STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195312	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierremont Healthcare Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708 Based on record reviews and interviews the facility failed to protect resident's right to be free from physical abuse by a staff member for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents. The deficient practice resulted in actual harm of Resident #1 on 01/10/2025 at 9:15 p.m. when S4 CNA (Certified Nursing Assistant) bent Resident #1's fingers back to her wrist. Resident #1 was assessed by S6 LPN (Licensed Practical Nurse) on the morning of 01/11/2025 and found to have swelling and bruising to her right hand. Resident #1's right hand x-ray dated 01/11/2025 revealed findings consistent with acute fracture of mid aspect of middle phalanx 2nd digit right hand with acute fracture of distal 2nd metacarpal. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility's Abuse Prohibition Policy dated 05/17/2024 revealed in part: Intent: Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse. Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of Resident #1 Minimum Data Set assessment dated [DATE] revealed a Brief Mental Status of 10 which indicated moderately impaired cognition and was dependent on staff for activities of daily living. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1 progress notes revealed in part a note dated 01/11/2025 at 9:30 a.m. signed per S6 LPN revealed Resident #1 complained of right hand pain to S5 CNA during breakfast service and told S5 CNA not to touch her right hand as it was broken. S5 CNA noted Resident #1's hand to be purplish in color and Resident #1 told her that the big girl pulled her fingers back to her wrist last night when she was changing her and hurt her hand. S6 LPN assessed Resident #1 and noted her right hand to be light purple in color to thumb and fingers and Resident #1 reported to S6 LPN it hurt. Resident #1 further reported to S6 LPN that big girl did it last night when she was changing me by pulling my fingers back to my wrist. Review of the facility's incident report dated 01/11/2025 at 9:45 a.m. regarding Resident #1 reported by S6 LPN revealed: -Description: resident noted to have bruise to right hand. -Resident description: resident states that between 8-9 last night while CNA was changing her the CNA told her to roll over and she was doing the best she could when CNA took her hand and bent her fingers back towards her wrist. -Immediate action taken: assessed from head to toe. Passive range of motion with some difficulty, resident able to use hand to take meds, drink soda, and eat. ___ (mobile imaging provider) notified of need for x-ray to right hand and wrist. -Pain level: 5 -refused ___ per standing orders for pain -Notified: Administrator, DON (Director of Nursing) and MD (Medical Doctor) Review of Resident #1's clinical record revealed x-ray report from ____ (mobile imaging provider) dated 01/11/2025 revealed: Right hand 2 views, osteopenia noted, obliquely oriented fracture demonstrated involving the distal aspect of 2nd metacarpal with some overlap of fracture fragments and displacement. There is also fracture of the mid aspect of the middle phalanx of the 2nd digit. Degenerative changes are noted. Soft tissue swelling noted. Impression: Findings consistent with acute fracture of mid aspect of middle phalanx 2nd digit right hand. Findings consistent with acute fracture of distal 2nd metacarpal. During an interview on 01/23/2025 at 2:15 p.m. Resident #1 reported her hand was broken and indicated her right hand. When asked how she broke her hand Resident #1 reported that big girl was changing me and told me to turn. Resident #1 reported she guessed she did not do it as the girl liked and the girl got mad and grabbed her arm and bent her fingers back. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/23/2025 at 2:26 p.m. S5 CNA reported on 01/11/2025 she was setting up breakfast for Resident #1 and was handing Resident #1 a drink and she reported her hand was broken. S5 CNA reported she assessed Resident #1's hand and it was purplish and swollen from her thumb all the way to the middle finger area. S5 CNA reported she asked Resident #1 what happened and Resident #1 told her that the big girl bent her fingers back to her wrist and broke her hand last night. S5 CNA reported she notified S6 LPN who came and assessed Resident #1 and Resident #1 told S6 LPN the same account of how her hand was hurt and named S4 CNA to S6 LPN and later police. S5 CNA reported she went with Resident #1 to the hospital for evaluation and Resident #1 told the nurses and doctors at the hospital the same account of the incident with her hand. During an interview on 01/27/2025 at 11:20 a.m. S7 CNA reported she worked 01/10/2025 on the 11 p.m. to 7 a.m. shift and was assisting Resident #1 with putting on a gown when Resident #1 complained of pain to her hand and reported the black girl bent her fingers back. S7 CNA reported she did not observe any bruising or swelling and reported to the nurse. During an interview on 01/27/2025 at 11:43AM S8 LPN reported she worked 