| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195500 | A. Building<br>B. Wing | 07/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tioga Community Care Center | 5201 Shreveport Hwy<br>Pineville, LA 71360 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality. The sampled residents were 31. The facility failed to: 1. Ensure proper physician orders were obtained for Resident #13's oxygen requirements.2. Ensure proper physician orders were obtained for Resident #36's rescue inhaler.3. Ensure Resident #36's rescue inhaler was stored in a safe and secure manner. Findings: Review of an undated facility policy on 07/23/2025 at 9:34 a.m. titled, Oxygen Administration revealed the following in part.The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or the facility protocol for oxygen administration. Review of a facility policy on 07/23/2025 at 9:34 a.m. titled, Storage of Medications with a revision date of 11/2020 revealed the following in part.The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications. Resident #13Review of Resident #13's medical record revealed an admission date of 07/09/2024, with diagnoses that included in part.Parkinson's Disease, Type II Diabetes Mellitus with other Specified Complication, Emphysema, and Schizophrenia. Review of Resident #13's admission MDS with an ARD of 07/14/2025 revealed a BIMS of 7, which indicated severe cognitive impairment. Resident #13 required total dependence with showering, bathing, and dressing and required partial/moderate assistance with personal hygiene.Review of Resident #13's current physician orders revealed orders for the following in part. -Oxygen at 2 liters per nasal cannula PRN O2 saturation less than 92% as needed for shortness of breath with a start date of 07/21/2025. -Resident #13 had no other current physician orders for oxygen therapy. Review of Resident #13's nursing progress notes revealed in part.Resident #13 received oxygen therapies on 07/20/2025: 4 liters nasal cannula; and 07/21/2025: 4 Liters nasal cannula. Observation on 07/21/2025 at 7:15 a.m. revealed Resident #13 with continuous oxygen therapy in progress. Observed oxygen settings at 4 liters via oxygen concentrator. Observation on 07/22/2025 at 1:45 p.m. revealed Resident #13 with continuous oxygen therapy in progress. Observed oxygen setting at 4 liters via oxygen concentrator. In an interview on 07/22/2025 at 2:15 p.m., S17 LPN revealed Resident #13 had continuous oxygen therapy in progress. S17 LPN confirmed Resident #13's oxygen settings were set at 4 liters via oxygen concentrator. In an interview and record review on 07/22/2025 at 3:16 p.m., S7 ADON revealed Resident #13's current physician's orders reflected an order for oxygen at 2 liters per nasal cannula as needed for shortness of breath or oxygen saturation less than 92%. S7 ADON confirmed there were no current physician orders for Resident #13 to have a continuous flow of 4 liters of oxygen via concentrator. S7 ADON confirmed the nurse should have obtained the required oxygen orders prior to applying a continuous flow of 4 liters of oxygen for Resident #13, but did not. Resident #36Review of Resident #36's medical record revealed an admission date of 07/08/2024, with diagnoses that included in part. Systolic (Congestive) Heart Failure, Non-St Elevation (Nstemi) Myocardial Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Cerebral Infarction, And Chronic Obstructive Pulmonary Disease. Review of<br>(continued on next page) |

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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #36's admission MDS with an ARD of 07/15/2025 revealed a BIMS of 15, which indicated intact cognition. Review of Resident #36's current physician orders (as of 07/21/2025) revealed no orders for any inhalers. Review of Resident #36's care plan with an initiated date of 07/10/2025 revealed in part.Problem: I have COPD. Approaches: I will receive aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. In an interview on 07/21/2025 at 8:14 a.m., with Resident #36 revealed that she uses her rescue inhaler daily every day since she admitted to the facility on [DATE]. Resident #36 stated the nurses know and do not help her with administering her inhaler. An inhaler was observed on the resident's bedside dresser at the time of interview. In an interview on 07/22/2025 at 3:02 p.m., with Resident #36 revealed she gave herself the rescue inhaler today. Resident #36 stated the doctor gave her orders to take the inhaler every day and