STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195515	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shreveport Manor Skilled Nursing & Rehabilitation	3302 Mansfield Road Shreveport, LA 71103

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957 Based on record review and interviews, the facility failed to ensure a resident's Physician/Physician's Representative and Responsible Party (RP) were notified after a fall for 1 (Resident #3) of 3 (Resident #1, #2, and #3) sampled residents. Findings: Review of facility's Assessing Falls and Their Causes policy with a revision date of March 2018 revealed in part: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After a fall: 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall occurs, or when the fall results in a significant injury or condition change, prompt notification of the physician by phone is indicated. Documentation: When a resident falls, the following information should be recorded in the resident's electronic medical record: 4. Notification of physician and family. Resident #3 was admitted to the facility on [DATE] with diagnoses including in part, severe dementia with other behavioral disturbances, persistent mood disorders, major depressive disorder, schizoaffective disorder, and Alzheimer's disease. Review of Resident #3's MDS (Minimum Data Set) dated 01/30/2024 revealed in part, Resident #3 had a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. Resident #3 required extensive assistance with bed mobility, transfers, and toilet use. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Medical Record revealed a nurse's note written by S6LPN (Licensed Practical Nurse) dated 04/20/2024 at 10:55 p.m., which read in part, S5CNA (Certified Nursing Assistant) came and told me (S6LPN) that Resident #3 was on the floor and that Resident #3 had fallen on the mat beside his bed. Further review of Resident #3's Medical Record failed to reveal Resident #3's Physician/Physician's Representative and RP had been notified of Resident #3's unwitnessed fall on 04/20/2024. During a telephone interview on 05/07/2024 at 11:45 a.m., Resident #3's RP reported facility never notified me of Resident #3's fall on 04/20/2024. During an interview on 05/09/2024 at 8:50 a.m., S2Corporate Nurse acknowledged Resident #3's Physician and RP had not been notified of the fall on 04/20/2024 and should have been.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957 Based on record review, video footage review, and interviews the facility failed to ensure the nursing staff possessed the competency to assess a resident after an unwitnessed fall and complete an internal report in a timely manner for 1 (Resident #3) of 3 (Resident #1, #2, and #3) sampled residents. Findings: Review of facility's Assessing Falls and Their Causes policy with a revision date of March 2018 revealed in part: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After a fall: 1. If a resident has just fallen, or is on the floor without a witness to the event, evaluate for possible injuries to the head, neck spine and extremities. 5. b. All unwitnessed falls regardless of orientation will require neurological checks using the approved neurological check forms. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 8. Complete an Incident Report for resident falls after the fall occurs. The Incident Report form should be completed by the Nursing Staff on duty at the time and submitted to the Director of Nursing. Documentation: When a resident falls, the following information should be recorded in the resident's electronic medical record: 1. The condition in which the resident was found . 2. Assessment data, including vital signs and any obvious injuries. Resident #3 was admitted to the facility on [DATE] with diagnoses including in part, severe dementia with other behavioral disturbances, persistent mood disorders, major depressive disorder, schizoaffective disorder, and Alzheimer's disease. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's MDS (Minimum Data Set) dated 01/30/2024 revealed in part, Resident #3 had a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. Resident #3 required extensive assistance with bed mobility, transfers, and toilet use. Review of Resident #3's Medical Record revealed a nurse's note written by S6LPN (Licensed Practical Nurse) dated 04/20/2024 at 10:55 p.m., which read in part, S5CNA (Certified Nursing Assistant) came and told me (S6LPN) that Resident #3 was on the floor and that Resident #3 had fallen on the mat beside his bed. When writer (S6LPN) arrived to room, Resident #3 was sitting on the floor next to the bed, looking up at the ceiling. Resident #3 denies any pain when asked, but began to say Ow when we picked Resident #3 up to put him back to bed. Further review of Resident #3's Medical Record failed to reveal a thorough head to toe assessment, vital signs and neurological checks had been completed by nursing staff after Resident #3's unwitnessed fall on 04/20/2024. Review of Resident #3's Hospice binder revealed a visit summary note written by S8Hospice Nurse dated 04/21/2024 at 4:00 pm, which read in part, Resident #3 had a fall from bed on 04/20/2024. Resident #3 was observed laying in the bed with head of bed at 30 degrees sleeping. Resident #3 does have his right leg drawn up/bent at the knee. Resident #3's right lower leg is leaned across the left leg above the left knee. Resident #3 has the right hip flexed also. When you go to move the right leg, Resident #3 does grimace and moan out like he is in pain. Resident #3 is rating a 5 out of 10 on a pain scale. Review of Resident #3's x-ray report dated 04/21/2024 revealed in part Resident #3 had a mildly displaced right great trochanter fracture. Review of internal incident report revealed in part Resident #3's unwitnessed fall on 04/20/2024 was not completed by S6LPN until 04/21/2024. Review of surveillance video footage provided by Resident #3's RP (Responsible Party) on 05/07/2024 at 2:00 p.m. revealed in part, motion activated video clips with a duration of 20 seconds each, as follows: 04/20/2024 at 10:39:17 p.m., Resident #3 was observed to be sitting on the floor. Resident #3 attempted to reach over and grab the end of his bed when both legs moved into an upward motion and caused Resident #3 to roll over backwards and onto his right side. During a telephone interview on 05/08/2024 at 5:45 p.m., S9LPN reported Resident #3 was noted to be grimacing with pain when staff attempted to change him on 04/21/2024 around lunchtime. S9LPN reported Resident #3 hollered out in pain when she examined his right leg. S9LPN reported she then telephoned S8Hospice Nurse to report findings. