

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 08/22/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on observations and interview the facility failed to accommodate the needs of 1 (#78) of 26 sampled residents. The facility failed to ensure Resident #78's call light was within reach.</p> <p>Findings:</p> <p>Review of Resident #78's medical record revealed an admitted [DATE] with diagnoses that included, in part, parkinsonism, unspecified dementia with psychotic disturbance, type 2 diabetes mellitus, pain unspecified, restlessness and agitation, and insomnia.</p> <p>Review of Resident #78's 06/06/2024 Quarterly MDS (Minimum Data Set) revealed Resident #78 had a Brief Interview Mental Status (BIMS) of 03 which indicated a severe cognitive impairment and required extensive assistance with bed mobility, transfer, and toilet use.</p> <p>Observation on 08/19/2024 at 8:20 a.m. revealed Resident #78's call light was on the bedside table where Resident #78 could not reach it.</p> <p>During an interview on 08/19/2024 at 8:20 a.m. this surveyor asked Resident #78 if he could reach his call light and Resident #78 was observed feeling around on his bed and answered no.</p> <p>Observation on 08/19/2024 at 8:56 a.m. revealed Resident #78 calling help repeatedly as this surveyor approached Resident #78's room. Call light was observed on Resident #78's bedside table and out of Resident #78's reach.</p> <p>During an interview on 08/19/2024 at 8:59 a.m. S4 CNA (Certified Nursing Assistant) observed Resident #78's call light on Resident #78's bedside table and reported the call light was out of Resident #78's reach and should not be.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure residents have a right to be free from any physical restraint not required to treat the resident's medical symptoms for 1 (Resident #360) out of 17 (#3, #17, #23, #39, #41, #66, #68, #72, #75, #78, #80, #87, #88, #96, #358, #360 and #361) residents investigated for physical restraints. The facility failed to ensure: 1.) a side rail utilization assessment was completed, 2.) a consent for the use of side rails was obtained, and 3.) a physician's order was in place for the use of bedrails for Resident #360.</p> <p>Review of facility's Use of Restraints policy with a revision date of April 2017 revealed in part:</p> <p>Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.</p> <p>Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline of staff convenience or for the prevention of falls.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.</p> <p>2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e. side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint.</p> <p>4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including:</p> <p>a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed .</p> <p>6. Prior to placing a resident in restraints, there shall be a Restraint Necessity/Positioning Device Assessment Form and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions .</p> <p>9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:</p> <p>a. the specific reason for the restraint (as it relates to the resident's medical symptom);</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. how the restraint will be used to benefit the resident's medical symptom; and</p> <p>c. the type of restraint.</p> <p>Review of Resident #360's medical record revealed an admitted [DATE] with diagnoses including heart failure, essential hypertension, and muscle wasting and atrophy.</p> <p>Review of Resident #360's Brief Interview for Mental Status (BIMS) Evaluation dated 08/14/2024 revealed Resident #360 had a BIMS score of 00, indicating severe cognitive impairment.</p> <p>Review of Resident #360's Nursing Admission assessment dated [DATE] revealed in part, Resident #360 was totally dependent on staff for bed mobility, transfers and locomotion.</p> <p>Review of Resident #360's Admission Fall Risk assessment dated [DATE] revealed Resident #360 was at high risk for falls.</p> <p>Review of Resident #360's physician's orders failed to reveal a physician's order for the use of side rails.</p> <p>Review of Resident #360's medical record failed to reveal an Admission Side Rail Utilization Assessment had been completed on 08/14/2024. Further review of the medical record also failed to reveal a consent for the use of side rails from Resident #360 or the Responsible Party (RP).</p> <p>Review of Resident #360's Admission Side Rail Utilization assessment dated [DATE] at 11:00 a.m. revealed in part, Resident #360 had a history of falls, an alteration in safety awareness and displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed. Further review revealed Resident #360 was not currently using the side rails for positioning or support and side rails were not indicated for mobility assistance.</p> <p>Review of Resident #360's interdisciplinary notes revealed nursing note entries by S8ADON (Assistant Director of Nursing) which read in part:</p> <p>08/19/2024 at 9:45 a.m. Resident #360 pulling to left side and continues to put arm in side rail. Pillow placed on left side for protection.</p> <p>08/19/2024 at 2:33 p.m. Resident #360 continues to pull to left side and put left arm in rail.</p> <p>An observation on 08/19/2024 at 8:30 a.m. revealed Resident #360 was asleep in bed with bilateral upper side rails in use.