she kept it at her bedside. Observation revealed an inhaler on the resident's bedside dresser. In an interview and record review on 07/22/2025 at 3:06 p.m., S17 LPN revealed she did see an inhaler on Resident #36's bedside dresser today. S17 LPN confirmed Resident #36 did not have current physician orders for a rescue inhaler. S17 LPN confirmed that there should had been physician orders obtained for Resident #36's rescue inhaler and the inhaler should had been stored/locked in the medication box, but was not. In an interview and record review on 07/22/2025 at 3:16 p.m., S7 ADON revealed the facility does not allow any residents to self-administer medications during their stay. S7 ADON confirmed Resident #36 did not have current physician orders for a rescue inhaler. S7 ADON confirmed that the inhaler should had been reconciled upon admission to the facility and correct doctor orders obtained for the inhaler, but was not. S7 ADON confirmed Resident #36's inhaler should not be stored at the bedside when not in use. |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 2 (#55, and #87) of 5 (#13, #22, #38 #55, and #87) residents reviewed for respiratory care. The facility failed to:1.Store nebulizer mask appropriately for Resident #55; and2. Ensure oxygen was given or set at prescribed rate for Resident #87.Findings:Resident #87<br><br>Review of the facility’s undated policy entitled “Oxygen Administration” revealed, in part…staff is to verify there is a physician’s order for oxygen administration and provide oxygen at the prescribed flow rate.<br><br>Review of Resident #87’s medical record revealed an admission date of 04/03/2023 with diagnoses including Chronic Obstructive Pulmonary Disease and Shortness of Breath.<br><br>Review of Resident #87’s Quarterly MDS with an ARD of 04/30/2025 revealed a BIMS Score of 15, indicating intact cognition.<br><br>Review of Resident #87’s physician’s orders revealed oxygen at 2 LPM per NC was ordered on 03/28/2025.<br><br>Observation of Resident #87 on 07/21/2025 at 11:00 a.m. revealed the resident’s oxygen flowmeter was set between 2.5 and 3 LPM.<br><br>Observation of Resident #87 on 07/22/2025 at 9:32 a.m. revealed the resident’s oxygen flowmeter was set between 2.5 and 3 LPM.<br><br>Observation of Resident #87 on 07/22/2025 at 11:10 a.m. accompanied by S1LPN revealed the resident’s oxygen flowmeter was set between 2.5 and 3 LPM. S1LPN confirmed Resident #87’s oxygen flowmeter should have been set at 2 LPM, but was not.<br><br>Review of the Facility undated policy titled “Administering Medications Through a Small Volume Nebulizer” read in part….Steps in procedure: When equipment is completely dry, store in a plastic bag with the residents name and the date on it.<br><br>Resident #55<br><br>Review of Resident #55's medical record revealed an admit date of 09/03/2021 with diagnoses that included: Unspecified Sequelae of Unspecified Cerebrovascular Disease, Atherosclerotic Heart Disease, Schizoaffective Disorder, Bipolar Type, Dysphagia, Epilepsy, Unspecified Dementia, and Heart Failure.<br><br>Review of Resident #55’s 07/2025 Physician Orders read in part….06/23/2025 Albuterol Solution 2.5 mg/3ml inhale orally via nebulizer every 6 hours as needed for shortness of breath.<br><br>Review of Resident #55’s Care plan with a review date of 10/14/2025 read in part… I have potential for altered respiratory status related to allergic rhinitis and potential for shortness of breath. Interventions: Nebulizer as ordered, change nebulizer mask and tubing as ordered, and monitor oxygen saturation as ordered.<br>(continued on next page) |

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| | 195500 | A. Building<br>B. Wing | 07/23/2025 |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an observation on 07/21/2025 at 1:09 p.m., Resident #55’s Nebulizer mask was observed sitting on the dresser, on top of nebulizer machine, not bagged and open to air.<br><br>In an observation on 07/22/2025 at 9:24 a.m., Resident #55’s Nebulizer mask was observed sitting on the dresser, on top of nebulizer machine, not bagged and open to air.<br><br>Interview on 07/22/2025 at 1:14 p.m. with S11 LPN confirmed that the nebulizer mask was left open to air, but should not have been. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on record review and interview, the facility failed to ensure the physician documented a clinical rationale for a denial of a gradual dose reduction for 2 (#30 and #77) of 5 (#6, #30, #55, #77, and #79) sampled residents reviewed for unnecessary medications. The facility failed to ensure the physician documented on the Pharmaceutical Consultant Report a clinical rationale for not reducing psychoactive medications recommended for gradual dose reduction (GDR).