STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195519	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Hills Healthcare and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44414 Based on record review and interview the facility failed to notify the resident's representative and physician after an incident of sexual abuse for 1 (#36) of 2 (#2 and #36) residents reviewed for abuse. Findings: Resident # 36 was admitted to the facility on [DATE] with diagnoses, which included in part, unspecified dementia, moderate, with other behavioral disturbances, schizophrenia unspecified, Alzheimer's disease with late onset, and major depressive disorder, recurrent, severe. Review of Resident #36's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #36 had a BIMS (Brief Interview of Mental Status) score of 03 out of 15 indicating severely impaired cognition. Review of Resident #36's medical record revealed, a nurse's note by S5 RN (Registered Nurse) dated 09/08/2024 at 9:24 p.m. which read in part, S4 CNA (Certified Nursing Assistant) reported to S5 RN that Resident #36 was being felt on in dining room by a male resident (Resident #2). Further review Resident #36's medical record failed to reveal Resident #36's representative or physician had been notified of the incident of sexual abuse on 09/08/2024. During an interview on 02/06/2025 at 1:30 p.m., S2 DON (Director of Nursing) acknowledged the incident of abuse had not been reported to Resident #36's representative and should have been. During an interview on 02/06/2025 at 2:30 p.m., S2 DON reported she could not produce documentation that Resident #36's physician was notified of the incident of sexual abuse towards Resident #36 and should have been. During a telephone interview on 02/06/2025 at 3:00 p.m., Resident #36's representative reported she has never been notified of any inappropriate resident to resident interactions towards Resident #36.

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

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 02/07/2025
NAME OF PROVIDER OR SUPPLIER Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 9105 Baird Road Shreveport, LA 71118	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897 Based on interviews and record reviews the facility failed to protect the residents' right to be free from sexual abuse and psychosocial harm from another resident for 1 (Resident #36) of 2 (Resident #2 and Resident #36) residents reviewed for abuse. Resident #36 was subject to unwanted sexual contact by Resident #2. The deficient practice resulted in an Immediate Jeopardy on 09/08/2024 at 9:00 p.m. when S4 CNA (Certified Nursing Assistant) observed Resident #2 touching Resident #36's breast in the facility's unlit dining room. S5RN (Registered Nurse) asked Resident #36, who was cognitively impaired, Were you (Resident #36) being touched by Resident #2? and Resident #36 replied, Well yeah, just down here as she pointed to S5 RN's breast. S5 RN asked Resident #36 if she wanted that to happen and Resident #36 replied, No. S5 RN asked Resident #36 if she was uncomfortable and Resident #36 stated, Yes. Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the sexual abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility. By the facility failing to implement protective measures, there was a high likelihood that additional severe harm, injury, or death could occur to any of the 74 residents residing in the facility. S1 Administrator was notified of the Immediate Jeopardy on 02/06/2025 at 3:30 p.m. The Immediate Jeopardy was removed on 02/07/2025 at 4:45 p.m. The facility implemented an accepted Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to the exit. Findings: Review of the facility's Incident Investigation and Reporting policy with a last review date of 05/2024, revealed in part: Purpose: To provide guidance to the facility for investigation and reporting incidents of abuse, neglect, exploitation, misappropriation of property and/or other reportable incidents to LDH (Louisiana Department of Health), Health Standards Section, local law enforcement, and others as required by state and federal requirements. To ensure reporting reasonable suspicion of crimes against a resident within prescribed timeframes. 1. Each resident residing in this facility has the right to be free from any type of abuse including: verbal, sexual, mental, physical abuse, neglect, exploitation, misappropriation of resident property . Relevant terms - Sexual abuse: Is nonconsensual sexual contact of any type with a resident. (continued on next page)

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 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Hills Healthcare and Rehabilitation	9105 Baird Road Shreveport, LA 71118

