

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Claiborne Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on observations, interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet resident's medical and nursing needs for 1 (#265) of 26 sampled residents. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1.) Resident #265 had an order and was care planned for left knee immobilizer and non-weight bearing to left leg. 2.) Resident #265 received diuretic as ordered by the physician due to diuretic not being reordered timely as per policy. <p>Findings:</p> <p>Review of Resident #265's medical record revealed an admitted [DATE] with diagnoses that included, in part, other fracture of left femur sequela, unspecified fracture of lower end of left femur subsequent encounter for closed fracture with routine healing, type 2 Diabetes, morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease, chronic combined systolic (congestive) heart failure, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, and chronic kidney disease unspecified.</p> <p>Review of Resident #265's 01/17/2025 Medicare 5 day MDS (minimum data set) revealed a BIMS (Brief Interview Mental Status) score of 15, which indicated Resident #265 was cognitively intact.</p> <ol style="list-style-type: none"> 1.) <p>Review of Resident #265's physician orders failed to reveal an order for left knee immobilizer and non-weight bearing to left leg.</p> <p>Review of Resident #265's care plan failed to reveal a care plan for having left knee immobilizer and non-weight bearing status.</p> <p>Review of 01/10/2025 general nurses' note indicated: . At 7:15 p.m. received resident from _____ hospital per stretcher . splint intact to left lower leg .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/27/2025 at 1:29 p.m. revealed Resident #265 wearing a full length knee immobilizer to left leg.</p> <p>During an interview on 01/27/2025 at 1:29 p.m. Resident #265 reported she had broken a few bones in the left leg and was non-weight bearing to that leg.</p> <p>Observation on 01/28/2025 at 12:51 p.m. revealed Resident #265 was lying in bed with knee immobilizer in place to left leg.</p> <p>During an interview on 01/29/2025 at 3:30 p.m. S3 DON (Director of Nursing) confirmed Resident #265 did not have a physician order for left leg knee immobilizer or non-weight bearing to left leg and should have. S3 DON confirmed Resident #265 was not care planned for having left knee immobilizer with interventions and should have been.</p> <p>2.)</p> <p>Review of Policy and Procedure Manual with revised date 10/01/2019</p> <p>Section: Medication Policies</p> <p>Subsection: Ordering and Receiving Medications from Pharmacy</p> <p>Subject: Ordering and Receiving Non-Controlled Medications revealed:</p> <p>Policy</p> <p>All medication orders will be faxed to the pharmacy or submitted via EHR using the 'MOST ORIGINAL' order. It will be the responsibility of the facility to re-order the medications to avoid any lapse in therapy.</p> <p>Procedure: .</p> <p>6. Refill Medication Ordering-Maintenance Reorders.</p> <p>B. All refills must be ordered before the last dose is administered. Reorder medications 3-4 days in advance of need to assure an adequate supply is on hand.</p> <p>Review of Resident #265's current physician orders revealed an order dated 01/15/2025 for Bumex oral tablet 1mg (milligram) (Bumetanide) - Give 2 tablets by mouth two times a day for diuretic.</p> <p>Review of Resident #265's January 2025 MAR (medication administration record) revealed Bumex oral tablet 1mg was not administered on 01/27/2025 for the 0800 and 1400 doses.</p> <p>During an interview on 01/27/2025 at 1:43 p.m. Resident #265 reported she takes Bumex twice a day and had not had a morning dose today. Resident #265 further reported the nurse told her they were out of her Bumex and she was going to order some.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/2025 at 2:15 p.m. S10 LPN (Licensed Practical Nurse) reported Resident #265's Bumex should have been ordered and was not.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897</p> <p>Based on record review, observation and interviews, the facility failed to provide services that met professional standards for 1 (#36) of 26 sampled residents. The facility failed to ensure safe oral medication administration practices by leaving medications at the bedside.</p> <p>Findings:</p> <p>Review of the facility's Medication Administration policy dated 07/08/2024 revealed in part:</p> <p>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.</p> <p>Review of Resident #36's medical record revealed an admitted [DATE] with diagnoses that include in part anxiety disorder, encephalopathy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and arthropathy.