

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30669</p> <p>Based on interviews and record reviews the facility failed to protect the residents' right to be free from sexual abuse and psychosocial harm from another resident for 3 (Resident #1, #6, #7) of 7 (Resident #1, #2, #3, #4, #5, #6, and #7) sampled residents.</p> <p>The deficient practice resulted in an Immediate Jeopardy on 12/27/2024 at approximately 2:38 a.m., when Resident #1 was approached at his bedside by Resident #2 with Resident #2's penis exposed playing with himself. Residents #6 and #7 resided in the shared resident room at the time of the event. Resident #1 was verbal and his cognition was intact. Resident #1 reported Resident #2 grabbed him by his upper arms and shoulders and he had to wrestle with Resident #2 to get away. Resident #1 reported Resident #2 asked him if he was gay and had his penis exposed, in his hand playing with it. The facility staff did not separate Resident #2 from the other residents in the shared room. Resident #2 remained in the shared room throughout the night and part of the following day with Residents #1, #6 and #7. S1 Administrator was made aware of the abuse on 12/27/2024 at approximately 8:00 a.m. when Resident #1 came to her office and reported Resident #2 had exposed himself.</p> <p>S1 Administrator and S2 DON (Director of Nursing) were notified of the Immediate Jeopardy on 01/30/2025 at 2:45 p.m.</p> <p>The Immediate Jeopardy was removed on 01/31/2025 at 12:15 p.m. The facility implemented an accepted Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to the exit.</p> <p>Findings:</p> <p>Abuse Prevention Policy (dated 9/5/16 and reviewed 11/15/22)</p> <p>Policy Statement:</p> <p>Standards:</p> <p>The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.</p> <p>The resident has the right to be free from mistreatment, neglect and misappropriation of property.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Facility has a zero-tolerance Abuse Standard regarding all proven allegations of verbal, sexual, physical, and mental, neglect</p> <p>Action</p> <p>Prevention: The abuse coordinator in the facility is the administrator.</p> <p>Reports of allegations or suspected abuse, neglect or exploitation including those involving taking photograph and video recording, using any type of equipment such as cameras, smart phones, and any other electronic devices of resident and his or her personal space on social media will be reported immediately to: Facility abuse coordinator, DON, State Agencies, Local Ombudsman office.</p> <p>5. Protect:</p> <p>Resident Protection after alleged Abuse, Neglect and Exploitation, taking, keep, share and distribute of unauthorized photograph of resident and his/her personal space in social media.</p> <p>It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed.</p> <p>Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include but not limited to:</p> <p>a) Temporary (less than 24 hours) separation from other residents if a resident's behavior poses a threat of abuse or violence.</p> <p>b) Temporary or permanent room or roommate change, where incompatibility creates the potential for abuse (follow change or room or roommate procedures)</p> <p>e) Temporary one-on-one supervision of a resident</p> <p>f) Engage a resident in diversionary activities</p> <p>g) Reassignment of nursing staff duties</p> <p>h) Time off for nursing staff</p> <p>i) Involve clergy, social services and counselors, as appropriate</p> <p>Resident #1</p> <p>Resident #1 was readmitted to the facility on [DATE] from a local hospital with diagnoses, which included in part, unspecified paraplegia, anxiety disorder, depression and post-traumatic stress disorder.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's most recent Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 15 indicating cognition was intact. Resident #1 was a paraplegic and used a wheelchair for mobility. Resident #1 required extensive assistance from 1-2 staff with bed mobility, transfers, and toileting.</p> <p>Review of Resident #1's comprehensive care plan revealed Resident #1 was care planned for the use of anti-anxiety medications relate to anxiety disorder and PTSD (Post Traumatic Stress Disorder). Some of the interventions are to give anti-anxiety medications ordered by physician and monitor/document side effects and effectiveness.</p> <p>Resident #1 was subject to an unwanted sexual advancement from resident #2. Residents #6 and #7 resided in the shared resident room at the time of the event and were not protected.</p> <p>Review of 2 videos from Resident #1's personal cell phone revealed:</p> <p>First video (dated 12/27/2024) with a start time of 2:38 a.m. - lasting 40 seconds:</p> <p>Resident #2 was standing at Resident #1's bedside facing Resident #1 while Resident #1 was lying in bed. Resident #2 was wearing a light blue denim button shirt unbuttoned with a black shirt underneath; black pants; red/black checkered underwear; underwear and pants pulled below his genitals; genitals fully exposed; Resident #2's right hand was on his own genitals. Resident #2's face fully visible in video.</p> <p>Resident #1 can be heard stating: Get the f--- away from me; gone cuz gone.</p> <p>Second video (dated 12/27/2024) moments after the first video lasting 1 min, 32 seconds:</p> <p>Resident #1 can be heard stating: Get your b -- ch a-- back; Get away [NAME] a--; Drop that sh--, drop that b--ch.