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No. 0938-0391

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	11/15/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30669 Based on observations, interviews, and record reviews the facility failed to provide services that meet professional standards for 2 of 2 (#44, #90) out of a total sample of 28 residents. The facility failed to ensure nurses administered medications and remained with the residents until the medications were taken. Findings: Review of the facility's Medication Administration Policy and Procedure dated 07/08/2024 revealed in part: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and implementation: 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Resident #44 Review of resident #44's medical records revealed an admitted [DATE]. Observation on 11/12/2024 at 08:40 a.m. revealed a medication cup that contained pills left on resident #44's breakfast tray at the bedside for resident #44 to take on his own by S8 LPN (Licensed Practical Nurse). During an interview on 11/12/2024 at 9:30 a.m. Resident #44 reported S8 LPN always left his medications at the bedside for him to take on his own. During an interview on 11/12/2024 at 9:40 a.m. S8 LPN reported she had left resident #44's medications for him to take on his own. S8 LPN reported she did not know if resident #44 had been assessed to give his own medications. Review of resident #44's medical record failed to reveal he had been assessed to self-administer his own medications. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90 Review of resident #90's medical record revealed an admitted [DATE]. Observation on 11/12/2024 at 8:40 a.m. revealed a medication cup that contained pills left on resident #90's over bed table by S8 LPN for him to on his own. During an interview on 11/12/2024 at 9:30 a.m. resident #90 reported S8 LPN always left his medications for him to take on his own. During an interview on 11/12/2024 at 09:45 a.m. S8 LPN reported she left resident #90's medications for him to take on his own. S8 LPN reported she did not know if resident #90 had been assessed to give his own medications. Review of resident #90's medical record failed to reveal he had been assessed to self-administer his own medications.

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F 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44414

Based on record review and interviews, the facility failed to ensure residents at risk for pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, and/or to prevent the development of new ulcers unless the individual's clinical condition demonstrated they were unavoidable for 1 (Resident #25) resident reviewed for transmission based precautions.

The deficient practice resulted in an Immediate Jeopardy for Resident #25 on 11/01/2024 when Resident #25 was admitted to the hospital when bilateral heel boot protectors were removed and a border dressing to the left heel dated 5/17 was found to be in place. Resident #25's dressing to his left heel was removed and assessment revealed a large area of superficial ulceration over the dorsal right foot measuring 7.0 cm (centimeter) x 7.0 cm in diameter with numerous areas of superficial ulcerations to dorsal aspect of the right foot, lateral right forefoot, and lateral left forefoot and posterior heel with green purulent drainage expressed from areas. Resident #25 was admitted to ICU (Intensive Care Unit) on 11/01/2024 with diagnoses including in part, sepsis with shock, UTI (Urinary Tract infection) and infected bilateral lower extremity pressure ulcers. An x-ray of Resident #25's left foot revealed possible osteomyelitis of the second digit. Resident #25's bilateral lower extremity wounds required surgical debridement by podiatry.

This deficient practice had the likelihood to cause more than minimal harm to the total census of 117 residents receiving weekly skin assessments.

S1Administrator and S3Corporate Nurse were notified of the Immediate Jeopardy on 11/15/2024 at 4:50 p.m.

The facility presented the following Plan of Removal on 11/15/2024 at 9:43 p.m.:

Plan of Removal for wound care: On November 15, 2024, facility administration was made aware of an immediate jeopardy concerning: (1) Failure to complete skin assessments accurately and timely and adequate skin care provided during activities of daily living on Resident #25.

Incident specific and immediate actions taken prior to and after IJ notification:

1. Director of Nurses (DON) will in-service licensed nursing staff on completion of weekly skin assessments accurately and timely beginning on November 15, 2024.

2. DON will in-service licensed nursing staff and certified nurse aides on providing skin care during ADLs, emphasizing to remove heel protector boots during bathing beginning on November 15, 2024.

