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	07/30/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on observations, interviews, and record review, the facility failed to ensure a resident was cared for with respect and dignity by failing to provide a privacy covering for a urinary catheter bag for 1 resident (#221) out of 4 (#35, #38, #42, #221) residents reviewed for dignity out of a total of 31 sampled residents. Findings: Review of resident #221's medical record revealed an admitted [DATE] with a diagnoses of, but not limited to, unspecified conversion disorder with seizures, bladder-neck obstruction, urinary tract infection and schizoaffective disorder bipolar type. Review of resident #221's Quarterly MDS (Minimum Data Set) dated 01/14/2024 revealed resident #221 had a BIMS (Brief Interview Mental Status) score of 10 indicating moderately impaired cognition. Review of resident #221's July Physician's Orders revealed an order for: Catheter: Urinary Catheter ensure tubing anchor and privacy bag is intact and secure every shift. Observation on 07/28/2024 at 8:00 a.m. revealed resident #221 was up in his room in the wheelchair. Resident #221's door was open and resident #221's catheter bag did not have a privacy cover over it. Observation on 07/28/2024 at 11:49 a.m. with S6 CNA (certified nursing assistant) revealed resident #221's catheter bag did not have a privacy cover over it. During an interview on 07/28/2024 at 11:45 a.m. resident #221 reported, I don't know why I don't have a blue cover over the bag, I get embarrassed especially when I am up front with the other people. During an interview on 07/28/2024 at 11:49 a.m. S5 LPN (licensed practical nurse) confirmed resident #221 should have a privacy cover on his catheter bag.

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on observations and interview the facility failed to accommodate the needs of 1 (#57) resident out of 4 (#20, #55, #57, #67) residents reviewed for environment. The facility failed to ensure resident #57's call device was within reach. Findings: Review of resident #57's medical record revealed an admitted [DATE] with a diagnoses of, but not limited to, Alzheimer's disease, unspecified need for assistance with personal care, essential hypertension, Parkinson's disease and anxiety disorder. Review of resident #57's quarterly MDS (minimum data set) dated 05/07/2024 revealed resident #57 did not have a BIMS (brief interveiw mental status) score because resident #57 was rarely or never understood. Review of resident #57's comprehensive plan of care revealed resident #57 had a self-care deficit and required assistance with bathing, bed mobility, dressing, eating, transferring and personal hygiene. Observation on 07/28/2024 at 7:45 a.m. revealed resident #57 in bed with his breakfast tray in front of him. Further observation revealed resident #57's call device was on the floor underneath his bed out of resident #57's reach. Observation with S5 LPN (licensed practical nurse) on 07/28/2024 at 7:45 a.m. revealed resident #57's call device was on the floor underneath his bed and out of resident #57's reach. During an interview on 07/28/2024 at 7:45 a.m. S5 LPN confirmed resident #57's call device should have been placed within resident #57's reach.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 36665 Based on observations and interview the facility failed to ensure the most current survey results were posted in a place readily accessible to the residents, family members or anyone to review. Findings: Observation on 07/28/2024 at 11:45 a.m. failed to reveal the most recent survey results were posted in a place that was readily accessible for review. Observation on 07/28/2024 at 11:45 a.m. with S1 Administrator revealed the most recent survey results were not posted in a place that was readily available for review. During an interview on 07/28/2024 at 11:45 a.m. S1 Administrator confirmed the most recent survey results should have been posted for residents, family and anyone to review.