</p> <p>Can hear a female voice (presumably staff) approach Resident #1 and then Resident #1 was heard saying: I didn't see him at first, I was looking at my phone, he snuck up on me; Tell her what you did; b--ch a-- tried to grab me; b--ch a-- was playing with his dick; he was standing over me asking if I'm crippled; right there by my bed looking at my phone; I was sitting on my bed and he tried to grab me because I'm crippled.</p> <p>At the end of the first video and throughout second video, the video was unsteady as Resident #1 was transferring himself from his bed to his wheelchair trying to move away from Resident #2.</p> <p>Review of Resident #2's admission photograph revealed the same clothing and face of Resident #2 in the video.</p> <p>Review of the Behavior Note dated 12/27/2024 at 3:09 a.m. by S5 RN (Registered Nurse) documented Resident #1 in hallway swinging his wheelchair arms at his roommate, Resident #2, saying, Tell them what you did B___ a___ n___! Tell them what you did. This nurse re-directed resident to calm down and go outside to get some air.</p> <p>Resident #2</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE] with the following diagnoses which included: Hypo-osmolality and hyponatremia (primary diagnosis); effusion, left wrist; chronic viral hepatitis C; cognitive communication deficit; and cannabis use, unspecified.</p> <p>Review of Resident #2's MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) of 6 which indicated severe cognitive impairment. Further review revealed Resident #2 was independent with indoor mobility. Resident #2 was marked as not using any devices such as a wheelchair, lift, or walker.</p> <p>Resident #6</p> <p>Review of Resident #6's medical record revealed an admitted [DATE] with diagnoses which included: Stroke, hemiplegia unspecified and cerebral vascular disease.</p> <p>Review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14 which indicated intact cognition and used a wheelchair for mobility.</p> <p>Resident #7</p> <p>Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses which included: chronic obstructive pulmonary disease, syncope, type 2 diabetes, and heart failure.</p> <p>Review of Resident #7's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated cognition was intact. Further review revealed Resident #7 had no range of motion impairment for bilateral lower or upper extremities. Resident #7 was independent with activities of daily living.</p> <p>Both Resident #6 and Resident #7 were interviewed on 01/30/2025 and denied knowledge of the incident on 12/27/2024.</p> <p>During an interview on 01/28/2025 at 2:00 p.m. Resident #1 reported he had PTSD and staff did not even check on him after the incident. Resident #1 reported staff told him to go outside and get some fresh air. Resident #1 reported the staff called it an argument, staff did not believe him. Resident #1 reported S2 DON said he was exaggerating and the accused resident remained in their room until after 12:00 p.m. the next day. Resident #1 reported the incident occurred on 12/27/2024 in their shared resident room while 2 other residents were in the room.</p> <p>During an interview on 01/28/2025 at 4:25 p.m. Resident #1 reported around 3:00 a.m. on 12/27/2024 one of his roommates, Resident #2, grabbed him by his upper arms and shoulders and he had to wrestle with him to get away. Resident #1 reported Resident #2 asked him if he was gay and had his penis exposed and in his hand playing with it. Resident #1 reported after the incident Resident #2 remained in the room with him. Resident #1 reported he was told to leave the room. Resident #1 reported he was not moved to another room until around noon on 12/27/2024 after his mother and his family came and moved his things to the first floor. Resident #1 reported the police attempted to interview him but he did not talk with them because he felt like no one cared. Resident #1 reported no one checked on him or asked if he was ok. Resident #1 reported it was like no one believed him.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 01/28/2025 at 3:45 p.m., S5 RN reported she worked on the night of the incident with Resident #1 and Resident #2. S5 RN reported she did not see the incident but heard Resident #1 yelling. S5 RN reported Resident #2 was standing over Resident #1 when she entered the room. S5 RN further reported Resident #1 stated Resident #2 was exposing himself. Resident #2 had no previous behaviors that she was aware of. S5 RN reported no facility employee remained with Resident #2 after the incident and Resident #2 did not receive one-on-one care after the incident. S5 RN confirmed Resident #2 remained in the room with Residents #1, #6 and #7 after the allegation of the sexual abuse was made. S5 RN reported before she left at the end of her shift around 7:00 a.m. Resident #2 remained in the same room with Residents #1, #6 and #7.</p> <p>During an interview on 01/28/2025 at 4:00 p.m., S6 ADON (Assistant Director of Nursing) reported she became aware of the incident around 3:00 a.m. on 12/27/2024 by S5 RN. S6 ADON reported when she checked on Resident #1 the morning of 12/27/2024, she saw Resident #1 coming out of the doorway of his room and Resident #2 was still in the room in the bed. S6 ADON reported Resident #2 did not say or do anything. S6 ADON reported Resident #2 was evaluated and sent to a local behavior hospital on 12/27/2024. S6 ADON reported she could not find documentation Resident #2 was placed with one-on-one monitoring after the incident. S6 ADON reported Resident #1 was still upset about Resident #2 exposing himself. S6 ADON reported Resident #1 was moved to the first floor around 12 noon on 12/27/2024.