

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Old Brownlee Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4680 Old Brownlee Rd Bossier City, LA 71111	
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867</p> <p>Based on record reviews, policy reviews, and interviews, the facility failed to ensure an allegation of physical abuse was reported to the State Agency within the required timeframe for 1 (#1) of 5 (#1, #2, #3, #4, #5) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's Abuse Components Plan Elder Justice Act and Affordable Care Act (Original effective date 09/11/2018, Revision #5 effective date 10/24/2022) policy revealed in part: All alleged violations involving abuse will be reported by the Administrator or designee to the Statewide Incident Tracking System (SIMS) (required) .All alleged violations involving abuse will be reported immediately, but no later than Two (2) hours if the alleged violation involves abuse. Immediately means as soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .</p> <p>Review of Resident #1's record revealed an admitted [DATE] and diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, generalized weakness, unspecified anxiety disorder, major depressive disorder, contracture left shoulder, left forearm, left hand, and left knee.</p> <p>Review of Resident #1's Significant Change MDS (Minimum Data Set) assessments with ARD (Assessment Reference Date) of 04/01/2024 revealed the resident had a BIMS score (Brief Interview for Mental Status) of 5 out of 15 indicating severe cognitive impairment. Further review of Resident #1's functional status revealed the resident was totally dependent on staff for activities of bed mobility, transfers, and toileting, with functional limitations in range of motion on one side for upper and lower extremities.</p> <p>Review of incident report for Resident #1 dated 04/10/2024 at 00:20 a.m. by S4 LPN (Licensed Practical Nurse) revealed in part: Writer was about to enter another resident room. Heard S6 CNA come out Resident #1's room yelling I'm not scared of him he not going to swing on me. Writer asked what happened and she said you better go talk to him. I'm not S8 CNA. Writer entered room noticed Resident #1's right nostril bleeding with two abrasion above upper lip. When asking resident what happened he stated she beat me up and I don't want her in my room Writer ask what happened he stated she jumped me and beat me up I want to speak with S3 ADON she can't come in here no more Writer advised S6 CNA not to go in room.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Nursing Note by S7 Hospice RN (Registered Nurse) revealed in part: S3 ADON (Assistant Director of Nursing) reported to hospice RN that there was an allegation of abuse with this patient which occurred the night of 04/09/2023, and it was reported that a CNA had hit patient and caused patient to have a bloody nose and scratches on his face.</p> <p>Review of the Statewide Incident Tracking System report revealed the allegation was not reported to the State Agency until 04/10/2024 at 7:35 a.m.</p> <p>During an interview on 04/22/2024 at 9:52 a.m. Resident #1 was asked if any staff members were mean to him or had hurt him, making his nose bleed. Resident #1 replied I don't know anything about that, the nurses know.</p> <p>During a repeat interview on 04/23/2024 at 11:38 a.m. Resident #1 said he remembered telling this surveyor yesterday that he didn't know anything about anyone hitting him. He then smiled and laughed and said S6 CNA stood on my right side then moved to my left side and started hitting me in the nose and it bled.</p> <p>During an interview on 04/22/2024 at 3:15 p.m. S1 Administrator indicated the State Agency was not notified via the SIMS system of Resident #1's allegation of abuse until 04/10/2024 at 7:35 a.m. S1 Administrator confirmed the State Agency should have been notified within 2 hours of staff becoming aware of the allegation of abuse and was not.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867</p> <p>Based on record review and interviews, the facility failed to protect 5 (#1, #2, #3, #4, #5) of 5 sampled residents investigated for abuse from the potential of further abuse during the investigation process of an allegation of physical abuse. The facility failed to remove S6 CNA (Certified Nursing Assistant) from duties involving resident care after Resident #1 alleged S6 CNA had hit him. This deficient practice had the potential to affect all of the residents in the building.</p> <p>Findings:</p> <p>Abuse Components Plan Elder Justice Act and Affordable Care Act (Original effective date 09/11/2018, Revision #5 effective date 10/24/2022) in part:</p> <p>The Administrator or designee will immediately ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. If the alleged perpetrator is an employee or staff member, the individual is immediately reassigned to duties that do not involve resident contact or are suspended until the findings of the investigation have been reviewed by the Administrator or their designee. Immediately means as soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .</p> <p>Review of Resident #1's record revealed an admitted [DATE] and diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, generalized weakness, unspecified anxiety disorder, major depressive disorder, contracture left shoulder, left forearm, left hand, and left knee.