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #2 Resident #2 was admitted to the facility on [DATE] with diagnoses, which included in part bipolar disorder, major depressive disorder-single episode severe with psychotic features, anxiety disorder, intellectual disabilities and delusional disorders. Review of Resident #2's most recent Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #2 had a BIMS (Brief Interview for Mental Status) score of 09 out of 15 indicating moderate cognitive impairment. Resident #2 used antipsychotic medication on a routine basis. Resident #2 required set-up help by staff for mobility and transfers. Review of Resident #2's comprehensive care plan failed to reveal that any interventions or monitoring following the incident of sexual abuse on 09/08/2024 had been implemented. Resident #36 Resident # 36 was admitted to the facility on [DATE] with diagnoses, which included in part, unspecified dementia, moderate, with other behavioral disturbances, schizophrenia unspecified, Alzheimer's disease with late onset, and major depressive disorder, recurrent, severe. Review of Resident #36's Quarterly MDS assessment dated [DATE] revealed in part, Resident #36 had a BIMS score of 03 out of 15 indicating severely impaired cognition. Resident #36 was able to walk 150 feet with supervision and utilized a wheelchair as a mobility device. Review of Resident #36's comprehensive care plan failed to reveal protective measures had been implemented related to an incident of unwanted sexual contact by Resident #2. Review of Resident #36's medical record revealed, a nurse's note by S5 RN dated 09/08/2024 at 9:24 p.m. which read in part, S4 CNA reported to S5 RN that Resident #36 was being felt on in dining room by a male resident (Resident #2). Resident #36 found in dining room, lights off, standing in front of Resident #2's walker. When asked what was going on, Resident #2 was silent. Both residents separated. S5 RN asked, Were you (Resident #36) being touched by him (Resident #2)? Resident #36 stated, Well yeah, just down here as she (Resident #36) pointed to my (S5 RN) breast. S5 RN asked if she (Resident #36) wanted that to happen. She (Resident #36) stated, No. S5 RN asked if she (Resident #36) was uncomfortable; she (Resident #36) stated, Yes . Resident #36 sent to room, in stable condition. Review of an incident report dated 09/08/2024 at 9:00 p.m. related to Resident #2, and prepared by S5 RN revealed in part: Description: S4 CNA reported to S5 RN that Resident #2 was sitting in dining room with a female resident (Resident #36), Resident #2 grabbed her hand, pulled her close and began to feel on her breast. S4 CNA reports that she knocked on the window and Resident #2 stopped. S5 RN entered dining area; Resident #2 was sitting and Resident #36 was standing in front of him and his walker. S5 RN asked Resident #2 if he touched Resident #36's breasts. Resident #2 stated, I'm sorry, I won't do it again, I didn't mean it, I'm sorry. S5 RN explained that these actions were inappropriate and actions would have to be reported. Resident #2 continues to apologize. Resident #2 encouraged to head to bed but Resident #2 refused multiple times, Resident #2 stated, It's too early, I'm going to the TV room . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 9105 Baird Road Shreveport, LA 71118	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's reportable incident list 05/01/2024 to 02/03/2025 failed to reveal a report of sexual abuse on 09/08/2024 had been submitted to the appropriate state agency for review. During an interview on 02/04/2025 at 1:00 p.m., S2 DON (Director of Nursing) reported she was unable to find any ongoing monitoring of Resident #2. S2 DON identified the staff involved in the reporting of the incident as S5 RN and S4 CNA, neither still work at the facility. S2 DON identified the victim as Resident #36. During an interview on 02/04/2025 at 4:30 p.m., S2 DON reported she had not provided in-service training to all staff on abuse and neglect following the incident with Resident #2 and should have. During a telephone interview on 02/06/2025 at 3:00 p.m., S4 CNA reported she was walking by the glassed-in dining room directly adjacent from the nurse's station and happened to notice Resident #2 and #36 in the dining room. Resident #36 was standing in front of Resident #2. She stopped to see what was going on because the lights were off and she saw Resident #2 playing with Resident #36's breast. She banged on the dining room window and called the nurse/S5 RN who immediately went in the dining room and separated them. S4 CNA reported she was not aware of any in-services done at the time or right after the incident about abuse. During an interview on 02/06/2025 at 10:50 a.m., S1 Administrator acknowledged she was not made aware of the sexual abuse incident of Resident #36 being inappropriately touched by Resident #2, until 02/04/2025. S1 Administrator reported she was out during the incident date and she had not been informed upon return. S1 Administrator acknowledged a report was never submitted to the appropriate state agency or law enforcement and should have been. During an interview on 02/06/2025 at 11:05 a.m., S2 DON reported she was working on the night of the incident and conducted an abuse in-service on 09/08/2024 with the on-site evening shift and oncoming night shift staff but had not in-serviced the day shift or remaining staff members on abuse. S2 DON acknowledged she was responsible for in-servicing the staff on the abuse/neglect policy including recognizing signs, investigations, protection, and reporting procedures and failed to ensure all staff had been in-serviced. S2 DON reported she was responsible for overseeing that interventions were put into place