3. Beginning November 15, 2024, Nursing Administration team, which includes DON, Unit Managers, and Treatment Nurse, will conduct facility wide head to toe assessments to ensure skin assessments reflect the current resident's skin status.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Unit Managers will provide oversight with licensed nursing staff during weekly skin assessments to validate accuracy of skin assessments and removal of heel protector boots during bathing beginning November 15, 2024. 5. DON will randomly validate accuracy of skin assessments and removal of heel protector boots during bathing twice weekly beginning November 15, 2024. 6. Corporate Clinical Specialist will conduct in-service with the nurse administration team which consists of the following, DON, Unit Managers, and Treatment Nurse, on importance of completing weekly skin assessments accurately and timely and removal of heel protector boots during bathing beginning November 15, 2024. 7. DON will start monitoring to ensure licensed nurses are completing weekly skin assessments accurately and timely beginning November 15, 2024. 8. Baylor weekend nurses, weekend Registered Nurses, and new hires will be in-serviced by DON on performing weekly skin assessments accurately and timely and emphasizing to remove heel protector boots during bathing beginning November 15, 2024 before their next scheduled shift. 9. Resident #25 was assessed by Wound Care Nurse Practitioner, November 15, 2024, and will continue until wound is healed. Seven residents are at risk and will be assessed by Wound Care Nurse Practitioner and will continue on caseload until healed. 10. Any identified issue will be addressed immediately and reported to the Quality Assurance Committee. The facility will ensure the likelihood of serious harm no longer exists beginning November 15, 2024. The Immediate Jeopardy was removed on 11/15/2024 at 10:15 p.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews and record reviews prior to exit. Findings: Review of the facility's The ________ Skin Integrity Prevention and Treatment Program with a review date of January 2023 revealed in part: ______ Skin Essentials Staff Education is completed via orientation in various methods such as but not limited to in person, virtual live and virtual recorded sessions. Session covers: a. the standards of ________ regarding skin/wound management and prevention b. documentation standards that include guidelines used in assessment and treatment d. best practice formulary approaches for treatment and prevention (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	g. importance of skin integrity quality assurance _____ Skin Essentials Assessment and Documentation Standards include but not limited to: Weekly Skin Integrity Checks: a. weekly assessment looking for new wounds - completed by a licensed nurse b. documented on/in treatment record Review of the facility's _____ Health Pressure Injury Prevention Program with a revision date of September 2024 revealed in part: Standard: All residents will be assessed for the risk of pressure injury development at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Each resident will also receive a weekly skin check to identify new areas of concern or the development of new pressure injuries to ensure a timely adjustment to the resident's change in condition/risk level. Based on the results of these assessments, specific interventions will be implemented to prevent the development of avoidable pressure injuries, or, to treat new/existing pressure injuries. Procedure: 4. All residents will have a head-to-toe assessment (skin check) completed on a weekly basis by a licensed nurse to identify any skin breakdown or at-risk areas for break down. The results of this assessment will be documented in the resident's medical record. 5. If a pressure injury/skin breakdown is identified, the following will be done - a. if new area found - - if pressure injury - complete new wound evaluation/assessment. - if non-pressure area - complete new wound evaluation/assessment. Review of the facility's Bath, Bed policy with a revision date of March 2021 revealed in part: Purpose - The purposes of this procedure are to promote cleanliness, provide comfort and to observe the condition of the resident's skin. Steps in the procedure: Legs and Feet: d. wash the foot e. observe toenails and the skin between the toes for redness and cracking of the skin. f. dry the foot and between the toes carefully. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Reporting: 2. Report other information in accordance with facility policy and professional standards of practice. Review of Resident #25's medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses that included, in part, quadriplegia, neuromuscular dysfunction of the bladder, and idiopathic peripheral neuropathy. Review of Resident #25's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed, in part, Resident #25 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. Further review Resident #25's Quarterly MDS assessment dated [DATE] revealed Resident #25 had no unhealed pressure ulcers. Review of Resident #25's comprehensive care plan revealed in part, Resident #25 was at risk for pressure ulcers due to impaired mobility, incontinence, and fragile skin with interventions in place for daily observation of skin with routine care. Further review of Resident #25's comprehensive care plan revealed Resident #25 had an ADL self-care performance deficit and required extensive assistance by staff. Review of Resident #25's Physician orders revealed in part: 11/13/2024 Isolation Precautions: Contact related to MRSA (Methicillin-resistant Staphylococcus aureus) every shift. Initials acknowledge the following: Resident remained in room, received all medications, participated in activities, received all meals, when applicable received all rehab services, and received all ADL care, in room entire shift. 