

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Magnolia Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1411 Claiborne Avenue 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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921</p> <p>Based on record review, surveillance video review, and interviews, the facility failed to protect the resident's right to be free from physical abuse and psychosocial harm by staff for 1 (#3) of 3 (#1, #2, #3) sampled residents.</p> <p>The actual harm resulted for Resident #3, who was cognitively impaired, on 07/04/2024 at approximately 7:33 p.m. when S7 Sunshine Aide was observed on surveillance video physically abusing Resident #3. S7 Sunshine Aide was observed hitting Resident #3 on her hands and forearm with a hard plastic kitchenware cup. Because this type of inappropriate, unwanted physical abuse would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in Resident #3's position would have experienced severe psychosocial harm-dehumanization, and humiliation- as a result of the physical abuse.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>Review of facility's Abuse/Neglect policy statement (revision date 12/11/2018) revealed in part: This facility will not condone any form of resident abuse or neglect. Each resident residing on the facility has the right to be free from verbal, sexual, mental, and physical abuse, including corporal punishment and involuntary seclusion, and use of photographs or recordings in any manner that would demean and humiliate a resident (s). Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Each resident also has the right to be free from mistreatment, neglect and misappropriation of property.</p> <p>1. Abuse- the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p> <p>6. Physical Abuse - includes hitting, slapping, pinching, and kicking. Additionally, it includes acts of corporal punishment to control behavior.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's medical record revealed an admitted [DATE] with medical diagnoses including, but not limited to Medical Diagnoses: generalized osteoarthritis unspecified diastolic (congestive) heart failure, type 2 DM (Diabetes Mellitus), vascular dementia with behavioral disturbances, chronic pain, long term insulin use, schizoaffective disorder/bipolar type, muscle wasting and atrophy multiple sites, right shoulder/ left shoulder, right lower leg, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, visual hallucinations, restlessness and agitation, schizophrenia.</p> <p>Review of Resident #3's Quarterly MDS (Minimum Data Set) dated 05/29/2024 revealed a BIMS (Brief Interview for Mental Status) of 5 out of 15 indicating severely impaired cognition. Further review of Resident #3's Quarterly MDS revealed no functional limitation in range of motion to upper or lower extremity.</p> <p>Review of Resident #3's Comprehensive Care Plan revealed:</p> <p>Behavior: verbally aggressive toward staff and other residents with interventions to talk calm voice when behavior is disruptive, remove from public area when behavior is disruptive and unacceptable, reinforce unacceptability of verbal abuse, monitor for target behaviors, do not argue with resident, discuss options for appropriate channeling of anger</p> <p>Thought process impaired: Impaired cognition related to diagnosis of dementia with behavioral disturbances.</p> <p>Resident has a history of visual hallucinations. Resident has a history of sun downing in evening times with interventions to administer medications as ordered, anticipate needs, approach in a calm manner, ask simple direct questions, call light within reach, calmly talk with resident and offer reassurance prior to care.</p> <p>Review of Resident #3's July 2024 Physician Orders revealed:</p> <p>10/18/2021: Namenda 10 mg tablet. Give one tab by mouth twice daily.</p> <p>10/30/2020: Monitor for behaviors and side effects -is on psychotropic medications</p> <p>Review of facility's incident investigation report revealed an altercation on 07/04/2024 with Resident #3 and S7 Sunshine Aide. Resident #3 in her wheelchair went up to the coffee cart, grabbed two empty coffee cups and threw them at S7 Sunshine Aide when she came out of a room. This occurred when they were approximately 3-4 feet apart. S7 Sunshine Aide reacted, she stated to protect herself. S7 Sunshine Aide said she was trying to knock the other cup out of her hand. They were both swinging their arms in front of them, and S7 Sunshine Aide appeared to make contact with Resident #3's arm 2-3 times.</p> <p>Review of the date and time stamped surveillance video with S1 Administrator revealed on 07/04/2024:</p> <p>7:33:04: Coffee cart on the hall with hard plastic kitchenware cups on top of the cart.