STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195500	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tioga Community Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observation, and record review, the facility failed to ensure a resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of his or her own quality of life by failing to honor a resident's right to be shaved prior to going to his medical appointment for 1 (Resident #71) of 2 residents reviewed for dignity. Findings: Review of the facility's policy titled, Resident Rights with a revised date of 12/2016, read in part.Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Review of Resident #71's medical record revealed an admission date of 06/01/2026 with diagnoses which included, in part.Spinal Stenosis, Cervical Region; Multiple Sclerosis; Muscle Weakness; and Other Lack of Coordination.Review of Resident #71's admission MDS with an ARD of 06/07/2026 revealed a BIMS score of 13, which indicated intact cognition. Resident #71 used a wheelchair for mobility and required partial/moderate assistance for personal hygiene.Review of Resident #71's care plan with an initiated date of 06/09/2026 revealed in part.Problem: I have an ADL self-care performance deficit related to activity intolerance, C-collar, impaired balance, and pain. Interventions: Personal Hygiene: I require limited assistance by (1) staff with personal hygiene.Interview and observation on 06/23/2026 at 9:41 a.m. revealed Resident #71 sitting up in a wheelchair in his bedroom unshaved with an untrimmed thick beard. Resident #71 stated he would like to be shaved and since being admitted to the facility, no one has ever offered to give him a shave. Resident #71 stated he has a medical appointment tomorrow and doesn't want to go looking like this. Resident #71 stated the facility always sent him to his appointments looking a mess and it made him feel embarrassed. Interview and observation on 06/24/2026 at 9:50 a.m., Resident #71 stated he just received his whirlpool shower and S4 CNA didn't shave him. Resident #71 stated he was getting ready to go to his medical appointment and stated, Now, I have to go to my appointment looking like a bum. Resident #71 stated he wanted to be shaved prior to his appointment this morning. Observed Resident #71 with an unshaved and untrimmed, thick beard. Interview on 06/24/2026 at 9:51 a.m., S4 CNA revealed she assisted Resident #71 with his whirlpool shower this morning. S4 CNA stated she didn't have time to shave Resident #71 prior to his appointment.Interview on 06/24/2026 at 10:24 a.m., S2 CNA Supervisor stated residents received a shave during their showers or when a barber came to the facility. S2 CNA Supervisor confirmed Resident #71 should have been shaved during his whirlpool shower prior to his appointment this morning, but did not.

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the physician and responsible party after a change in resident's condition for 1 (Resident #9) of 2 residents investigated for accidents. The facility failed to notify the physician and responsible party in a timely manner after a witnessed fall, which resulted in an injury.Findings:Review of a facility policy on 06/24/2026 at 3:00 p.m. titled, Change in Resident's Condition or Status with a revision date of 03/2024 revealed the following in part.Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (example: changes in level of care) in a timely manner. 1. The nurse will notify the resident's attending physician or physician on call when there has been a. accident or incident involving the resident; d. significant change in the resident's physical/emotional/mental condition; g. need to transfer the resident to a hospital/treatment center. 3. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in any injury including injuries of an unknown source. 6. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of a facility policy on 06/24/2026 at 3:00 p.m. titled, Falls and Fall Risk, Managing with a revision date of 03/2018 revealed the following in part.According to the MDS (Minimum Data Set), a fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (example: resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not another person if he or she had not caught him/herself is considered a fall. A fall without injury is still a fall. Review of Resident #9's medical record revealed an admission date of 05/02/2025 with diagnoses which included in part.Acquired Absence of the Left Leg Above the Knee (onset date: 11/26/2023), Acquired Absence of Right Leg Below the Knee (onset date: 08/04/2023), and Unspecified Fracture of the Lower End of Right