for use of bed rails, and residents did not have a physician order or a care plan for use of bed rails. 34708 40015 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44414

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015 Based on record review and interviews, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 (#148) of 5 (#11, #32, #36, #148, #149) residents reviewed for unnecessary medications. The facility failed to monitor Resident #148 for bleeding while receiving an anticoagulant and for behaviors and side effects while receiving an antidepressant. Findings: Review of Resident #148's medical record revealed an admitted [DATE] with diagnoses that included, in part, depression, atherosclerotic heart disease of native coronary artery, heart failure unspecified, and presence of cardiac pacemaker. Review of Resident #148's physician orders revealed a 02/18/2025 order for Eliquis 2.5mg (milligram) tablet - give one tablet by mouth twice a day and 02/18/2025 order for Celexa 10mg tablet - give one tablet by mouth at bedtime. Review of February 2025 MAR (Medication Administration Record) failed to reveal monitoring for bleeding had been conducted with 8:00 a.m. dose of Eliquis on 02/21/2025, 02/22/2025, and 02/24/2025 and the 8:00 p.m. dose of Eliquis on 02/24/2025. Further review of the MAR failed to reveal monitoring for behaviors and side effects had been conducted from 02/21/2025 to 02/24/2025. Review of Resident #148's care plan revealed: New symptoms of depression with approaches that included, in part, evaluate resident's effectiveness of anti-depressant medication therapy, monitor resident for suicidal ideation, record/monitor resident for patterns of target behaviors, and resident prescribed Celexa. Decreased cardiac output with approaches that included, in part, administer medication as ordered, document adverse reactions, notify MD (medical doctor) of concerns, and treat as ordered. Resident is prescribed Eliquis. During an interview on 02/26/2025 at 12:06 p.m. S2 DON (Director of Nursing) reviewed Resident #148's February 2025 MAR and reported there was no evidence that monitoring for behaviors and side effects had been conducted from 02/21/2025 to 02/24/2025. During an interview on 02/26/2025 at 1:06 p.m. S3 RN (Registered Nurse) reviewed Resident #148's February 2025 MAR and confirmed there was no evidence monitoring for bleeding had been conducted with the morning dose of Eliquis on 02/21/2025, 02/22/2025, and 02/24/2025 and the evening dose of Eliquis on 02/24/2025 and should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115 Based on observations, record reviews and interviews the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection for 2 (Resident #32 and #149) residents out of a total sample of 20 residents. The facility failed to ensure: 1. Enhanced Barrier Precautions (EBP) were in place for Resident #32 and Resident #149; 2. Staff donned with proper Personal Protective Equipment (PPE) when performing high-contact resident care for Resident #149. Findings: Review of the facility's Enhanced Barrier Precautions Policy and Procedure dated 03/25/2024 revealed in part: Policy: It is the policy of ____________ to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism (MDRO). Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: 2. An order for enhanced barrier precautions will be obtained for residents with any of the following: 1. Wounds (for example chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds .) and/or indwelling medical devices (for example central lines, urinary catheters .) even if the resident is not known to be infected or colonized with a MDRO . 3. Implementation of Enhanced Barrier Precautions: 1. Make gowns and gloves available immediately near or outside of the resident's room . 2. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room . 4. High-contact resident care activities include: 8. Wound care; any skin opening requiring a dressing. 1. Resident #32 Review of Resident #32's medical record revealed an admitted [DATE] with diagnoses including, in part, peripheral vascular disease, dysphagia, type 2 diabetes mellitus, unspecified dementia, cerebral ischemia, acquired absence of right leg above knee, acquired absence of left leg above knee and peripheral vascular disease. Review of Resident #32's physician orders dated 12/16/2024 revealed and order to clean coccyx wound until resolved. Further review revealed an order dated 09/21/2024 for Foley catheter care every shift. Review of Resident #32's physician orders dated 05/03/2024 revealed an order for Enhanced Barrier Precautions while providing direct patient car, such as, bathing, grooming and transferring. Gown and gloves must be worn. Ensure that dedicated disposable equipment or cleaning and disinfecting equipment before use on another resident. Review of Resident #32's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 02 indicating severe cognitive impairment. Further review of Resident #32's MDS revealed Resident #32 was marked as having an unhealed, unstageable pressure ulcer and an indwelling catheter. An observation on 02/24/2025 at 8:25 a.m. revealed Resident #32 did not have Enhanced Barrier Precautions signage on the door or PPE readily available. An observation on 02/24/2025 at 10:45 a.m. revealed Resident #32 with an indwelling Foley catheter. During an interview on 02/24/2025 at 11:51 a.m. S4 ADON (Assistant Director of Nursing) confirmed Resident #32 did have a catheter and a PU (Pressure Ulcer). S4 ADON acknowledged Resident #32 should have PPE available and Enhanced Barrier Precaution signage. Resident #149 Review of Resident #149's medical record revealed an admitted [DATE] with diagnoses including, in part, chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with hyperglycemia and stage 2 pressure ulcer of other site. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER: Progressive Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2715 Albert L. Bicknell Dr Shreveport, LA 71103	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #149's physician orders revealed a 02/20/2025 order for Mid Upper Spine-Clean with wound cleanser, pat dry, apply adaptic non-adherent film then apply a dry dressing to the wound bed every 3 days until resolved. Further review of the orders revealed a 02/20/2025 order for Currently on enhanced barrier precautions. While providing direct patient care, bathing, grooming, transferring etc. gown and gloves must be worn. Ensure that dedicated disposable equipment or cleaning disinfecting equipment before use on another resident. Observation on 02/25/2025 at 9:45 a.m. failed to reveal EBP signage was in place on Resident #149's door. During an interview on 02/25/2025 at 9:45 a.m. S5 Treatment Nurse reported Resident #149 had an open wound and should be on EBP. S5 Treatment Nurse further confirmed there was no EBP signage on Resident #149's door and no gowns available on the hall and should be. During an interview on 02/25/2025 at 10:02 a.m. S6 LPN (Licensed Pratical Nurse) confirmed there were no gowns available on Resident #149's hall for residents on EBP and should be. 2. Observation of wound care for Resident #149 on 02/25/2025 at 10:50 a.m. by S5 Treatment Nurse with S2 DON (Director of Nursing) at bedside revealed S5 Treatment Nurse had donned a sleeveless PPE gown over her scrub jacket. Further observation revealed S5 Treatment Nurse was observed removing the bandage from Resident #149's spinal wound while wearing the sleeveless PPE gown. During an interview on 02/25/2025 at 10:50 a.m. S5 Treatment Nurse and S2 DON (Director of Nursing) acknowledged the sleeveless PPE gown did not provide full arm coverage as a protective barrier and should have. 40015 44414