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	06/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews, the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment that promotes or enhances his or her quality of life for 1 (#6) of 6 (1, #2, #3, #4, #5, #6) sampled residents. The facility failed to ensure communication by staff was dignified and respectful while assisting Resident #6 with care. Findings:Review of the facility's Resident Rights policy (revised 04/2017) revealed:Facilities shall have a written policy on resident rights and shall post and distribute a copy of those rights. In addition to the basic civil and legal rights enjoyed by other adults, residents shall have the rights listed below. Facility policies and procedures must be in compliance with these rights. Residents shall: .b. Be treated as individuals in a manner that supports their dignity; . Review of Resident #6's medical record revealed and initial admission date of 06/17/2025 with diagnoses including, in part, acquired absence of left leg above knee, Diabetes Mellitus due to underlying condition with diabetic polyneuropathy, peripheral vascular disease unspecified, essential (primary) hypertension, other schizophrenia, and chronic combined systolic (congestive) and diastolic (congestive) heart failure. Review of Resident #6's 02/24/2026 Significant Change MDS (Minimum Date Set) revealed Resident #6 had a (Brief Interview Mental Status) of 15 which indicated intact cognition. During an interview on 04/14/2026 at 2:35 p.m. Resident #6 reported a CNA was in the room yesterday changing her and complaining of her back while providing incontinent care. Resident #6 further reported when CNA was done, she told the CNA she wanted to get back up and the CNA asked the nurse who was tending to Resident #6's roommate if she had to get Resident #6 back up. During an interview on 04/16/2026 at 2:50 p.m. S5 LPN (Licensed Practical Nurse) reported she heard Resident #6 ask to be assisted back into her wheelchair and heard S6 CNA say there was not going to be any up and down tonight, with an attitude. During a phone interview on 04/15/2026 at 10:02 a.m. S6 CNA reported on 04/13/2026 in the afternoon Resident #6 had asked to be changed and once changed, asked to get back up in wheelchair. S6 CNA further reported she asked S5 LPN if Resident #6 could stay in the bed and that it was a lot on her back getting Resident #6 in and out of bed. S6 CNA also reported S5 LPN said to get Resident #6 up and S6 CNA told S5 LPN it was on her back and not S5 LPNs back. During an interview on 04/15/2026 at 11:58 a.m. S7 CNA reported she was in Resident #6's room the afternoon of 04/13/2026 helping S5 LPN with Resident #6's roommate's care while S6 CNA was assisting Resident #6 with care. S7 CNA further reported she heard S6 CNA ask S5 LPN if she had to get Resident #6 up. During an interview on 04/16/2026 at 7:50 a.m. S2 DON (Director of Nursing) reported an investigation revealed S6 CNA's communication in front of Resident #6 was unprofessional in conduct and not respectful.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews the facility failed to ensure residents received adequate supervision to prevent elopement for 1 (#1) of 3 (#1, #2, #3) residents reviewed for elopement. The facility failed to provide adequate supervision for Resident #1 who was a known elopement risk. This deficient practice resulted in an immediate jeopardy situation for Resident #1 on 04/03/2026 at 5:31p.m., when he eloped from the facility through the front door unnoticed by staff while following visitors out of the building. Resident #1 had a history of exit seeking behaviors, had been identified as an elopement risk, and wore a wander guard ankle bracelet. Resident #1 was picked up by a local police officer about 0.9 miles from the facility on the interstate highway. Resident #1 was returned, uninjured, to the facility at approximately 6:45 p.m. on 04/03/2026. As a result of the investigation, it was determined the cause to be more than likely a staff member entered the door code in the system to deactivate the alarm but failed to ensure that a resident with a wander alert bracelet had not triggered the alarm and/or left the building. The immediate jeopardy situation ended on 04/03/2026 at approximately 6:45 p.m. when the resident was placed on every 30 minutes supervision and monitoring around the clock. Due to the facility's failed practice, residents are at risk to suffer with the likelihood of serious injury, serious harm, serious impairment or death. The deficient practice had the potential to affect 4 other residents in the facility who had been assessed as an elopement risk. 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 policy and procedure titled Wanderer Management, Monitoring System and Resident Elopement Protocol dated 07/01/2025 revealed, in part, the following:Purpose: To monitor safety of residents at risk for elopement. To provide a system to alert staff that a resident may be attempting to leave the facility.Policy: It is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible. Procedures: B.2. When a door alarm sounds, staff shall respond immediately and determined cause of the alarm. The staff member responding to the alarm shall check the outside of the building to determine if a resident has left the building.Review Resident #1's medical record revealed an admit date of 05/15/2023, with diagnoses that included, in part, memory deficit, dementia in other diseases classified elsewhere mild with other behavior disturbance, major depressive disorder recurrent, mild neuro-genitive disorder due to known physiological condition