<br><br>Findings:<br><br>Review of a facility policy on 07/23/2025 at 9:34 a.m. titled, “Psychotropic and Antipsychotic Medications and Non-Pharmacological Intervention” with an effective date of 01/2025 revealed in part…Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Residents should only receive psychotropic medications when other non-pharmacological interventions have been attempted and/or have been documented as being clinically contraindicated. Gradual Dose Reductions: Residents must only remain on psychotropic medications when gradual dose reduction and behavioral interventions (non-pharmacological interventions) have been attempted and/or deemed clinically contraindicated.<br><br>Resident #30<br><br>Review of Resident #30’s medical record revealed an admission date of 03/06/2024 with diagnoses that included in part… Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation, and Depression.<br><br>Review of Resident #30’s current physician orders revealed an order for Trazodone HCl Tablet 50 mg by mouth at bedtime related to depression with a start date of 05/19/2025.<br><br>Review of Resident #30’s Quarterly MDS with an ARD of 06/11/2025 revealed the resident received antidepressants and had a BIMS of 13, which indicated intact cognition.<br><br>Review of Resident #30’s “Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction” form completed on 03/28/2025 revealed the pharmacy consultant requested a gradual dose reduction for Trazodone HCL 50mg tablet. The report read in part…Note to Physician: According to CMS Interpretive Guidelines for Long Term Care Facilities, justification for not reducing a psychoactive must be documented. Further review of the document revealed, the physician did not document if a dose reduction was appropriate or a clinical rationale for the psychotropic medication.<br><br>In an interview and record review on 07/22/2025 at 3:16 p.m., S7 ADON revealed Resident #30 currently received Trazodone HCL 50mg tablet at bedtime related to depression. S7 ADON confirmed the GDR written on 03/28/2025 for Resident #30 did not have documentation regarding if the dose reduction was appropriate or a documented clinical rationale, but should have.<br><br>Resident #77<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #77’s medical record revealed an admit date of 11/12/2024 with diagnoses that included in part…Type 2 Diabetes Mellitus without complications, Alzheimer’s Disease, UTI, Dysphagia, Unspecified Dementia-mild with mood disturbance, Major Depressive Disorder, Essential Hypertension, Hyperlipidemia, Constipation, Vitamin D deficiency, and other Seizures.<br><br>Review of Resident #77’s Quarterly MDS with an ARD of 02/01/2024 revealed a BIMS of 14, which indicated intact cognition. Further review of MDS revealed Resident #77 had no behaviors. Resident #77 received an antipsychotic and an antidepressant medication.<br><br>Review of Resident #77’s care plan with a start date of 11/12/2024 revealed in part she was care planned for impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's Dementia and Potential for behavior problem related to dementia, mild with mood disturbances, attention seeking behaviors, gets upset when unable to complete sentences…<br><br>Review of Resident #77’s Physician’s orders revealed the following:<br><br>Aripiprazole tablet 2 mg by mouth one time a day<br><br>Sertraline HCL Oral tablet 100 mg by mouth one time a day<br><br>Review of the Pharmaceutical Consultant Report that was sent to NP on 05/26/2025 revealed the following: The Pharmacy Consultant Note to Physician read: According to CMS Interpretive Guidelines for Long Term Care Facilities, justification for not reducing a psychoactive must be documented either on this form or within the clinical record in order to be considered “clinically contraindicated” as to why the reduction is not desired at this time.<br><br>Review of the 05/26/2025 GDR revealed no documentation was noted for the questions of: Is a dose reduction appropriate, and is the dose a minimal effective dose. Further review revealed the NP failed to provide a handwritten clinical rationale explaining why a dose reduction would be clinically contraindicated. The facility NP documented “continue current plan of care.”