</p> <p>During an interview on 01/29/2025 at 9:07 a.m. S2 DON reported he was out sick the week of 12/27/2024 when the incident occurred. S2 DON reported Resident #2 should have been placed with one-on-one care after the incident and that would have been found in Resident #2's notes or the shift report notes. S2 DON was unable to provide any documentation that Resident #2 was placed on one-on-one monitoring after the incident occurred.</p> <p>During an interview on 01/29/2025 at 9:26 a.m. S1 Administrator reported on 12/27/2024 at 8:00 a.m. Resident #1 came to her office and reported Resident #2 had exposed himself to him during the early morning hours. S1 Administrator confirmed she was not notified of the incident until Resident #1 told her. S1 Administrator reported she should have been notified immediately and called S5 RN to find out the details about the incident with Resident #1 and Resident #2. S1 Administrator reported S5 RN got Resident #1 calmed down and Resident #2 was in bed and there were no issues. S1 Administrator confirmed Resident #1 and Resident #2 were in the same room with Resident #6 and Resident #7 until Resident #1 was moved later in the day on 12/27/2024.</p> <p>During an interview on 01/29/2025 at 12:50 p.m., S1 Administrator confirmed the facility did not have documentation of Resident #2 receiving one-on-one supervision after the incident on 12/27/2024 involving Resident #1 and Resident #2.</p> <p>During an interview on 01/29/2025 at 9:50 a.m. S7 SSD (Social Service Director) reported on 12/27/2024 she was instructed by S2 DON that she needed to do a trauma assessment for Resident #1. S7 SSD reported she was told very little about why the trauma assessment was needed. S7 SSD reported she was only made aware something had happened and she did not know what occurred. S7 SSD reported Resident #1 was emotional. S7 SSD reported Resident #1 was already being seen by their psych NP (Psychiatric Nurse Practitioner) for his diagnosis of PTSD.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of S9 Psych NP Follow-up evaluations notes dated 01/13/2025 revealed documentation of Resident #1's recent exacerbation of PTSD. Resident #1 reported recent exacerbation of PTSD symptoms after another resident at the facility reportedly exposed himself in front of him. Resident #1 reports that the other resident was lingering around him, causing his obsessive thoughts/anxiety. Resident #1 was now reporting hypervigilance and persistence of obsessive thoughts. Resident #1 also reported increase anxiety, currently taking clonazepam 0.5 mg (milligram) twice daily for anxiety treatment. Resident #1 stated increased depressive symptoms as well, currently taking Cymbalta 30 mg twice daily for depression/anxiety.</p> <p>During an interview on 01/29/2025 at 3:45 p.m., S9 Psych NP reported he had seen Resident #1 a few times after the incident on 12/27/2024. S9 Psych NP reported Resident #1 had PTSD due to gunshot wounds. S9 Psych NP reported Resident #1 had shown exacerbation of his PTSD and he was working with Resident #1 trying to adjust his medications.</p> <p>During an interview on 01/30/2025 at 10:30 a.m. S5 RN reported on 12/27/2024 she did not suspect abuse between Resident #1 and Resident #2 because she did not see it. S5 RN reported she placed a phone call to S6 ADON immediately after the incident because S6 ADON was on call for administration. S5 RN reported S6 ADON instructed her to separate them with no other instruction given. S5 RN reported she further informed S6 ADON that the situation had deescalated and both had calmed down. S5 RN reported she separated Resident #1 and Resident #2 by telling Resident #1 to go out and get some fresh air. S5 RN reported Resident #2 remained in the room along with the 2 other residents (Residents #6, and #7). S5 RN reported Resident #2 had an unsteady gait but could walk. S5 RN admitted telling Resident #1 that Resident #2 was probably using his urinal. When S5 RN was asked if Resident #2 went to the bathroom on his own, she verified Resident #2 was able to go to the bathroom on his own without assistance and he did not use a urinal. S5 RN further reported the other 2 residents, #6 and #7, remained in the room asleep during the incident and were unaware of the incident. S5 RN confirmed S6 ADON did not ask specific questions about the incident. S5 RN confirmed there was no other staff in the resident room when she left at the end of her shift at 7:00 a.m. S5 RN further reported at the end of her shift Resident #1 had returned to the shared resident room and was in his bed, Resident #2 was in his bed and the other 2 residents remained in bed.</p> <p>The facility's Plan of Removal:</p> <p>Resident #1 was the victim at the time of the event on 12/27/024 at 2:38 a.m. The perpetrator, Resident #2, was discharged from the center on 12/27/2024 at 6:08 p.m. Roommates, Resident #6 and Resident #7 had the potential to be affected since they were in the room at the time of the event and afterwards until the aggressor was discharged . To address the psychosocial/sexual abuse aspect of Resident #1, the Social Services Director completed Trauma Assessments on 12/27/2024, 12/30/2024, 01/02/2025 and 01/03/2025. The psychiatric nurse practitioner assessed Resident #1 on 12/30/2024 and 01/13/2025 to address psychiatric issues after the incident. Resident #1 will continue to see the psychiatric nurse practitioner on a monthly basis and as needed for any psychiatric concerns. Resident and staff interviews started 01/30/2025 and are in progress to identify any other residents who may have the potential to be affected.</p> <p>1. Any allegation of abuse - the center must follow the abuse/neglect policy to protect residents, effective 01/30/2025.