

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 02/26/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</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** 51503</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from staff to resident verbal abuse for 1 (Resident #4) of 9 (#1, #2, #3, #4, R1, R2, R3, R4, and R5) sampled residents investigated for abuse. Resident #4, a cognitive residents, experienced mental anguish and psychosocial harm as a result of the verbal abuse by staff.</p> <p>This deficient practice resulted in an actual harm on 02/11/2025 at 10:00 a.m., when S3 CNA told Resident #4, Shut the F*** up and F*** this Sh**! during ADL care (showering). Resident #4 stated this caused him mental anguish and psychosocial harm/emotional distress, as he felt disrespected, insulted, and pissed off that S3 CNA cursed and spoke to him in that way. Resident #4 reported the incident to staff and told them he did not want S3 CNA in his room again.</p> <p>Findings:</p> <p>Review of the facility's policy on 02/26/2025 at 4:03 p.m. titled, Abuse Components Plan, Elder Justice Act and Affordable Care Act, with an effective date of 10/24/2022, read in part .Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.</p> <p>Review of the facility's employee Relias Training course on 02/26/2025 at 4:03 p.m. titled, Abuse, Neglect, and Exploitation dated 00/00/2022 read in part .Mental Abuse can be verbal or non-verbal .Mental Abuse includes: Humiliating .Verbal Abuse is a type of Mental Abuse. It includes: Mocking or ridiculing, yelling, threatening to withhold contact from others, and scolding .these actions are Verbal Abuse even if the resident does not understand what the person says.</p> <p>Review of Resident #4's medical record revealed an admitted [DATE], with diagnoses that included in part . Myotonic Muscular Dystrophy, Abdominal, Anxiety Disorder, Chronic Inflammatory Demyelinating Polyneuritis, Muscular Dystrophy, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, and Anxiety Disorder.</p> <p>Review of Resident #4's Quarterly and State Optional MDS with an ARD of 01/01/2025, revealed a BIMS score of 14, which indicated cognition was intact. Resident #4 required total dependence with two person physical assistance with bed mobility, toilet use, and transfers.</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>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #4's care plan with a start date of 01/24/2025, revealed the following the part . -Problem: I have an ADL-self-care performance deficit, wheelchair bound with diagnosis of Muscular Dystrophy. Interventions included bathing/showering - I am totally dependent on one staff to provide bath/shower, with a start date of 11/01/2018. -Problem: Potential for Depression. Interventions included - may see LCSW of choice with a start date of 11/03/2023, and psych visits as needed/scheduled with a start date of 08/31/2021.</p> <p>Review of a Visitation/Progress Note completed by S9 Social Worker on 02/20/2025, revealed the following in part .Resident #4 mentioned that he had not been feeling good recently. He expressed that he's been having rough days and did not feel good after recent events .reports an incident with a staff member who said ugly things and she got fired .I didn't want her to get fired but she did it to herself.</p> <p>Review of a facility report completed by S1 Administrator titled, Grievance: Other dated 02/11/2025 at 10:15 a.m., revealed the following in part .Grievance dated 02/11/2025 for Resident #4: Resident Description: Nurse Aide Supervisor reported to DON and Administrator that resident just complained that a particular nurse aide did not know how to do her job, and that he wanted her wrote up for telling him to Shut the F*** up. Notes: 02/11/2025: Resident has a BIMS of 14, cognitively intact. Administrator and DON met with resident to discuss incident. Resident verified identity of aide and witnesses. Resident stated that aide did not cover the bed sheets and they were getting wet after his shower. Resident stated that he wanted her written up because she told him to shut the F*** up when he said she did not know how to do her job.</p> <p>Review of a written statement completed by S6 CNA on 02/11/2025, revealed the following in part .I, S6 CNA, was helping S3 CNA do Resident #4, getting him out of the shower, and Resident #4 said that you don't know your job. S3 CNA said Shut the F*** up, I know my job.</p> <p>Review of a written statement completed by S8 Treatment Nurse on 02/11/2025, revealed the following in part .While I was doing treatments down Hall X, S3 CNA requested my assistance in Resident #4's room. Verbal conflict with resident to aide continued the entire time of patient care, resident repeatedly called out S4 CNA Supervisor's name.</p> <p>Review of a written statement completed by S3 CNA on 02/11/2025, revealed the following in part .I was showering Resident #4. Once he was done he told me I needed to cover the sheets because they was going to get wet. I already did that, and I explained that to him. He proceeded to say I didn't. I told him once again I did and this is not my first time taking care of him. I know how to do my job. He then told me I don't. I'm retarded, I'm dumb and slow. I told him I wasn't and that was not nice. I stepped out and asked S8 Treatment Nurse to assist for a witness because he (Resident #4) asked for S4 CNA Supervisor.