02/23/2023 Heel protector boots to float heels bilaterally, as tolerated, every shift. 08/11/2023 Weekly skin checks every Monday for immobility, bedbound, and muscle wasting. Review of S5Wound Care NP's note dated 05/17/2024 revealed in part, Resident #25's pressure wound to left lateral heel was healed, had no s/s (signs and symptoms) of infection and wound care had been discontinued. Review of Resident #25's Weekly Skin Assessment Evaluations from 05/29/2024 - 10/29/2024 revealed no new skin issues had been identified for Resident #25's feet. Further review of Resident #25's Weekly Skin Assessment Evaluations from 05/29/2024 - 10/29/2024 failed to reveal weekly skin assessments were completed during the weeks of: 06/10/2024 - 06/16/2024; 06/17/2024 - 06/23/2024; 06/24/2024 - 06/30/2024; 07/01/2024 - 07/07/2024; 07/15/2024 - 07/21/2024; 07/22/2024 - 07/28/2024, 08/05/2024 - 08/11/2024 and 10/14/2024 - 10/20/2024. Review of Resident #25's October 2024 ADL log revealed Resident #25 had been receiving bed baths, with the last bath documented on 10/28/2024. Review of Resident #25's interdisciplinary notes revealed Resident #25 was transported to ER by stretcher on 10/31/2024 related to issues with his suprapubic catheter. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #25's hospital records revealed a Physician's note dated 11/01/2024, which revealed in part, Resident #25's history of present illness included chronic sacral decubitus and bilateral lower extremity pressure ulcers . Resident #25's urinalysis is positive for UTI (urinary tract infection) and Resident #25 has severely infected wounds to bilateral lower extremities with drainage . Resident #25 will be admitted to ICU for sepsis with shock. Further review of Resident #25's hospital records revealed a Podiatric Consultation note dated 11/01/2024, which read in part: Multi-Podus boots to both lower extremities were removed this morning. A border gauze dressing to the left heel marked 5/17 was removed and documented. Large area of superficial ulceration over the dorsal right foot measuring 7.0 cm x 7.0 cm diameter with numerous areas of superficial ulceration to dorsal aspect of the right foot, lateral right forefoot, and lateral left forefoot and posterior left heel. [NAME] purulent drainage expressed from areas . All nonviable tissue was removed with saline soaked gauze with manual means. Purulent drainage was expressed from dorsal right foot and lateral right forefoot. All wounds were debrided of nonviable tissue to good bleeding tissue using scalpel blade and forceps. All xerotic tissue was removed and both feet were irrigated with saline wash. The nursing home was contacted this morning to inquire about dressing to the left heel with a date of May 17th. The nurse at the facility stated she did not realize there was a dressing on his left heel. Photos of the dressing and the foot were taken for documentation. Further review of Resident #25's hospital records revealed an Infectious Disease Consult note dated 11/02/2024 which included the following in part, severely infected wounds to bilateral lower extremities with drainage . left foot wound with heavy growth of Staphylococcus Aureus. X-ray of left foot with possible osteomyelitis of the second digit. Of note, there are pictures in chart from heel ulcer dressing dated back from May 17 that apparently was not removed at nursing home. Further review of Resident #25's hospital records from hospital stay 11/01/2024 - 11/06/2024 revealed in part, black and white pictures of an un-initialed foam border dressing dated 5/17 with soiled areas to the inside of foam border dressing. During an interview on 11/14/2024 at 11:00 a.m., S2DON acknowledged she signed Resident #25's 10/29/2024 skin assessment. S2DON could not confirm if there was a dressing on Resident #25's left heel or if heel boots had been taken off during the assessment. S2DON further acknowledged heel protector boots should be taken off during weekly skin assessments. During an interview on 11/14/2024 at 11:15 a.m., Resident #25 reported when he went to the hospital recently he thought his left heel wound was healed, until the doctor told him they removed a dressing from May from his left foot. Resident #25 further reported his left heel had not had any dressing changes or wound care since healing in May. During an interview on 11/14/2024 at 11:40 a.m., S13CNA (Certified Nursing Assistant) reported Resident #25 was compliant with his baths. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/14/2024 at 11:55 a.m., S12LPN (Licensed Practical Nurse) reported she took a call on 11/01/2024 from a hospital physician who questioned if she was aware Resident #25 had a dressing on his left foot dated 05/17/2024. S12LPN reported she informed the physician she was not aware Resident #25 had a dressing on his left foot. S12LPN reported she was unsure of who placed a dressing on Resident #25's left foot. S12LPN further reported the dressing must have been dated from last wound care visit and left in the room. S12LPN stated someone just probably grabbed it out of his (Resident #25) drawer to use. During a telephone interview on 11/14/2024 at 12:10 p.m., S5Wound Care NP confirmed he closed out Resident #25's left heel pressure wound as healed on 05/17/2024. S5Wound Care NP confirmed all wound care and dressing changes were discontinued on 05/17/2024. S5Wound Care NP reported he was not aware Resident #25's left heel had developed an issue prior to going to the hospital on 10/31/2024. S5Wound Care NP reported good foot care was not being administered if this was the case. S5Wound Care NP reported he could not confirm who applied the dressing or why it was applied to Resident #25's left heel. S5Wound Care NP acknowledged it was not good practice for an opened, dated dressing to be left in a resident's room for future use. S5Wound Care NP