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. If an abuse allegation is made, the abuse aggressor will be place on one-on-one with the behavior monitoring which will continue until cleared by a medical provider or until discharged , effective 01/20/2025.</p> <p>3. The Administrator and DON are responsible for ensuring that all aspects of the abuse/neglect policy are carried out and that all components, such as one-on-one documentation and behavior monitoring, are implemented, effective 01/30/2025.</p> <p>4. Administrator and Director of Nursing (DON) have been educated on abuse/neglect, the abuse/neglect policy to indicate reporting timeframes, and following all administration and reporting requirements for abuse/neglect and the follow-up of handling abuse/neglect allegations. This education occurred on 01/30/2025 by the RN, Chief Nursing Officer.</p> <p>5. Residents #6 and #7 have had trauma assessments completed on 01/30/2025 by the Social Services Director.</p> <p>Education started immediately on 01/30/2025 (see attached) to include 100% of staff and contract staff. This education will include the abuse/neglect policy with timeframes and will include initiation of the one-on-one with behavior monitoring form.</p> <p>The mode of education will be verbal in person via staff meeting as well as a voice and text message communication blast.</p> <p>The voice and text message blast communication were sent out by the Regional Administrator. The in-person staff meetings for education were/is being completed by the following staff members: RN, Director of Nursing; Associate Director of Nursing; and RN, Assistant Director of Nursing.</p> <p>All education was initiated on 01/30/2025 and will continue daily until 100% is achieved. No one will work until education has been validated as received.</p> <p>The Nursing Home Administrator or Designee will review all sign-in sheets/electronic documentation of text message communication blasts against the staff roster and contract staff roster on 01/30/2025. This will be continue until it is completed, no later than 02/03/2025. If any further staff are awaiting education, these staff will not work until their education completion has been validated.</p> <p>All new hires will receive this education prior to working.</p> <p>Ad hoc QAPI (Quality Assurance and Performance Improvement) was held on 01/31/2025 at 5:30 p.m. with Nursing Home Administrator, Director of Nursing, Management Nurses, Department Heads, Medical Director, and a floor staff licensed nurse and certified nursing assistant to discuss the systemic changes of facility practice.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30669</p> <p>Based on record reviews and interview, the facility failed to ensure an alleged violation of sexual abuse was reported immediately to the facility's administrator and to the state agency within 2 hours after the allegations were made for 1 (#1) of 7 (#1, #2, #3, #4, #5, #6 and #7) sample residents.</p> <p>Findings:</p> <p>Review of the facility's Abuse Prevention Policy last reviewed date of 11/15/2022 revealed in part:</p> <p>1. Prevention: The abuse coordinator in the facility is the administrator. Reports of allegations or suspected abuse, neglect .will be reported immediately to Facility Abuse Coordinator, Director of Nursing.</p> <p>6. Report and Investigate: (e) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made .to the administrator of the facility and to other officials (including to the State Agency .in accordance with state law).</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses, which included in part, unspecified paraplegia, anxiety disorder, depression and PTSD (post-traumatic stress disorder).</p> <p>During an interview on 01/28/2025 at 4:25 p.m. Resident #1 reported around 3:00 a.m. on 12/27/2024 one of his roommates, Resident #2, grabbed him by his upper arms and shoulders and he had to wrestle with him to get away. Resident #1 reported Resident #2 asked him if he was gay and had his penis exposed and in his hand playing with it.</p> <p>Review of 2 videos from Resident #1's personal cell phone revealed:</p> <p>First video (dated 12/27/2024) with a start time of 2:38 a.m. - lasting 40 seconds:</p> <p>Resident #2 was standing at Resident #1's bedside facing Resident #1 while Resident #1 was lying in bed. Resident #2 was wearing a light blue denim button shirt unbuttoned with a black shirt underneath; black pants; red/black checkered underwear; underwear and pants pulled below his genitals; genitals fully exposed; Resident #2's right hand was on his own genitals. Resident #2's face fully visible in video.</p> <p>Resident #1 can be heard stating: Get the f--- away from me; gone cuz gone.</p> <p>Second video (dated 12/27/2024) moments after the first video lasting 1 min, 32 seconds:</p> <p>Resident #1 can be heard stating: Get your b -- ch a-- back; Get away [NAME] a--; Drop that sh--, drop that b--ch.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Can hear a female voice (presumably staff) approach Resident #1 and then Resident #1 was heard saying: I didn't see him at first, I was looking at my phone, he snuck up on me; Tell her what you did; b--ch a-- tried to grab me; b--ch a-- was playing with his dick; he was standing over me asking if I'm crippled; right there by my bed looking at my phone; I was sitting on my bed and he tried to grab me because I'm crippled.</p> <p>During an interview on 01/28/2025 at 4:00 p.m., S6 ADON (Assistant Director of Nursing) reported she became aware of the incident around 3:00 a.m. on 12/27/2024 by S5 RN (Registered Nurse). S6 ADON acknowledged she did not report the incident that occurred on 12/27/2024 to the Administrator.