to protect the residents but she had not reviewed the assessments and monitoring findings and should have. S2 DON acknowledged she did not notify the Administrator of the sexual abuse allegations towards Resident #36 or report it to the appropriate state agency or law enforcement and should have. During an interview on 02/06/2025 at 11:20 a.m., S3 Corporate Nurse reported she was notified of the incident by the DON the following day 09/09/2024. S3 Corporate Nurse acknowledged S1 Administrator had never been informed of the sexual abuse incident and she should have made sure S1 Administrator was made aware. S3 Corporate Nurse reported she would be responsible to oversee the monitoring. S3 Corporate Nurse acknowledged she had not confirmed the completion of ongoing monitoring. During an interview on 02/07/2025 at 10:30 a.m., S2 DON acknowledged no interventions had been put into place for the safety of Resident #36 or all other residents related to the sexual abuse incident and should have been. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 9105 Baird Road Shreveport, LA 71118	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 02/06/2025 at 4:00 p.m., S1 Administrator and S3 Corporate Nurse acknowledged the facility failed to properly report the allegation of sexual abuse and appropriately monitor the situation and should have. The facility's Plan of Removal: Resident #36 and all other residents have the potential for similar outcome. Two residents were unsupervised in the facility dining room with lights off on 09/08/2024. S4 CNA witnessed in the facility dining room with lights off Resident #2 touching Resident #36's breast. Resident #2 and Resident #36 were immediately separated by S4 CNA and S5 RN. Resident #2 was placed on one-on-one supervision until NP (Nurse Practitioner) saw him 09/09/2024. On 09/08/2024 Resident #36 had body audit completed by RN with no bruising, discoloration or skin impairment. Facility will ensure on February 6, 2025 residents are free from sexual abuse to prevent the likelihood of serious injury, serious harm, serious impairment or death. On February 6, 2025 the facility conducted body audits on all twenty-five cognitively impaired female residents. On February 6 and 7, 2025 Facility interviewed 8 male and 27 female residents who were interviewable to ensure there has been no other occurrence. On February 5, 2025 facility began immediately all facility staff in-servicing on how to report allegation of abuse/suspicion of inappropriate sexual conduct and who to report the allegation of abuse/suspicion if noted. Staff will not be allowed to perform their duties until they have been properly trained by the Administrator or properly trained designee. The facility will include in Resident #2's care plan and task behaviors q (every) 2 hours to be monitored by staff. The DON or designee will review behaviors five days a week beginning 02/07/2025 with ongoing monitoring. Resident #2's plan of care has been reviewed/revised with increased supervision. Any resident that exhibits inappropriate sexual behavior will have an individualized Person-Centered Care Plan developed with the appropriate goals to address the protection of those residents deemed incapable of making consent. Beginning February 7, 2025 nursing staff will visually observe Resident #2 every two hours for increased supervision and will be ongoing. The Regional Supervisor conducted an in-service on 02/06/2025 at 5:00 p.m. with Department Head Staff to include Administrator/Abuse Coordinator, DON, Department Staff on Abuse & Neglect, Elder Justice Act, Review of corporate training video on Abuse and Neglect, State Agency and Law Enforcement. These Department heads will conduct further training of staff during monthly staff meeting. Regional Corporate Supervisors will oversee to ensure compliance. Administrator/designee began in-servicing all facility staff beginning on February 5, 2025 on how to report allegations of abuse/suspicion of any type of abuse to include inappropriate sexual conduct and who to report the allegation/suspicion if noted. Staff will not be allowed to perform their duties until they have been properly trained by the Administrator or properly trained designee. This in servicing began on February 5, 2025 at 4:00 p.m. and will continue until all staff have been in-serviced. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	All Residents that exhibit inappropriate sexual behavior will be monitored by all staff beginning on February 6, 2025. The facility Abuse Coordinator plans to monitor staff competency by direct observation, and continued in-servicing. All residents will be monitored for through direct observations, interviews and staff interviews 5 times per week and documenting effects on a facility QA (Quality Assurance) tool. These audits will continue until substantial compliance is achieved and monthly times two months. QA monitoring tools were initiated on February 6, 2025 and will be ongoing. On February 6, 2025 the Facility conducted an Emergency QA with the facility Medical Director's Nurse Practitioner to outline all a fore mentioned protocol. The QA will be on going until substantial compliance is achieved. Any residents that exhibit inappropriate sexual behavior will have an individualized/Person Centered Care Plan developed with the appropriate goals to address the protection of those residents deemed incapable of making consent. QAPI (Quality Assurance Performance Improvement) was initiated on February 6, 2025, along with corrective action plan and monitoring tools. QA Committee will review in next Quarterly Meeting with Medical Director in attendance to give guidance and input to QA program. Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 02/07/2025. 44414