<br><br>Review of the Pharmaceutical Consultant Report that was sent to NP on 11/24/2024 revealed the following: The pharmacy consultant Note to Physician read: According to CMS Interpretive Guidelines for Long Term Care Facilities, justification for not reducing a psychoactive must be documented either on this form or within the clinical record in order to be considered “clinically contraindicated” as to why the reduction is not desired at this time.<br><br>Upon reviewing the 11/24/2024 GDR, it was checked “no” for question of was a dose reduction appropriate and checked “yes” to Minimal Effective Dose. Facility NP failed to provide a handwritten clinical rationale explaining why a dose reduction would be clinically contraindicated.<br><br>Review of the Pharmaceutical Consultant Report that was sent to NP on 11/12/2024 revealed the following: The pharmacy consultant Note to Physician read: According to CMS Interpretive Guidelines for Long Term Care Facilities, justification for not reducing a psychoactive must be documented either on this form or within the clinical record in order to be considered “clinically contraindicated” as to why the reduction is not desired at this time.<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Upon reviewing the 11/12/2024 GDR, no documentation was noted for the questions of is a dose reduction appropriate and is the dose a Minimal Effective Dose. NP failed to provide a handwritten clinical rationale explaining why a dose reduction would be clinically contraindicated. The facility NP documented “no changes.”<br><br>Review of Resident #77’s 05/30/2025 Psychiatric NP progress notes revealed in part…No changes. Diagnoses were Dementia, mild without behaviors and Major Depression. No clinical rationale was provided for not attempting a GDR.<br><br>Review of Resident #77’s MD progress notes from 06/02/2025 and 07/02/2025 revealed no rationales for continued medication therapy of Aripiprazole and Sertraline HCL.<br><br>Review of Resident #77’s NP progress notes from 05/14/2025 and 07/14/2025 revealed no rationales for continued medication therapy of Aripiprazole and Sertraline HCL.<br><br>Interview with S6 DON on 07/23/2025 at approximately 3:00 p.m., acknowledged Resident #77 had no GDR attempted and no physician rationale listed on GDR requests or medical record as required. S6 DON stated Resident #77 had been on both of these medications since she was admitted to the facility. |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observations, record review, and interviews, the facility failed to implement the care plan for 2 (#5 and #13) of 31 sampled residents. The facility failed to: 1. Place an assist rail to the left side of Resident #5's bed, ensuring the resident could reposition himself as needed to maintain bed mobility as indicated on the patient-centered care plan; and2. Use ear protectors on Resident #13's nasal cannula as indicated in the resident's care plan.<br><br>Findings:<br><br>Review of a facility policy on 07/23/2025 at 9:34 a.m. titled, “Care Plans, Comprehensive Person-Centered” with a revision date of 03/2022 revealed the following part…A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. G. Receive the services and/or items included in the plan of care.<br><br>Resident #13<br><br>Review of Resident #13’s medical record revealed an admission date of 07/09/2024, with diagnoses that included in part…Parkinson’s Disease, Type II Diabetes Mellitus with other Specified Complication, Emphysema, and Schizophrenia.<br><br>Review of Resident #13’s admission MDS with an ARD of 07/14/2025 revealed a BIMS of 7, which indicated severe cognitive impairment. Resident #13 required total dependence with showering, bathing, and dressing and required partial/moderate assistance with personal hygiene.<br><br>Review of Resident #13’s current physician orders revealed orders for the following in part… -Oxygen at 2 liters per nasal cannula PRN O2 saturation less than 92% as needed for shortness of breath with a start date of 07/21/2025. -Treatment #13: Pressure, medical device related, stage 1, front right ear-cleanse with wound cleanser and 4X4 gauze, pat dry, apply Betadine, leave open to air (OTA) with an order date of 07/21/2025.<br><br>Review of Resident #13’s care plan with an initiated date of 07/09/2025 revealed the following part…Problem: (date initiated 07/21/2025) I have a pressure ulcer related to oxygen tubing-Treatment #13: 07/21/2025 pressure, medical device related injury (MDRI), stage 1, front right ear. Approaches: (date initiated 07/21/2025) Nasal cannula ear cushions.