with behavioral disturbance, and gastric reflux disease.Review of Resident #1's Quarterly Wander Data Collection assessment dated [DATE] revealed Resident #1 was assessed to have a score of 22 indicating Resident #1 was high risk for wandering and was marked, yes resident verbally expressed desire to go home and yes the resident's wandering placed the resident in significant risk of getting to a potentially dangerous place such as outside the facility. Review of Resident #1's Brief Interview Mental Status Interview dated 04/07/2026 completed after his elopement revealed Resident #1 had a score of 4 indicating severely impaired cognition. Review of Resident #1's Quarterly Minimum Data Set, dated [DATE] revealed Resident #1 was assessed to have used a wander guard bracelet daily and ambulated independently.Review of Resident #1's comprehensive plan of care revealed a problem of:The resident is an elopement risk/wanderer with an initiation date of 12/04/2025 with interventions/approaches that included in part; Wander Bracelet related to wandering/exit seeking behaviors; Nurse to check placement every shift including skin check under bracelet. Location of bracelet on resident: Right Ankle. Further review revealed other interventions dated 05/24/2023 in place at the time of Resident #1's elopement included; check my location frequently, encourage me to participate in activities, engage me in diversional activities when indicated, observe me for agitation, pacing, repetitive verbalization of wanting to leave or go home, restlessness and report increased behaviors to the nurses, provide me with re-orientation as (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needed.Review of Resident #1's April 2026 Physician Orders revealed an order for a Wander Bracelet related to wandering/exit seeking behaviors; Nurse to check placement every shift, location of bracelet on resident right ankle dated 12/03/2025.Review of Resident #1's progress notes revealed the following entries: 04/03/2026 at 7:25 p.m. - This resident was brought back to the facility per local police department [at approximately 6:45 p.m.], awake alert and oriented with confused conversation noted, saying he was going home. The police officer stated that he observed resident walking the interstate highway and picked him up. He stated he asked for the resident's address and then noticed the wander guard. The police officer stated he talked to the resident's wife and she informed him the resident was at the facility and he then brought him back to the facility.Observation on 04/13/2026 at 11:00 a.m. of the facilities outside camera footage from 04/03/2026, the date of Resident #1's elopement revealed the following:5:31 p.m. Front entrance door outside camera: Three people exited the facility through the front door, Resident #1 walked out behind them, one of the visitors held the door and Resident #1 walked out. The visitors left and Resident #1 stood at the entrance door.5:33 p.m. Resident #1 turned to the entrance door and pulled on the handle in an attempt to open it, entrance door did not open. Resident #1 then walked away from the door in the direction of the east wing of the facility until he was out of camera view. 5:33:45 p.m. East wing outside camera: Resident #1 walked past the east wing door on the side walk until Resident #1 walked out of camera view.During an interview on 06/05/2026 at 4:30 p.m. S12 LPN (licensed practical nurse) reported she was working on the evening that Resident #1 eloped but was unaware of his elopement until the police came to the facility with Resident #1. S12 LPN further reported she was alerted by a CNA (certified nursing assistant) that the police were at the front entrance door and went to let the policeman in, who was a large man, and when the policeman moved aside, and Resident #1 walked forward to come inside the facility's front entrance door the alarm sounded (in response to his wander guard bracelet). S12 LPN then entered the door code to deactivate the alarm.During an interview on 04/13/2026 at 4:16 p.m. S5LPN confirmed she was assigned to Resident #1 when he eloped from the facility on 04/03/2026. S5LPN reported she last saw Resident #1 in the dining room eating dinner around 5:00 p.m. S5LPN confirmed she did not know Resident #1 had eloped until 6:45 p.m. when he was returned to the facility by a local police officer. S5LPN further reported the police officer told her Resident #1 was found walking on the interstate highway and had called Resident #1's wife. S5LPN confirmed Resident #1 did not have any injuries and his wander guard bracelet remained in place. S5LPN reported she confirmed Resident #1's wander guard bracelet was functioning. S5LPN reported Resident #1 told her he was trying to get home. During an interview on 04/14/2026 at 11:15 a.m. S9 CNA reported, she was not aware of Resident #1's elopement from the facility until she saw the police officer returning Resident #1 back to the facility. S9 CNA reported she had last saw Resident #1 during dinner, eating at the table. S9 CNA further reported Resident #1 was a wanderer and required frequent redirection and close monitoring. S9 CNA further reported after Resident #1 was returned to the facility staff went room to room and made sure all the residents were present. All staff was in-serviced on elopement, wandering and wander guard alarms and we had an elopement drill.During an interview on 04/14/2026 at 12:00 p.m. S10 CNA reported, I was sitting at the nurse's station but I didn't see Resident #1 leave out of the facility, I found out Resident #1 had eloped when the was returned by the police. S10 CNA also reported Resident #1 would often wander around the facility, confused and lost and would require redirection. S10 CNA further reported after Resident #1 eloped we were in-serviced on elopement, all the codes to the facility doors was changed and we had an elopement drill.During an interview on 04/14/2026 at 10:30 am S6 CNA confirmed she was working on the day when Resident #1 eloped from the facility. S6 CNA reported she had no knowledge of Resident #1's elopement until the police returned him to the facility. S6 CNA reported she had last saw the resident during dinner sitting at the table eating. S6 CNA further reported after Resident #1's elopement the staff on duty went room to room checking on the other resident and check all residents with wander guard bracelets to ensure they worked properly. S6 CNA confirmed Resident #1 was a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wanderer and would often get lost in the facility and required frequent redirection. During an interview on 06/05/2026 at 10:00 a.m. S16 Maintenance Director reported anyone with a wander bracelet will activate the door alarm. The alarm continues to sound once activated until someone goes to the door and enters the door code into the keypad. S16 Maintenance Director confirmed there was no other way to silence the alarm. Each door had its own alarm that will go off when a wander bracelet was near. A nurse or staff member has to go to whatever door was alarming and enter the code to silence that alarm.During an interview on 04/13/2026 at 1:45p.m. S2 DON (director of nurses) reported on 04/03/2026 around 7:00 p.m., S5LPN notified her Resident #1 had eloped from the facility. S5 LPN reported to her that the police had returned him uninjured. S5 LPN reported Resident #1 had been picked by the police walking on the interstate highway. S2 DON reported a head count of all the other residents in the facility was done to account for all the residents. Resident #1's wander-guard was checked to ensure it functioned properly, and Resident #1 was placed on every 30 minute monitoring. All wander guard bracelets in use in the facility were checked to ensure proper functioning. All staff were in-serviced on the facility's elopement policy and all door codes were changed. Statements were taken from all staff on duty on 04/03/2026. S1 Interim Administrator was notified.During an interview on 04/13/2026 at 9:00 a.m. S1 Interim Administrator confirmed Resident #1 had eloped from the facility on 04/03/2026. S1 Interim Administrator confirmed he saw Resident #1 follow visitors through the entrance door on the facilities outside camera footage. S1 Interim Administrator reported as a result of this incident the DON in-serviced department heads and staff on the facility elopement policies, maintenance director checked all doors and wander guard alarms on 04/03/2026, all facility door codes were changed. All resident assessed as wanderers and at risk for elopement care plans were updated and elopement drill were done. S1 Interim Administrator further reported putting signs at each facility door requesting visitors not to allow resident out of the facility without speaking to a nurse.During an interview on 06/05/2026 at 2:45 p.m. S8 Corporate Nurse, S13 Administrator and S2 DON, confirmed the root cause of Resident #1's elopement on 04/03/2026 was more than likely a staff member entered the door code in the system to deactivate the alarm but failed to ensure that a resident with wander alert bracelet had not triggered the alarm and/or left the building. S8 Corporate Nurse, S13 Administrator and S2 DON further confirmed all staff on duty at the time of Resident #1's elopement were interviewed and failed to confess to deactivating the alarm by entering a door code.Review of Resident #1's medical record revealed Resident #1 was discharged on 04/09/2026 to a local inpatient geriatric psychiatric facility and had not returned to the facility.Through observation, interview and record review, surveyors were able to verify that the facility has implemented the following actions to correct the deficient practice. Review of the facility's corrective actions with a completion date of 04/07/2026 revealed the following:1. Resident #1 was assessed immediately upon return to the facility on [DATE] at 6:45 p.m. by S8LPN.2. All Residents were accounted for by a head count on 04/03/2026 to ensure safety. 3. Written statements taken from all staff on duty at the time of the elopement on 04/03/2026.4. All facility doors and wander guards alarms were assessed on 04/03/2026 for proper functioning. Exit codes to all facility doors were changed. Door signs posted instructing visitors not to allow resident out of the facility doors. Door alarm codes were changed. On 04/07/2026 an inspection of the facility doors was completed by the alarm service company as requested by S16 Maintenance Director. All testing failed to indicate there was a maintenance issue with any of the facility doors.5. Resident #1 was placed on every 30 min monitoring to ensure of whereabouts from 04/03/2026 to 04/07/2026.6. All-staff in-services on the facility wandering and elopement policies, visitor interaction and reporting and response expectations were started on 04/03/2026 and completed by 04/07/2026 which included competency tests by S2 DON.7. Elopement/wander guard assessments and care plans on all residents in the facility who were at risk for elopement were updated by nursing administration by 04/06/2026.8. The facility Elopement Binder was assessed to be up to date on 04/03/2026 by S2 DON.9. Elopement Drills was conducted with all staff on 04/04/2026 and 04/07/2026 by S2 DON10. All residents monitored by S2DON/designee (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	through incident report review, observation and communication with staff for potential risk of elopement.11. Administrator to conduct elopement drill quarterly for up to a year and then biannually afterwards. 