

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Roseview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3405 Mansfield Road 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 - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40957</p> <p>Based on record reviews, interviews, and video footage the facility failed to protect the resident's right to be free from verbal abuse by a staff member for one (Resident #1) of three (#1, #2, #3) sampled residents.</p> <p>Findings:</p> <p>Review of Resident #1's record revealed an admitted [DATE] with diagnoses including in part. ESRD (End Stage Renal Disease), history of falling, fluid overload, anemia in chronic kidney disease, anxiety disorder, lack of coordination, cirrhosis of the liver, COPD (Chronic Obstructive Pulmonary Disease), viral hepatitis C without hepatic coma, muscle wasting and atrophy .</p> <p>Review of Resident #1's MDS (Minimum Data Set) dated 10/16/2024 revealed a BIMS (Brief Interview of Mental Status) of 15 which would indicate the resident was cognitively intact.</p> <p>Review of the facility's Employee Statement dated 10/28/2024 revealed S2 DON (Director of Nursing) interviewed Resident #1. Resident #1 reported S3 CNA (Certified Nursing Assistant) came into her room complaining about having to provide incontinent care.</p> <p>During an interview on 11/04/2024 at 1:32 p.m. Resident #1 stated S3 CNA came into her room one day and said, I guess I have to change your sh---y a-- diaper again.</p> <p>During a telephone interview on 10/29/2024 at 4:30 p.m. Resident #1's RP (Responsible Party) reported the staff were unprofessional. On 10/24/2024 Resident #1 fell in her room, called the RP and the RP heard S3 CNA say, Shut the f--k up, you haven't been on the floor that long. Stop lying on me.</p> <p>Review of the facility's video footage with audio on 10/24/2024 revealed the following:</p> <p>At 4:30 a.m. S6 LPN (licensed practical nurse) was in the hallway with med-cart when Resident #1 screamed out. S6 LPN looked inside the door and told S4 CNA and S5 CNA Resident #1 was on the floor and they both went to the room.</p> <p>At 4:34 a.m. S3 CNA entered Resident #1's 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 4:35 a.m. S3 CNA, S4 CNA, and S5 CNA left Resident #1's room and they walked towards the camera. Audio revealed S3 CNA talking loudly in the hall. Some curse words were said by S3 CNA.</p> <p>S3 CNA went back to Resident #1's room at 5:19 a.m. and came out of room at 5:21 a.m. Then S3 CNA entered Resident #1's room again at 5:36 a.m. and exited at 5:39 a.m. S3 CNA had supplies in hand, which appeared to be diaper and pads.</p> <p>During a telephone interview on 10/30/2024 at 2:00 p.m. S3 CNA reported on 10/24/2024 Resident #1 was on the phone telling her daughter she was on the floor. S3 CNA told Resident #1 to tell the truth, don't be lying on her. S3 CNA reported Resident #1 was telling her daughter she was on the floor when she was in her wheelchair.</p> <p>During an interview on 10/30/2024 at 3:15 p.m. S2 DON reported Resident #1's RP called S2 DON on 10/24/2024 to report S3 CNA cursed at Resident #1. S2 DON interviewed S3 CNA and S3 CNA did say that she said to Resident #1, Why are you lying, you were not on the floor long? S2 DON reported the language used by S3 CNA violated company policy and they terminated her.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957</b></p> <p>Based on record review, interview, and facility camera footage, the provider failed to ensure services were provided to meet professional standards of quality by failing to complete a full head to toe assessment with vital signs after a resident fall prior to being moved from the floor to a wheelchair for one (Resident #1) of three (#1, #2, #3) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of the facility's policy for falls (Nursing G-10 p. 1),</p> <p>Policy:</p> <p>To provide emergency care.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Resident will not be moved until a Licensed Nurse has ascertained resident's condition.</li> <li>2. Assess resident for any abnormalities: i.e.,             <ol style="list-style-type: none"> <li>a. Deformed, discolored or painful body parts.</li> <li>b. Open wounds, hemorrhaging.</li> <li>c. Vitals (Vital Signs).</li> <li>d. State of consciousness .</li> </ol> </li> </ol> <p>Review of Resident #1's record revealed an admitted [DATE] with diagnoses including, in part, ESRD (End Stage Renal Disease), history of falling, fluid overload, anemia in chronic kidney disease, anxiety disorder, lack of coordination, cirrhosis of the liver, COPD (Chronic Obstructive Pulmonary Disease), viral hepatitis C without hepatic coma, muscle wasting and atrophy .</p> <p>Review of Resident #1's MDS (Minimum Data Set) dated 10/16/2024 revealed a BIMS (Brief Interview of Mental Status) of 15 which would indicate the resident was cognitively intact. Resident #1 required one person assistance for bed mobility, transfers, and toileting.</p> <p>Review of Resident #1's progress notes revealed the following, in part:</p> <p>Incident note dated 10/24/2024 at 3:32 a.m. by S1 LPN (Licensed Practical Nurse) entered note time 7:10 a. m.: CNA called downed the hall and stated resident was on the floor when entering resident was laying on left side on the side of the bed with wheelchair beside resident. Wheelchair noted not locked. Resident was assessed and resident was crying out complaining of left hip pain. ROM (Range of Motion) done resident was able stand and transfer to wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/24/2024 at 12:12 p.m.: Stat x-ray of the left hip.</p> <p>10/24/2024 at 2:40 p.m.: Received ___ IMAGING results related fall and complains of left hip pain. Findings: No acute fracture or dislocation is identified. Mild joint space reduction of the hip noted. Bony mineralization and the visualized portion of the pelvis are unremarkable. Impressions: No acute findings. Degenerative changes, mild joint space reduction of the hip noted. Notified resident of results.