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/08/2024 at 5:00 p.m., S8Hospice Nurse reported she was telephoned on 04/21/2024 by S9LPN who stated Resident #3 was in pain and she could not figure out what was wrong. S8Hospice Nurse reported when she arrived to facility, she assessed Resident #3 who grimaced in pain when his right leg was examined. S8Hospice Nurse reported she called Resident #3's RP while she was still in the room and Resident #3's RP went to look at the video footage. S8Hospice Nurse further reported while on the phone, Resident #3's RP informed her she saw where Resident #3 had a fall the night before. S8Hospice Nurse reported an x-ray was ordered and the result of right hip fracture came back on 04/22/2024. During an interview on 05/09/2024 at 8:45 a.m., S3ADON (Assistant Director of Nursing) acknowledged a thorough head to toe assessment, vital signs and neurological checks had not been performed by the nurse after Resident #3's unwitnessed fall on 04/20/2024 and should have been. During an interview on 05/09/2024 at 8:50 a.m., S2Corporate Nurse, acknowledged a thorough assessment to include vital signs and neurological checks had not been completed by the nurse after Resident #3's unwitnessed fall on 04/20/2024 and should have been. S2Corporate Nurse reported S6LPN did not complete the internal incident report for Resident #3 until the next day, 04/21/2024, after Resident #3's injury had been discovered, and should have been completed at the time of incident. During a telephone interview on 05/09/2024 at 10:10 a.m., S6LPN reported she was called to Resident #3's room on 04/20/2024 by S5CNA who told her she found Resident #3 on the floor. S6LPN reported when she entered the room, Resident #3 was sitting on the floor and she (S6LPN) and S5CNA assisted Resident #3 back into bed. S6LPN acknowledged Resident #3 voiced pain when moved back into bed and could not provide documentation of vital signs or neurological checks.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40957 Based on record review, video footage review and interviews, the facility failed to ensure it operated and provided services in compliance with Federal, State, and local laws by not ensuring a resident's RP (Responsible Party) installed surveillance camera was not hampered with and/or obstructed for 1 (Resident #3) of 3 (Resident #1, #2, and #3) sampled residents. Findings: The current Nursing Home Virtual Visitation Act 596 revealed in part: Prohibited Acts Under the Nursing Home Virtual Visitation Act: 2. No person shall intentionally hamper, obstruct, tamper with, or destroy a monitoring device or a recording made by a monitoring device installed in a nursing home; this does not apply to the resident. Resident #3 was admitted to the facility on [DATE] with diagnoses including in part, severe dementia with other behavioral disturbances, persistent mood disorders, major depressive disorder, schizoaffective disorder, and Alzheimer's disease. Review of Resident #3's MDS (Minimum Data Set) dated 01/30/2024 revealed in part, Resident #3 had a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. Resident #3 required extensive assistance with bed mobility, transfers, and toilet use. Review of Resident #3's Medical Record revealed a nurse's note written by S6LPN (Licensed Practical Nurse) dated 04/20/2024 at 10:55 p.m., which read in part, S5CNA (Certified Nursing Assistant) came and told me (S6LPN) that Resident #3 was on the floor and that Resident #3 had fallen on the mat beside his bed. When writer (S6LPN) arrived to room, Resident #3 was sitting on the floor next to the bed, looking up at the ceiling. Resident #3 denies any pain when asked, but began to say Ow when we picked Resident #3 up to put him back to bed. Review of surveillance video footage provided by Resident #3's RP on 05/07/2024 at 2:00 p.m. revealed in part, motion activated video clips with a duration of 20 seconds each, as follows: 04/20/2024 at 10:39:17 p.m. Resident #3 was observed to be sitting on the floor at the foot of his bed. Resident #3 attempted to reach over and grab the end of his bed when both legs moved into an upward motion and Resident #3 rolled over backwards and onto his right side. 04/20/2024 at 10:55:58 p.m. Resident #3 was observed in semi-sitting position supported by his right arm on the floor at the foot of his bed with left knee in a bent position and right leg in an extended position. S5CNA and S7CNA entered Resident #3's room. S7CNA approached Resident #3 and stated, Resident #3, hey, what you doing? Why are you down here? S5CNA was observed turning the video surveillance camera towards the wall and further view of Resident #3 was blocked. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/20/2024 at 11:04:48 p.m. Resident #3's video surveillance camera was observed to be turned back around in view of Resident #3 by an unidentifiable staff. Resident #3 was observed lying in bed and covered with a blanket. Upon completion of the review of video clips provided by Resident #3's RP, the care provided by staff after Resident #3 was found on the floor on 04/20/2024 was unable to be documented due to the obstructed view. Review of Resident #3's x-ray report dated 04/21/2024 revealed in part Resident #3 had a mildly displaced right great trochanter fracture. During an interview with S4Care Plan Nurse on 05/09/2024 at 9:00 a.m., S4Care Plan Nurse viewed the video clip dated 04/20/2024 at 10:55:58 p.m. and identified S5CNA as the staff who turned Resident #3's surveillance camera around. S4Care Plan Nurse acknowledged Resident #3's camera should not have been hampered with and view of Resident #3's care after a fall had been obstructed. During an interview on 05/09/2024 at 10:20 a.m., S2Corporate Nurse reported it was the family's right to have video surveillance without interruption from staff and S5CNA should not have hampered with the surveillance camera.