

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 9105 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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure a resident received adequate supervision to prevent incidents and accidents. The facility failed to ensure a resident received supervision during incontinent care for 1 (#2) of 3 (#1, #2, #3) residents reviewed for falls.</p> <p>The deficient practice resulted in an immediate jeopardy for Resident #2 on 04/26/2025 at approximately 5:00 a.m. when Resident #2 fell out on the left side of the bed during incontinent care when S4CNA (Certified Nursing Assistant) failed to ensure the resident was secured and safe in the bed to prevent her from falling before she turned away to retrieve an adult brief from the over bed table leaving Resident #2 unsupervised causing Resident #2's fall resulting in a fractured right femur. Resident #2 was transferred to a local ER (Emergency Room) on 04/26/2025.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation.</p> <p>Findings:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses, which included in part, unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing, Rheumatoid arthritis, type 2 diabetes mellitus without complications, other lack of coordination, pain unspecified and unspecified abnormalities of gait and mobility.</p> <p>Review of Resident #2's most recent completed Quarterly MDS(Minimum Data Set) assessment dated [DATE] revealed in part, Resident #2 had a BIMS (Brief Interview Status) score of 15, which indicated Resident #2 was cognitively intact that includes normal thinking, learning, and memory abilities. Resident #2 was always incontinent of bowel and bladder and dependent on staff for ADL (activities of daily living) care.</p> <p>Review of Resident #2's comprehensive care plan revealed in part, Resident #2 was at risk for falls related to impaired mobility, with approaches in place prior to the fall injury. ADLs were bed mobility Resident #2 needed extensive assistance.</p> <p>Review of the facility's Incident Report dated 04/26/2025 at 05:00 a.m., revealed in part, S4CNA stated during Resident #2's incontinent care, she (S4CNA) turned away to retrieve an adult brief from the over bed table leaving Resident #2 unsupervised causing Resident #2's fall resulting in a fractured right femur. Resident #2 was transferred to a local ER (Emergency Room) on 04/26/2025.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of S4CNA's signed witness statement dated 04/27/2025 revealed S4CNA documented she was changing Resident #2, Resident #2 had turned and grabbed the side rail so I (S4CNA) reached the other way to grab a diaper that was on the other side which took 2 seconds I (S4CNA) look back over Resident #2 had must got weak and let go. After the fall I (S4CNA) immediately got the nurse.</p> <p>Review of Resident #2's nurse's progress notes dated 04/26/2025 at 5:00 a.m. by S5LPN (licensed practical nurse) which read in part: S5LPN notified per S4CNA Resident#2 was on the floor. Upon entry of room S5LPN noted Resident #2 laying on her left side on the floor with the bed in the high position. When asked what happened S4CNA reported she was changing Resident #2 reached over to grab a diaper to put under her, turn back around and Resident #2 was on the floor. S5LPN assessed Resident #2's range of motion, pain and skin. Resident #2 complained of pain level of 8 to 10 to right knee. S5LPN noted &frac12; centimeter skin tear to Resident #2's jaw, blood pressure 152/93, pulse 82, respiration 18. Temp. 98.4, oxygen saturation 90%, oxygen at 2 liters continuous by way of nasal cannula. Resident #2 assisted from floor per Hoyer Lift. Resident #2 was administered 2 Tylenol 325 for pain per standing orders. At 5:08 a.m. order received from on call nurse practitioner to send Resident #2 to E.R. (emergency room). At 5:12 a.m. ambulance called, 5:19 a.m. spouse was called no answer. At 5:22 a.m. Resident #2's son was notified of incident. At 5:26 a.m. Resident #2 left facility via stretcher per ambulance to local hospital E.R. DON (Director of Nursing) notified</p> <p>Review of Resident #2's hospital records dated 04/26/2025, revealed she was diagnosed with a non-operative right distal femur fracture. Resident #2 is to remain in an immobilizer for 6 to 8 weeks.</p> <p>Observation on 05/13/2025 at 9:40 a.m. Resident #2 was alert and talkative sitting up in a wheelchair at the bedside. Resident #2 had an immobilizer to her right leg that was slightly elevated. Resident #2's fingers and hands were deformed and twisted. Resident #2's bed had a weight reduction mattress on it, bilateral assisted side rails attached properly to the bed.