</p> <p>In an interview on 02/26/2025 at 10:12 a.m., S4 CNA Supervisor revealed in part .recently (about 2 weeks ago-could not remember the exact date) there was a situation where a CNA was terminated for verbal abuse. The verbal abuse was from the CNA to a resident. S4 CNA Supervisor could not remember the details of the verbal abuse incident or the CNA and Resident involved because she was out of the facility at that time. S4 CNA Supervisor stated that S2 DON and S5 ADON investigated the verbal abuse incident.</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>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 02/26/2025 at 10:35 a.m., S2 DON revealed she was not aware of any verbal abuse situations, or SIMS reports in the last two weeks - four weeks. S2 DON stated there were no verbal abuse allegations reported or investigated. S2 DON stated that she was alerted by S4 CNA Supervisor via telephone and was told of a situation. S2 DON stated she and S1 Administrator interviewed S3 CNA in the administrative office. S3 CNA stated Resident #4 was having an episode and S3 CNA fussed at him because he wanted the bedding changed. S2 DON stated S1 Administrator sent S3 CNA home on suspension pending the investigation. S2 DON said she and S1 Administrator then interviewed Resident #4, and he stated that S3 CNA said F*** you, during his shower. S2 DON stated she and S1 Administrator terminated S3 CNA via telephone for unprofessional interaction with a resident. S2 DON stated they did not classify this as verbal abuse, and did not report the incident. S2 DON stated they filed it as a facility Other Grievance. S2 DON stated she could not remember the actual date and time of the event because there was no abuse incident report.</p> <p>In an interview on 02/26/2025 at 11:20 a.m., Resident #4 revealed he remembered the incident with S3 CNA very well. Resident #4 stated it happened on 02/11/2025 before 10:00 a.m., when S3 CNA told him, F*** you and F*** this S***! during his shower on that day. Resident #4 revealed that S3 CNA had an attitude and was mad the entire time of the shower because she did not want to shower him. Resident #4 revealed that he felt disrespected, insulted, and pissed off that S3 CNA cursed and spoke to him in that way. Resident #4 stated that he hollered out for S4 CNA supervisor during that time, but S4 CNA Supervisor did not come. Resident #4 stated that he did not know S3 CNA very well and she should have never spoken to him like that. Resident #4 stated that S6 CNA and S8 Treatment Nurse were in the room assisting S3 CNA during the incident. Resident #4 stated that this had never happened to him from any other staff members, and was the first time. Resident #4 revealed that he was upset that it even happened to him. He stated that S3 CNA left his room after he was put back to bed and the situation was over. Resident #4 stated that S5 ADON, S2 DON, and S1 Administrator came to his room to talk to him later that day. Resident #4 stated that he was told by S1 Administrator that S3 CNA was sent home on suspension.</p> <p>In a telephone interview on 02/26/2025 at 12:37 p.m., S6 CNA revealed that she witnessed the situation with Resident #4 on 02/11/2025 at about 10:00 a.m. S6 CNA stated S3 CNA asked her on Hall X to assist with showering Resident #4. S6 CNA stated she went into the resident's shower stall and Resident #4 was upset about his neck placement, and he told S3 CNA to adjust his neck. S6 CNA confirmed that at this time, S3 CNA stated to the resident, Shut the F*** up, F*** this shit, and I know how to do my job! S6 CNA stated she immediately left the resident's room and told the closest CNA on the hall, which was S7 CNA. S6 CNA stated that S7 CNA then phoned S4 CNA Supervisor and reported what S3 CNA said to Resident #4.</p> <p>In an interview on 02/26/2025 at 12:40 p.m., S7 CNA revealed that on 02/11/2025 at about 10:00 a.m., she was alerted by S6 CNA that S3 CNA cursed out Resident #4 during his shower. S7 CNA immediately called S4 CNA Supervisor and reported the situation. S7 CNA revealed that she cared for Resident #4 the rest of the day, and he was still upset about the situation that occurred earlier in the day. S4 CNA stated that Resident #4 kept telling her to not let S3 CNA back in his room.</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>Note: The nursing home is disputing this citation.</p>	<p>In a telephone interview on 02/26/2025 at 1:30 p.m., S8 Treatment Nurse revealed that she was present on 02/11/2025 at about 10:00 a.m. when the situation happened with Resident #4. S8 Treatment Nurse stated that she did assist S3 CNA briefly with supervising Resident #4 in the shower and then dressing. S8 Treatment Nurse stated she remembered Resident #4 hollering out for S4 CNA Supervisor. S8 Treatment Nurse stated that Resident #4 was very upset at this point. S8 Treatment Nurse stated she did not hear any cursing from S3 CNA during her interactions; however, S8 Treatment Nurse was not present in the shower and bedroom the entire time.</p> <p>In a telephone interview on 02/26/2025 at 1:45 p.m., S9 Social Worker revealed in part .she visited with Resident #4 on 02/20/2025, during her routine rounds, and he brought to her attention a recent incident that occurred with a CNA who cursed at him and that she was fired.