acknowledged Resident #25 was very high risk for wounds due to his immobility and history of chronic wounds and should have been monitored closely. During an interview on 11/14/2024 at 3:00 p.m., Resident #25 reported the CNAs do not take his boots off when they are giving him a bed bath and stated they (CNAs) do not want to get my feet wet. Resident #25 reported staff are afraid because I got septic once before from my feet getting too wet. Resident #25 further reported the nurses do not take his boots off during the weekly skin assessments and just look at the tips of his feet during the assessment. Resident #25 was unable to recall the last time his boots were removed prior to his recent hospitalization . During an interview on 11/15/2024 at 7:50 a.m., S4Wound Care Nurse viewed photographs from Resident #25's hospital records and confirmed the dressing removed in the hospital was the same dressing she left at the bedside on 05/17/2024. S4Wound Care Nurse reported dressing was dated and left in opened package which was exposed to air. S4Wound Care Nurse acknowledged the dressing could have remained in place over a long period of time because Resident #25 cannot move his lower extremities and if his boots remained in place, the dressing would not have been disturbed. During an interview on 11/15/2024 at 8:00 a.m., S5Wound Care NP confirmed leaving Resident #25's boots in place could lead to skin breakdown. S5Wound Care NP acknowledged he had not documented any assessments of Resident #25's feet since 05/17/2024. S5Wound Care NP reported residents with weekly skin assessments should have a full head to toe skin assessment. During an interview on 11/15/2024 at 8:45 a.m., S2DON reported she does not review the entire hospital record once a resident is discharged back to the facility and had only reviewed Resident #25's Physician orders. S2DON reported she was not aware Resident #25 had been admitted to ICU and photographs had been taken of Resident #25's wound dressing dated 5/17/2024. S2DON confirmed Resident #25's wound dressing which was removed at the hospital had been placed in the facility. S2DON acknowledged skin assessments should be head to toe and Resident #25's boots should be removed for skin assessments as well as bathing. S2DON reported Resident #25 was compliant with ADL care, including baths. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/15/24 at 9:00 a.m., S6LPN reported on 10/31/2024 Resident #25 was sent to a local hospital for urinary related issues. S6LPN acknowledged she did not assess Resident #25's feet prior to going out and Resident #25 was transported to the ER with bilateral heel protector boots in place. During an interview on 11/15/2024 at 10:35 a.m., S14CNA reported when she last bathed Resident #25 on 10/28/2024, Resident #25 had a large white dressing intact to his left foot, but could not recall the date on the dressing. During an interview on 11/15/2024 at 2:30 p.m., S3Corporate Nurse reported the hall nurses were responsible for weekly skin assessments. S3Corporate Nurse further reported S2DON was responsible for overseeing all nursing staff to ensure proper skin assessments and skin care were performed. During an interview on 11/15/2024 at 4:00 p.m., S2DON acknowledged she was responsible for overseeing the nursing staff for adequate skin assessments and proper skin care. S2DON confirmed Resident #25's wounds had not been identified prior to admission to the hospital and wounds should have been identified through weekly skin assessments and ADL care. During an interview on 11/15/2024 at 5:05 p.m., S3Corporate Nurse acknowledged a process was not in place to ensure accurate, timely skin assessments were being performed weekly and proper skin care was being provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30669 Based on record reviews, observations, and interview the facility failed to provide services to prevent further contractures and potential decline in range of motion for 1 (#34) of 2 (#34, #90) residents reviewed for limitations in ROM (range of motion). Findings: Review of resident #34's medical record revealed an admitted [DATE] with diagnoses that included cerebral infarction, aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral affecting left non-dominant side, contracture of right knee, contracture of left knee, and other reduced mobility. Review of resident #34's November 2024 physician's orders revealed an order dated 04/05/2024 for resident to wear right resting hand splint and left palmar guard, on before breakfast and off after lunch or as tolerated. Nurse to check skin prior to application and after removal of splint. ROM to be performed prior to application. Nurse to complete in the absence of restorative nurse assistant. Review of resident #34's Comprehensive Plan of Care revealed a problem of activities of daily living self-care performance deficit related to hemiplegia with interventions that included resident has right resting hand splint and left palmar guard for contracture management. During an observation on 11/12/2024 at 10:00 a.m. resident #34's right hand was contracted with no brace or splint in place. Review of resident #34's November 2024 medication administration record failed to reveal documentation of right hand splint and left palmar guard being used as ordered and failed to reveal skin checks being performed as ordered. During an observation on 11/13/2024 at 12:10 p.m. with S11 LPN (Licensed Practical Nurse) revealed resident #34 did not have a splint on her right hand and did not have a palmar guard in her left hand. During an interview on 11/13/2024 at 12:10 p.m. S11 LPN reported she was not aware that resident #34 was to have a right resting hand splint or left palmar guard on her hands. During an observation on 11/15/2024 at 7:50 a.m. revealed resident #34 did not have a splint on her right hand and did not have a palmar guard in her left hand.

