

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 03/26/2026
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** Based on record review and interview, the facility failed to report a resident's elopement to the State Survey Agency in accordance with State law, for 1 (#4) of 5(#1, #2, #3, #4, #5) sampled residents. Based on record review and interview, the facility failed to report a resident's elopement to the State Survey Agency in accordance with State law, for 1 (#4) of 5(#1, #2, #3, #4, #5) sampled residents. Findings: Review of the facility's Wandering and Elopement Policy dated 11/15/2023 revealed the following: 3. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse Shall. Examine the resident for injuries; Notify the Attending Physician and report findings and conditions of the resident: Complete and file Report of Incident/Accident; and Document the event in the resident's medical record; Notify regulatory agencies per state guidelines indicated. Review of Resident #4's medical record revealed an admit date of 01/09/2026 with a diagnosis of but not limited to, type 2 diabetes mellitus, cognitive communication deficit; aphasia; muscle wasting and atrophy, not elsewhere classified, multiple sites; other abnormalities of gait and mobility, disorientation, unspecified; unspecified dementia, unspecified severity, with anxiety, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, and essential (primary) hypertension. Review of resident #4's Quarterly Minimum Data Set, dated [DATE] revealed Resident #4 was assessed to have a Brief Interview Mental Status score of 4 indicating severely impaired cognition. Review of Resident #4's medical record revealed Resident #4 was assessed to be an elopement risk at a level of 3 due to a history of attempted elopement at home, wandering with a purpose in the facility and exit seeking behavior. During a phone interview on 03/23/2026 10:00 a.m. Resident #4's nephew/responsible party reported Resident #4 was found outside in the front of the facility alone on 02/08/2026. Review of Resident #4's progress notes revealed on 02/08/2026 at 6:06 p.m. Resident #4 was found outside of the facility in the flower bed in the front of the facility bent over with her hands in the dirt by an oncoming nurse. During a telephone interview on 03/25/2026 at 2:17 p.m. S3 licensed practical nurse confirmed on 02/08/2026 at approximately 6:00 p.m. she observed Resident #4 outside of the facility bent over in the flower bed in the front of the facility near the front door when she arrived for her scheduled shift. S3 licensed practical nurse further reported she parked her car and went to assist Resident #4 and alerted the staff inside the facility that Resident #4 was outside alone on 02/08/2026. During an interview on 03/24/2026 at 9:00 a.m. S1 Administrator confirmed on 02/08/2026 Resident #4 was found outside in the flower bed in the front of the facility and although Resident #4 had diagnosis of dementia and a BIMS score of 4 he did not report this incident to the State Survey Agency.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interviews the facility failed to ensure residents plan of care was revised after a change in condition for 1 (#4) of 5 residents whose plan of care was reviewed. The facility failed to revise Resident #4's plan of care after an elopement and after the development of a diabetic ulcer. Based on record review and interviews the facility failed to ensure residents plan of care was revised after a change in condition for 1 (#4) of 5 residents whose plan of care was reviewed. The facility failed to revise Resident #4's plan of care after an elopement and after the development of a diabetic ulcer. Findings: Review of Resident #4's medical record revealed an admit date of 01/09/2026 with a diagnosis of but not limited to, type 2 diabetes mellitus, cognitive communication deficit; aphasia; muscle wasting and atrophy, not elsewhere classified, multiple sites; other abnormalities of gait and mobility, disorientation, unspecified; unspecified dementia, unspecified severity, with anxiety, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, and essential (primary) hypertension. Review of Resident #4's progress notes revealed on 02/08/2026 at 6:06 p.m. Resident #4 was found outside of the facility in the flower bed in the front of the facility bent over with her hands in the dirt by an oncoming nurse. Further review of Resident #4's progress notes revealed a diabetic ulcer was found on Resident #4's right heel on 02/09/2026. Review of Resident #4's comprehensive plan failed to reveal a revision had been made to reflect Resident #4's elopement from the facility and development of a diabetic ulcer on the right heel. During an interview on 03/24/2026 at 12:10 p.m. S4 MDS Coordinator confirmed Resident #4's plan of care should have been revised to reflect an actual elopement and to reflect Resident #4's development of a diabetic ulcer.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive plan of care for 1 (#4) of 5 sampled residents. The facility failed to develop and implement approaches addressing Resident #4's risk of developing a diabetic foot ulcer. Findings: Review of Resident #4's medical record revealed an admit date of 01/09/2026 with a diagnosis of but not limited to, type 2 diabetes mellitus, cognitive communication deficit; aphasia; muscle wasting and atrophy, not elsewhere classified, multiple sites; other abnormalities of gait and mobility, disorientation, unspecified; unspecified dementia, unspecified severity, with anxiety, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, and essential (primary) hypertension. Review of Resident #4's admission MDS dated [DATE] revealed Resident #4 t was assessed to have a deep tissue injury on the righth heel. Review of Resident #4's skin assessment dated [DATE] revealed Resident #4 had a deep tissue injury on the right heel. Review of Resident #4's progress note by S6 Nurse Practitioner dated 01/12/2026 revealed: Deep tissue injury on right heel which is being treated with gentian violet and foam. Right heel is tender to touch. Review of Resident #4's January and February 2026 Physicians Orders failed to reveal any wound care treatment orders between 01/09/2026 and 02/08/2026. Review of Resident #4's January and February 2026 Treatment Administration Record failed to reveal any wound care treatments were provided between 01/09/2026 and 2/8/2026. Review of Resident #4's progress note by S5 Wound Care Nurse dated 02/09/2026 at 11:59 a.m. revealed a diabetic ulcer on resident #4's right heel was identified, right heel was tender and spongy to touch. Applied gentian violet soaked gauze and a foam dressing applied for protection. Review of Residents #4's skin assessment dated [DATE] revealed: Skin not intact-existing, treatment in place-diabetic ulcer to right heel. Review of Resident #4's Plan of care for diabetes initiated 01/09/2026 revealed these approaches; Check all of body for breaks in skin and treat promptly as ordered by doctor. Review of Resident #4's February 2026 Physician's Order revealed an order for: Diabetic area to right heel, monitor skin integrity to area, apply gentian violet dampened gauze and protective dressing on Monday and Thursday dated 02/09/2026. Review of Resident #4's February 2026 Treatment Administration Record revealed documentation of treatment as ordered above on the right heel on Monday 02/09/2026, Thursday 02/12/2026 and 02/16/2026 only. During an interview on 03/23/2026 at 10:00 a.m. Resident #4's responsible party reported Resident #4 was discharged from the facility on 02/16/2026 and had to be seen in the local emergency department for treatment of an infected diabetic ulcer on the right heel that required antibiotics. Review of Resident #4's emergency room Visit Notes dated 02/17/2026 revealed Resident #4 was treated for cellulitis due to a diabetic ulcer on the right heel and discharged home with antibiotics. During an interview on 03/25/2026 at 9:00 a.m. S5 Wound Care nurse confirmed the documentation of a deep tissue injury on Resident #4's 01/09/2025 skin assessment without any physicians orders for treatment. S5 Wound care nurse also confirmed Resident #4 developed a diabetic ulcer that was not identified until 02/09/2026 on Resident #4's right heel. During an interview on 03/25/2026 at 9:00 a.m. S6 Nurse Practitioner confirmed his documentation of Resident #4's right heel deep tissue injury in his notes dated 01/12/2026. S6 Nurse Practitioner confirmed he had only examined Resident #4's right heel on 01/12/2026.</p>		