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>7:33:08: Resident #3 exited her room in her wheel chair and continued toward the cart with cups and silverware.</p> <p>7:33:26-30: Resident #3 continued down the hall way, picked up 1 cup with her left hand and 2 cups with her right hand off the coffee cart.</p> <p>7:33:34: S5 RN (Registered Nurse) came out of another resident room and attempted to redirect Resident #3 to put the cups back on the coffee cart. Attempt was unsuccessful as Resident #3 was moving her mouth appearing to be talking and did not return the cups to the cart. The video did not have sound.</p> <p>7:33:39: S7 Sunshine Aide exited another room across the hall with a cup in her right hand and walked around the cart to Resident #3. Resident #3 had cups in both her right and left hands with her right hand raised. S7 Sunshine Aide had a cup in her right hand with her right hand raised.</p> <p>7:33:43: As S7 Sunshine Aide walked closer to Resident #3, Resident #3 begin to swing her right hand holding 2 cups and S7 Sunshine Aide moved to dodge the swing of Resident #3. S7 Sunshine Aide was also swinging at Resident #3 with a cup in her right hand. Both S7 Sunshine Aide and Resident #3 continued to swing at each other as cups fell from Resident #3 hands. S7 Sunshine Aide still had cups in her right hand and made contact with Resident #3's hands and forearm.</p> <p>7:33:48: S7 Sunshine Aide pushed the other cups on the cart and walked away from Resident #3. Resident #3 attempted to pick up silverware and cups that were on the floor as the video ended.</p> <p>Review of S5 RN (Registered Nurse), nursing note dated 07/09/2024 at 5:59 p.m. (late entry): Resident #3 in wheelchair in hall when she saw S7 Sunshine Aide picking up silverware. Resident #3 rolled over to her cart and picked up silverware and started to throw them at S7 Sunshine Aide; but dropped some. S7 Sunshine Aide picked them up. Resident #3 was cursing and making threats and attempted to throw silverware at S7 Sunshine Aide. S7 Sunshine Aide came out of room with arms raised in order to guard her face. Resident #3 continued to yell at S7 Sunshine Aide as S7 Sunshine Aide was working in another resident room. Writer attempted to calm res down when S7 Sunshine Aide stepped close and begin to attempt to hit resident.</p> <p>Addendum nursing note by S5 RN dated 07/11/2024 at 1:46 p.m. revealed a late entry for 07/04/2024 when the above incident occurred. S8 Physician was notified and attempted to notify responsible party and S7 Sunshine Aide was sent home. A body audit was completed with another nurse and no injuries found.</p> <p>During an interview on 07/23/2024 at 4:21 p.m. S5 RN reported she was in another resident's room on the night of 07/04/2024. Resident #3 was throwing a cup of silverware and S7 Sunshine Aide got upset. S5 RN reported Resident #3 and S7 Sunshine Aide were separated and S7 Sunshine Aide was told to clock out and go home. Resident #3 was assessed with no injuries.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/23/2024 at 4:45 p.m. S6 CNA (Certified Nurse Assistant) reported she did not see the beginning. S6 CNA reported she was in the breakroom when she heard lots of noise and commotion. S6 CNA reported she walked to the end of the hall and witnessed S7 Sunshine Aide swinging at Resident #3 who was in the hallway, in her wheel chair. Resident #3 and S7 Sunshine were swinging at each other. S6 CNA reported S7 Sunshine Aide did hit Resident #3 on the arm. S6 CNA reported she also heard Resident #3 say you hit me.</p> <p>During an interview on 7/23/2024 at 3:50 p.m. S4 Assistant Administrator reported the administrator was out of town when the incident occurred on 07/04/2024. S4 Assistant Administrator reported she started the facility's incident investigation report after being notified on 07/04/2024 around 8:15 p.m. by S2 DON (Director of Nursing) of an altercation and S4 Assistant Administrator needed to come to the facility to view the surveillance video. S4 Assistant Administrator reported she then watched the surveillance video and the footage showed S7 Sunshine Aide did hit Resident #3's arm. S4 Assistant Administrator reported the authorities were notified, Resident #3's responsible party was also notified. S4 Assistant Administrator reported Resident #3 was interviewed. S4 Assistant Administrator reported during the interview with Resident #3, Resident #3 stated the girl hit my arm. S4 Assistant Administrator reported when she arrived to the facility S7 Sunshine Aide had already left and did not answer telephone calls.