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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** 30669 34708 45317 Based on record reviews, observations, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails and failed to obtain informed consent from the resident or resident's representative prior to installation of bed rails for 9 (#8, #9, #16, #39, #44, #90, #94, #108, #368) out of 9 (#8, #9, #16, #39, #44, #90, #94, #108, #368) residents reviewed for bed rails. Findings: Review of the Facility Policy on Physical Restraints and Involuntary Seclusion dated 03/2023 revealed in part: 13. Side rails or side rail assist bars/enablers used as an enabler for mobility or transfers must include: -Side Rail evaluation completed -Assessment of the resident's ability to move about in bed. -Determination of whether the resident is able to use the side rails in turning. -Determination that the patient's/resident's ability to transfer considering that the side rail may add risk to the patients/residents self-transfer -Purpose of bedrail and notation that no appropriate alternative exists -An entrapment risk assessment of the resident and the bedrail -Monitoring and Documentation should include an assessment of the risks vs. benefits that is reviewed with the resident and resident representative, who must give informed consent summarized as -Routine assessment for monitoring of appropriateness -Ensuring informed consent -Ensuring appropriateness of bed -Ensuring ongoing inspection and maintenance (continued on next page)

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 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierremont Healthcare Center	725 Mitchell Lane Shreveport, LA 71106