</p> <p>During an interview on 05/13/2025 at 9:50 a.m., Resident #2 reported she had slipped out of her bed on the left side when S4CNA was cleaning her up. Resident #2 reported S4CNA just wasn't paying attention, talking on that phone. When Resident #2 was asked if she used the side rails to turn and reposition herself she responded, No. Resident #2 reported she was not able to hold on to the side rails for a long time due to the arthritis in her hands. Resident #2 reported she did not have much pain in that right leg now. Resident #2 reported the pain was nothing like the pain she had when she first fell. She reported the nurses gave her something for pain and it worked.</p> <p>During an interview on 05/13/2025 at 12:15 p.m., S3CNA Supervisor reported she was not working when the incident occurred with Resident #2 and S4CNA. S3CNA Supervisor reported S4CNA reported to her she was providing incontinent care to Resident #2 when she turned around to get an adult brief from the over bed table and Resident #2 fell out of the bed. S3CNA Supervisor reported S4CNA reported Resident #2's bed was in a high level so that she could work. S3CNA Supervisor reported S4CNA reported to her Resident #2 was holding on to the side rails and lost her grip and fell on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/13/2025 at 12:35 p.m., S1Administrator reported when she was notified about the incident with Resident #2 she went to the hospital to interview her (Resident #2). S1Administrator reported Resident #2 reported she lost her grip on the side rail. S1Administrator reported Resident #2 reported she was turned on her left side when her legs and feet dragged her to the floor. S1Administrator reported Resident #2 reported S4CNA was on her cell phone. S1Administrator reported she believed Resident #2 when she said S4CNA was on her cell phone. S1Administrator reported S4CNA should not have been on her cell phone. S1Administrator reported S4CNA was sent home immediately by S2DON.</p> <p>During an interview on 05/13/2025 at 12:50 p.m., S4CNA reported she was providing incontinent care for Resident #2 and she had turned on her on side away from her. S4CNA reported Resident #2 was holding onto the side rail. S4CNA reported Resident #2 let go of the side rail when she turned around to get a brief from the over bed table. S4CNA reported resident #2's legs went off the bed and she fell out the bed. S4CNA reported the bed was positioned high so she could work. S4CNA reported she did not go off and leave Resident #2, she hollered for a nurse in the hall to get Resident #2's nurse to come. S4CNA reported Resident #2 complained of right knee pain.</p> <p>During an interview on 05/13/2025 at 3:00 p.m., S2DON reported when she was notified about the incident she sent S4CNA home immediately pending the investigation. S2DON reported they called S4CNA to come back into the facility Monday 04/28/2025 to write her statement of what happened. S2DON reported S4CNA was suspended for three days and returned to work 05/01/2025. S2DON reported S4CNA was placed on the evening shift so that she could work with another CNA and be monitored. S2DON agreed a resident's bed should never be left in a high position when staff is not right there with them providing care. S2DON agreed even if staff steps or turns away for even a second to make sure that a resident is in a safe positon and the bed is in a low position.</p> <p>During an interview on 05/14/2025 at 10:25 a.m., S1Administrator confirmed the corrective actions put into place were completed on 05/01/2025 and monitoring would be ongoing for three months or until compliance is achieved per QA (quality assurance) committee.</p> <p>During the survey, in-services records, QAPI (Quality Assessment and Performance Improvement), and monitoring tools were reviewed and it was determined the facility had implemented the following actions prior to surveyor entering the facility to correct the deficient practice.</p> <p>The facility implemented the following actions to correct the deficient practice beginning on 04/26/2025 with a completion date of 05/01/2025:</p> <ol style="list-style-type: none"> 1. On 4/26/2025 S4CNA was sent home immediately by S2DON and suspended for 3 days. 2. On 04/26/2025, 04/27/2025 and 04/28/2025 The facility initiated in-services, QAPI, Corrective Action Plan, monitoring tools were implemented to ensure compliance with ADL care provided for Dependent Residents twice weekly times three months and CNA Evaluations were conducted with CNAs on ADL care, resident rights, reporting accurately status of resident; Resident Rights & Accident Prevention, change in condition, skin breaks, bruises and injuries. 3. On 04/26/2025, 04/27/2025 and 04/28/2025 S3CNA Supervisor in-serviced all CNAs, Nurses, and Van Driver on the facility's cell phone policy, resident ADL care, fall prevention and safety and repositioning. <p>(continued on next page)</p>		

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