STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195316	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claiborne Healthcare Center	1536 Claiborne Ave. 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 verbal abuse by a staff member for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents. 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. Definitions: Verbal abuse is defined as the use of, oral, written or gestured language that willfully includes disparaging or derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal/mental abuse include, but are not limited to, cursing, yelling, saying thing to frighten a resident, denying food or care, isolating a resident etc. Review of the facility's Self-Reported Incident Report initiated on 03/11/2025 revealed in part: Victim: Resident #1 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Accused: S4 CNA (Certified Nursing Assistant) Allegation: Verbal Abuse-substantiated Employee S4 CNA was immediately suspended pending investigation. After facility investigation substantiated allegation of verbal abuse, the employee was terminated. Review of Resident #1's medical record revealed an admitted [DATE] with a re-admission on 06/03/2024. Resident #1's diagnoses included but not limited to Post-Traumatic Stress Disorder, Schizoaffective disorder-Bipolar type, Anxiety disorder, and Major Depressive disorder. Review of Resident #1's Minimum Data Set assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status score of 15 which indicated Resident #1 was cognitively intact. Review of signed statement provided by Resident #1 on 03/11/2025 revealed in part: Resident #1 voiced to S4 CNA she did not want a dinner tray, then changed her mind and notified S4 CNA. Resident #1 voiced the S4 CNA acted as she did not hear her. Resident #1 voiced that everyone in the dining room was served except for her. Resident #1 voiced S4 CNA continued to fill the dinner cart with trays. Resident #1 voiced she was tired of waiting and went to go outside. Resident #1 reported S4 CNA was coming by with the cart as she was going out the door and S4 CNA was talking fast and yelling at her. Resident #1 voiced she shouted back and went out the door to get away. Resident #1 voiced S3 LPN (Licensed Practical Nurse) intervened and provided her dinner tray. Resident #1 voiced later as she passed S4 CNA on the hall to her room S4 CNA started yelling and talking fast saying b**** you got the right one. Review of signed statement provided by S4 CNA on 03/11/2025 revealed in part: S4 CNA voiced before dinner started Resident #1 told and her that she did not want a dinner tray. S4 CNA voiced after dinner was served and she was loading dinner carts for the hall, Resident #1 came into the dining room demanding her dinner tray. S4 CNA voiced she completed the cart and Resident #1 was headed out the door when she went to give Resident #1 her tray. S4 CNA voiced Resident #1 snapped at her. S4 CNA voiced she tried to talk to Resident #1 to let her know it was a misunderstanding. S4 CNA she left to take the cart to the hall and voiced S3 LPN told her to calm down. Review of signed statement provided by S3 LPN on 03/11/2025 revealed in part: S3 LPN voiced she was at the nurse's station when she overheard loud shouting coming from the dining area. S3 LPN voiced she walked toward the dining room door that opened to the patio and observed S4 CNA in the doorway and Resident #1 on the patio. S3 LPN reported Resident #1 yelled b**** I don't want the tray motherf***er and was yelling more that she could not understand. S3 LPN voiced S4 CNA yelled you a motherf***er and b***h too. S3 LPN voiced she asked S4 CNA and Resident #1 to please just stop talking. S3 LPN reported S4 CNA went on with the dining cart and Resident #1 remained on the patio. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/31/2025 at 12:04 p.m. S1 Administrator confirmed she was the facility's abuse coordinator. S1 Administrator reported she was notified of the verbal abuse incident regarding S4 CNA and Resident #1 by S3 LPN and S2 DON (Director of Nursing) by phone around 8:20 p.m. on 03/11/2025. S1 Administrator reported S3 LPN obtained a written statement from Resident #1 and S4 CNA and sent S4 CNA home. S1 Administrator reported she was notified S4 CNA and Resident #1 got into a cursing match in the dining room and resident smoking area after dinner was served in the dining room and trays were being sent to the halls. S1 Administrator reported she spoke with Resident #1 the next morning in her office and was notified by Resident #1 of the same. S1 Administrator reported S3 LPN noted no changes in Resident #1 and she noted no changes in Resident #1 when she spoke with her then next morning. S1 Administrator reported life satisfaction rounds were performed with no concern noted and continued weekly. S1 Administrator reported the S4 CNA was terminated 03/12/2025. During an interview on 03/31/2025 at 1:30 p.m. Resident #1 reported the incident that happened between her and S4 CNA, S4 CNA started cursing at her first. Resident #1 reported she told S4 CNA she did not want a dinner tray but changed her mind. Resident #1 reported S4 CNA started hollering and screaming at her in the dining area. Resident #1 reported she hollered and screamed back and went to the smoking patio to get away because she was embarrassed. Resident #1 reported S4 CNA came after her and S3 LPN broke it up. Resident #1 reported when she went back to her room, S4 CNA was sitting in one of the chairs on the hall and started yelling. Resident #1 reported S3 LPN sent her home and reported S4 CNA. Resident #1 reported she spoke with S1 Administrator, and S2 DON about the incident. Resident #1 reported she was fine, denied any concerns, and felt safe at the facility. During an interview on 03/31/2025 at 3:58 p.m. S3 LPN