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 Review of Resident #8's medical record revealed a readmitted [DATE] with diagnoses, including but not limited to, epileptic syndromes with seizures of localized onset, lack of coordination, and vascular dementia. Review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9 which indicated moderately impaired cognition. Review of Resident #8's physician's orders revealed an order dated 09/05/2024 for assist bars times 2 related to transfer and/or bed mobility. Review of Resident #8's medical record failed to reveal Resident #8 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #8 or Resident #8's representative prior to installation of bed rails. During an observation on 11/12/24 at 8:30 a.m. revealed Resident #8 lying in bed with assist rails bilaterally in an up position at head of bed (HOB). During an observation on 11/13/2024 at 2:25 p.m. revealed Resident #8 received assistance with repositioning and Resident #8 was observed holding onto bilateral assist rails which were in an up position. During an observation on 11/14/2024 at 11:00 a.m. revealed Resident #8 lying in bed with bilateral assist rails in an up position at HOB. During an interview on 11/14/2024 at 11:02 a.m. S9 CNA reported Resident #8 used assist rails during repositioning. Resident #9 Review of Resident #9's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, cerebral vascular accident (CVA) with hemiplegia and morbid obesity. Review of Resident #9's five day admission MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Review of Resident #9's physician's orders revealed an order dated 10/16/2024 for assist bars times 2 to assist with bed mobility/transfer every shift. Review of Resident #9's medical record failed to reveal Resident #9 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #9 or Resident #9's representative prior to installation of bed rails. During an observation on 11/12/2024 at 10:30 a.m. revealed bilateral assist rails attached to the upper part of Resident #9's bed in an up position. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pierremont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Mitchell Lane Shreveport, LA 71106	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/12/2024 at 10:30 a.m., Resident #9 reported she used the bilateral assist rails to help position herself in bed. Resident #16 Review of Resident #16's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified site and contracture of muscle, multiple sites. Review of Resident #16's quarterly MDS dated [DATE] revealed Resident #16 had a BIMS score of 13, which indicated Resident #16 was cognitively intact. Review of Resident #16's physician orders revealed an order dated 08/29/2023 for assist bars times 2 every shift. Review of Resident #16's medical record failed to reveal Resident #16 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #16 or Resident #16's representative prior to installation of bed rails. During an observation on 11/12/2024 at 2:00 p.m. revealed Resident #16 asleep in bed with bilateral upper assist bars in use. During an observation on 11/13/2024 at 11:00 a.m. revealed Resident #16 awake in bed with bilateral upper assist bars in use. During an observation on 11/14/2024 at 12:11 p.m. revealed Resident #16 sitting up in bed with bilateral assist bars in use. Resident #39 Review of Resident #39's medical record revealed an admitted [DATE] with a readmitted [DATE]. Resident #39's diagnose included, but not limited to, morbid (severe) obesity due to excess calories, acquired absence of left leg below knee, and dementia in other diseases classified elsewhere. Review of Resident #39's quarterly MDS dated [DATE] revealed Resident #39 had a BIMS score of 8, which indicated Resident #39 had moderately impaired cognition. Review of Resident #39's physician orders revealed an order dated 08/29/2023 for bariatric bed with assist bars times 2 for bed mobility and pressure redistribution mattress to bed every shift. Further review of Resident #39's order revealed an order dated 11/08/2024 for assist bars times 2 to assist with bed mobility/transfer every shift. Review of Resident #39's medical record failed to reveal Resident #39 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #39 or Resident #39's representative prior to installation of bed rails. During an observation on 11/12/2024 at 2:00 p.m. revealed Resident #39 sitting upright in bariatric bed with bilateral upper quarter side rail 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 observation on 11/13/2024 at 11:00 a.m. revealed Resident #39 sitting upright in bariatric bed with bilateral upper quarter side rail in use. During an observation on 11/14/2024 12:13 p.m. revealed Resident #39 sitting upright in bariatric bed with bilateral upper quarter side rails in use. Resident #44 Review of Resident #44's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, idiopathic chronic gout multiple sites, other cerebral infarction, dysphagia, end stage renal disease, and dependence on dialysis. Review of Resident #44's quarterly MDS dated [DATE] revealed a BIMS score of 14 which indicated intact cognition. Review of Resident #44's physician's orders revealed an order dated 09/04/2024 for assist bars times 2 to assist with bed mobility/transfer every shift. Review of Resident #44's medical record failed to reveal Resident #44 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #44 or Resident #44's representative prior to installation of bed rails. During an observation on 11/12/2024 at 08:40 a.m. revealed Resident #44 had 1 assist rail to the right upper side of the bed in an up position. During an interview on 11/12/2024 at 8:40 a.m., Resident #44 reported he used the assist rail to get up and out of bed. Resident #90 Review of Resident #90's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, stroke with hemiplegia or hemiparesis and seizure disorder Review of Resident #90's quarterly MDS dated [DATE] revealed a BIMS score of 14 which indicated intact