STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195533	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health Care at the Glen	403 E. Flournoy Lucas Shreveport, LA 71115

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview the facility failed to ensure resident's medical records reflected the resident's advance directive wishes for 1 (#92) of 1 resident reviewed for advance directives. The facility failed to ensure resident #92's medical records were consistent with the resident's wishes. Findings:Review of resident #92's records revealed an admit date to this facility 05/05/2026.Review of resident #92's records revealed diagnoses that include unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified pain, muscle wasting and atrophy, not elsewhere classified, multiple sites, and unspecified heart failure.Review of resident #92's Physician Orders revealed an order dated 05/05/2026 for a Full Code.Review of resident #92's Face Sheet revealed the Advance Directive section indicated Full Code.Review of resident #92's records with S7 LPN (license practical nurse) revealed resident #92 as a Full Code.Review of the resident #92's records on 06/24/2026 at 2:30 p.m. with S3 ADON (assistant director of nursing) revealed the LaPOST (Louisiana Physician Orders for Scope of Treatment) signed and dated 01/27/2022 by the resident physician and personal health care representative indicated the resident was DNR (do not resuscitate) /Do Not Attempt Resuscitation (Allow Natural Death). During an interview on 06/24/2026 at 2:30 p.m. S3 ADON agreed resident #92 records should have indicated DNR status.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record reviews and interviews the facility failed to ensure residents maintained acceptable parameters of nutritional status by failing to ensure weights were obtained monthly for 2 (#2, #9) of 3 (#2, #3, #9) residents reviewed for nutrition. Findings:Review of undated Policy titled Weighing and Measuring the Resident revealed:PurposeThe purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident.Preparation1. Review the resident's care plan to assess for any special needs of the resident.4. Weight is usually measured upon admission and monthly during the resident's stay. (Note: Weight is measured in pounds [16 ounces=1 pound]) .DocumentationThe following information should be recorded in the resident's medical record:1. The date and time the procedure was performed.3. The height and weight of the resident.6. If the resident refused the procedure, the reason (s) why and the intervention taken.Reporting1. Report significant weight loss/weight gain to the nurse supervisor.3. Notify the Nurse Supervisor if the resident refuses the procedure. Resident #2 Review of Resident #2's medical record revealed an admission date of 02/03/2025 with diagnoses that included, in part, other encephalopathy, Alzheimer's disease with early onset, moderate protein-calorie malnutrition, vitamin D deficiency, and hypomagnesemia. Review of Resident #2's physician orders revealed a 01/01/2026 order for Monthly weight unless specified otherwise. Special Instructions: Monthly weight on the 1st. Once a morning on the 1st of the month. Review of Resident #2's weights revealed the following weights, in part:06/22/2026 178.2 pounds04/09/2026 192 poundsFurther review of Resident #2's weights failed to reveal any weight was obtained between 04/09/2026 and 06/22/2026. During an interview on 06/22/2026 at 12:25 p.m. S2 DON (Director of Nursing) reported the staff had indicated Resident #2 would refuse weights and confirmed there was no documentation that Resident #2 had refused to be weighed since the 04/09/2026 weight. S2 DON further confirmed no weight had been obtained between 04/09/2026 and 06/22/2026 and should have been conducted monthly. Resident #9 Review of Resident #9's medical record revealed an admission date of 01/28/2026 with diagnoses that included, in part, mild protein-calorie malnutrition, Alzheimer's disease unspecified, major depressive disorder, generalized anxiety disorder, and iron deficiency. Review of Resident #9's weights revealed the following weights, in part:06/23/2026 95.2 pounds04/09/2026 103.1 poundsFurther review of Resident #9's weights failed to reveal any weight was obtained between 04/09/2026 and 06/23/2026. Review of Resident #9's Care Plan revealed Resident #9 was care planned for a potential for altered nutritional status with an approach that included monitor weight per facility protocol and report significant changes in weight to MD (Medical Doctor) and RD (Registered Dietician). During an interview on 06/22/2026 at 4:12 p.m. S2 DON confirmed there had not been a weight obtained since 04/09/2026 and Resident #9 should have been weighed monthly.

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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 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. Based on record review, observations and interview, the facility failed to ensure residents who required respiratory care received the care and services consistent with professional standards of practice for 1 (#4) of 3 (#4, #61, #80) residents reviewed for respiratory care. The facility failed to ensure Resident #4's oxygen tubing was changed weekly, nebulizer tubing was dated, and nebulizer mouthpiece was stored properly when not in use. Findings:Review of undated policy titled Departmental (Respiratory Therapy) - Prevention of Infection revealed:PurposeThe purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff.Preparation1. Review the resident's care plan to assess for any special circumstances or precautions related to the resident.Infection Control Considerations Related to Oxygen Administration .7. Change the oxygen cannulae and tubing every seven (7) days, or as needed.8. Keep the oxygen cannulae and tubing used prn (as needed) in a plastic bag when not in use.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.9. Discard the administration set-up every seven (7) days. Review of Resident #4's medical record revealed an admission date of 11/05/2020 with diagnoses that included, in part, senile degeneration of brain not elsewhere classified, chronic obstructive pulmonary disease unspecified (history of), chronic diastolic (congestive) heart failure, and unspecified asthma uncomplicated. Review of Resident #4's physician orders revealed the following orders, in part:-04/29/2026 Oxygen every week change oxygen tubing, water and clean filter Q (every) weekly on Saturday label and date. Once a day on Saturday.-06/20/2025 Change nebulizer tubing/mask, initial and date all pieces. Attach a Ziploc bag to for storage. Every week. Once a day on Saturday. Observation on 06/22/2026 at 8:37 a.m. revealed Resident #4 was asleep in bed with head of bed elevated, oxygen on via nasal cannula and oxygen tubing dated 05/23/2026. Further observation revealed nebulizer machine on Resident #4's nightstand beside bed with undated tubing attached and nebulizer mouthpiece lying unbagged on the nightstand. Observation on 06/22/2026 at 2:10 p.m. revealed Resident #4 dressed and seated in chair at bedside with oxygen on via nasal cannula and oxygen tubing dated 05/23/2026. Further observation revealed nebulizer machine on Resident #4's nightstand beside bed with undated tubing attached and nebulizer mouthpiece lying unbagged on the nightstand. During an interview on 06/22/2026 at 2:15 p.m. S6 ADON (Assistant Director of Nursing) observed Resident #4's oxygen tubing in use that was dated 05/23/2026, the undated nebulizer machine tubing, and the unbagged nebulizer mouthpiece lying directly on the nightstand and reported the tubing should have been changed each Saturday night by the night shift and nebulizer mouthpiece should have been bagged when not in use and was not.