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 02/07/2025
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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897 Based on record reviews and interviews, the facility failed to ensure an alleged violation of sexual abuse was reported immediately to the facility's administrator, to the appropriate state agency within 2 hours after the allegations were made and to local law enforcement for 1 (Resident #36) of 2 (Resident #2 and Resident #36) residents reviewed for abuse. Resident #36 was subject to unwanted sexual contact by Resident #2. The deficient practice resulted in an Immediate Jeopardy on 09/08/2024 at 9:00 p.m. when S4 CNA (Certified Nursing Assistant) observed Resident #2 touching Resident #36's breast in the facility's unlit dining room. S5 RN (Registered Nurse) asked Resident #36, who is cognitively impaired, Were you (Resident #36) being touched by Resident #2? and Resident #36 replied, Well yeah, just down here as she pointed to S5 RN's breast. S5 RN asked Resident #36 if she wanted that to happen and Resident #36 replied, No. S5 RN asked Resident #36 if she was uncomfortable and Resident #36 stated, Yes. Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the sexual abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility. By the facility failing to implement protective measures, there was a high likelihood that additional severe harm, injury, or death could occur to any of the 74 residents residing in the facility. S1 Administrator was notified of the Immediate Jeopardy on 02/07/2025 at 11:10 a.m. The Immediate Jeopardy was removed on 02/07/2025 at 5:15 p.m. The facility implemented an accepted Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to the exit. Findings: Review of the facility's Incident Investigation and Reporting policy with a last review date of 05/2024, revealed in part: Purpose: To provide guidance to the facility for investigation and reporting incidents of abuse, neglect, exploitation, misappropriation of property and/or other reportable incidents to LDH (Louisiana Department of Health), Health Standards Section, local law enforcement, and others as required by state and federal requirements. To ensure reporting reasonable suspicion of crimes against a resident within prescribed timeframes. 1. Each resident residing in this facility has the right to be free from any type of abuse including: verbal, sexual, mental, physical abuse, neglect, exploitation, misappropriation of resident property . Relevant terms - Sexual abuse: Is nonconsensual sexual contact of any type with a resident. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Abuse, Neglect .are crimes and shall be reported to proper authorities as such. In the event of any incident involving an allegation or suspicion of mistreatment, exploitation, neglect, abuse ., each occurrence will be reported immediately to the Administrator of the Facility . The Administrator shall report to the State Survey Agency and local law enforcement entities in which the facility is located, any allegation or reasonable suspicion of a crime against any resident. The administrator shall report not later than 2 hours after forming the suspicion. 5. Additional incidents that must have a thorough investigation and may require reporting, as determined by the NF (Nursing Facility) especially in consideration to abuse and/or neglect, to the state agency with the implementation of corrective action(s), and referrals, as appropriate to the appropriate authorities/agencies. 6. The facility will thoroughly investigate all alleged violations under the direct supervision of the Administrator. The facility will take all necessary steps to prevent occurrence and/or further potential abuse. 7. During and after the investigation, the residents will be protected from harm through frequent supervision by staff. Resident # 36 was admitted to the facility on [DATE] with diagnoses, which included in part, unspecified dementia, moderate, with other behavioral disturbances, schizophrenia unspecified, Alzheimer's disease with late onset, and major depressive disorder, recurrent, severe. Review of an incident report dated 09/08/2024 at 9:00 p.m. related to Resident #2, and prepared by S5 RN revealed in part: Description: S4 CNA reported to S5 RN that Resident #2 was sitting in dining room with a female resident (Resident #36), Resident #2 grabbed her hand, pulled her close and began to feel on her breast. S4 CNA reports that she knocked on the window and Resident #2 stopped. S5 RN entered dining area; Resident #2 was sitting and Resident #36 was standing in front of him and his walker. S5 RN asked Resident #2 if he touched Resident #36's breasts. Resident #2 stated, I'm sorry, I won't do it again, I didn't mean it, I'm sorry. S5 RN explained that these actions were inappropriate and actions would have to be reported. Resident #2 continues to apologize. Resident #2 encouraged to head to bed but Resident #2 refused multiple times, Resident #2 stated, It's too early, I'm going to the TV room . Review of the facility's reportable incident list 05/01/2024 to 02/03/2025 failed to reveal a report of sexual abuse on 09/08/2024 had been submitted to the appropriate state agency for review. Review of Resident #2's record failed to reveal a police report had been completed or police had been notified. During an interview on 02/06/2025 at 10:50 a.m., S1 Administrator acknowledged she was not made aware of the sexual abuse incident of Resident #36 being inappropriately touched by Resident #2, until 02/04/2025. S1 Administrator reported she was out during the incident date and she had not been informed upon return. S1 Administrator acknowledged a report was never submitted to the appropriate state agency or law enforcement and should have been. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 02/06/2025 at 11:05 a.m., S2 DON (Director of Nursing) confirmed she was working on the night of the incident. S2 DON acknowledged she did not notify the Administrator of the sexual abuse allegations towards Resident #36 by Resident #2 or report it to the appropriate state agency or law enforcement and should have. During an interview on 02/06/2025 at 11:20 a.m., S3 Corporate Nurse reported she was notified of the incident by the DON the following day 09/09/2024. S3 Corporate Nurse acknowledged S1 Administrator had never been informed of the sexual abuse incident and she should have made sure S1 Administrator was made aware. During an interview on 02/06/2025 at 4:00 p.m., S1 Administrator and S3 Corporate Nurse acknowledged the facility failed to properly report the allegation of sexual abuse. The facility's Plan of Removal: Resident #36 was the victim at the time of the event on 09/08/2024 at 9:00 p.m. The perpetrator, Resident #2 continues to reside in the facility. Resident #36 and all residents with an adverse event or incident that required reporting to the Administrator, State Agency and Law Enforcement. Education began on February 5, 2025, the Administrator began immediately in-servicing all facility staff on how to report an allegation of abuse, including the two hour time line to report with ongoing monitoring. The Regional Supervisor conducted an in-service on 02/06/2025 at 5:00 p.m. with the Administrator/Abuse Coordinator, DON, Corporate Nurse and Department Heads on timeline reporting requirements of two hours for any allegation or suspicion of adverse event or incident that requires reporting to the Administrator, State Agency and Law Enforcement. Education included Abuse & Neglect, Elder Justice Act, Review of corporate training video on Abuse and Neglect, State Agency and Law Enforcement. These Department heads will conduct further training of staff during monthly staff meeting. On February 7, 2025, nursing staff was in-serviced on a Reporting Decision Tree, which was placed at the nurse's station to give additional guidance to staff on reporting requirements. The facility Administrator will report within two hours, any allegation or suspicion of adverse event or incident that requires reporting to state agency and law enforcement. Monitoring: Regional Corporate Supervisors will oversee to ensure compliance. On February 6, 2025 the Facility conducted an Emergency QA (Quality Assurance) with the facility Medical Director's Nurse Practitioner to outline all aforementioned protocol. The QA will be on-going until substantial compliance is achieved. The facility will report within two hours any allegation or suspicion of abuse to State reporting office and Law Enforcement. QAPI (Quality Assurance Performance Improvement) was initiated on February 6, 2025, along with corrective action plan and monitoring tools. QA Committee will review in next Quarterly Meeting with the Medical Director in attendance, to give guidance and input to QA program. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 02/07/2025. 44414