<br><br>Review of Resident #13’s nursing progress notes revealed in part…Resident #13 received oxygen therapies via nasal cannula on 07/19/2025, 07/20/2025, 07/21/2025, and 07/22/2025.<br><br>Observation on 07/21/2025 at 7:15 a.m. revealed Resident #13 with oxygen therapy in progress. Resident #13 was observed with redness behind bilateral ears and no ear protectors/cushions were observed to the nasal cannula.<br><br>Observation on 07/22/2025 at 1:45 p.m. revealed Resident #13 with oxygen therapy in progress. Resident #13 was observed with redness behind bilateral ears and no ear protectors/cushions were observed to the nasal cannula.<br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 07/22/2025 at 2:15 p.m., S17 LPN revealed Resident #13 had oxygen therapy in progress. S17 LPN confirmed Resident #13 had no ear cushions applied to his nasal cannula and he had redness behind bilateral ears. S17 LPN confirmed Resident #13 should have had bilateral ear cushions applied to his oxygen tubing, but did not.<br><br>In an interview on 07/22/2025 at 2:45 p.m., S4 RN Wound Care revealed she was aware of the redness behind Resident #13’s bilateral ears and verified that the right ear had a medical device acquired injury (stage 1 pressure injury). S4 RN Wound Care confirmed that she care-planned for Resident #13 to have ear cushions applied to his oxygen tubing, but the ear cushions were not in place.<br><br>Findings:<br><br>Resident #5<br><br>Review of Resident #5’s medical record revealed an admit date of 05/20/2025 with diagnoses including Intraspinal Abscess and Granuloma, Cutaneous Abscess of Back, PVD, COPD, A-Fib, Pressure Ulcers, and Edema.<br><br>On 07/21/2025 at 6:35 a.m., Resident #5 was observed lying on his back with the head of the bed elevated with an assist rail on the right side of the bed and a trapeze bar above the bed. The resident stated he can reposition himself. He also stated that the staff does not come routinely or every two hours to help reposition him. The resident stated that he can use the assist rail on the right side and the trapeze above the bed and had requested an assist rail for the left side of the bed. The resident demonstrated that the trapeze is loose, and he states that he has been told the left assist rail had been ordered.<br><br>Review of Resident #5’s current care plan revealed a problem section for “ADL self-care performance deficit” initiated on 08/1/2022 and revised on 6/24/2025. Interventions revealed: “Bed Mobility: I require total dependent x 2, trapeze to assist with bed mobility and bilateral side rails.” This task has an initiated date of 08/01/2022 and a revision date of 05/08/2025.<br><br>In an interview on 07/22/2025 at 10:34 a.m., S2 MDS confirmed Resident #5’s bed should have two assist rails. S2 MDS stated that the request was sent to maintenance on 07/09/2025. S2 MDS stated S8 MDS, texted the maintenance supervisor, S9 Maintenance, to install an additional assist rail on the left side of Resident #5’s bed.<br><br>On 07/22/2025 at 11:02 a.m., S9 Maintenance was asked if he knew about Resident #5’s bed needing a left side rail. S9 Maintenance stated he was told about the assist rail need “a couple of days ago.” S9 Maintenance was asked if he could produce the order for a new left side rail for the resident’s bed. S9 Maintenance stated that there would not be an order because he would just take the assist rail from another bed frame that was not in use currently. S9 Maintenance was asked why he hadn’t done this yet, he stated that he “forgot about it.”<br><br>In an interview on 07/22/2025 at 3:50 p.m., S6 DON and S7 ADON both confirmed that Resident #5’s care plan had two assist rails specified and the resident should have had two assist rails on each side of bed and did not. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195500 | A. Building<br>B. Wing | 07/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tioga Community Care Center | 5201 Shreveport Hwy<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain good personal hygiene for 2 (#61 and #77) of 3 (#11, #61, and #77) residents reviewed for ADL care. The facility failed to ensure oral care was provided for Resident #61; and Bath/Shower was provided for Resident #77. Findings:Review of the facility's policy dated 03/2018 titled Activities of Daily Living, Supporting read in part Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal/oral health.