cognition. Review of Resident #90's medical record failed to reveal Resident #90 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #90 or Resident #90's representative prior to installation of bed rails. During an observation on 11/12/2024 at 08:40 a.m. revealed Resident #90 had 1 assist rail to the right upper side of the bed in an up position. During an interview on 11/12/2024 at 8:40 a.m., Resident #90 reported he used the assist rail to get up from bed and to turn and reposition. Resident #94 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pierremont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Mitchell Lane Shreveport, LA 71106	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #94's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Review of Resident #94's quarterly MDS dated [DATE] revealed a BIMS score of 3 which indicated severely impaired cognition. Review of Resident #94's medical record failed to reveal Resident #94 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #94 or Resident #94's representative prior to installation of bed rails. During an observation on 11/12/2024 at 09:50 a.m. revealed Resident #94 had bilateral assist rails in an up position attached to the head of her bed. Resident #108 Review of Resident #108's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #108's admission MDS dated [DATE] revealed Resident #108 had a BIMS of 15 which indicated Resident #108 was cognitively intact. Review of Resident #108's physician orders revealed an order dated 11/13/2024 for assist bars times 2 to assist in bed mobility/transfer. Review of Resident #108's medical record failed to reveal Resident #108 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #108 or Resident #108's representative prior to installation of bed rails. During an observation on 11/12/2024 at 3:00 p.m. revealed Resident #108 asleep in bed with bilateral upper assist rails in use. During an observation on 11/13/2024 at 11:00 a.m. revealed Resident #108 asleep in bed with bilateral upper assist rails in use. During an observation 11/14/2024 12:10 p.m. revealed Resident # 108 siting up in bed with bilateral upper assist rails in use. Resident #368 Review of Resident #368's medical record revealed a readmitted [DATE] with diagnoses, including but not limited to, paranoid schizophrenia, seizures, and Alzheimer's disease. Review of Resident #368's quarterly MDS assessment dated [DATE] revealed a BIMS score of 5 which indicated severely impaired cognition. (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 #368's physician's orders revealed an order dated 09/05/2024 for assist bars times 2 related to transfer and/or bed mobility. Review of Resident #368's medical record failed to reveal Resident #368 was assessed for the risk of entrapment from bed rails and failed to reveal an informed consent was obtained from Resident #368 or Resident #368's representative prior to installation of bed rails. During an observation on 11/12/24 at 1:50 p.m. revealed Resident #368 sitting in wheelchair at bedside. Further observation revealed Resident #368's bed had assist rails bilaterally in an up position at the HOB. During an observation on 11/13/2024 at 1:45 p.m. revealed Resident #368 sitting up in chair at bedside. Further observation revealed Resident #368's bed had assist rails bilaterally in an up position at the HOB. During an observation on 11/14/2024 at 11:10 a.m. revealed Resident #368 sitting up in chair at bedside. Further observation revealed Resident #368's bed had assist rails bilaterally in an up position at the HOB. During an interview on 11/14/2024 at 11:15 a.m. S10 LPN reported Resident #368 used assist rails to help with position changes. During an interview on 11/14/2024 at 3:00 p.m. S3 Corporate Nurse reviewed Resident #8, #9, #16, #39, #44, #90, #94, #108, and #368's medical records and confirmed the residents were not assessed for the risk of entrapment from bed rails and an informed consent was not obtained from the resident or resident's representative prior to installation of bed rails.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44414 Based on record review and interviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 (Resident #25) resident reviewed for transmission based precautions. The facility failed to ensure Resident #25 received complete and timely skin assessments and proper ADL (Activities of Daily Living) care. The deficient practice resulted in an Immediate Jeopardy for Resident #25 on 11/01/2024 when Resident #25 was admitted to the hospital when bilateral heel boot protectors were removed and a border dressing to the left heel dated 5/17 was found to be in place. Resident #25's dressing to his left heel was removed and assessment revealed a large area of superficial ulceration over the dorsal right foot measuring 7.0 cm (centimeter) x 7.0 cm in diameter with numerous areas of superficial ulcerations to dorsal aspect of the right foot, lateral right forefoot, and lateral left forefoot and posterior heel with green purulent drainage expressed from areas. Resident #25 was admitted to ICU (Intensive Care Unit) on 11/01/2024 with diagnoses including in part, sepsis with shock, UTI (Urinary Tract infection) and infected bilateral lower extremity pressure ulcers. An x-ray of Resident #25's left foot revealed possible osteomyelitis of the second digit. Resident #25's bilateral lower extremity wounds required surgical debridement by podiatry. This deficient practice had the likelihood to cause more than minimal harm to the total census of 117 residents receiving weekly skin assessments. S1Administrator and S3Corporate Nurse were notified of the Immediate Jeopardy on 11/15/2024 at 4:50 p.m. The facility presented the following Plan of Removal on 11/15/2024 at 9:43 p.m.: Plan of Removal for administration oversight: On November 15, 2024, facility administration was made aware of an immediate jeopardy (IJ) concerning: (1) Failed to administer in a manner to ensure Resident #25 had accurately and timely wound care assessments and proper skin care provided during activities of daily living. Incident specific and immediate actions taken prior to and after IJ notification: The facility failed to ensure accurate and timely weekly wound care assessment as ordered. The resident did not receive accurate and timely skin assessment and proper skin care provided during ADLs. 1. Corporate Clinical Specialist will in-service Administrator, beginning November 15, 2024, on validating weekly skin assessments are accurate and timely and proper skin care during ADLs. 2. Administrator/designee will attend the clinical morning meeting with the administration nurses twice weekly to ensure weekly skin assessments are accurate and timely and proper skin care is provided during ADLs beginning November 15, 2024. