STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195350	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Place Rehab and Nursing Center	1736 Irving Place Shreveport, LA 71101

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record review and interviews, the facility failed to ensure resident's responsible party was notified when there was a change in condition for 1 (#2) out of 4 (#1, #2, #3, #4) sampled residents. The facility failed to notify Resident #2's responsible party of an infection requiring antibiotic treatment. Findings: Review of Facility's Notification of Resident's Change in Condition (November 2019) revealed, in part: Policy Statement: This facility will promptly notify the resident, his or her Attending Physician, and Responsible Party of changes in the patient's medical/mental condition and/or status (for example (e.g.), changes in level of care, billing/payments, resident rights, etc.). Procedure: Quality of Life - notification of changes - 4. Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident, family, or responsibility party of any changes in his/her medical care or nursing treatments. 5. The Nurse Supervisor/Charge Nurse will record document the name of the responsible party that was notified of the change, date, time and response in electronic health record. Review of Resident #2's medical records revealed an admitted [DATE] and discharge date of [DATE]. Review of Resident #2's physician's orders revealed an order dated 06/22/2024 for Keflex Oral Capsule 500 mg (milligram). Give 500 mg via (by way of) PEG (Percutaneous Endoscopic Gastrostomy) - Tube three times a day - antibiotic for 7 days. Review of Resident #2's medical record failed to reveal responsible party was notified of antibiotics ordered for a urinary tract infection on 06/22/2024. During an interview on 08/27/2024 at 2:45 p.m. S2 LPN (Licensed Practical Nurse) acknowledged she made a progress note entry on 06/24/2024 for Resident #2's new order for Keflex 500 mg x 7 days and does not remember if she notified the family. S2 LPN reported it is the nurse's responsibility to notify the responsible party of any changes in the resident's condition. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 11:35 a.m. S1 DON (Director of Nursing) acknowledged Resident #2's responsible party should have been notified of antibiotics ordered for a urinary tract infection on 06/22/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives to meet residents' medical, nursing, mental and psychosocial needs for 2 (#2, #4) of 4 (#1, #2, #3, #4) sampled residents. The facility failed to ensure: 1.) Resident #2's physician orders had been followed, and 2.) Resident #4's care plan had been revised with each of Resident #4's falls Findings: Resident #2 Review of Resident #2's medical records revealed an admitted [DATE] and discharge date of [DATE] with the following diagnoses, including in part: acute respiratory failure with hypoxia, dysphagia/unspecified, encounter for attention to gastrostomy, and traumatic subdural hemorrhage without loss of consciousness/subsequent encounter. Review of Resident #2's physician's orders revealed an order dated 06/22/2024 for Keflex Oral Capsule 500 mg (milligram). Give 500 mg via (by way of) PEG (Percutaneous Esophageal Gastrostomy) - tube three times a day - antibiotic for 7 days. Review of Resident #2's June 2024 Medication Administration Record revealed Keflex 500 mg via PEG tube three times a day x 7 days was not administered on June 25th at 0600 and June 26th at 0600, 1400 and 2200. Review of Resident #2's nurse's notes revealed the following entries: - 06/24/2024 at 10:40 - received new orders from NP (Nurse Practitioner) for Keflex 500 mg PPT (per PEG tube) tid (three times a day) x 7 days .S2 LPN (Licensed Practical Nurse) - 06/26/2024 at 12:02 - spoke with pharmacy worker. Writer to refax order for Keflex 500 mg via PEG tube. During an interview on 08/28/2024 at 1:30 p.m. S4 Pharmacist reported Resident #2's Keflex 500 mg x 7 days was faxed on 06/26/2024 and sent to the facility the same day. S4 Pharmacist further reported no withdrawals of Keflex were taken out of the facility's automated medication dispensing system for Resident #2 on June 24th or June 25th. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 3:10 p.m. S1 DON (Director of Nursing) reported S2 LPN reported she did not wait for a return fax from the pharmacy on 06/24/2024 to determine if they received it. S1 DON further reported she spoke with a pharmacist at ____ and there was no activity on the facility's automated medication dispensing system on the dates of 06/24/2024 or 06/25/2024 for Resident #2 which would indicate he did not receive the antibiotic. S1 DON acknowledged there were missing doses of Keflex on June 25th at 0600 and June 26th at 0600, 1400 and 2200 and should not have been. Resident #4 Review of Resident #4's medical records revealed an admitted [DATE] with the following diagnoses, including in part: acute respiratory failure with hypoxia, burns involving 10-19% of body surface with 0% to 9% third degree burns, personal history of traumatic brain injury, post-traumatic stress