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 Based on record reviews, observations, and interviews the facility failed to develop and implement a comprehensive person-centered care plan for 2 (#22, #326) out of 18 sampled residents reviewed. The facility failed to ensure a physician's order was in place for Resident #22's wander guard alarm device and for the maintenance/monitoring and/or discontinuation of Resident #326's PICC (Peripherally Inserted Central Catheter) line. Findings: Resident #22 Review of Resident #22's medical record revealed an admitted [DATE] with diagnoses that included, in part, Alzheimer's disease, anxiety disorder, and chronic kidney disease. Review of Resident #22's physician orders failed to reveal an order for wander guard alarm device. Review of Resident #22's annual MDS (minimum data set) assessment dated [DATE] revealed in part, Resident #22 had a BIMS (brief interview for mental status) score of 03, indicating severely impaired cognition. Review of Resident #22's current care plan revealed Resident #22 was an elopement risk, wanderer, and had impaired safety awareness. Resident #22 has a wander/elopement alarm device to ankle. Observation on 02/04/2024 at 10:30 a.m. revealed resident #22 sitting in common area on a couch in close proximity to the nurses' station with walker at side and wander-guard alarm device noted to right ankle. During an interview on 02/06/2024 at 12:40 p.m., S2 DON (Director of Nursing) acknowledged Resident #22 did not have a physician's order in place for the use of wander guard alarm device and should have. Resident #326 Review of the facility's General Central Venous Policies and Procedures policy dated October 2016 revealed in part: These procedures pertain to the access and maintenance of central venous catheters . These include peripherally inserted central catheters, tunneled catheters ., and implanted ports. B. Peripherally Inserted Central Catheters (PICCS) PICC line indications: Limited Peripheral venous access (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 9105 Baird Road Shreveport, LA 71118	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional recommendations for routine maintenance and care: Flushing: use of heparin flushes and the recommended concentration and frequency of flushing are determined in accordance with manufacturer's instructions and per the physician's orders . Review of Resident #326 medical record revealed an admitted [DATE] with diagnoses that included in part spinal stenosis, fusion of spine, Parkinson's disease, Type 2 diabetes and UTI (urinary tract infection). Review of Resident #326's physician orders failed to reveal an order for the maintenance/monitoring and/or discontinuation of Resident #326's PICC line. Review of Resident #326's admit nurse's note by S16 LPN (Licensed Practical Nurse) dated 01/30/2025 at 3:03 p.m. revealed in part, Resident #326 has a midline in upper left arm and an IV (intravenous) in lower left arm. During an interview on 02/06/2025 at 4:05 p.m., S2 DON reported Resident #326 was admitted with a PICC line for 1 dose of antibiotic. S2 DON acknowledged a physician's order was not in place to maintain, monitor and/or discontinue PICC line and should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897 Based on record review and interview, the facility failed to ensure the care plan had been revised for 1 (Resident #2) of 18 sampled residents. The facility failed to update Resident #2's care plan to include increased monitoring/supervision after an incident of resident to resident abuse. Findings Resident #2 was admitted to the facility on [DATE] with diagnoses, which included in part bipolar disorder, major depressive disorder-single episode severe with psychotic features, anxiety disorder, intellectual disabilities and delusional disorders. Review of Resident #2's most recent quarterly MDS (Minimum data Set) assessment dated [DATE] revealed in part, Resident #2 had a BIMS (Brief Interview of Mental Status) score of 09 out of 15 indicating moderate cognitive impairment. Resident #2 used antipsychotic medication on a routine basis. Review of Resident #2's comprehensive care plan failed to reveal Resident #2's care plan had been updated to include increased monitoring/supervision after a resident to resident incident on 09/08/2024 when Resident #2 sexually abused another resident. During an interview on 02/04/2025 at 1:00 p.m., S2 DON (Director of Nursing) reported she was unable to find any monitoring of Resident #2. During an interview on 02/07/2025 at 10:30 a.m., S2 DON acknowledged Resident #2's care plan had not been updated to include increased monitoring and supervision after the 09/08/2024 incident and should have been.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897 Based on observations, interview, and record review, the facility failed to ensure that a resident with a urinary catheter received appropriate care and services to prevent urinary tract infections by having the urinary catheter tubing on the floor for 1 (#70) of 1 (#70) resident reviewed for urinary catheters. Findings: Review of Resident #70's medical record revealed an admitted [DATE] with diagnoses that include in part cerebral infarction, essential hypertension, symbolic dysfunctions, dementia with behavioral disturbance, benign prostatic hyperplasia with lower urinary tract symptoms and delusional disorders. Review of Resident #70's physician orders revealed an order dated 10/29/2024; catheter type 16; French 5 bulb size. Review of Resident #70's Minimum Data Set assessment dated [DATE] revealed the resident #70 is rarely or never understood. Resident #70 is totally dependent for toileting, has an indwelling catheter, and is frequently incontinent of bowel. Observation on 02/03/2025 at 8:30 a.m. revealed Resident #70 lying in bed with Foley catheter bag sitting on the floor. Observation on 02/03/2025 at 3:00 p.m. with S2 DON revealed Resident #70's Foley catheter bag sitting on the floor. S2 DON confirmed the Foley catheter bag should not be on the floor. During an interview on 02/04/2025 at 10:54 a.m. S3 Corporate Nurse acknowledged that is basic standard of care that the Foley catheter bag should not be on the floor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36664 Based on record review, observations, and interview, the facility failed to ensure appropriate treatment and services to prevent potential complications from enteral feeding not infusing at the ordered rate ordered for 1 (#18) out of 1 (#18) residents reviewed for tube feedings. Findings Review of Resident #18's medical diagnoses revealed the following, but not limited to moderate protein calorie malnutrition, dysphagia, atrial fibrillation, and Parkinson's disease. Review of Resident #18's MDS (Minimum Data Set) assessment dated [DATE] revealed Resident #18 received 51% or more of total calories through feeding tube and 501cc (cubic centimeters)/day or more of average fluid intake per day through feeding tube. Resident #18's Physician order dated 12/17/2024 revealed every shift related to encounter for attention to gastrostomy Isosource 1.5 at 45ml/hr (milliliter/hour) for 20 hours to deliver 1620 calories, 73 grams of protein, 1080 total volume. Observation on 02/03/2025 at 9:52 a.m. revealed Resident #18's enteral feeding pump infusing Isosource 1.5 at 60 ml/hr to percutaneous endoscopic gastrostomy (peg) tube. Observation on 02/03/2025 at 3:00 p.m. revealed Resident #18's enteral feeding pump was infusing Isosource 1.5 at 60 ml/hour to peg tube. During an interview on 02/03/2025 at 3:19 p.m. with S6 LPN (Licensed Practical Nurse) Resident #18's enteral feeding pump was infusing at a rate of 60 ml/hr and should have been running at 45 ml/hr.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921 Based on record reviews, observations, and interviews, the facility failed to ensure correct use and maintenance of bed rails by ensuring 3 (#13, #50, #51) out of 3 residents reviewed for bed rails were assessed for the risk of entrapment from bed rails and 1 (#51) out of 3 residents nurse data collection and screening for bed rails was completed correctly. Findings: Review of facility's Physical Restraints/Devices Policy (revision date 03/2024) revealed: Purpose: to ensure that the resident is given the least restrictive options to care. To ensure resident safety and promote wellbeing. Potential reasons for using a physical restraint: 1. to improve the resident's mobility and independent function. 