</p> <p>Review of the facility's incident investigation report revealed the incident occurred on 12/27/2024 at 2:38 a.m. and the incident was not entered until 12/27/2024 at 12:09 p.m.</p> <p>During an interview on 01/29/2025 at 9:26 a.m. S1 Administrator reported she should have been notified immediately about the sexual abuse allegation with Resident #1 and Resident #2 and she was not. S1 Administrator confirmed she or S2 DON (Director of Nursing) were responsible for reporting the incident investigation report to the state agency when there was an allegation of abuse. S1 Administrator confirmed she did not enter the incident investigation report within the required time.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30669</p> <p>Based on record review and interviews the facility failed to thoroughly investigate an allegation of sexual abuse for 1 (#1) of 7 (#1, #2, #3, #4, #5, #6 and #7) sample residents.</p> <p>Findings:</p> <p>Review of the facility's Abuse Prevention Policy (dated 9/5/16 and reviewed 11/15/22) revealed in part the following:</p> <p>Policy Statement: Standards</p> <p>The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.</p> <p>The resident has the right to be free from mistreatment, neglect and misappropriation of property.</p> <p>Facility has a zero-tolerance Abuse Standard regarding all proven allegations of verbal, sexual, physical, mental, neglect</p> <p>Action</p> <p>Prevention: The abuse coordinator in the facility is the administrator.</p> <p>6. Report and Investigate: When suspicion of reports of abuse, neglect or exploitation occur, an investigation is immediately warranted.</p> <p>Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include:</p> <p>a) Interview with the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses.</p> <p>b) Interview all witnesses separately. Include roommates, residents in adjoining rooms, and staff members in the area and visitors in the area. Obtain witness statements, according to policy. All statements should be signed and dated by the person making the statement.</p> <p>c) Document the entire investigation chronologically.</p> <p>d) Notify the Local Ombudsman office to report the alleged abuse.</p> <p>Review of Resident #1 records revealed an admitted [DATE] with diagnoses, which included in part, unspecified paraplegia, anxiety disorder, depression and post-traumatic stress disorder.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/28/2025 at 4:25 p.m. Resident #1 reported around 3:00 a.m. on 12/27/2024 one of his roommates, Resident #2, grabbed him by his upper arms and shoulders and he had to wrestle with him to get away. Resident #1 reported Resident #2 asked him if he was gay and had his penis exposed and in his hand playing with it.</p> <p>Review of 2 videos from Resident #1's personal cell phone revealed:</p> <p>First video (dated 12/27/2024) with a start time of 2:38 a.m. - lasting 40 seconds:</p> <p>Resident #2 was standing at Resident #1's bedside facing Resident #1 while Resident #1 was lying in bed. Resident #2 was wearing a light blue denim button shirt unbuttoned with a black shirt underneath; black pants; red/black checkered underwear; underwear and pants pulled below his genitals; genitals fully exposed; Resident #2's right hand was on his own genitals. Resident #2's face fully visible in video.</p> <p>Resident #1 can be heard stating: Get the f--- away from me; gone cuz gone.</p> <p>Second video (dated 12/27/2024) moments after the first video lasting 1 min, 32 seconds:</p> <p>Resident #1 can be heard stating: Get your b -- ch a-- back; Get away [NAME] a--; Drop that sh--, drop that b--ch.</p> <p>Can hear a female voice (presumably staff) approach Resident #1 and then Resident #1 was heard saying: I didn't see him at first, I was looking at my phone, he snuck up on me; Tell her what you did; b--ch a-- tried to grab me; b--ch a-- was playing with his dick; he was standing over me asking if I'm crippled; right there by my bed looking at my phone; I was sitting on my bed and he tried to grab me because I'm crippled.</p> <p>During an interview on 01/30/2025 at 9:15 a.m., S3 Staffing Coordinator (as of 01/01/2025 worked in admissions) reviewed the staff schedule for 12/26/2024 to 12/27/2024 and confirmed 4 CNAs (certified nursing assistance), one RN (Registered Nurse) and one LPN (licensed Practical Nurse) worked 11 p.m. -7:00 a.m. on the second floor the night of the incident 12/26/2024 - 12/27/2024 with Resident #1 and Resident #2.</p> <p>During an interview on 01/30/2025 at 9:56 a.m., S1 Administrator reported she only interviewed two employees about the incident on 12/27/2024 with Resident #1 and Resident #2. S1 Administrator acknowledged the two employees interviewed were not working on 12/27/2024. S1 Administrator confirmed that to perform a thorough investigation, all employees working on the second floor at the time of incident, should have been interviewed and they were not. S1 Administrator acknowledged a thorough investigation was not done.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30669</p> <p>Based on record review and interviews, the facility failed to ensure pain management was provided to a resident who required such services, consistent with professional standards of practice for 1 (#4) of 5 (#1, #2, #3, #4, and #5) sampled residents reviewed for pain. The facility failed to ensure Resident #4, who reported pain after a post-surgery wound, received medication or interventions to alleviate pain.