

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER The Bradford Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Baird Road Shreveport, LA 71118	

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 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record review and interviews the facility failed to ensure provision of services in compliance with all applicable Federal, State, and local laws, regulations and codes by failing to investigate an incident involving resident to staff violence for 1 (Resident #1) of 3 (Residents #1, #2, and #3) sampled residents. The facility failed to follow the facility's policy by failing to investigate a resident to staff verbal exchange that progressed to a physical exchange between Resident #1 and S6 LPN (Licensed Practical Nurse).</p> <p>Findings:</p> <p>Review of Workplace Aggression/Violence Policy revised April 2023</p> <p>Policy Statement</p> <p>It is the policy of this facility that all employees, residents, family members, visitors, contractors, vendors, etc. , enjoy a positive, respectful, productive and safe environment while on our premises.</p> <p>Policy Interpretation and Implementation</p> <p>1. Workplace violence is defined as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. Violent acts include, but are not limited to:</p> <ul style="list-style-type: none"> a. Verbal or physical harassment; b. Verbal or physical threats; c. Assaults or other violence made directly or indirectly by words, gestures, or symbols; d. Any other behavior that causes others to feel unsafe (e.g., bullying, sexual harassment); and/or <p>.</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 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. This facility has implemented a Workplace Corporate Compliance Program. The goal of this program is to promote an environment free of behavior, actions, or language causing or contributing to workplace violence, harassment or bullying.</p> <p>.</p> <p>5. It is the responsibility of all employees to notify the appropriate supervisor or HR (Human Resources) Director of any threats which they have witnessed, received, or been told that another person has witnessed or received.</p> <p>.</p> <p>Review of Resident #1's medical record revealed an initial admitted [DATE] with diagnoses that included, in part, bipolar disorder current episode depressed moderate 05/07/2024, anxiety disorder 11/16/2023, and violent behavior 05/22/2024.</p> <p>Review of Resident #1's 06/12/2024 Admission MDS (Minimum Data Set) revealed Resident #1 had a BIMs score of 15 which indicated Resident #1 was cognitively intact.</p> <p>Review of Resident #1's Progress Notes revealed a 05/21/2024 at 22:42 Nurses Note by S6 LPN which read in part:</p> <p>12am: . resident was rolling down hallways yelling, screaming and using profanity . Writer entered resident room and observed resident sitting in wheelchair by door. Writer informed resident to not yell down hallways while others are sleeping. resident rolled next to writer . writer then asked resident . to move back away from writer and resident then stood up and pushed writer out of resident room and slammed door . Writer then . went to front nurses station and notified DON (Director of Nursing). Resident then came to front nurses station yelling at staff and saying to writer just wait until I finish with you, you _(profanity)__, you won't have a job. Writer informed resident to please leave nurses station and go back to room. Resident then left nurses' station.</p> <p>Review of undated witness statement documentation revealed the following:</p> <p>To whom it may concern,</p> <p>On May 21st on the 11-7pm shift I witnessed Resident #1 push the nurse, S6 LPN and slammed the door. Sincerely, S7 CNA (Certified Nursing Assistant)</p> <p>Review of the facility's Incident Log failed to reveal an incident report with investigation had been completed in regard to the 05/21/2024 incident between Resident #1 and S6 LPN.</p> <p>During an interview on 06/26/2024 at 3:03 p.m. S7 CNA reported she had been seated in the dining room near the hall entrance and in sight of Resident #1's door, and heard Resident #1 yelling and cussing and got up to see what was going on and saw Resident #1 push S6 LPN, who had been standing in Resident #1's doorway, toward the hallway and slam the door.</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/25/2024 at 11:29 a.m. S5 DON reported an incident report had not been completed for the 05/21/2024 incident between staff and Resident #1 as she saw the progress note entered in Resident #1's medical record and did not think it was necessary to write an incident report for it.</p> <p>During an interview on 06/25/2024 at 10:22 p.m. S4 Administrator reported an incident report had not been completed for what occurred between Resident #1 and S6 LPN on 05/21/2024, he had not viewed the camera recording from the 05/21/2024 incident, and the recording of the incident was no longer available.</p> <p>During an interview on 06/25/2024 at 2:35 p.m. S9 NP (Nurse Practitioner) reported Resident #1 had a history of running into people with his wheelchair, would roll over their feet, would throw trays, would scream and yell, had charged a nurse, would fly off the handle when he did not get his way and always denied any accusations. S9 NP further reported she had been made aware of the incident that occurred between Resident #1 and staff member the night of 5/21/2024 and she had visited with Resident #1 on the morning of 05/22/2024 and found Resident #1 to be more aggressive than normal and was unable to calm Resident #1 down. The decision was made to PEC (Physician's Emergency Certificate) Resident #1 and after Resident #1's refusal to go, police were called and assisted with transfer to Behavioral hospital.</p> <p>During a phone interview on 06/27/2024 at 10:11 a.m. S8 NP reported he had been consulted by S9 NP the morning of 05/22/2024 regarding Resident #1's current behavior of agitation and pushing of a staff member the night before. S8 NP further concurred the behavior was notably above Resident #1's baseline, it was reasonable Resident #1 could be aggressive again, and was in need of an inpatient treatment.</p> <p>During an interview on 06/27/2024 at 9:05 a.m. S1 Regional Vice-President reported, if notified of a workplace violence issue, that issue would be reported to the facility's Corporate Compliance Officer. S1 Regional Vice-President further reported the facility had not considered the 05/21/2024 occurrence between Resident #1 and a staff member an incident, but a behavior and it was not investigated nor was it reported to the facility's Corporate Compliance Officer. S2 Corporate Nurse was present during the interview and confirmed.</p>		