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on record reviews, observations, and interviews the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 (#53, #57, #221) of 4 (#5, #53, #57, #221) residents reviewed for ADLs (activities of daily living). The facility failed to ensure nail care was provided. Findings: Resident #53 Review of resident #53's medical record revealed an admitted [DATE] with a diagnoses of, but not limited to, unspecified dementia, major depressive disorder, recurrent, severe with psychotic symptoms, unspecified dementia, mild, with mood disturbance, unsteadiness on feet, and cognitive communication deficit. Review of resident #53's quarterly MDS (minimum data set) dated 05/10/2024 revealed a BIMS (brief interview mental status) of 4 indicating severely impaired cognition. Review of resident #53's comprehensive plan of care revealed resident #53 had a self-care deficit, was totally dependent and required assistance with bathing and personal hygiene. Observation on 07/28/2024 7:45 a.m. with S5 LPN (licensed practical nurse) revealed resident #53's fingernails protruded past nailbeds and had not been trimmed. During an interview on 07/28/2024 at 7:35 a.m. S5 LPN confirmed resident #53's fingernails should have been trimmed. Resident #57 Review of resident #57's medical record revealed an admitted [DATE] with a diagnoses of, but not limited, to Alzheimer's disease, unspecified need for assistance with personal care, essential hypertension, Parkinson's disease and anxiety disorder. Review of resident #57's quarterly MDS (minimum data set) dated 05/07/2024 revealed resident #57 did not have a BIMS (brief interview mental status) because resident #57 was rarely or never understood. Review or resident #57's comprehensive plan of care revealed resident #57 had a self-care deficit and required assistance with bathing, bed mobility, dressing, eating, transferring and personal hygiene. Observation on 07/28/2024 at 7:55 a.m. with S5 LPN revealed resident #57's fingernails on both hands had not been trimmed and protruded past the nailbeds. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/28/2024 at 7:55 a.m. S5 LPN confirmed resident #57's fingernails should have been trimmed. Resident #221 Review of resident #221's medical record revealed an admitted [DATE] with a diagnoses of, but not limited, muscle wasting and atrophy, lack of coordination, unspecified conversion disorder with seizures or convulsions, schizoaffective disorder, bipolar type, chronic hepatitis, and essential hypertension. Review of resident #221's quarterly MDS (minimum data set) dated 05/14/2024 revealed resident #221 had BIMS (brief interview mental status) score of 10, indicating moderately impaired cognition. Review of resident #221's comprehensive plan of care revealed resident #221 had a self-care deficit and required assistance with bathing, bed mobility, dressing, eating, transferring and personal hygiene. Observation on 07/28/2024 at 8:00 a.m. revealed resident #221 had fingernails that protruded past his nailbeds on both hands. During an interview on 07/28/2024 at 8:00 a.m. S5 LPN confirmed resident #221's fingernails should have been trimmed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on observations, record reviews and interviews the facility failed to ensure residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (#35) of 2 (#5, #35) residents reviewed for position and mobility. The facility failed to ensure Resident #35's splint was in place to treat a contracture. Findings: Review of Resident #35's medical record revealed an admitted [DATE] with the following diagnoses, in part: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, direct infection of unspecified hand in infectious and parasitic diseases classified elsewhere, need for assistance with personal care, contracture/right hand and unspecified lack of coordination. Review of Resident #35's comprehensive care plan revealed at risk for complications due to right hand decreased strengthening and positioning - 06/26/2024 right palm pressure ulcer treat as ordered per medical director. Review of Resident #35's physician's orders revealed an order dated 07/10/2024 - May use/wear right hand orthotic daily as tolerated every shift r/t (related to) contracture right hand .every day as tolerated. Review of Resident #35's Nurse Practitioner's progress note dated 07/01/2024 revealed chief complaint of right hand wound infection .New finding of right palm wound likely 2/2 (secondary to) contracture Observation on 07/28/2024 at 8:55 a.m. failed to reveal a splint in Resident #35's right hand. Observation on 07/28/2024 at 2:30 p.m. failed to reveal a splint in Resident #35's right hand. Observation on 07/29/2024 at 11:00 a.m. failed to reveal a splint in Resident #35's right hand. Observation on 07/29/2024 at 3:30 p.m. failed to reveal a splint in Resident #35's right hand. During an interview on 07/29/2024 at 8:15 a.m. S4 LPN (Licensed Practical Nurse) reported Resident #35 should have a splint in her right hand. S4 LPN confirmed a splint should have been placed in Resident #35's right hand and was not. During an interview on 07/29/2024 at 10:20 a.m. S7 OT (Occupational Therapy) reported Resident #35 had a splint that was to be placed in her right hand for a contracture. S7 OT further reported her right hand was in a tight fist and her nails dug into her palm.