Femur, Initial Encounter For Closed Fracture (onset date: of 05/20/2026). Review of Resident #9's Quarterly MDS with an ARD of 05/25/2026 revealed a BIMS score of 10, which indicated moderate cognitive impairment. Resident #9 required partial/moderate assistance with chair to bed transfers and used a wheelchair for mobility. Review of Resident #9's Fall Risk Evaluation dated 05/18/2026 revealed a score of 20, which indicated At Risk for Falls.Review of Resident #9's care plan with an initial date of 08/05/2023 revealed the following in part.Problem: I am high risk for falls related to history of falls, below the knee and above the knee amputations; 05/19/2026 fall. Review of a facility witnessed fall report on 06/23/2026 at 2:45 p.m. revealed the following in part.Resident #9 had a witnessed fall on 05/19/2026 at 4:47 p.m., which occurred in the resident's room. -Nursing Description: CNA came into the hallway from the resident's room and stated that the resident was eased to the floor during transfer. -Resident Description: Resident stated, I fell, it was an accident. Level of Pain: 4/10 on pain scale. -Physician Notification: 05/20/2026 at 7:43 a.m. -Family Member Notification: 05/20/2026 at 7:35 a.m. -Notes: 05/20/2026 written by S2 DON- Resident seen by Nurse Practitioner on rounds and continued to complain of pain of the right knee/leg area. An X-Ray was ordered. 05/20/2026: X-Ray showed acute impacted fracture of the distal femur. Resident was sent to the emergency room for evaluation and treatment. Returned to the facility with a knee mobilizer in place. In a telephone interview on 06/19/2026 at 11:06 a.m., S3 CNA revealed she transferred Resident #9 from wheelchair to bed on 05/19/2026 in the afternoon and had to ease him down to the floor. S3 CNA stated Resident #9 complained of his leg hurting and S3 CNA notified S6 LPN immediately. In an interview on 06/23/2026 at 9:29 a.m., Resident #9 revealed he had a fall recently. Observed right lower extremity with an external immobilizer in place. In an interview on 06/23/2026 at 9:34 a.m., S5 LPN revealed she worked 6:00 a.m.-2:00 p.m. on 05/20/2026, during nursing report she was not notified of Resident (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#9 having a fall from the previous evening. S5 LPN revealed Resident #9 requested pain medication around breakfast-time and stated to S5 LPN he fell the night before (05/19/2026). S5 LPN then assessed the resident, Resident #9 stated to S5 LPN that he told S6 LPN about his fall on 05/19/2026. S5 LPN then notified the Nurse Practitioner on 05/20/2026 at 7:43 a.m. of Resident #9's fall which occurred on 05/19/2026 in the afternoon. S5 LPN revealed when a resident falls the nurse on duty is to complete an assessment on the resident and notify the MD/NP/RP (Medical Director/Nurse Practitioner and the Responsible Party) immediately. In an interview on 06/23/2026 at 4:10 p.m., S6 LPN revealed she worked on 05/19/2026 from 2:00 p.m.-10:00 p.m. and at the time of Resident #9's fall. S6 LPN stated S3 CNA called her to Resident #9's room to inform her that S3 CNA had to lower Resident #9 to the floor during a transfer. S6 LPN stated Resident #9 reported he just fell, pointed to his right knee and complained of pain. S6 LPN confirmed she forgot to call the MD/NP/RP and document the incident in the medial record. S6 LPN confirmed Resident #9's fall that occurred on her shift was a change in condition and S6 LPN should have contacted the MD/NP/RP, and document the incident in the medial record immediately, but did not.In an interview on 06/23/2026 at 4:11 p.m., S2 DON revealed when she arrived to the facility on [DATE], staff reported to her Resident #9 fell on [DATE]. S2 DON became aware S6 LPN did not complete the incident report or notify the MD/NP/RP at the time of the fall. S2 DON revealed she expected the nurses to complete a head-to-assessment with vital signs, complete a fall/incident report, and contact the MD/NP/RP as soon as possible after a resident falls. S2 DON confirmed S6 LPN failed to document and notify the MD/NP/RP timely of Resident #9's fall (change in condition) immediately, which resulted in a fracture. In a telephone interview on 06/23/2026 at 6:38 p.m., S7 LPN revealed she relieved S6 LPN on 05/19/2026 and S7 LPN worked 10:00 p.m. - 6:00 a.m. S7 LPN stated she was not told in report given by S6 LPN of Resident #9's fall, which occurred earlier that afternoon. S7 LPN stated Resident #9 slept for the 10:00 p.m. - 6:00 a.m. shift. S7 LPN revealed if she was aware of Resident #9's fall, she would have assessed him and notified the proper personnel of the fall, but was not.