disorder unspecified, and bipolar disorder. Review of Resident #4's 08/08/2024 Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed Resident #4 had a BIMS (Brief Interview Mental Status) of 15, indicating Resident #4 was cognitively intact. Further review of MDS revealed Resident #4 required extensive assistance with bed mobility and transfers and was totally dependent with toilet use. Review of Incident Log revealed Resident #4 had falls on 06/29/2024, 07/12/2024, 08/18/2024, and 08/23/2024. Review of Resident #4's comprehensive care plan failed to reveal Resident #4's care plan had been revised for Resident #4's 07/12/2024 and 08/23/2024 falls with interventions. During an interview on 08/28/2024 at 3:52 p.m. S1 DON reviewed Resident #4's incident reports for falls and comprehensive care plan and acknowledged the care plan had not been revised for the 07/12/2024 and 08/23/2024 falls and should have been.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record review, observation, and interview the facility failed to ensure residents with an indwelling catheter received appropriate care and services to prevent urinary tract infections to the extent possible for 1 (#4) of 4 (#1, #2, #3, #4) sampled residents. Findings: Review of policy and procedure reviewed/revised on 04/01/2018 titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing revealed: Purpose: The purpose of this procedure is to provide guidelines for the prevention of Catheter-Associated Urinary Tract Infections (CAUTIs). Policy Interpretation and Implementation .Steps in the procedure The following CAUTI prevention strategies have been adopted and are to be followed by clinical staff: . 6. Maintain unobstructed urine flow .c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor. Review of Resident #3's medical records revealed an admitted [DATE] with the following diagnoses, including in part: acute respiratory failure with hypoxia, acute kidney failure unspecified, quadriplegia unspecified, encounter for fitting and adjustment of urinary device, encounter for attention to colostomy, other muscle spasm, and essential hypertension. Review of Resident #3's Physician's Orders revealed an order dated 07/30/2024 for Suprapubic Cath (on admission) 18 FR (French)/cc (cubic centimeter). Insert ML (milliliter) sterile water in bulb. Use sterile catheter insertion tray and fig leaf urinary drain bag. Change monthly. Indwelling catheter assessment must be completed with each change - one time a day every 30 day(s) for change monthly. Observation on 08/28/2024 at 11:45 a.m. revealed Resident #3's urinary catheter drainage bag was hanging from Resident #3's bedframe and the drain port tubing at the bottom of bag was touching the floor. During an interview on 08/28/2024 at 11:50 a.m. S5 LPN (Licensed Practical Nurse) observed Resident #3's catheter bag and reported it was touching the floor and should not be.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40193 Based on record reviews, observations, and interviews, the facility failed to ensure received a written order from the physician for and an informed consent for bed rails prior to installation for 1 (#2) out of 4 (#1, #2, #3, #4) sampled residents. Findings: Review of Facility's Bed Rail Policy (December 5, 2017) revealed, in part: Policy Statement: It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use .The facility's priority is to ensure safe and appropriate bed rail use. It is the policy of this facility to prevent entrapment and other safety hazards associated with bed rail use . Procedure: 1. Resident Assessment - e. facility has indicated documentation that the side rail is the least restrictive alternative for the least amount of time, f. the facility will document ongoing need for the use of a bed rail, .h. obtain informed consent, i. obtain physician order for medical symptom assessed for need for bed rail use, j. resident care plan will include use of bed rails Review of Resident #2's medical records revealed an admitted [DATE] and discharge date of [DATE] with the following diagnoses, including in part: acute respiratory failure with hypoxia, encounter for attention to gastrostomy, traumatic subdural hemorrhage without loss of consciousness/subsequent encounter, agitation or psychosis, tremors, and muscle spasms. Review of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] revealed resident is rarely/never understood; severely impaired cognitive skills. Review of Resident #2's Bed Environment assessment dated [DATE] revealed - assist grab bar .is resident able to show you how they safely use the rail (s) - No. Review of Resident #2's medical records failed to reveal an informed consent and physician's order for bed rail use. During a telephone interview on 08/27/2024 at 2:20 p.m. S3 LPN (Licensed Practical Nurse) reported Resident #2 had grab bars in place on his bed. During an interview on 08/27/2024 at 2:45 p.m. S2 LPN reported Resident #2 had mobility bars on his bed. During an interview on 08/28/2024 at 11:35 a.m. S1 DON (Director of Nursing) acknowledged Resident #2 did not have an informed consent or a physician's order for a bed rail and should have.