01/10/2025 on the 11 p.m. to 7 a.m. shift and was asked by S7 CNA to talk to Resident #1. S8 LPN reported Resident #1 told her the girl with long black hair bent her fingers back and she did not want her back in the room. S8 LPN reported she observed no swelling or bruising to Resident #1's hand and Resident #1 could move her fingers without any increase in pain. S8 LPN reported Resident #1 had no complaints regarding her hand throughout the rest of her shift. S8 LPN had knowledge of Resident #1 being resistive to care and indicated without swelling, bruising, and increased pain with movement it was not something she needed to report. S8 LPN reported she was notified of Resident #1 right hand being swollen and bruised when she was called to make a statement on 01/11/2025 the following morning. During a telephone interview on 01/27/2025 at 12:24 p.m. S6 LPN reported on 01/11/2025 S5 CNA told her Resident #1's hand was bruised and purple. S6 LPN reported when she assessed Resident #1 she noted the bruising and swelling to her right hand. S6 LPN reported Resident #1 was using her fingers to eat but did not want her hand touched and reported it was broken. S6 LPN reported Resident #1 told her the big girl S4 CNA last night told her to roll over and got mad and bent her fingers back. S6 LPN reported she notified S3 DON and S1 Administrator who was the Abuse Coordinator. S6 LPN reported Resident #1's doctor was notified and an x-ray was done which indicated Resident #1 hand was broken. S6 LPN reported Resident #1 told the police the same accounts of the incident and called S4 CNA by name to police. During a telephone interview on 01/28/2025 at 9:36 a.m. S4 CNA reported she was not aware of any incident or concern with Resident #1's hand until she was notified by phone on 01/11/2025 that Resident #1 reported the big girl bent her hand back. S4 CNA reported she worked the 3 p.m. to 11 p.m. shift on 01/10/2025 and had not been back to the facility since. S4 CNA reported on her last rounds of the evening 01/10/2025 before the end of her shift she provided pericare to Resident #1 first and worked her way down the hall providing care to other residents. S4 CNA reported she did not go back in Resident #1 room before leaving a little after 11:00 p.m. S4 CNA reported after her final rounds she allows residents to sleep and reported she sat at the nurses station that was just outside Resident #1 door after completion of her rounds until she left for the evening. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/28/2025 at 1:08 p.m. S3 DON reported she was at the facility when she was notified on 01/11/2025 by S1 Administrator who is also the abuse coordinator that Resident #1 told S5 CNA that her fingers were bent back by the big aide. S3 DON reported when she assessed Resident #1 she was using her right hand trying to drink. S3 DON reported Resident #1's right hand was bruised and swollen and Resident #1 reported it hurt to touch it and when she moved it. S3 DON reported Resident #1 said the big aide pulled her hand back. S3 DON asked Resident #1 if she remembered the name of the CNA because there were a lot of big aides. S3 DON reported Resident #1 replied S4 CNA. S3 DON reported Resident #1 reported S4 CNA pulled her hand back on purpose. S3 DON reported she notified S1 Administrator of her assessment and he started the reporting process. S3 DON reported she notified the police, Resident #1's responsible party, and Resident #1's physician was notified. S3 DON reported she did not tell police the accused CNA's name and reported she was in the room when the police questioned Resident #1 and when they asked who bent her fingers back Resident #1 screamed S4 CNA. S3 DON reported Resident #1's account of the incident and who bent her fingers remained consistent. S3 DON reported an x-ray confirmed fracture of Resident #1's hand and Resident #1 was sent to the hospital for evaluation. During an interview on 01/28/2025 at 2:10 p.m. S1 Administrator confirmed he was the facility's abuse coordinator. S1 Administrator reported he was notified by S6 LPN around 9:00 a.m. on the morning of 01/11/2025 that S5 CNA came to her and reported Resident #1 hand was swollen and bruised. S1 Administrator reported Resident #1 told her the big black aide with the long hair hurt her hand and bent her fingers back to her wrist. S1 Administrator reported he notified S3 DON who was already in the building and notified his Regional [NAME] President. S1 Administrator reported S3 DON assessed Resident #1 hand to be swollen and confirmed Resident #1 named S4 CNA as the one who bent her fingers back. S1 Administrator reported the police interviewed Resident #1 and she remained consistent in naming S4 CNA as the one who bent her fingers back. During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility. Review of the facility's corrective action plan initiated on 01/11/2025 with a completion date of 01/13/2025 consisted of the following: The accused, S4 CNA, was suspended 01/11/2025 and terminated on 01/13/2025. Resident #1 was assessed on 01/11/2025, Police were contacted on 01/11/2025, and X-rays were obtained on 01/11/2025. Resident