reported when the verbal abuse incident occurred after dinner between S4 CNA and Resident #1 she was at the nurses station in front of the dining area charting on the computer. S3 LPN reported during dining there was sometimes just loud talking and was not anything out of the ordinary loudness was occurring until she heard Resident #1 call S4 CNA a motherf***ing b***h*. S3 LPN reported she got up to see what was going on and saw Resident #1 headed to the smoking patio and S4 CNA stood in the door and said no you're the mother***ing b***h not me S3 LPN reported she told S4 CNA to stop and S4 CNA was talking as she went away but she could not understand her and Resident #1 remained on the smoking patio. S3 LPN reported she notified S1 Administrator of the incident. S3 LPN reported S1 Administrator told her to send S4 CNA home and S4 CNA sat in the front lobby and wrote her statement and left. S2 DON was on vacation during the time of the survey and could not be reached by phone. During a phone interview on 04/01/2025 at 3:11 p.m. S4 CNA reported Resident #1 notified her she did not want a dinner tray. S4 CNA reported Resident #1 came into the dining room after dinner was served and trays were being prepared to take to the halls and told her from across the dining room she wanted a tray. S4 CNA reported she made eye contact with Resident #1 to let her know she heard her and put her tray on top of the cart she was preparing. S4 CNA reported as Resident #1 was going out to the smoking patio she told Resident #1 she heard her the first time and had put her tray on top of the cart to bring to her. S4 CNA reported Resident #1 got loud and screamed at her. S4 CNA reported she was trying to tell Resident #1 it was all a misunderstanding. S4 CNA reported she and Resident #1 did not call each other names and she did not curse or anything like that because that would be unprofessional. S4 CNA reported the nurse came and told them not to be loud. S4 CNA reported she then took a break. S4 CNA reported she was told to write her statement and was sent home. S4 CNA reported she had not been back to the facility and confirmed she was terminated the next day. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the survey, in-service records and 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 03/11/2025 with completion date of 03/13/2025 consisted of the following: The accused, S4 CNA, was suspended on 03/11/2025 and terminated on 03/12/2025. Resident life satisfaction were performed on Resident #1 and residents who resided on Resident #1's hall and completed on 03/12/2025 with no concerns noted. Further resident life satisfaction rounds were performed on 03/20/2025 on 03/28/2025 with no concerns noted. The administrator will continue resident life satisfaction rounds weekly for 4 weeks and then monthly for 3 months. The administrator will monitor the results of life satisfaction rounds and grievance logs along with the QA committee to ensure any issues are addressed. The facility completed an in-service with staff on 03/13/2025 regarding verbal abuse prevention and response which included understanding, identifying, preventing, and reporting allegations of verbal abuse.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708 Based on record reviews and interviews the facility failed to implement written policies and procedures for 1 (Resident #1) of 2 (Resident #1, Resident #3) residents reviewed with incidents in the past 4 months. An incident report was not completed for a verbal abuse incident involving Resident #1. Findings: Review of the facility's Policy for Resident and Visitor Accident Report dated as reviewed June 2024 revealed in part: A. Procedure Reporting of Resident Incidents and Visitor Accidents: An Incident Report must be completed by the person reporting the incident or the supervisor on the shift that the incident occurred. B. Resident Incident/Accidents: 1. Licensed nurse must: e. Notify the physician family, legal representative. 5. Document in the medical record -Date and Time of Incident -Nature of injury -Circumstances surrounding the incident (FACTS ONLY) -Resident's account of the incident -Names of witnesses -Time that the physician and family were notified -Physician orders received -Condition of resident (VS, Orthostatic BPs (Blood Pressures), mental status, physical status, etc. [et cetera/and other things]) -Disposition of resident (example: transferred to hospital, etc.) -Action taken to prevent a re-occurrence (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow up documentation regarding the resident's treatment and condition -Other pertinent data Review of Resident #1's medical record revealed an admitted [DATE] with a re-admission 06/03/2024. Resident #1's diagnoses included but not limited to Post-Traumatic Stress Disorder, Schizoaffective disorder-Bipolar type, Anxiety disorder, and Major Depressive disorder. Review of Resident #1's Minimum Data Set assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status score of 15 which indicated Resident #1 was cognitively intact. Review of Resident #1's progress notes for March 2025 failed to reveal documentation of a verbal abuse incident on 03/11/2025. Review of the facility's Incidents by Incident Type report for the date range 11/01/2024 to 03/31/2025 failed to reveal an incident on 03/11/2025. During an interview on 03/31/2025 at 3:58 p.m. S3 LPN (Licensed Practical Nurse) reported she notified S1 Administrator of the verbal abuse incident involving Resident #1 on 03/11/2025 and had not completed an incident report regarding the incident. During an interview on 03/31/2025 at 4:20 p.m. S1 Administrator confirmed S3 LPN notified her of the verbal abuse incident regarding Resident #1 on 03/11/2025. S1 Administrator confirmed an incident report was not completed as per policy and should have been.