

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 01/08/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 40193</p> <p>Based on record reviews and interviews, the facility failed to ensure an alleged violation involving abuse was reported to the State Survey and Certification Agency for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of Facility's Abuse and Neglect Policy (revised October 15, 2022) revealed: Policy Statement - The facility will ensure that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility will provide a safe resident environment and protect residents from abuse. Staff to resident abuse of any type: The facility assumes the responsibility upon admission of ensuring safety and well-being of the resident. Staff are expected to be in control of their behavior and behave professionally. Treatment/Management: 2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies.</p> <p>Review of Resident #1's medical records revealed an admitted [DATE] with the following diagnoses, including in part: persistent mood (affective) disorder/unspecified, other specified mental disorders due to known physiological condition, insomnia/unspecified, neurocognitive disorder with Lewy Bodies, dementia in other diseases classified elsewhere/ unspecified severity with agitation, history of falling, cognitive communication deficit, pseudobulbar affect, anxiety disorder/unspecified, age-related physical debility and major depressive disorder/recurrent/unspecified.</p> <p>Review of Resident #1's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) of 03 (severely impaired cognition).</p> <p>Review of Facility's State Survey and Certification Agency Reports since last survey failed to reveal an incident of alleged abuse for Resident #1.</p> <p>Review of Facility's investigation of Resident #1's alleged abuse reported on 12/25/2024 revealed interviews with the staff reporting the abuse and the staff accused of abuse. Further review revealed witness written statements, body audits completed on residents residing in the memory care unit and an in-service conducted on reporting abuse.</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: 195513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/2025 at 2:40 p.m. S1 DON (Director of Nursing) confirmed she was notified on 12/25/2024 by S1 CNA (Certified Nursing Assistant) S2 CNA kicked resident when she stepped over him and cursed at Resident #1. S1 DON acknowledged the incident involving Resident #1's alleged abuse was investigated but the facility failed to notify the State Agency and should have.		