12. The Quality Assurance team will meet weekly for the next eight weeks to review compliance with the plan of action. Facility Monitoring Plan:Monitor exit door signage for placement weekly for 4 weeks (maintenance and administration).Staff education completion, one time audit by DON/staff development at 30 daysCare Plans monitored weekly for 4 weeks by DON for accuracy and updates. Door alarm functionality checks daily per facility practice daily.Door alarm functionality check daily per facility practice by nursing and maintenance.Random staff interviews for elopement awareness weekly for 4 weeks by administrator/DON. Validation of review of the facility's corrective actions revealed the following:1. Review of Resident #1's progress notes for revealed he was assessed immediately upon return to the facility on by S8LPN on 04/03/2026 at 6:45pm.2. Review of the facility investigative documentation revealed a count of all residents in the facility was done to ensure safety on 04/03/2026. All residents were accounted for.3. Review of the facility's investigative documentation revealed written statements taken from all staff on duty at the time of the elopement on 04/03/2026.4. Review of the facility's monitoring documentation initiated on 04/02/2026 revealed documentation of assessment of all facility doors and wander guards alarms on 04/07/2026 for proper functioning. Further review revealed exit codes to all facility doors were changed on 04/07/2026. Observation on 04/13/2026 at 9:00 a.m. revealed signage stating, Do not let residents out the door. Ask nurses if they are allowed to go out. Warning!! on all doors of the facility.Review of the facility's alarm service company's invoice dated 04/07/2026 revealed and confirmed the facility's doors were inspected and the door codes were changed. Services performed: changed codes on exit doors, tested wander guard on all doors, range tested good and replaced overlay on smoking door. Showed maintenance how to program the panel and change codes. All testing failed to indicate there was a service issue with any of the facility doors.5. Review of Resident #1's medical record revealed documentation of the monitoring of Resident #1's whereabouts every 30 minutes from 04/03/2026 to 04/07/2026.6. Review of the facility's training records revealed documentation of all-staff in-services done on the facility's wandering and elopement policies, visitor interaction and reporting and response expectations were started on 04/03/2026 and completed by 04/07/2026 which included competency tests by S2 DON. Review of 16 staff competency tests revealed the answer to the question: What should staff do when a door alarm sounds? was correctly marked as Respond immediately and check the outside of the building.7. Review of the medical records of residents who were at risk for elopement and had a wander guard alarm revealed care plans were documented as reviewed and up to date with problems and approaches addressing risk for elopement. Further review revealed all residents who at risk were reassessed by nursing administration by 04/06/2026.8. Review of the facility?s Elopement binder on 04/14/2026 revealed all residents who were assessed as elopement risks and who wore a wander guard bracelet were included in the elopement binder with photos.9. Review of the facility's training documentation revealed an elopement drill was conducted with all staff on 04/04/2026 and 04/07/2026.10: Review of the facility's monitoring documentation revealed monitoring of all residents for risk of elopement by S2DON/designee through incident report review, observation and communication with staff for potential risk of elopement initiated on 04/04/26.11. Review of the facility training documentation revealed documentation of on-going facility elopements drills that were held on 04/04/2026 and 04/07/2026.12. Observation on 4/13/2026 at 8:00 a.m. revealed a sign stating, Do not let residents out the door. Ask nurses if they are allowed to go out. Warning!! was posted on each facility door.13. Review of the facility training records revealed all staff in-services on the facility elopement policy and procedure was initiated on 04/04/2026 and completed on 04/07/2026 with competency examinations.14. Review of the facility monitoring revealed documentation of monitoring of resident care plans weekly for 4 weeks by DON for accuracy and updates.15. Review of the facility's maintenance documentation revealed documentation of daily door alarm checks for functionality and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	daily monitoring of sign presence. Observation on 04/14/2026 at 3:45p.m. Of the activation of the facility's door alarm in response to a resident with a wander guard alarm in close proximity confirmed functionality.16. Review of the facility's monitoring documentation revealed random staff interviews were conducted to ensure competency of the facility's elopement policies and procedures. Interviews during the survey confirmed knowledge of the facility's policies on elopement and documentation by staff. Additional interviews on 06/05/2026 with S12 LPN, S5 LPN, S14 Activities Director and S15 Social Service Assistant/CNA confirmed knowledge that the facility's policy and procedure for elopement included checking the outside of the building to determine if a resident had left the building.