</p> <p>Review of Resident #36's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition.</p> <p>Observation on 01/27/2025 at 1:45 p.m. with S3 DON (Director of Nursing) and S4 Corporate Nurse revealed 2 medicine cups sitting on the bedside table in reach of Resident #36; first cup containing 1 blue and red capsule, 7 white tablets and 1 orange tablet and a second cup containing 2 white tablets and 10 pink tablets.</p> <p>During an interview on 01/27/2025 at 1:45 p.m. Resident #36 reported a lady brought them in and left them for him to take and he was not sure what the pills were or what they were for.</p> <p>During an interview on 01/27/2025 at 1:45 p.m. S3 DON and S4 Corporate Nurse confirmed the medications should not be left on the bedside table.</p> <p>Review of Resident #36's physician's orders failed to reveal an order for self-administration of medications.</p> <p>Review of Resident #36's evaluations failed to reveal an evaluation for self-administration of medications.</p> <p>During an interview on 01/29/2025 at 11:10 a.m. S4 Corporate Nurse acknowledged there is no evaluation or physician's order for Resident #36 to be able to keep meds at the bedside or self-administer medications.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on observation and interviews the facility failed to ensure dependent residents were provided activities of daily living (ADLs) for 1 (#47) of 26 sampled residents. The facility failed to ensure Resident #47's fingernails and toe nails were trimmed.</p> <p>Findings:</p> <p>Review of Resident #47's medical revealed an admitted [DATE] with diagnoses that included, in part, end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, paraplegia incomplete, and other intervertebral disc degeneration thoracic region.</p> <p>Review of Resident #47's care plan revealed an ADL self-care performance deficit r/t (related to) intervertebral disc degeneration, thoracic region, other cord compression, paraplegia incomplete with interventions that included, in part, personal hygiene: substantial/maximal assistance, and nail care as needed.</p> <p>Review of Resident #47's 01/04/2025 Quarterly MDS (Minimum Data Set) revealed Resident #47 had a BIMS (Brief Interview Mental Status) score of 12, which indicated a moderate cognitive impairment.</p> <p>Observation on 01/27/2025 at 8:20 a.m. revealed Resident #47's nails on bilateral hands and toenails were long, extending past the end of fingertips and extending past the end of toes.</p> <p>During an interview on 01/27/2025 at 8:20 a.m. Resident #47 reported she did not like her fingernails and toenails long and had asked staff to trim her nails but they would always come to trim her nails while she was out at dialysis so they were never trimmed.</p> <p>During an interview on 01/27/2025 at 2:35 p.m. S3 DON (Director of Nursing) and S4 Corporate Nurse observed Resident #47's fingernails and toenails and acknowledged both were long and should have been trimmed.</p>

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record reviews and interviews the facility failed to ensure residents' medical records reflected the resident's wishes for 1 (#20) of 26 residents reviewed for advance directives. The facility failed to ensure Resident #20's medical records were consistent with resident's wishes for DNR (Do Not Resuscitate).</p> <p>Findings:</p> <p>Review of undated policy titled Do Not Resuscitate Order revealed:</p> <p>Policy Statement</p> <p>Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect.</p> <p>Policy Interpretation and Implementation</p> <p>1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record.</p> <p>Review of Resident #20's medical record revealed an admitted [DATE] with diagnoses that included, in part, metabolic encephalopathy, type 2 diabetes mellitus with diabetic nephropathy, acquired absence of left and right leg above the knee, other specified peripheral vascular diseases, dementia, and functional quadriplegia.</p> <p>Review of Resident #20's LaPOST (Louisiana Physician's Orders for Scope of Treatment) signed on 12/23/2024 revealed a check beside DNR/Do not attempt resuscitation (Allow Natural Death).</p> <p>Review of Resident #20's profile header on EHR (electronic health record) failed to indicate a code status.</p> <p>Review of Resident #20's current physician orders failed to reveal an order for code status of DNR.</p> <p>Review of Resident #20's care plan revealed have decided that I am a 12/23/2024 DNR .</p> <p>Review of Resident #20's 12/11/2024 Quarterly MDS (Minimum Data Set) revealed Resident #20 had a BIMS (Brief Interview Mental Status) score of 03, which indicated a severe cognitive impairment.