life satisfaction rounds were completed on 01/11/2025 on residents who resided on Resident #1 hall with no concerns noted. Head to toe assessments were performed on all residents and completed on 01/13/2025. The facility performed an in-service with staff on 01/11/2025 regarding abuse prohibition, resident rights, and call light response with the content of abuse coordinator, when to report abuse, resident's rights, neglect, repositioning and transfers, and signs and symptoms of burnout. Random daily observations of care were initiated on 01/13/2025 with weekly staff checks to identify sign and symptoms of burnout/stress. The monitoring will continue for 30 days with review daily by the DON and the Corporate Clinical Specialist and will be reduced to monthly for 3 months.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708 Based on record reviews and interviews the facility failed to ensure staff reported alleged violations regarding abuse immediately to the proper facility authority as per facility policy for 1 (#1) of 3 (#1, #2, #3) sampled residents. Findings: Review of the facility's Abuse Prohibition Policy dated 05/17/2024 revealed in part: Intent: Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse. Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. 2. The facility will conduct an investigation of alleged or suspected abuse, neglect, or misappropriation of property, and will provide notification of information to the proper authorities according to state and federal regulations. Definitions: -Abuse means the willful infliction of injury, withholding or misappropriating property or money, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Physical abuse includes hitting, slapping, kicking, shoving, pinching, and controlling behavior through corporal punishment. Identification: 1. Any allegation of abuse/neglect, made by residents/staff/visitors shall be reported to the Abuse Coordinator and investigated immediately. 4. All incidences of unknown origin will be investigated. Reporting/Response: 1. Any employee who becomes aware of an allegation of abuse, or neglect or misappropriation of resident property shall report the incident to Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1 Minimum Data Set assessment dated [DATE] revealed a Brief Mental Status of 10 which indicated moderately impaired cognition and was dependent on staff for activities of daily living. Review of Resident #1 comprehensive care plan revealed in part the following problems with appropriate approaches: resident has activities of daily living self-performance deficit and resident is resistive to care. During an interview on 01/27/2025 at 11:20 a.m. S7 CNA reported she worked 01/10/2025 on the 11 p.m. to 7 a.m shift and was assisting Resident #1 with putting on a gown when Resident #1 complained of pain to her hand and reported the black girl bent her fingers back. S7 CNA reported she did not observe any bruising or swelling and reported to the nurse. During an interview on 01/27/2025 at 11:43AM S8 LPN reported she worked 01/10/2025 on the 11 p.m. to 7 a.m. shift and was asked by S7 CNA to talk to Resident #1. S8 LPN reported Resident #1 told her the girl with long black hair bent her fingers back and she did not want her back in the room. S8 LPN reported she observed no swelling or bruising to Resident #1's hand and Resident #1 could move her fingers without any increase in pain. S8 LPN reported Resident #1 had no complaints regarding her hand throughout the rest of her shift. S8 LPN had knowledge of Resident #1 being resistive to care and indicated without swelling, bruising, and increased pain with movement it was not something she needed to report. S8 LPN reported she was notified of Resident #1 right hand being swollen and bruised when she was called to make a statement on 01/11/2025 the following morning. During an interview on 01/30/2025 at 8:47 a.m. S7 CNA acknowledged she did not suspect abuse when Resident #1 reported the girl bent her fingers back. S7 CNA reported she did not ask if the girl bent her fingers back intentionally and had reported only to the nurse. S7 CNA reported knowledge that suspected abuse was to be reported to the abuse coordinator. During an interview on 01/30/2025 at 9:08 a.m. S8 LPN acknowledged she did not suspect abuse when Resident #1 reported the girl bent her fingers back. S8 LPN reported she did not ask if the girl bent her fingers back intentionally and had not reported the allegation to the abuse coordinator. S8 LPN reported knowledge that suspected abuse was to be reported to the abuse coordinator. During an interview on 01/30/2025 at 9:50 a.m. S1 Administrator, S2 Corporate Clinical Specialist, and S3 Director of Nursing reported any allegation of suspected abuse should be reported immediately to the abuse coordinator. S1 Administrator, S2 Corporate Clinical Specialist, and S3 Director of Nursing acknowledged when Resident #1 reported to staff on 01/11/2025 that the girl bent her fingers back the night before and did not want her in her room again the allegation should have been reported to the abuse coordinator as potential abuse and it was not reported.