</p> <p>During an interview on 07/24/2024 at 10:00 a.m. Resident #3 reported staff was nice to her. Resident #3 denied being scared or fearful at the facility. Resident #3 was unable to recall S7 Sunshine Aide.</p> <p>During an interview on 07/25/2024 at 10:00 a.m. S3 ADON (Assistant Director of Nursing) reported on 07/05/2024 S7 Sunshine Aide came straight to the S3ADON's office after clocking in. S3 ADON reported asking S7 Sunshine Aide to provide details of the incident but S7 Sunshine Aide was not able to explain what happened. S3 ADON reported she informed S7 Sunshine Aide that the S1 Administrator and S4 Assistant Administrator would also like to speak to her and walked S7 Sunshine to the front foyer to wait on the S1 Administrator and S4 Assistant Administrator. S3 ADON reported S7 Sunshine Aide left the facility and they have not been able to make contact with her. S3 ADON reported Resident #3 was being seen by a behavioral health nurse practitioner and was care planned for aggressive behaviors. S3 ADON reported at times Resident #3 is not easily redirected and staff should walk away.</p> <p>Attempted telephone interview with S7 Sunshine Aide on 07/25/2024 at 1:00 p.m. telephone call went to voicemail.</p> <p>During an interview on 07/25/2024 at 2:30 p.m. S9 NP (Nurse Practitioner) reported Resident #3 had aggressive behaviors and received a report of an incident on 07/04/2024. Resident #3 was assessed on 07/05/2024 and S9 NP ordered lab, urine and changed her medications. S9 NPs Assessment found no injuries and Resident#3 had not been withdrawn or appeared fearful since incident. S9 NP reported the behavioral health nurse practitioner would have followed up with Resident #3's medications.</p> <p>Attempted telephone interview with S10 Behavioral Health NP on 07/25/2024 at 4:00 p.m Office staff reported S10 Behavioral Health NP was not in the office, message left with office staff.</p> <p>Multiple observations during survey revealed Resident #3 ate lunch in dining room with other residents. Observations during survey revealed Resident #3 was talkative with other residents and staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the survey, in-service records and QA (Quality Assurance) monitoring records were reviewed, and it was determined that the facility had implemented the following actions to correct the deficient practice.</p> <p>Review of facility's Performance Improvement Plan revealed the following with a completion date of 7/11/2024:</p> <p>Topic: Abuse/ Neglect</p> <p>Areas identified as needing improvement: knowing de-escalation tactics and dealing with burnout</p> <p>Plan implementation:</p> <ol style="list-style-type: none"> 1. Abuse-Neglect monitoring was started on 07/05/2024 and in-service (Abuse and Neglect) with all staff 2. 07/05/2024 census was pulled, care plan nurse ask residents the attached questions. All staff were given test regarding abuse and neglect. 3. 07/10/2024 De-escalation training was done by all staff <p>Implemented changes will be monitored by ADON and DON for 6 weeks beginning 07/04/2024.</p> <p>Plan will be evaluated for effectiveness by review of incidents and review of monitoring.</p> <p>Review of typed facility's incident investigation report time line by S3 ADON dated 07/11/2024 revealed in part,</p> <p>07/05/2024 S9 NP made rounds and increased Seroquel to 50 mg in the a.m. and 100 mg in the p.m. as well as adding Vistaril 25 mg every evening. New order to collect a urinalysis with culture and sensitivity. S10 Behavioral Health NP notified of resident behavior and medication change. Resident #3's care plan updated to notify staff to only remove dishes etc. from room while Resident #3 is out of the room. Updated the aggression to the care plan to include: (resident becomes angry and physically aggressive with staff when staff attempts to assist or redirect).</p> <p>Resident #3 hoards silverware including coffee cups and utensils in her room. Added to wall care sign in room.</p> <p>07/05/2024: In-service initiated on abuse-which includes both physical and mental abuse, in-service initiated on burn-out, de-escalation-report abusive patient as soon as it is noted to happen to supervisor or nurse. Communication in-service staff to be in close proximity with communicating patient care. Testing completed for all staff on abuse and neglect. Resident interviews completed to ensure all resident feel safe and have no concerns.</p> <p>07/08/2024: Abuse and Neglect-Grievance monitor added as a QA (Quality Assurance) tool for administrative staff to complete with all residents and to for six weeks and then weekly which includes a questionnaire for reside to ensure they feel safe and have no other concerns.</p> <p>(continued on next page)</p>

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