</p> <p>The deficient practice resulted in an actual harm for Resident #4 on 01/10/2025 at approximately 6:00 p.m. when Resident #4 requested pain medication for her post-surgical wound. Resident #4 requested Tylenol on the evening shift from S3 LPN (Licensed Practical Nurse). S3 LPN told Resident #4 she could not give her anything for pain. Resident #4 called 911 as a result of not getting pain medication. Resident #4 was eventually admitted to the hospital ER (emergency room ) for acute pain on 01/10/2024 where she received 2 doses of Dilaudid for acute pain.</p> <p>Findings:</p> <p>Pain Policy: Pain management Program dated 04/2022.</p> <p>Policy: The facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Evaluate the resident for pain upon admission, to include prior use of pain medication</li> <li>2. Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to: <ul style="list-style-type: none"> <li>d. Resisting care, striking out.</li> <li>f. Fidgeting, increased or recurring restlessness.</li> <li>g. Facial expressions: grimacing, frowning, fear, grinding of teeth</li> <li>h. Change in behavior: depressed mood, decreased participation in usual activities of daily living</li> <li>k. Sighing, groaning, crying, breathing heavily</li> </ul> </li> <li>3. Assessment and evaluation by the appropriate members of the interdisciplinary team may include: <ul style="list-style-type: none"> <li>a. Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident.</li> <li>h. Current prescribed pain medications, dosages and frequency</li> </ul> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>7. Non-pharmacological pain management interventions include but are not limited to:</p> <ul style="list-style-type: none"> <li>a. Adjusting room temp</li> <li>b. Smoothing linens</li> <li>c. Turning and repositioning to comfortable position</li> <li>d. Loosen any constrictive bandage or device</li> <li>e. Apply splinting (e.g., pillow or folded blanket)</li> <li>f. Physical modalities (e.g., cold compress, warm shower or bath)</li> <li>g. Exercises to address stiffness</li> <li>h. Cognitive/behavioral interventions (e.g., music, diversions, pain education)</li> </ul> <p>Review of facility policy dated 04/2022 and titled Pain Management Program, revealed the policy did not address the administration of pain medication, as ordered.</p> <p>Review of the Resident #4's medical record revealed an admitted date of 01/09/2025, with diagnoses that included, in part: Encounter for orthopedic aftercare flowing surgical amputation; acquires absence of other right toe(s); acute osteomyelitis, right ankle and foot; severe sepsis without septic shock; encounter for surgical aftercare following surgery on the circulatory system; atherosclerosis of native arteries of extremities with gangrene, right leg; peripheral vascular disease; and malignant neoplasm of endometrium.</p> <p>Review of Resident #4's Medicare 5 day MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 15 indicating intact cognition.</p> <p>Review of the Discharge MDS assessment dated [DATE] revealed Resident #4 was independent with eating, toileting hygiene and shower/bathing.</p> <p>Review of Resident #4's admission pain assessment on 01/09/2025 revealed resident was marked as having mild pain in the last 5 days.</p> <p>Review of the progress notes revealed, in part, on 01/10/2025 at 8:21 p.m. Resident #4 came to the nurses' station inquiring about pain medication which there was a problem with the medication prescription. Several attempts were made to correct the problems with no success.</p> <p>Review of the progress notes revealed, in part, on 01/10/2025 at 8:50 p.m. Resident #4 was transferred to a local hospital per ambulance per stretcher.</p> <p>Review of Resident #4's hospital medical records revealed an admitted [DATE] at 9:19 p.m. with acute pain and discharge date of [DATE]. Further review revealed Resident #4 received 2 doses of Dilaudid (pain medication) on 01/10/2025 after being admitted to the hospital. Resident #4 was discharged home from the hospital on 01/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/30/2025 at 2:50 p.m. S3 LPN recalled she worked on 01/10/2025 on the 3P-11P shift and cared for Resident #4. S3 LPN reported Resident #4 knew the staff were working on getting her pain prescription filled. S3 LPN confirmed Resident #4 did ask for a pain pill and S3 LPN explained she didn't have anything for pain. S3 LPN reported she did not ask Resident #4 what her pain level was because she was trying to send her out to the hospital per Resident #4's request, but acknowledged Resident #4 was in pain. S3 LPN further reported she could have had Tylenol but Resident #4 did not ask for it (Tylenol). When asked if Resident #4 refused Tylenol, S3 LPN replied I guess you could say that. S3 LPN reviewed the January 2025 MAR (Medication Administration Record) and confirmed Resident #4 did not receive anything for pain during her 3P-11P shift on 01/10/2025. When the surveyor reviewed the January 2025 MAR with S3 LPN and asked why there was not a documented pain level on 01/10/2025 during her 3P-11P shift, S3 LPN reported Resident #4 was discharged before med pass time and that was why a pain assessment was not done on 01/10/2025 on the 3P-11P shift.