<br><br>Resident #61<br><br>Review of Resident #61's medical record revealed an admission date of 01/31/2020 with diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Spinal Stenosis, Dysphagia, and Disturbance of Salivary Secretions<br><br>Review of Resident #61’s Quarterly MDS with ARD of 06/18/2025 revealed a BIMS of 03, indicating severely impaired cognition. Resident #61 required substantial/max assistance with oral hygiene and dependent on staff for personal hygiene.<br><br>Review of Resident #61's care plan with a review date of 10/01/2025 read in part<br><br>Problem: have an ADL self-care performance deficit.<br><br>Approach: I require extensive assistance by (1) staff with personal hygiene and oral care.<br><br>Problem: I have potential for oral/dental health problems related to poor hygiene/condition.<br><br>Approach: I will be provided mouth care as per ADL personal hygiene.<br><br>Observation on 07/21/2025 at 8:01 a.m. revealed Resident #61’s was observed lying in bed awake but unable to answer questions when asked. Resident #61 was observed with a large amount of brown and yellow build up to teeth, lips, and gums.<br><br>Interview on 07/21/2025 at 1:08 p.m. with S13 CNA revealed that she provided oral care this morning but resident has a lot of buildup in his mouth. S13 CNA stated that Resident #61 does not refuse oral care.<br><br>Observation on 07/22/2025 at 9:40 a.m. revealed Resident #61 continued with a large amount of dried, stuck on brown and yellow build up on teeth.<br><br>Observation on 07/22/2025 at 1:30 p.m. revealed Resident #61 continued with large amount of dried, yellow and brown build up on teeth.<br><br>Observation on 07/22/2025 at 1:35 p.m. of S14 CNA providing oral care with S2 DON present. S14 CNA removed a significant amount of yellow/brown buildup from teeth with mouth swabs and water, while some buildup still remained. S14 CNA stated it was dried and she didn't want to rub too hard (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195500 | A. Building<br>B. Wing | 07/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tioga Community Care Center | 5201 Shreveport Hwy<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and make Resident #61’s gums bleed. S14 CNA stated she will attempt with a wash cloth.<br><br>In an interview on 07/22/2025 at 1:45 p.m., S2 DON confirmed that oral care for Resident #61 did not appear to have been provided after observation of oral care, but should had been done. S2 DON stated that she will be initiating an in service on oral care.<br><br>Resident #77<br><br>Review of Resident #77’s medical record revealed an admit date of 11/12/2024 ….with diagnoses that included in part…Type 2 Diabetes Mellitus without complications, Alzheimer’s Disease, UTI, Dysphagia, Unspecified dementia-mild with mood disturbance, Major depressive disorder, Essential hypertension, Hyperlipidemia, Constipation, Vitamin D deficiency, Other seizures.<br><br>Review of Resident #77’s Quarterly MDS with an ARD of 05/07/2025 revealed a BIMS of 14, which indicated intact cognition. Further review of MDS revealed Resident #77 required partial/moderate assistance with bathing, supervision or touching assistance with toileting, set-up or clean-up assistance with transfers and bed mobility, and resident was independent with eating.<br><br>Review of Resident #77’s care plan with a start date of 11/12/2024 revealed she was care planned for assistance with adls and required limited assist of 1 person with bathing.<br><br>Review of the CNA tasks revealed no documentation of bathing Resident #77 since 07/15/2025.<br><br>In an interview with Resident #77 on 07/22/2025 at 9:10 a.m., she stated she had not received a bath or bed bath in 7 days. She stated she had not been offered a bath. Observed there were no toiletries in resident’s room.<br><br>In an interview on 07/22/2025 at 9:45 a.m., S15 CNA stated Resident #77 cannot go to whirlpool because she was on isolation and stated she was independent and can do everything herself.<br><br>In an interview on 07/22/2025 at 9:45 a.m., S16 CNA stated non skilled residents get bed baths every other day and Resident #77 was independent.<br><br>In an interview on 07/22/2025 at 3:15 p.m., S7 ADON acknowledged there wasn’t any documentation of Resident #77 getting a bath in over a week. S7 ADON stated when she asked CNA about bathing Resident #77, the CNA stated, “She’s in isolation.” S7 ADON stated she had to explain to CNAs that residents in isolation still require baths, just like COVID patients did. S7 ADON acknowledged that Resident #77 had not been bathed in a week. |