

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Tioga Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Shreveport Hwy Pineville, LA 71360	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44315</p> <p>Based on interview and record review the facility failed to ensure Resident #1's Responsible Party (RP) was informed of changes in the resident's condition for 1 (Resident #1) of 3 (Resident #1, Resident #2 and Resident #3) sampled residents. Findings:</p> <p>Review of the facility's policy titled Change in a Resident's Condition or Status read in part . Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status in a timely manner.</p> <p>Review of Resident #1's clinical record revealed an admitted [DATE] with diagnoses that included Alzheimer's disease with late onset, Generalized Anxiety Disorder (GAD), Major Depressive Disorder, Recurrent, Insomnia and Dementia, unspecified severity with other behavioral disturbance.</p> <p>Review of Resident #1's Annual MDS Assessment with an ARD of 07/03/2024 revealed a BIMS score of 3 indicating severe cognitive impairment. Resident #1 received antianxiety and antidepressant medications.</p> <p>Review of Resident #1's Quarterly MDS with an ARD of 05/29/2024 revealed a BIMS score of 3, indicating severe cognitive impairment. Resident #1 received antidepressant medications.</p> <p>Review of Resident #1's Care Plan with a target date of 06/20/2024 revealed a problem initiated on 04/17/2024 when Resident #1 was prescribed anti-anxiety meds related to Anxiety disorder with interventions that included in part . to monitor/record/report prn if exhibited adverse reactions to anti-anxiety therapy.</p> <p>Review of Resident #1's Physician's Orders read in part .</p> <p>04/17/2024 - Trazodone HCl oral tablet give 12.5mg by mouth 2 times a day for anxiety and depression.</p> <p>Start date 04/17/2024. Discontinued 04/24/2024.</p> <p>04/24/2024 - Trazodone HCl oral tablet give 25mg by mouth 2 times a day for anxiety and depression. Start date 04/24/2024. Discontinued 05/22/2024.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Tioga Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Shreveport Hwy Pineville, LA 71360	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>05/22/2024 - Trazodone HCl oral tablet give 50mg by mouth 2 times a day for anxiety and depression. Start date 05/22/2024.</p> <p>05/31/2024 - Xanax oral tablet 0.25mg 1 tablet by mouth BID for GAD. Start dated 05/31/2024. 06/13/2024 - Xanax oral tablet 0.25 mg 1 tablet by mouth every p.m. for GAD. Start dated 06/13/2024.</p> <p>Review of Resident #1's Progress or Nurses Notes revealed no documentation of the above medication changes and no documentation that Resident #1's RP was notified of medication changes.</p> <p>Telephone interview on 08/13/2024 at 3:50 p.m. with S3 LPN revealed she had cared for Resident #1. S3 LPN revealed she had spoken with Resident #1's daughter a couple of times when she would visit about some of her care and behaviors but could not recall what and when she had documented.</p> <p>Interview on 08/14/2024 at 10:20 a.m. with S2 ADON verified that the nurses should have informed Resident #1's RP of medication changes but did not.</p> <p>Interview on 08/14/2024 at 10:40 a.m. with S1 DON revealed there was no evidence that Resident #1's RP had been notified of medication changes. S1 DON confirmed Resident #1's RP should have been notified of changes in her medication regimen and had not been.</p>