</p> <p>Review of Resident #1's Significant Change MDS (Minimum Data Set) assessments with ARD (Assessment Reference Date) of 04/01/2024 revealed the resident had a BIMS score (Brief Interview for Mental Status) of 5 out of 15 indicating severe cognitive impairment. Further review of Resident #1's functional status revealed the resident was totally dependent on staff for activities of bed mobility, transfers, and toileting, with functional limitations in range of motion on one side for upper and lower extremities.</p> <p>Review of incident report for Resident #1 dated 04/10/2024 at 00:20 a.m. by S4 LPN (Licensed Practical Nurse) revealed in part: Writer was about to enter another resident room. Heard S6CNA come out Resident #1's room yelling I'm not scared of him he not going to swing on me. Writer asked what happened and she said you better go talk to him. I'm not S8 CNA. Writer entered room noticed Resident #1's right nostril bleeding with two abrasion above upper lip. When asking resident what happened he stated she beat me up and I don't want her in my room Writer ask what happened he stated she jumped me and beat me up I want to speak with S3 ADON (Assistant Director of Nursing) she can't come in here no more Writer advised S6 CNA not to go in room. Immediate Action Taken: S6 CNA notified to not enter resident room anymore until situation is cleared.</p> <p>Review of Resident #1's Nursing Note by S7 Hospice RN (Registered Nurse) revealed in part: S3 ADON (Assistant Director of Nursing) reported to hospice RN that there was an allegation of abuse with this patient which occurred the night of 04/09/2023, and it was reported that a CNA had hit patient and caused patient to have a bloody nose and scratches on his face.</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 - Some</p>	<p>During an interview on 04/22/2024 at 9:52 a.m. Resident #1 was asked if any staff members were mean to him or had hurt him making his nose bleed. Resident #1 replied I don't know anything about that, the nurses know.</p> <p>During a repeat interview on 04/23/2024 at 11:38 a.m. Resident #1 said he remembered telling this surveyor yesterday that he didn't know anything about anyone hitting him. He then smiled and laughed and said S6 CNA stood on my right side then moved to my left side and started hitting me in the nose and it bled.</p> <p>During an interview on 04/23/2024 at 6:21 a.m. S4 LPN indicated she did not send S6 CNA home after Resident #1 alleged she hit him on 04/09/2024 because she didn't know she should have. S4 LPN further reported she just told S6 CNA not to go back in Resident #1's room, and she swapped assignments with another CNA.</p> <p>During an interview on 04/23/2024 at 6:41 a.m. S5 LPN indicated she was working with S4 LPN on the night of 04/09/2024. S5 LPN indicated S4 LPN had asked her to witness her assessment of Resident #1 after he alleged S6 CNA had hit him and made his nose bleed. S5 LPN reported when she entered Resident #1's room on 04/09/2024 at around midnight his nose was bleeding and he told her the bitch jumped on me and punched me in the face, and S6 CNA was immediately told not to go back in the room. S5 LPN reported she and S4 LPN were told by S2 DON during a phone call on 04/10/2024 at around 6:30 a.m. that they should have immediately suspended S6 CNA and sent her home as soon as they learned of Resident #1's allegations. S5 LPN reported they did not know they should have sent S6 CNA home, and had only removed her from working with Resident #1.</p> <p>During an interview on 04/23/2024 at 8:05 a.m. S6 CNA reported when she went in to check on Resident #1 on 04/09/2024 a little before midnight he was wet, but when I told him I needed to change him he started swinging his right arm all over the place. I went ahead and changed him and then left the room to tell the nurse he was swinging at me and she needed to check on him, and then I went to check on another resident. S4 LPN came back out and told me Resident #1's nose was bleeding, and he said I had hit him. She told me not to go back in his room, then she went and got S5 LPN from the other hall. S6 CNA confirmed she swapped care of Resident #1 with another CNA and continued to work with other residents until she was suspended at around 7:00 a.m. on 04/10/2024.</p> <p>During an interview on 04/22/2024 at 11:21 a.m. S2 DON (Director of Nursing) Indicated S4 LPN (Licensed Practical Nurse) tried to call her on 04/10/2024 at 1:01 a.m., but she was asleep and did not answer the call. When she woke up the morning of 04/10/2024 and saw she had a missed call, she called the nurse back at 6:32 a.m. S4 LPN told her S6 CNA came out of Resident #1's room at around midnight saying he's not gonna talk to me like I'm S8 CNA. S4 LPN conveyed to her she went into Resident #1's room and his nose was bleeding and he was saying S6 CNA had hit him. S4 LPN reported she told S6 CNA not to go back into Resident #1's room. I asked her if she had contacted S1 Administrator when she couldn't reach me, and she had not, so we added S1 Administrator to the call and explained to her what was going on. I told them S6 CNA needed to go home, and she was suspended pending investigation. S2 DON further confirmed S6 CNA had been allowed to continue her shift with resident care and should not have been. S1 DON indicated S6 CNA should have been suspended immediately pending the outcome of the investigation.</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 - Some</p>	<p>During an interview on 04/22/2024 at 3:15 p.m. S1 Administrator confirmed S6 CNA should have been suspended immediately after staff was notified of Resident #1's allegation of abuse and was not. S1 Administrator further confirmed S6 CNA was allowed to continue working with residents for the remainder of her shift and should not have been.</p>		