</p> <p>During a phone interview on 02/04/2025 at 12:20 p.m. Resident #4 reported she was admitted to the facility on [DATE]. She was not in great pain at the time of admit; but, she liked to keep her pain under control. Resident #4 reported she asked S3 LPN on 01/10/2025 at 6:00 p.m. for Tylenol. Resident #4 reported S3 LPN told her she could not get anything until orders were put in. Resident #4 reported she had pain at her surgical site from having metatarsals removed, and pain in her knees and her hips. Resident #4 reported, ultimately, she ended up with nothing for pain. Resident #4 reported S3 LPN triggered her and made her get irate when she told her she could not have anything for pain. Resident #4 reported feeling mad at the end. At this point, Resident #4 reported she was done with S3 LPN and called 911 to take her to the hospital. Resident #4 reported S3 LPN triggered her and it caused me to jump over the moon; she caused me to get irate. Resident #4 reported around 8:00 p.m. on 01/10/2025 the ambulance service picked her up from the facility and took her to the ER per her request because she had not received anything for pain and she was in pain. When the surveyor asked about Resident #4's pain level at the time she left the facility, on a scale of 0-10, Resident #4 reported her pain level was about a 6.</p> <p>During an interview on 01/30/2025 at 3:10 p.m. S2 DON (Director of Nursing) acknowledged Resident #4 did not receive pain medication and should have received something for pain.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>30669</p> <p>Based on interviews and record reviews, 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 #1) of 7 (#1, #2, #3, #4, #4, #5, #6, and #7) residents.</p> <p>The deficient practice resulted in an Immediate Jeopardy on 12/27/2024 at approximately 2:38 a.m., when Resident #1 was approached at his bedside by Resident #2 with Resident #2's penis exposed playing with himself. Residents #6 and #7 resided in the shared resident room at the time of the event. Resident #1 was verbal and his cognition was intact. Resident #1 reported Resident #2 grabbed him by his upper arms and shoulders and he had to wrestle with Resident #2 to get away. Resident #1 reported Resident #2 asked him if he was gay and had his penis exposed, in his hand playing with it. The facility staff did not separate Resident #2 from the other residents in the shared room. Resident #2 remained in the shared room throughout the night and part of the following day with Residents #1, #6 and #7. S1 Administrator was made aware of the abuse on 12/27/2024 at approximately 8:00 a.m. when Resident #1 came to her office and reported Resident #2 had exposed himself.</p> <p>S1 Administrator and S2 DON (Director of Nursing) were notified of the Immediate Jeopardy on 01/30/2025m at 2:45 p.m.</p> <p>The Immediate Jeopardy was removed on 01/31/2025 at 12:15 p.m. The facility implemented an accepted Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit.</p> <p>Findings:</p> <p>Cross Reference F600</p> <p>During a phone interview on 01/28/2025 at 3:45 p.m., S5 RN (Registered Nurse) reported no facility employee remained with Resident #2 after the incident on 12/27/2024 and Resident #2 did not receive one-on-one care after the incident. S5 RN confirmed Resident #2 remained in the room with Residents #1, #6 and #7 after the allegation of the sexual abuse was made. S5 RN reported before she left at the end of her shift around 7:00 a.m. Resident #2 remained in the same room with Residents #1, #6 and #7.</p> <p>During an interview on 01/28/2025 at 4:00 p.m., S6 ADON (Assistant Director of Nursing) reported she became aware of the incident around 3:00 a.m. on 12/27/2024 by S5 RN. S6 ADON reported when she checked on Resident #1 the morning of 12/27/2024, she saw Resident #1 coming out of the doorway of his room and Resident #2 was still in the room in the bed. S6 ADON reported Resident #2 did not say or do anything. S6 ADON reported she could not find documentation Resident #2 was placed with one-on-one monitoring after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/2025 at 9:07 a.m. S2 DON reported Resident #2 should have been placed with one-on-one care after the incident and that would have been found in Resident #2's notes or the shift report notes. S2 DON was unable to provide any documentation that Resident #2 was placed on one-on-one monitoring after the incident occurred.</p> <p>During an interview on 01/30/2025 at 10:30 a.m. S5 RN confirmed there was no other staff in the resident room when she left at the end of her shift at 7:00 a.m. on 12/28/2024. S5 RN further reported at the end of her shift, Resident #1 had returned to the shared resident room and was in his bed, Resident #2 was in his bed and the other 2 residents remained in bed.</p> <p>During an interview on 01/29/2025 at 9:26 a.m. S1 Administrator reported on 12/27/2024 at 8:00 a.m. Resident #1 came to her office and reported Resident #2 had exposed himself to him during the early morning hours. S1 Administrator confirmed she was not notified of the incident until Resident #1 told her. S1 Administrator reported she should have been notified immediately and called S5 RN to find out the details about the incident with Resident #1 and Resident #2. S1 Administrator confirmed Resident #1 and Resident #2 were in the same room with Resident #6 and Resident #7 until Resident #1 was moved later in the day on 12/27/2024.</p> <p>During an interview on 01/29/2025 at 12:50 p.m., S1 Administrator confirmed the facility did not have documentation of Resident #2 receiving one-on-one supervision after the incident on 12/27/2024 involving Resident #1 and Resident #2.</p> <p>During an interview on 01/30/2025 at 9:56 a.m. S2 DON reported he was responsible for overseeing all staff are trained on the abuse/neglect policy including recognizing signs, investigations, protection, and reporting procedures.