</p> <p>An observation on 08/19/2024 at 12:30 p.m. revealed Resident #360 was asleep on left side and positioned close to the upper left side rail with legs partially hanging out of bed. Resident #360 appeared restless and was reaching at left side rail.</p> <p>An observation on 08/20/2024 at 8:20 a.m. revealed Resident #360 was asleep on left side and positioned near the raised upper left side rail.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/21/2024 at 4:20 p.m., S3Corporate Nurse acknowledged Resident #360 had bed rails in use without a physician's order, side rail assessment or consent. S3Corporate Nurse acknowledged Resident #360 would not be able to use an assist rail for mobility and side rails were used as a restraint.</p> <p>During an interview on 08/22/2024 at 9:00 a.m., S9Physical Therapist acknowledged Resident #360's admission side rail assessment failed to reveal side rails were indicated for mobility assistance. S9Physical Therapist acknowledged Resident #360 had bilateral upper side rails in use without a completed admission side rail assessment.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36664</p> <p>Based on record reviews, observations and interviews, the facility failed to ensure correct use and maintenance of bed rails. The facility failed to assess residents for use of bed rails (side rails), obtain an informed consent from resident or resident representative prior to installation of bed rails, and/or obtain physician order for bed rails for 11 (#3, #17, #23, #41, #66, #68, #72, #78, #80, #88, #96) out of 17 (#3, #17, #23, #39, #41, #66, #68, #72, #75, #78, #80, #87, #88, #96, #358, #360 and #361) residents investigated for physical restraints.</p> <p>Findings:</p> <p>Review of the facility's Proper Use of Side Rails policy with a revision date of January 16, 2024 revealed in part:</p> <p>Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of the side rails as restraints unless necessary to treat a resident's medical symptoms.</p> <p>Definition</p> <p>Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.</p> <p>General Guidelines</p> <ol style="list-style-type: none"> 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: the side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat a resident's medical symptoms and/or assist with mobility and transfer of residents. 3. Upon admission, readmission, with routine quarterly or significant change MDS and PRN, therapy/designee will complete the Side Rail Utilization Assessment or equivalent form to determine the resident's symptoms, risk of entrapment and rationales for using side rails prior to implementation. When used for mobility or transfer, the assessment will include a review of the resident's: <ol style="list-style-type: none"> a. bed mobility <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. ability to change positions, transfer to side of bed and from bed to chair, and to stand and toilet;</p> <p>c. risk of entrapment from the use of side rails and</p> <p>d. that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>4. Consent for use of side rail will be obtained if used as a restraint, from the resident or legal representative after presenting the potential benefits and risk using the Informed Consent for Use of Bed Rails.</p> <p>10. The resident will be checked at least every shift for safety and proper functioning of the side rail use</p> <p>Resident #3</p> <p>Review of Resident #3's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertension, hypothyroidism, pain, other seizures, hereditary and idiopathic neuropathy unspecified, schizophrenia, and chronic obstructive pulmonary disease unspecified.</p> <p>Review of Resident #3's physician orders revealed an order dated 02/02/2024 that read:</p> <p>May have (Right/Left/Bilateral) assist rails to promote independence in bed mobility. Check for placement and functioning every shift.</p> <p>Review of Resident #3's medical record failed to reveal a side rail assessment had been conducted.</p> <p>Review of Resident #3's medical record failed to reveal a consent for side rails had been obtained.</p> <p>Observation on 08/19/2024 at 1:30 p.m. revealed Resident #3 was lying in bed with head of bed elevated and side rails were raised to each side of upper bed.</p> <p>Observation on 08/21/2024 at 8:25 a.m. revealed Resident #3 had a side rail raised on the left side of the upper bed.</p> <p>During an interview on 08/22/2024 at 1:10 p.m. S3 Corporate Nurse reviewed Resident #3's medical record and reported Resident #3 did not have an assessment or consent for side rails.</p> <p>Resident #17</p> <p>Review of Resident #17's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: Alzheimer's disease, spinal stenosis, and history of falling.</p> <p>Review of Resident #17's physician orders revealed an order dated 01/31/2024 that read:</p> <p>May have (Right/Left/Bilateral) assist rails to promote independence in bed mobility. Check for placement and functioning every shift.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #17's August 2024 MAR (Medication Administration Record) failed to reveal check for placement and functioning of side/assist rails had been conducted.