2. to treat resident's medical symptoms 3. in an emergency to restrict movement to protect the resident during treatment and diagnostic procedures. 4. to prevent the resident from injuring himself or others. Side rails: 4. Ensure that there is not a gap between the mattress and the side rail, as per facility policy. 8. Document all appropriate information in the clinical record. Resident #13 Review of Resident #13's face sheet revealed an initial admitted on 05/08/2024 and a re-entry admitted on 10/21/2024 with a medical diagnosis but not limited to unspecified glaucoma. Review of Resident #13's February 2025 Physician orders revealed an order dated 09/11/2024: may have assist rails for bed mobility and positioning Review of Resident #13's care plan revealed resident's current safety devices and special equipment included assist rails times two for bed mobility and positioning related to decreased strength to promote comfort and independence of bed mobility with interventions to assist rails times two half rails to assist with bed mobility and positioning to promote comfort and independence. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's State Operational MDS (Minimum Data Set) assessment revealed Resident #13 required extensive assistance with two person physical assist with bed mobility. Review of Resident #13's device/physical restraint consent for bedrails revealed a verbal consent was received on 11/01/2024. Review of Resident #13's medical record failed to reveal any assessments for entrapment after assist rails were applied. Observation on 02/03/2025 at 10:38 a.m. revealed Resident #13 had raised assist rails to both sides of the bed. Observation on 02/03/2025 at 10:31 a.m. revealed Resident #13 had raised assist rails to both sides of the bed. Resident #50 Review of Resident #50's face sheet revealed an initial admitted on 03/14/2024 and an re-entry admitted on 09/25/2024 with the following medical diagnoses but not limited to schizoaffective disorder and hypertension. Review of Resident #50's February 2025 Physician orders dated 09/11/2024 revealed may have assist rails for bed mobility and positioning. Review of Resident #50's Care Plan revealed a focus on current safety devices and special equipment assist rails times two for bed mobility and positioning related to decreased strength to promote comfort and independence of bed mobility with interventions for assist rail times 2 for bed mobility and repositioning to promote comfort and independence Review of Resident #50's State Operational MDS assessment revealed Resident #50 required limited assistance with one person physical assist with bed mobility. Review of Resident #50's Device/Physical Restraint Consent for bed rails was signed and dated by Resident #50's representative on 11/01/2024. Review of Resident #50's medical record failed to reveal any assessments for entrapment after assist rails were applied. Observation on 02/03/2025 at 10:31 a.m. revealed Resident #50 had raised assist rails to both sides of the bed. Observation on 02/06/2025 at 9:46 a.m. revealed Resident #50 had raised assist rails to both sides of the bed. Resident #51 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's face sheet revealed an initial admissiom date on 08/02/2023 and a re-entry admission on 09/19/2024 with the following medical diagnoses but not limited to cerebral infarction, unspecified dementia, unspecified abnormalities of gait and mobility, lack of coordination, muscle weakness, primary generalized (osteo) arthritis, muscle wasting and atrophy, cognitive communication deficit, and delusional disorders. Review of Resident #51's February 2025 Physician order dated 01/21/2025 revealed may have assist rails for bed mobility and positioning. Review of Resident #51's State Operation MDS assessment dated [DATE] revealed Resident #51 required extensive assistance with one person physical assist with bed mobility. Review of Resident #51's Care Plan revealed resident current safety devices and special equipment assist rails times 2 for bed mobility and positioning related to decreased strength to promote comfort and independence of bed mobility with interventions to assist rails times two. Review of Resident #51's Device/Physical restraint consent for bed rails was signed and dated by Resident #51 on 11/11/2024. Review of Resident #51's restraint necessity/positioning device dated 10/04/2024 revealed Resident #51 did not currently have a device (bed/side rail) in use. Observation on 02/03/2025 at 10:48 a.m. revealed Resident #51 had raised quarter side rails to both sides of the bed. Observation on 02/06/2025 at 10:05 a.m. revealed Resident #51 had raised quarter side rails to both sides of the bed. During an interview on 02/06/2025 at 9:55 a.m. S1 Administrator reported maintenance checks beds for risk for entrapment. S1 Administrator reported she did not know whether maintenance had performed the assessment for risk for entrapment. During an interview on 02/06/2025 at 11:30 a.m. S8 Maintenance reported residents with bed rails should be assessed monthly for risk for entrapment. S8 Maintenance reported residents #13, #50, #51's bedrails have not been assessed for risk for entrapment. During an interview on 02/07/2025 at 5:30 p.m. S1 Administrator reviewed Resident #51's restraint necessity/positioning device form and confirmed Resident #51's restraint necessity/positioning device form was incorrect and should reveal Resident #51 had side rails in use.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36921 Based on review of personnel records and an interview the facility failed to ensure an annual performance review was completed for 1 (S11) of 5 (S11, S12, S13, S14, & S15) CNAs (Certified Nurse Assistant) at least once every 12 months. Findings: Review of S11 CNA's personnel record revealed a hire date 02/03/2017 and a re-hire date 10/28/2021. Review of S11 CNA's personnel record failed to reveal a 2024 annual performance review was completed. During an interview on 02/06/2025 at 8:40 a.m. S9 Human Resources reviewed S11 CNA's personnel file and confirmed an annual performance review had not been completed for 2024.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39897 Based on interviews and record reviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 (Resident #36) of 2 (Resident #2 and Resident #36) residents reviewed for abuse. The facility failed to have an effective system in place to: 1. protect Resident #36 from sexual abuse by Resident #2 and ensure all residents were free from abuse; 2. report abuse to the appropriate state agency and law enforcement. The deficient practice resulted in an Immediate Jeopardy on 09/08/2024 at 9:00 p.m. when S4 CNA (Certified Nursing Assistant) observed Resident #2 touching Resident #36's breast in the facility's glassed-in, unlit dining room. S5 RN (Registered Nurse) asked Resident #36, who is cognitively impaired, Were you (Resident #36) being touched by Resident #2? and Resident #36 replied, Well yeah, just down here as she pointed to S5 RN's breast. S5 RN asked Resident #36 if she wanted that to happen and Resident #36 replied, No. S5 RN asked Resident #36 if she was uncomfortable and Resident #36 stated, Yes. Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the sexual abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility. By the facility failing to implement protective measures, there was a high likelihood that additional severe harm, injury, or death could occur to any of the 74 residents residing in the facility. S1 Administrator was notified of the Immediate Jeopardy on 02/06/2025 at 3:30 p.m. The Immediate Jeopardy was removed on 02/07/2025 at 4:45 p.m. Findings, Cross reference F600 and F609: During an interview on 02/04/2025 at 1:00 p.m., S2 DON (Director of Nursing) reported she was unable to find any monitoring of Resident #2. During an interview on 02/04/2025 at 4:30 p.m., S2 DON reported she had not provided in-service training to all staff on abuse and neglect following the incident with Resident #2 and should have. During an interview on 02/06/2025 at 10:50 a.m., S1 Administrator acknowledged she was not made aware of the sexual abuse incident of Resident #36 being inappropriately touched by Resident #2, until 02/04/2025. S1 Administrator reported she was out during the incident date and she had not been informed upon return. S1 Administrator acknowledged a report was never submitted to the appropriate state agency or law enforcement and should have been. (continued on next page)