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Corporate Nurse Specialist will provide oversight that the Administrator has attended the clinical morning meeting and reviewed that weekly skin assessments are accurate and timely and proper skin care provided during ADLs beginning November 15, 2024. 4. Corporate Clinical Specialist will conduct in-service with the nurse administration team on importance of completing weekly skin assessments accurately and timely and removal of heel protector boots during bathing beginning November 15, 2024. 5. Baylor weekend nurses, weekend Registered Nurses, and new hires will be in-serviced by DON (Director of Nursing)/designee on performing weekly skin assessments accurately and timely and emphasizing to remove heel protector boots during bathing beginning November 15, 2024 before their next scheduled shift. 6. DON will in-service Licensed Practical Nurses (LPN)/Unit Managers/Treatment Nurse on completion of weekly skin assessments accurately and timely beginning on November 15, 2024. 7. DON will start monitoring to ensure LPN are completing weekly skin assessments accurately and timely beginning November 15, 2024. 8. DON will in-service LPN and certified nurse aides on providing skin care during ADLs, emphasizing to remove heel protector boots during bathing beginning on November 15, 2024. 9. Beginning November 15, 2024, Nursing Administration Team, which consist of DON, Unit Managers, and Treatment nurse will conduct facility wide head to assessment to ensure skin assessments reflect the current resident's skin status. 10. Unit Managers will provide oversight with LPNs during weekly skin assessments to validate accuracy of skin assessment and removal of heel protector boots during bathing beginning November 15, 2024. 11. DON will randomly validated accuracy of skin assessments and removal of heel protector boots during bathing twice weekly beginning November 15, 2024. 12. Any identified issue will be addressed immediately and reported to the Quality Assurance Committee. The facility will ensure the likelihood of serious harm no longer exists beginning November 15, 2024. The Immediate Jeopardy was removed on 11/15/2024 at 10:15 p.m. when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews and record reviews prior to exit. Findings, Cross Reference F686 Interviews: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/15/2024 at 2:30 p.m., S3Corporate Nurse reported the hall nurses were responsible for weekly skin assessments. S3Corporate Nurse further reported S2DON was responsible for overseeing all nursing staff to ensure proper skin assessments and skin care were performed. During an interview on 11/15/2024 at 4:00 p.m. S2DON acknowledged she was responsible for overseeing the nursing staff for adequate skin assessments and proper skin care. S2DON confirmed Resident #25's wounds had not been identified prior to admission to the hospital and wounds should have been identified from weekly skin assessments and adl care. During an interview on 11/15/2024 at 5:05 p.m., S3Corporate Nurse acknowledged a process was not in place to ensure accurate, timely skin assessments were being performed weekly and proper skin care was being provided. During an interview on 11/15/2024 at 8:30 p.m. S1Administrator acknowledged the break in the system was not ensuring residents were receiving accurate skin assessments.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 40957 Based on observations and interviews the facility failed to ensure the kitchen's dishwasher was working in a safe operating condition. Findings: During a tour of the kitchen on 11/12/2024 at 7:50 a.m. with S7 Dietary Manager revealed the following: Observation of the facility's mechanical dishwasher revealed staff loading dishes in a bin and then running the bin through the dishwasher. The bin is placed on the left side of the mechanical dishwasher and when finished the bin exits the right side. Observed water flowing to the left side of the mechanical dishwasher and staff were having to squeegee the water into the sink. Observed staff had put a blanket behind the sink to help with drainage of the water. Observed the right side of the dishwasher and a gap was between the mechanical dishwasher and the table. This caused water to flow out of the gap and onto the floor. Observed the motor for the mechanical dishwasher and it was covered with a plate lid under the gap where water was running out. During an interview on 11/12/2024 at 8:05 a.m. S7 Dietary Manager reported that she reported the problem with the mechanical dishwasher about the drainage to administration a long time ago and it still has not been fixed. During an interview on 11/12/2024 at 10:05 a.m. S3 Corporate Nurse observed the water from mechanical dishwasher and reported that it needed to be fixed. During an interview on 11/13/2024 at 2:35 p.m. S1 Administrator observed the water drainage from the mechanical dishwasher. S1 Administrator verified the water was not flowing to the sink as it should be and a blanket was placed behind the sink. S1 Administrator verified the water was also dripping on the right side of the mechanical dishwasher and verified a plate lid cover was placed over the motor of the sink due to water dripping.