</p> <p>Review of Resident #17's medical records failed to reveal a consent for side rails.</p> <p>Observation on 08/19/2024 at 9:30 a.m. revealed Resident #17's side rails were raised on each side of upper bed.</p> <p>Observation on 08/19/2024 at 3:45 p.m. revealed Resident #17's side rails were raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 10:30 a.m. revealed Resident #17's side rails were raised on each side of upper bed.</p> <p>Observation on 08/22/2024 at 8:15 a.m. revealed Resident #17's side rails were raised on each side of upper bed.</p> <p>During an interview on 08/21/2024 at 11:30 a.m. S3 Corporate Nurse confirmed that there was no consent for bed rails for resident #17. S3 Corporate Nurse also confirmed that medical records for resident #17 failed to reveal any checks completed for placement or function of bilateral assist rails.</p> <p>Resident #23</p> <p>Review of Resident #23's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: schizoaffective disorder bipolar type, repeated falls, restlessness and agitation, other seizure, and atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>Review of Resident #23's physician orders revealed an order dated 08/20/2024 that read:</p> <p>May have (bilateral) assist rails to promote independence in bed mobility. Check for placement and functioning every shift. Directions: every shift for promote independence.</p> <p>Further review of Resident #23's physician orders revealed failed to reveal an order for side rails prior to 08/20/2024.</p> <p>Review of Resident #23's medical record failed to reveal a consent for side rails prior to 08/20/2024.</p> <p>Observation on 08/19/2024 at 09:10 a.m. revealed Resident #23's right upper side rail was raised while lying on back in bed.</p> <p>Observation on 08/20/24 at 08:45 a.m. revealed Resident #23's side rails were raised on each side of upper bed.</p> <p>Observation on 08/20/2024 at 3:06 p.m. revealed Resident #23 was resting quietly in bed with side rails were raised on each side of upper bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/22/2024 at 1:10 p.m. S3 Corporate Nurse reviewed Resident #23's medical record and reported Resident #23 did not have a side rail assessment, consent for side rails, or physician order for side rails prior to 08/20/2024.</p> <p>Resident #41</p> <p>Review of Resident # 41's medical record revealed an initial admitted [DATE] and a re-entry admitted [DATE] with the following diagnoses, including but not limited to: idiopathic progressive neuropathy, overactive bladder, history of falling, unspecified dementia, and lack of coordination.</p> <p>Review of Resident #41's physician orders failed to reveal an order for side rails.</p> <p>Review of Resident #41's current medical record failed to reveal a quarterly side rail utilization assessment had been done after the initial assessment was done on 05/31/2022.</p> <p>Observation on 08/20/24 at 10:09 a.m. revealed Resident # 41 was in bed resting with eyes closed. Further observation revealed side rails were raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 12:30 p.m. revealed Resident #41 was in room sitting up in wheel chair. Further observation revealed side rails were raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 8:10 a.m. revealed Resident #41 in bed eating breakfast. Further observation revealed side rails were raised on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:30 p.m. S3 Corporate Nurse reviewed Resident # 41's current medical record and confirmed a quarterly side rail assessment had not been done.</p> <p>During an interview on 08/22/2024 at 1:40 p.m. S3 Corporate Nurse reviewed medical record and confirmed Resident #41 did not have a physician order for side rails.</p> <p>Resident #66</p> <p>Review of Resident #66's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dysphagia and depression.</p> <p>Review of Resident #66's physician orders revealed an order dated 01/30/2024 that read:</p> <p>May have bilateral assist rails to promote independence in bed mobility. Check for placement and functioning every shift.</p> <p>Review of Resident #66's medical record failed to reveal a consent for side rail use had been obtained.</p> <p>Review of Resident #66's medical record failed to reveal a quarterly side rail utilization assessment had been done after the initial assessment was done on 07/29/2022.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 08/19/2024 at 10:30 a.m. revealed Resident #66's side rails were raised on each side of upper bed.</p> <p>Observation on 08/20/2024 at 8:30 a.m. revealed Resident #66 was in the bed with side rails raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 8:20 a.m. revealed Resident #66 was asleep in bed with side rails raised on each side of upper bed.</p> <p>During an interview on 08/21/2024 at 4:20 p.m., S3 Corporate Nurse acknowledged a consent for side rail use had not been obtained and ongoing quarterly assessments had not been completed on Resident #66 and should have been.</p> <p>Resident #68</p> <p>Review of Resident #68's medical record revealed an initial admitted [DATE] and an admission (re-entry) date of 08/06/2024 with the following diagnoses, including but not limited to: pressure ulcer of sacral region, stage 4 and pressure ulcer of sacral region, stage 3, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, and muscle wasting and atrophy, multiple sites.