</p> <p>During an interview on 01/28/2025 at 4:14 p.m. S11 LPN (Licensed Practical Nurse) was asked by this surveyor where to find Resident #20's code status. S11 LPN reviewed Resident #20's EHR profile header initially and then reviewed physician orders and reported no code status was found and should have been there.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/28/2024 at 4:30 p.m. S3 DON (Director of Nursing), with S4 Corporate Nurse present, reviewed Resident #20's LaPOST and reported she would initially pull up the LaPOST and reported Resident #20 was a DNR. S3 DON acknowledged there was no order for Resident #20's code status of DNR and should be.</p> <p>During an interview on 01/28/2025 at 4:32 p.m. S4 Corporate Nurse confirmed there was not an order for Resident #20's Code status of DNR and should be.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>44414</p> <p>Based on record reviews and interviews, the facility failed to ensure all certified nursing assistant (CNA) staff had documented new hire and/or annual competency demonstrations for all skills related to their expected roles for 2 out of 5 personnel files reviewed. This had the potential to affect all 72 residents residing in the facility.</p> <p>Findings:</p> <p>Review of S6CNA's personnel file revealed S6CNA's date of hire was 08/07/2024. Further review revealed no documented evidence of any competencies being completed upon hire.</p> <p>Review of S7CNA's personnel file revealed S7CNA's date of hire was 12/06/2023. Further review revealed no documented evidence of any competencies being completed upon hire and/or annually.</p> <p>During an interview on 01/29/2025 at 9:30 a.m., S8Human Resources, reported he could not produce documentation of competencies being completed upon hire and/or annually for S6CNA and S7CNA .</p> <p>During an interview on 01/29/2025 at 10:00 a.m., S1Administrator, acknowledged skill competencies had not been completed by employees S6CNA and S7CNA prior to providing patient care and should have been.</p> <p>During an interview on 01/29/2025 at 10:30 a.m., S4Corporate Nurse reported CNA competency checks had not been completed on S6CNA and S7CNA upon hire and should have been.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193</p> <p>Based on record reviews and interviews, the facility failed to ensure residents were free from unnecessary medications for 2 (#5, #29) out of 5 (#5, #28, #29, #45, #265) residents reviewed for unnecessary medications. The facility failed to monitor Resident #5 for bleeding while receiving an anticoagulant and Resident #29 for edema while receiving a diuretic.</p> <p>Findings</p> <p>:</p> <p>Resident #5</p> <p>Review of Resident #5's medical records revealed an admitted [DATE] with the following diagnoses, including in part: cerebral infarction due to thrombosis of unspecified precerebral artery and paroxysmal atrial fibrillation.</p> <p>Review of Resident #5's physician's orders revealed an order dated 03/20/2023 for Eliquis Oral Tablet 5 mg (milligram); give 1 tablet by mouth two times a day for anticoagulant. Further review revealed an order dated 09/09/2022 for anticoagulant medication - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, and sudden changes in mental status every shift.</p> <p>Review of Resident #5's January MAR (Medication Administration Record) failed to reveal bleeding was monitored the month of January.</p> <p>During an interview on 01/29/2025 at 10:00 a.m. S5 LPN (Licensed Practical Nurse) reported Resident #29 receives an anticoagulant and confirmed bleeding had not been monitored in January and should have been.</p> <p>During an interview on 01/29/2025 at 10:05 a.m. S4 Corporate Nurse acknowledged Resident #5 was not monitored for bleeding while receiving an anticoagulant for the month of January and should have been.</p> <p>Resident #29</p> <p>Review of Resident #29's medical records revealed an admitted [DATE] with the following diagnoses, including in part: chronic systolic (congestive) heart failure and edema/unspecified.</p> <p>Review of Resident #29's comprehensive care plan revealed the resident has hypertension (HTN), CHF (congestive heart failure) - monitor for and document any edema/notify MD (medical director).</p> <p>Review of Resident #29's physician's orders revealed an order dated 01/08/2025 for Bumex oral tablet 1 mg; give 1 tablet by mouth one time a day for heart failure.</p> <p>Review of Resident #29's January MAR failed to reveal edema was monitored from January 4-21st.