</p> <p>During an interview on 01/30/2025 at 9:56 a.m. S1 Administrator acknowledged she was responsible for providing oversight of the facility's abuse/neglect policy including reporting timeframes, one on one monitoring and making sure staff was educated on the necessary steps to ensure the safety and well-being of all resident.</p> <p>The facility's Plan of Removal:</p> <p>Resident #1 was the victim at the time of the event on 12/27/2024 at 2:38 a.m. The perpetrator, Resident #2, was discharged from the center on 12/27/2024 at 6:08 p.m. Roommates, Resident #6 and Resident #7 had the potential to be affected since they were in the room at the time of the event and afterwards until the aggressor was discharged. Resident and staff interviews started 01/30/2025 and are in progress to identify any other residents who may have the potential to be affected.</p> <p>1. Any allegation of abuse - the center must follow the abuse/neglect policy to protect residents, effective 01/30/2025.</p> <p>2. If an abuse allegation is made, the abuse aggressor will be placed on one-on-one with the behavior monitoring which will continue until cleared by a medical provider or until discharged, effective 01/20/2025.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. The Administrator and DON are responsible for ensuring that all aspects of the abuse/neglect policy are carried out and that all components, such as one-on-one documentation and behavior monitoring, are implemented, effective 01/30/2025.</p> <p>4. Administrator and Director of Nursing (DON) have been educated on abuse/neglect, the abuse/neglect policy to indicate reporting timeframes, and following all administration and reporting requirements for abuse/neglect and the follow-up of handling abuse/neglect allegations. This education occurred on 01/30/2025 by the RN, Chief Nursing Officer.</p> <p>5. Residents #6 and #7 have had trauma assessments completed on 01/30/2025 by the Social Services Director.</p> <p>Education started immediately on 01/30/2025 (see attached) to include 100% of staff and contract staff. This education will include the abuse/neglect policy with timeframes and will include initiation of the one-on-one with behavior monitoring form.</p> <p>The mode of education will be verbal in person via staff meeting as well as a voice and text message communication blast.</p> <p>The voice and text message blast communication were sent out by the Regional Administrator. The in-person staff meetings for education were/is being completed by the following staff members: RN, Director of Nursing; Associate Director of Nursing; and RN, Assistant Director of Nursing.</p> <p>All education was initiated on 01/30/2025 and will continue daily until 100% is achieved. No one will work until this education has been validated as received.</p> <p>All new hires will receive this education prior to working.</p> <p>Ad hoc QAPI (Quality Assurance and Performance Improvement) was held on 01/31/2025 at 5:30 p.m. with Nursing Home Administrator, Director of Nursing, Management Nurses, Department Heads, Medical Director, and a floor staff licensed nurse and certified nursing assistant to discuss the systemic changes of facility practice.</p> <p>Starting the week of 02/03/2025, the center social service director or designee will interview five residents weekly for four weeks to ask about abuse and follow up. The abuse interview monitoring process will continue after the initial four weeks monthly for three months. The results of these audits will be brought to the quality assurance/performance improvement committee to ensure all processes are followed and to ensure continued compliance. If it is determined that processes are not followed, the center will perform a 100% re-education of all staff and follow up directly with the responsible at the time of the incident.</p> <p>Administrative oversight of the process will be completed by the Nursing Home Administrator and the Director of Nursing. As of 01/30/2025 and ongoing, the Regional Director Clinical Operations will provide oversight of the Nursing Home Administrator and Director of Nursing administrative oversight by reviewing and providing feedback on allegations of abuse and providing further supervision and training as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 01/30/2025.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30669</p> <p>Based on record reviews and interviews, the facility failed to ensure medical records were accurately documented for 1 (Resident #2) of 7 (Resident #1, #2, #3, #4, #5, #6, and #7) sampled residents. The facility failed to have documentation of a physician's discharge order.</p> <p>Findings:</p> <p>Review of Resident #2's record revealed an admitted [DATE] and a discharge date of [DATE].</p> <p>Review of Resident #2's medical record revealed the following diagnoses which included but not limited to: Pain in left wrist, chronic viral hepatitis C, cognitive communication deficit, cannabis use, unspecified.</p> <p>Review of Resident #2's MDS (Minimum Data Set) revealed a BIMS (Brief Interview of Mental Status) of 06 indicated severe impaired cognition.</p> <p>Review of Resident #2's physician orders failed to reveal a discharge order to the hospital on 12/27/2024.</p> <p>During an interview on 01/20/2025 at 3:20 p.m. S6 ADON (Assistant Director of Nursing) reported she could not locate the discharge order for Resident #2. S6 ADON reported she was responsible for taking the order and misplaced the verbal order from the physician. S6 ADON acknowledged there was not a system in place for taking verbal orders.</p>		