</p> <p>Review of Resident #68's physician orders failed to reveal an order for side rails.</p> <p>Observation on 08/20/2024 at 10:01 a.m. revealed Resident #68 was resting with eyes closed with side rails raised on each side of upper bed.</p> <p>Observation on 08/20/2024 12:05 p.m. revealed Resident #68 was resting with eyes closed with side rails raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 8:00 a.m. revealed Resident # 68 was resting with eyes closed with side rails raised on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:50 p.m. S3 Corporate Nurse reviewed medical record and confirmed Resident #68 did not have physician orders for side rails.</p> <p>Resident #72</p> <p>Review of Resident #72's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: cerebral vascular accident, hemiplegia and hemiparesis on right side and lack of coordination.</p> <p>Review of Resident #72's physician orders revealed an order dated 01/31/2024 that read:</p> <p>May have bilateral assist rails to promote independence in bed mobility. Check for placement and functioning every shift.</p> <p>Review of Resident #72's August 2024 MAR (Medication Administration Record) failed to reveal any monitoring for placement and functioning had been conducted.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #72's medical record failed to reveal a consent for side rails or quarterly assessments for side rail utilization.</p> <p>Observation on 08/19/2024 at 9:30 a.m. revealed Resident #72 had side rails raised on each side of upper bed.</p> <p>Observation on 08/19/2024 at 3:45 p.m. revealed Resident #72 had side rails raised on each side of upper bed.</p> <p>Observation on 08/21/2024 at 10:30 a.m. revealed Resident #72 had side rails raised on each side of upper bed.</p> <p>Observation on 08/22/2024 at 8:10 a.m. revealed Resident #72 had side rails raised on each side of upper bed.</p> <p>During an interview on 08/21/2024 at 11:30 a.m. S3 Corporate Nurse confirmed that there was no consent for bed rails for resident #72. S3 Corporate Nurse also confirmed that medical records for resident #72 failed to reveal any monitoring had been completed for placement or function of bilateral assist rails.</p> <p>During an interview on 08/22/2024 at 1:25 p.m., S3 Corporate Nurse confirmed that there are no quarterly assessment for side rail utilization assessment for resident #72.</p> <p>Resident #78</p> <p>Review of Resident #78's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: Parkinsonism, pain unspecified, restlessness and agitation, pure hypercholesterolemia unspecified, dementia, type 2 diabetes mellitus without complications.</p> <p>Review of Resident #78's physician orders failed to reveal an order for the use of side rails.</p> <p>Review of Resident #78's August 2024 MAR failed to reveal any monitoring had been conducted in regard to Resident #78's side rails.</p> <p>Observation on 08/19/2024 at 9:10 a.m. revealed Resident #78's side rails were up on each side of upper bed.</p> <p>Observation on 08/21/2024 at 8:10 a.m. revealed Resident #78's side rails were up on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:15 p.m., S3 Corporate Nurse reviewed Resident #78's medical record and reported Resident #78 did not have an order for side rails and monitoring had not been conducted for Resident #78 who used side rails.</p> <p>Resident #80</p> <p>(continued on next page)</p>		

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 08/22/2024
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.			
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #80's medical record revealed an admitted [DATE] with following diagnoses, but not limited to: muscle wasting and atrophy, multiple sites, type 2 DM, muscle weakness (generalized), primary generalized (osteo) arthritis, aphasia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and lack of coordination.</p> <p>Review of Resident #80's physician orders failed to reveal an order for the use of side rails.</p> <p>Observation on 08/20/2024 at 9:09 a.m. revealed Resident #80 was in bed watching television with side rails raised on each side of upper bed.</p> <p>Observation on 08/21/2021 at 8:10 a.m. revealed Resident #80 was in bed eating breakfast with side rails raised on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:40 p.m., S3 Corporate Nurse reviewed Resident #80's medical record and confirmed Resident #80 did not have a physician order for side rails.</p> <p>Resident #88</p> <p>Review of Resident #88's medical record revealed an initial admitted [DATE] and a re-entry date of 03/06/2024 with the following diagnoses, including but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, type 2 diabetes mellitus, abnormalities of gait and mobility, lack of coordination, muscle wasting and atrophy.</p> <p>Review of Resident #88's physician orders failed to reveal an order for the use of side rails.</p> <p>Observation on 08/20/24 at 9:09 a.m. revealed Resident #88 was in bed watching television with side rails raised on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:40 p.m. S3 Corporate Nurse reported Resident #88 did not have a physician order for bed rails.</p> <p>Resident #96</p> <p>Review of Resident #96's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: rhabdomyolysis, lack of coordination and rheumatoid arthritis.</p> <p>Review of Resident #96's physician orders failed to reveal an order for the use of side rails.</p> <p>Review of Resident #96's medical record failed to reveal a side rail utilization assessment consents.</p> <p>Observation on 08/20/24 at 9:40 a.m. revealed Resident # 96 was in bed with side rails raised on each side of upper bed.</p> <p>Observation on 08/20/2024 at 12:20 p.m. revealed Resident # 96 was in bed watching television with side rails raised on each side of upper bed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Bradford Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Baird Road Shreveport, LA 71118	