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

During an interview on 02/06/2025 at 11:05 a.m., S2 DON reported she was working on the night of the incident and conducted an abuse in-service on 09/08/2024 with the on-site evening shift and oncoming night shift staff but had not in-serviced the day shift or remaining staff members on abuse. S2 DON acknowledged she was responsible for in-servicing the staff on the abuse/neglect policy including recognizing signs, investigations, protection, and reporting procedures and failed to ensure all staff had been in-serviced. S2 DON reported she was responsible for overseeing that interventions were put into place to protect the residents but she had not reviewed the assessments and monitoring findings and should have. S2 DON acknowledged she did not notify the Administrator of the sexual abuse allegations towards Resident #36 or report it to the appropriate state agency or law enforcement and should have.

During an interview on 02/06/2025 at 11:20 a.m., S3 Corporate Nurse reported she was notified of the incident by the DON the following day 09/09/2024. S3 Corporate Nurse reported she should have made sure S1 Administrator was made aware of the sexual abuse incident and she did not. S3 Corporate Nurse acknowledged she was responsible for overseeing the ongoing monitoring put into place and could not confirm the findings or completion of the monitoring.

During an interview on 02/07/2025 at 10:30 a.m., S2 DON acknowledged no interventions had been put into place for the safety of Resident #36 or all other residents related to the sexual abuse incident and should have been.

During an interview on 02/06/2025 at 4:00 p.m., with S1 Administrator and S3 Corporate Nurse, S1Administrator acknowledged she was responsible for providing oversight of the facility's abuse/neglect policy including reporting timeframes and making sure staff was educated on the necessary steps to ensure the safety and well-being of all residents. S1 Administrator and S3 Corporate Nurse acknowledged the facility failed to properly report the allegation of sexual abuse and appropriately monitor the situation and should have.

The facility implemented an accepted Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to the exit.

The facility's Plan of Removal:

Resident #36 and all other residents has the potential for similar outcome.