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36665 Based on observations and interview the facility failed to ensure residents' environment remained free of accident hazards on the locked memory unit by failing to ensure all rooms had a door handle. This had the potential to effect 14 residents residing on the memory care unit. Findings: Observation on 07/28/2024 at 8:00 a.m. on the locked memory unit revealed room A failed to have a door handle in place, exposing a sharp edge. Observation on 07/29/2024 at 8:15 a.m. with S8 Maintenance Supervisor on the memory unit revealed room A failed to have a door handle in place, exposing a sharp edge. During an interview on 07/29/2024 at 8:15 a.m. S8 Maintenance Supervisor reported the door handle to room A had been off since the unit was established and confirmed the door handle should have been repaired.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on observations, record reviews and interview, the facility failed to provide residents necessary respiratory care and services in accordance with accepted professional standards of practice for 2 (#20, #67) of 2 (#20, #67) residents reviewed for respiratory services. The facility failed to ensure resident's hand held nebulizer (HHN) masks and tubing were dated and stored in a plastic bag. Findings: Review of the facility's Departmental Respiratory Therapy Policy (revised November 2021) revealed: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection control considerations related to medication nebulizers/continuous aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. Resident #20 Review of Resident #20's medical record revealed an admitted [DATE] with the following diagnoses, in part: chronic obstructive pulmonary disease/unspecified, acute and chronic respiratory failure with hypoxia, panlobular emphysema, and encounter for attention to tracheostomy. Review of Resident #20's physician's orders revealed an order dated 04/26/2022 for Acetylcysteine Inhalation Solution 20% 3 ml (milliliter) inhale orally three times a day related to acute and chronic respiratory failure with hypoxia. Observation on 07/28/2024 at 8:40 a.m. revealed Resident #20's HHN on bedside table. Further observation revealed mask and tubing sitting on top of the machine with no date and not stored in a plastic bag. Resident #67 Review of Resident #67's medical records revealed an admit of 06/19/2024 with the following diagnoses, in part: Alzheimer's disease/unspecified, chronic obstructive pulmonary disease/unspecified, and acute and chronic respiratory failure with hypoxia. Review of Resident #67's physician's orders revealed orders dated 07/19/2024 for Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT (microgram/actuation) (Ipratropium- Albuterol) 1 puff inhale orally every 6 hours as needed for wheezing and Fluticasone-Salmeterol Aerosol Powder Breath Activated 250-50 MCG/DOSE 1 inhalation inhale orally every 12 hours for wheezing. Observation on 07/28/2024 at 9:15 a.m. revealed Resident #67's HHN on bedside table. Further observation revealed mask and tubing sitting on top of the machine with no date and not stored in a plastic bag. During an interview on 07/28/2024 at 9:20 a.m. S4 LPN (Licensed Practical Nurse) acknowledged Resident #20 and Resident #67's HHN mask and tubing should be dated and stored in a plastic bag.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40193 Based on record review and interviews the facility failed to accurately submit mandatory direct care staffing information to Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) Quarter 2 2024 (January 1 - March 31). Findings: Review of the facility Payroll Based Journal (PBJ) Staffing Data Report for FY Quarter 2 2024 (January 1 - March 31) revealed triggers for the following: One Star Staffing Rating and Excessively Low Weekend Staffing. Review of the facility's weekend staffing pattern forms for FY Quarter 2 2024 revealed hours of direct care provided exceeded the hours of care required. During an interview on 07/29/2024 at 8:05 a.m. S3 Director of Nursing reported she did not understand why the facility triggered for low staffing and did not know why the data entered would be incorrect because the facility always overstaffs. During an interview on 07/30/2024 at 10:45 a.m. S2 Corporate Nurse reported she did not know why the PBJ Staffing Data Report for FY Quarter 2 2024 to CMS shows low weekend staffing.