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 8/21/2024 at 8:10 a.m. revealed #96 in bed eating breakfast with side rails raised on each side of upper bed.</p> <p>During an interview on 08/22/2024 at 1:40 p.m. S3 Corporate Nurse reported an initial side rail assessment and consent had not been completed for Resident #96. S3 Corporate Nurse further reported Resident #96 did not have a physician order for side rails.</p> <p>36921</p> <p>40015</p> <p>44414</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>40015</p> <p>Based on observation of the medication pass, review of current physician orders, and interviews, the facility failed to ensure that it is free from medication error rate of 5% or greater by committing 2 errors (#19, #93) out of 29 opportunities for an error rate of 6.9%.</p> <p>Findings:</p> <p>Resident #19</p> <p>Observation during medication pass on 08/20/2024 at 8:20 a.m. revealed S6 LPN (Licensed Practical Nurse) administered Fluticasone Propionate and Salmeterol 250mcg (microgram) /50mcg by oral inhalation to Resident #19.</p> <p>Review of Resident #19's current physician orders revealed a 07/16/2024 order for Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 mcg/act (actuation) (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day related to chronic obstructive pulmonary disease.</p> <p>During an interview on 08/20/2024 at 2:30 p.m. S6 LPN reviewed Resident #19's medication container from medication cart which read Fluticasone Propionate and Salmeterol 250mcg/50mcg and reviewed Resident #19's physician order and reported the medication was not administered as per the physician order and should have been.</p> <p>Resident #93</p> <p>Observation of the medication pass on 08/20/2024 at 7:37 a.m. revealed S6 LPN administered one-half tablet of Metoprolol Succ (Succinate) ER (Extended Release) 25mg (milligram) by mouth to Resident #93.</p> <p>Review of Resident #93's current physician orders revealed a 03/13/2024 order for Metoprolol Succinate ER Tablet Extended Release 24 hour 25mg - give 1 tablet by mouth one time a day related to essential hypertension.</p> <p>During an interview on 08/20/2024 at 2:35 p.m. S6 LPN reviewed Resident #93's medication card from the medication cart which contained half tablets equaling 12.5mg in each blister and read Metoprolol Succ ER 25mg tab (Toprol XL 25mg) - give one-half tablet by mouth once daily and reviewed Resident #93's physician order and reported the medication was not administered as per the physician order and should have been.</p> <p>During an interview on 08/20/2024 at 2:37 p.m. S7 NP (Nurse Practitioner) reviewed the order for Resident #93's Metoprolol Succinate ER 25mg tablet and confirmed Resident #93 should have received a full tablet.</p> <p>During an interview on 08/20/2024 at 3:50 p.m. S2 DON (Director of Nursing) observed Resident #19's medication container for Fluticasone Propionate and Salmeterol 250mcg/50mcg and Resident #93's medication card for Metoprolol Succinate and agreed the medications did not match the physician orders.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>36921</p> <p>Based on record review and interviews, the facility failed to electronically submit accurate payroll information for direct care staffing as required.</p> <p>Findings:</p> <p>Review of PBJ (Payroll Based Journal) [NAME] Report 1705D for the fiscal year 2024, 2nd quarter (January 1-March 31) revealed excessively low weekend staffing was triggered.</p> <p>During an interview on 08/22/2024 at 10:10 a.m S1 Administrator reported S5 Human Resources submits the agency staffing information to corporate and corporate submits PBJ report quarterly to CMS (Centers for Medicare & Medicaid Services). S1 Administrator reported the facility had adequate staff. S1 Administrator reported an agency invoice may have been missed or corporate may not have had the agency invoice at the time of reporting.</p> <p>During an interview on 08/22/2024 at 10:25 a.m. S5 Human Resources reported the PBJ staffing report is completed by the corporate office. S5 Human Resources reported when staffing agencies send staffing hours to the facility late, the staffing hours reported to corporate office will show that the facility did not have enough staff. S5 Human Resources reported when staffing agency hours are late to the facility and corporate sends the information into the PBJ system, the staffing numbers do not show the agency staff hours and it appears the facility did not have adequate staffing.</p>		