On February 5, 2025 the facility began immediate all facility staff in-servicing on how to report allegation of abuse/suspicion of inappropriate sexual conduct and who to report the allegation of abuse/suspicion if noted. Staff will not be allowed to perform their duties until they have been properly trained by the Administrator or properly trained designee. The facility will include in Resident #2's care plan and task behaviors q (every) 2 hours to be monitored by staff. The DON or designee will review behaviors five days a week beginning 02/07/2025 with ongoing monitoring. Resident #2's plan of care has been reviewed/revised with increase supervision. Any resident that exhibits inappropriate sexual behavior will have an individualized Person-Centered Care Plan developed with the appropriate goals to address the protection of those residents deemed incapable of making consent. Beginning February 7, 2025 nursing staff will visually observe Resident #2 every two hours for increase supervision and will be ongoing. Beginning on February 7th Facility Administrator will conduct monthly in-services continuing to educate staff on abuse and reporting requirements.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On February 7, 2025 signs will be placed in designated areas as reminder on reporting abuse and signs of abuse. All facility staff will be in-serviced immediately beginning on February 5,2025 on how to report allegation of abuse/suspicion of any type of abuse and who to report the allegation/suspicion if noted. Staff will not be allowed to perform their duties until they have been properly trained by the Administrator or properly trained designee. This in servicing began on February 5, 2025 at 4:00 p.m. and ongoing until all staff have been in-serviced. Any residents that exhibit inappropriate sexual behavior will be monitored by all staff beginning on February 6, 2025. The facility Abuse Coordinator plans to monitor staff competency by direct observation, continued in-servicing, and resident and staff interviews 5 times per week and documenting effects on a facility QA (Quality Assurance) tool. These audits will continue until substantial compliance is achieved and monthly times two months. QA monitoring tools were initiated on February 6, 2025. The Regional Supervisor conducted an in-service on 02/06/2025 at 5:00 pm with Department Head Staff to include Administrator/Abuse Coordinator, DON on Abuse &Neglect, Elder Justice Act, Review of corporate training video on Abuse and Neglect, State Agency and Law Enforcement. These Department heads will conduct further training of staff during monthly staff meeting. Regional Corporate Supervisors will oversee to ensure compliance. On February 6, 2025, the facility conducted an Emergency QA with the facility Medical Director's Nurse Practitioner to outline all a fore mentioned protocol. The QA will be ongoing until substantial compliance is achieved. Any residents that exhibit inappropriate sexual behavior will have an individualized/Person Centered Care Plan developed with the appropriate goals to address the protection of those residents deemed in capable of making consent. QAPI (Quality Assurance Performance Improvement) was initiated on February 6, 2025, along with corrective action plan and monitoring tools. QA Committee will review in next Quarterly Meeting. Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 02/07/2025. 44414

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 36921 Based on record review and an interview, the facility failed to ensure the required members were present for quarterly Quality Assessment and Assurance (QAA) meetings reviewed since last annual survey. Findings: Review of the facility's Quality Assessment and Assurance Committee Summary sign-in sheet since the last annual survey with S1 Administrator revealed the QAA committee meeting on 10/09/2024 had signatures of the Administrator, DON (Director of Nursing), Medical Director and a Nurse Practitioner. During an interview on 2/07/2025 at 5:30 p.m. S1 Administrator confirmed the required members were not present during the QAA committee meeting on 10/09/2024.

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 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Southern Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 9105 Baird Road Shreveport, LA 71118	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 Based on record reviews, observation, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure Enhanced Barrier Precautions (EBP) were in place for 1 (#326) of 1 (#326) resident reviewed for antibiotic use. Findings: Review of the facility's Enhanced Barrier Precautions policy with a revision date of 03/2024 revealed in part: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBPs (Enhanced barrier precautions) involve gown and glove use during high-contact resident care activities for residents know to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). EBPs are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of Precautions and the recommended PPE (personnel protection equipment) to be worn when caring for the resident. Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. Resident #326 was admitted to the facility on [DATE] with the following diagnoses not limited to spinal stenosis, fusion of spine, Type 2 Diabetes, and UTI (Urinary tract infection) . Review of Resident #326's physician orders revealed in part: 01/31/2025 surgical site: posterior middle neck. Clean with wound cleanser and apply island dressing. Monitor for any s/s (signs and symptoms) of infection or increased drainage. 01/31/2025 Ertapenem sodium solution reconstituted 1 gm (gram), use 1 gm intravenously at bedtime for infection related to spinal stenosis, cervical region for 1 day. (continued on next page)

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 02/07/2025
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #326's medical record revealed a progress note by S17 Nurse Practitioner dated 01/31/2025 which revealed in part: . seen today status post hospitalization for posterior cervical fusion decompression . Resident #326 was also found to have UTI and culture grew ESBL (Extended Spectrum Beta-Lactamase) Klebsiella. Patient was seen in consultation with Infectious Disease and was ordered for Ertapenem 1gm IV (intravenous) every 24 hours for 5 days. Last dose 01/31/2025. Review of Resident #326's medical record revealed an admit nurse's note by S16 LPN (Licensed Practical Nurse) dated 01/30/2025 at 3:03 p.m. which revealed in part, Resident #326 has a midline in upper left arm and an IV in lower left arm. Observation on 02/03/2025 at 8:00 a.m. revealed a midline catheter site to left upper arm. Further observation failed to reveal appropriate signage for EBPs and available PPE supplies for use. During an interview on 02/03/2025 at 8:00 a.m., Resident #326 reported he had just had neck surgery and IV access was from when he was in the hospital. During an interview on 02/03/2025 at 1:00 p.m., S2 DON (Director of Nursing) acknowledged Resident #326 had a midline peripheral central catheter in place to left upper arm and a surgical wound to his neck and should have been placed on EBP. S2 DON further acknowledged EBP signage was not in place and PPE was not readily available for staff to use and should be.