</p> <p>10/24/2024 at 5:33 p.m.: While CNA's were changing resident writer was notified to resident's room to assess resident's right leg. Writer noted right hip swollen and resident c/o pain. Writer notified NP (Nurse Practitioner), ordered stat x-ray for right hip. --- IMAGING notified. S2 DON (Director of Nursing), and Daughter notified. Pain medication given. Blood pressure 134/64, pulse 81, respirations 18, temperature 99.0 Fahrenheit.</p> <p>10/24/2024 at 9:27 p.m.: Resident refused ___ IMAGING and stated she wants to go to the hospital. Writer notified NP, NP gave order to send out for evaluation. Resident's daughter and S2 DON, notified, _____ Transportation notified for transport. Resident was transported to hospital at 7:25pm.</p> <p>10/28/2024 at 4:40 p.m.: Resident returned to facility at 2:30 p.m. via ___ Transportation from hospital, Diagnosis, displaced right peri-trochanteric femur fracture. Resident is in stable condition, in bed resting quietly requesting inflated mattress from hospital be taken off, stated it's uncomfortable. Writer notified CNA's to remove inflated mattress.</p> <p>Review of resident #1's comprehensive care plans included the following, in part:</p> <p>At high risk for falls related to lack of coordination; 02/02/2023 resident lost footing wearing slides while ambulating with walker, no injuries noted, educated on proper shoes to wear. 06/16/2023 resident wheelchair bound, non-ambulatory related to overall decline in physical function since Diagnosis of ESRD. She has increased weakness, debility, and decreased ROM. Anti-anxiety med use 05/16/2024 ambulating with four wheel walker with limited assistance. Non-compliant with asking for assistance 10/02/2024. Supervision with four wheel walker ambulation. 10/24/2024 actual fall when forgot to lock wheelchair brakes- PT/OT in place and notified, stat left hip x-ray ordered, education to lock brakes during transfers. Sent out to hospital for complaint of right hip pain. Daughter called and reported resident has fractured right hip.</p> <p>Interventions included ensure proper footwear, falling star program, keep assistive devices in reach, make sure pathways are clear, resident uses wheelchair for mobility, and needs staff propelling most distances .</p> <p>Review of Resident #1's hospital discharge record revealed the following in part:</p> <p>Discharge 10/28/2024</p> <p>Patient is a [AGE] year old female .who experienced a ground level fall onto her hip, experienced pain, inability to bear weight, loss of ROM prompting her to seek medical care .</p> <p>Hospital course- Patient with multiple medical problems, nursing home resident. admitted with fall and right femur fracture. She underwent ORIF (Open Reduction and Internal Fixation) .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Discharge Diagnosis- Femoral fracture, diabetes, alcoholic cirrhosis, coronary artery disease, hypertension, chronic kidney disease, and Anemia.</p> <p>During an interview on 10/30/2024 at 12:21 p.m., Resident #1 reported she had a fall when she was trying to get into her wheelchair and wound up with a right hip fracture. Two CNAs (S4 CNA and S5 CNA) came in and helped her up to wheelchair after the fall.</p> <p>Review of the facility's video footage with audio on 10/24/2024 revealed the following:</p> <p>At 4:30 a.m. S6 LPN (licensed practical nurse) was in the hallway with med-cart when Resident #1 screamed out. S6 LPN looked inside the door and told S4 CNA and S5 CNA Resident #1 was on the floor and they both went to the room. S6 LPN entered Resident #1's room [ROOM NUMBER]:34:24 a.m. and exited from the room at 4:34:50 a.m. (26 seconds).</p> <p>During an interview on 11/06/2024 at 6:20 a.m. S6 LPN reported on 10/24/2024 at 4:30 a.m. she heard Resident #1 holler and then went to door and saw Resident #1 on the floor. S6 LPN indicated she called out for the CNAs (S4 CNA and S5 CNA) to come to Resident #1's room. S6 LPN verified that she did not complete an assessment for Resident #1 before they moved Resident #1. S6 LPN verified she held the wheelchair in place while S4 CNA and S5 CNA got Resident #1 into the wheelchair.</p> <p>During an interview on 11/06/2024 at 6:35 a.m. S1 LPN reported on 10/24/2024 S6 LPN told S1 LPN that Resident #1 had fallen on the floor. S1 LPN verified when she got in Resident #1's room the resident was sitting in her wheelchair. S1 LPN verified S4 CNA and S5 CNA had gotten Resident #1 off the floor and placed her in a wheelchair. S1 LPN indicated she completed an assessment while Resident #1 was in the wheelchair and Resident #1 complained of left hip pain. S1 LPN verified Resident #1 should have had a full assessment prior to being moved.</p> <p>During an interview on 11/06/2024 at 7:00 a.m. S4 CNA reported she got to the room and Resident #1 was on the floor. S4 CNA indicated her and S5 CNA got Resident #1 off the floor and into her wheelchair while S6 LPN held the wheelchair in place. S4 CNA verified when any resident has a fall they call for the nurse to come and assess the resident, then after assessment is completed they will move the resident off of the floor if the nurse says it is ok to move. If a resident has an injury, a staff member is to remain in room with the resident until EMS (Emergency Medical System) arrives.</p> <p>During an interview on 11/06/2024 at 7:45 a.m. S5 CNA reported S6 LPN called out for help when Resident #1 fell to the floor. S5 CNA then indicated her and S4 CNA got Resident #1 off of the floor and into wheelchair while S6 LPN was holding wheelchair steady. S5 CNA verified that a nurse was supposed to do an assessment before moving a resident off the floor.</p> <p>During an interview on 11/06/2024 at 8:30 a.m. S2 DON verified a full head to toe assessment was to be completed for any resident that had a fall before being moved from the floor. S2 DON further indicated Resident #1 should have had a full assessment before being moved from the floor.</p>		