

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Pierremont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Mitchell Lane Shreveport, LA 71106	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>30669</p> <p>Based on record reviews and interviews, the facility failed to develop an individualized person-centered plan of care to meet the needs of 1 (#3) of 5 (#1, #2, #3, #4, and #5) residents whose plan of care was reviewed. The facility failed to ensure the plan of care included an accurate assessment for resident #3 by not acknowledging the behaviors exhibited. The facility failed to develop a plan of care and implement interventions to care for resident #3's behaviors.</p> <p>Findings:</p> <p>Review of resident #3's clinical record revealed an admitted to this facility of 03/21/2024. Diagnoses include but not limited to dementia with behavior disturbance, Schizoaffective /Bipolar disorder, insomnia, history of Syphilis, encephalopathy toxic, psychotic disturbance, mood disturbance, anxiety, and cognitive communication deficit.</p> <p>Review of resident #3's MDS (Minimum Data Set) with assessment reference date of 03/29/2024 revealed a BIMS (Brief Interview for Mental Status) Summary Score of 06 which indicates severe cognitive impairment. Review of resident #3's MDS Section E - Behavior failed to reveal physical and verbal behavioral symptoms directed towards others, which included in part cursing at others, and hitting had been exhibited. Further review of resident #3's MDS failed to reveal other behavioral symptoms not directed towards others, which included in part rejection of care, wandering, and disrobing in public, had been exhibited by resident #3</p> <p>Review of resident #3's Comprehensive Plan of Care failed to reveal interventions were put into place when resident #3 refused ADL Care/Assistance from staff or for other behaviors exhibited. Further review revealed the facility documented resident #3 was an elopement risk, wandered aimlessly and no interventions were listed.</p> <p>Review of the Nurse's Progress notes dated 04/01/2024 at 2:51 p.m. S1 LPN (Licensed Practical Nurse) documented resident #3 is still wearing the same clothes that she had on when admitted . She (resident #3) continues to refuse to allow anyone to assist her with bathing and changing clothes. Resident #3 has dementia and is severely confused. Uses profanity with staff and tells us to get out and leave her alone.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/29/2024 at 1:42 p.m. with resident #3's RP (responsible party) reported resident #3 was admitted to this facility needing care due to dementia. Resident #3's RP reported when she visit resident #3 on 04/02/2024 she still had on the same clothing as when she was transferred on 03/21/2024 to the facility. Resident #3's RP reported that is when she went to the nurse's station and spoke with one of the nurses (name unknown). Resident #3's RP reported that is when she was told her sister had been refusing to take a bath or change her clothing. Resident #3's RP reported no one from the facility had notified her that her sister was refusing care. Resident #3's RP reported if she had known she could have come and helped.</p> <p>During an interview on 04/29/2024 at 3:00 p.m. S2 LPN reported resident #3 was very confused, would refuse care, and wander in and out of other residents' rooms. S2 LPN further reported resident #3 would curse you out and would not let you in her room.</p> <p>During an interview on 04/30/2024 at 10:30 a.m. S3 CNA (Certified Nursing Assistant) reported resident #3 would wander in the hallway and into other residents' rooms. S3 CNA reported resident #3 would refuse to let her give her a bath. S3 CNA reported resident #3 did not want any female staff to do anything for her. S3 CNA reported on the day resident #3 was transferred out to the behavior hospital she was cursing and hit one of the nurses. S3 CNA reported resident #3 became more agitated and combative when she would attempt to bath or change her clothing.</p> <p>During an interview on 04/30/2024 at 10:30 a.m. S4 LPN reported she observed resident #3 and she had behaviors. S4 LPN reported resident #3 wandered in the hallway and into other residents' rooms. S4 LPN reported resident #3 was confused and combative toward the staff. S4 LPN reported even if they think a resident should be placed on the Dementia Unit they can only make those suggestions but it is up to the IDT (Interdisciplinary Team) to have them placed there. S4 LPN reported usually if a resident wanders like resident #3 they are placed on the Dementia Unit.</p> <p>During an interview on 04/30/2024 at 11:10 a.m. S5 LPN reported resident #3 was confused, combative, and would curse at staff. S5 LPN reported resident #3 would wander in the other resident's room and in the hallway. S5 LPN reported resident #3 would remove her clothing and come out in the hallway.</p> <p>During an interview on 04/30/2024 at 1:15 p.m. S6 SS (Social Service) reported she is the one that completed Section E - Behavior of the MDS for resident #3. S6 SS reported she completed Section E - Behavior by doing a 7 day look back period of what the floor nurses chart on each shift. S5 SS reported the Care Plan is completed from the documentation on the MDS. S5 SS reported after reviewing the nurses' documentations on resident #3's Nurse's Progress Notes, S6 SS acknowledged behaviors should have been answered as yes for behaviors.</p>		