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/2025 at 8:50 a.m. S5 LPN reported Resident #29 has edema in her lower extremities and receives a diuretic. S5 LPN acknowledged edema was not monitored from January 4-21st.</p> <p>During an interview on 01/29/2025 at 10:05 a.m. S4 Corporate Nurse acknowledged Resident #29 was not monitored for edema from January 4-21st while receiving a diuretic and should have been.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39897</p> <p>Based on observations and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure food was stored properly to prevent cross contamination, utensils were not properly stored when not in use, freezer without a thermometer, and undated food items. This had the potential to affect the 70 residents who received food trays from the kitchen.</p> <p>Findings:</p> <p>Observation on 01/27/2025 at 6:30 a.m. during a brief tour of the kitchen revealed the following:</p> <ol style="list-style-type: none"> 1. Ground beef stored on the top shelf of freezer sitting on top of an opened box of frozen fish, directly above an open box of cookie dough and bags of frozen vegetables. 2. Flour scoop left on top of a box on a shelf above the flour bin not bagged, sugar scoop left inside the container, food serving plates and cover lids stored in an upright position. 3. Upright back-up freezer containing food items without a thermometer 4. Undated items: 1/2 gallon Pimento cheese spread, gallon Ranch dressing, gallon sweet and sour sauce, and a 32 ounce jar of lemon juice. Open and undated items: 5 pound block sliced cheese with exposed slices, sandwich size Ziploc bag of cherry pie filling, gallon bag uncooked fried squash, opened gallon cole slaw dressing, and a box containing a 5 gallon open/unsecured bag of powdered food thickener. <p>During an interview on 01/27/2025 at 7:30 a.m. S9 Dietary Manager acknowledged the above kitchen deficiencies related to professional standards for food service safety, sanitary conditions and the prevention of foodborne illness that should have been instituted prior to the survey.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>44414</p> <p>Based on record review and interviews, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee meeting included the required 6 staff members for the facility's last 2 quarterly committee meetings.</p> <p>Findings:</p> <p>Review of the facility's QAA committee sign-in sheets dated 06/12/2024 and 10/30/2024 failed to reveal S2Medical Director was in attendance.</p> <p>During an interview on 01/29/2024 at 1:40 p.m., S1Administrator acknowledged S2Medical Director or representative were not in attendance of the quarterly QAA meetings on 06/12/2024 and 10/30/2024. S1Administrator further reported she was not aware the facility's Medical Director was required to attend.</p> <p>During an interview on 01/29/2024 at 1:45 p.m., S3DON (Director of Nursing) reported S2Medical Director does not regularly attend QA meetings.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>39897</p> <p>Based on observation and interviews, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition by failing to ensure 1) dishwasher food trap was cleaned out preventing water from overflowing onto the kitchen floor, 2) refrigerator #1 was not leaking water onto the floor and 3) freezer #1 contained food items maintained at a safe temperature range to keep foods frozen. This deficiency had the potential to affect the health and safety of persons entering or working in the kitchen.</p> <p>Findings:</p> <p>Observation on 01/27/2025 at 6:30 a.m. during initial kitchen tour revealed the kitchen area with water standing approximately 1/2 inch deep and 3 feet wide at the entry door of the kitchen between the dishwasher and the steam table. Further observation revealed water pooling on the floor under refrigerator #1 extending approximately 2 feet into the floor walkway of the dry food storeroom. Observation of external temperature reading on freezer #1 revealed -5 degrees (F) Fahrenheit and internal temperature reading revealed 38 degrees F.</p> <p>During an interview on 01/27/2025 at 7:30 a.m. S9 Dietary Manager acknowledged maintenance issues with the refrigerator/freezers and dishwasher and water leakage from the dishwasher and refrigerator/freezer but had not repaired them. S9 Dietary Manager reported he was not aware of the temperature variance for freezer #1.</p> <p>During an interview on 01/29/2025 at 2:00 p.m. S12 Service Technician acknowledged there was kitchen equipment that needed repair.</p> <p>During an interview on 01/29/2025 at 3:45 p.m. S1 Administrator acknowledged the kitchen maintenance issues and reported she felt the kitchen deficiencies were more of a training issue with staff.</p>