</p> <p>In an interview on 02/26/2025 at 2:00 p.m., S2 DON revealed in part .she was alerted by S4 CNA Supervisor via telephone at about 10:00 a.m. on 02/11/2025 .she revealed that during her investigation of the incident, Resident #4 complained about wet linens, how S3 CNA could not do her job, and how S3 CNA cursed at him. S2 DON stated that Resident #4 had a louder tone and voice during this interview. S2 DON stated she could not remember if she contacted S10 NP, but she must have, because she got the order for psychosocial monitoring every shift for Resident #4. S2 DON stated she did not consider cursing a resident as verbal abuse; however, she considered it as an unprofessional interaction. S2 DON confirmed that she does not expect staff to curse at residents, and the incident with S3 CNA and Resident #4 should not have happened.</p> <p>In an interview on 02/26/2025 at 2:16 p.m., S1 Administrator revealed in part .he was alerted on 02/11/2025 in the morning by S2 DON of the situation with Resident #4. S1 Administrator stated he, S2 DON, and S5 ADON started an investigation. S1 Administrator stated during an interview with Resident #4, he (Resident #4) was mad, and told S1 Administrator that S3 CNA cursed him saying, F*** you, and F*** this S***! during his shower. S1 Administrator stated he, S2 DON, and S5 ADON obtained S3 CNA's statement, and then sent her home on suspension. S1 Administrator stated this was not verbal abuse, and referred to a facility form dated 00/00/2018 and stated, Because the resident did not have psychosocial harm, it was not verbal abuse, and not a reportable event. S1 Administrator stated he telephoned S9 Social Worker on 02/11/2025, who said she was going to visit Resident #4 on her next rounds (02/20/2025). S1 Administrator stated that S9 Social Worker determined there was no psychosocial harm when she saw Resident #4 on 02/20/2025, 9 days after the incident. S1 Administrator revealed that no in-servicing of staff was completed post event and he did not notify S10 NP nor S11 MD. S1 Administrator denied this event being verbal abuse or a reportable event. S1 Administrator confirmed the incident did occur and confirmed S6 CNA witnessed S3 CNA tell Resident #4 to Shut the F*** up.</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>Note: The nursing home is disputing this citation.</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** 38373</p> <p>Based on record review and interview, the facility failed to ensure an incident of abuse was reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency in accordance with state law for 1 (#4) of 9 (#1, #2, #3, #4, R1, R2, R3, R4, and R5) residents reviewed for abuse The provider failed to report staff to resident verbal abuse for Resident #4.</p> <p>Findings:</p> <p>On 02/26/2025, a review of the facility's policy titled Abuse Components Plan, Elder Justice Act and Affordable Care Act with an effective date of 10/24/2022 read in part .Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .</p> <p>Reporting:</p> <p>All alleged violations involving abuse, neglect, exploitation, mistreatment .will be reported by the Administrator or designee, to the following persons or agencies as required to provide notification:</p> <p>a. LDH online tracking system, Statewide Incident Tracking System (SIMS).</p> <p>b.</p> <p>An alleged violation involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of property/funds, and/or any other reportable incident will be reported immediately, but no later than:</p> <p>a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or</p> <p>b. Twenty four (24) hours if the alleged violation does not involve abuse .</p> <p>Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses that included in part . Anxiety and Major Depressive Disorder.</p> <p>Review of Resident #4's Quarterly MDS with an ARD of 01/01/2025 revealed a BIMS score of 14, which indicated the resident was cognitively intact. Review of the MDS revealed Resident #4 was dependent with eating, showering/bathing, rolling left or right, sitting to lying, lying to sitting on side of bed, and chair/bed to chair transferring.</p> <p>Review of a grievance dated 02/11/2025 revealed .</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>Note: The nursing home is disputing this citation.</p>	<p>Resident Description: Nurse Aide Supervisor reported to DON and Administrator that resident just complained that a particular nurse aide (S3 CNA) did not know how to do her job and that he wanted her wrote up for telling him to Shut the f___ up.</p> <p>In an interview on 02/26/2025 at 11:20 a.m., Resident #4 stated S3 CNA cursed at him. Resident #4 reported S3 CNA had an attitude because she had to give him a shower. Resident #4 stated he told her she was getting his sheets wet and she started cursing him. Resident #4 reported S3 CNA told him to Shut the f___ up and F___ this sh___. Resident #4 stated this made him feel mad and disrespected. Resident #4 stated he told administration he didn't want her in his room anymore.</p> <p>In an interview on 02/26/2025 at 2:20 p.m., S1 Administrator confirmed S3 CNA cursed Resident #4 and confirmed it was witnessed by another CNA. S1 Administrator reported he did not report this incident to the State Agency because he did not feel it met the definition of abuse because Resident #4 did not show evidence of psychological harm. S1 Administrator reported the incident was not abuse, but an unprofessional interaction with a resident by staff. S1 Administrator confirmed the incident was never reported to the State Agency and a SIMS was never completed.</p>		