STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195583	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadway Nursing and Rehabilitation Ctr	7534 Highway 1 Lockport, LA 70374

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47327 48855 Based on record reviews and interviews, the facility failed to: 1. Ensure a fall which resulted in serious bodily injury was reported to State Survey Agency for 1 (Resident #69) of 3 (Resident #69, Resident #21, Resident #26) sampled residents investigated for falls; and, 2. Ensure an alleged incident of sexual abuse was reported to the State Survey Agency for 1 (Resident #118) of 1 (Resident #118) sampled residents investigated for sexual abuse. Findings: Review of the facility's undated policy and procedure titled Abuse and Neglect revealed, in part, the definition of abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Further review revealed neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Further review revealed when the facility becomes aware of abuse or neglect, including injuries of unknown source or alleged misappropriation of resident property, staff shall immediately report to the facility Administrator or Director of Nurses. Further review revealed Administrator or designee will notify the Regional Director and Corporate Nurse and the Administrator or designee is to complete a report to the mandated state agency according to state guidelines upon notification of an alleged abuse. Further review revealed reports may also be made to local law enforcement agency if abuse or seriously body injury is involved and Administrator or designee will have 5 working days from the initial report of abuse to complete State Incident Management System (SIMS) report according to Louisiana Department of Health (LDH) guidelines. Further review revealed immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than 2 hours after the allegation is made, if the event that caused the allegation involve abuse or result in seriously bodily injury, or not later than 24 hour if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #69's medical record revealed, in part, an admitted [DATE] and a readmitted [DATE]. Further review revealed, in part, diagnoses of lumbosacral spine fracture (broken bone), pelvis fracture, and right hip fracture. Review of the facility Incident Accident Log revealed, in part, Resident #69 had an unobserved fall with skin tear and fractured femur (thigh bone) and pelvis on 03/15/2024. Review of an emergency room history and physical dated 03/16/2024 revealed Resident #69 was seen after a fall resulting in a closed fracture of right hip and closed fracture of right pelvis. Review of Resident #69's record revealed, in part, no documentation and the facility was unable to present documentation, a fall with a major injury was reported on the Statewide Incident Management System (SIMS). In an interview on 05/28/2024 at 12:55 p.m., S1Administrator stated he did not complete a Statewide Incident Management System (SIMS) report for Resident #69's fall with a major injury that occurred on 03/15/2024. 2. Review of Resident #118's medical record revealed an admitted [DATE] with a diagnosis of Unspecified Dementia. Review of Resident #118's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/2024 revealed, in part, Resident #118 had a Brief Interview for Mental Status (BIMS) of 1 which indicated his cognition was severely impaired. Further review revealed Resident #118 had behavioral symptoms directed toward others and was independent with transfers and walking. Review of Resident #118's nurse's note dated 05/06/2024 at 7:22 a.m., revealed, in part, Resident #67 was heard yelling from her room. Further review revealed when S20LPN walked into the room to investigate the reason for yelling, she found Resident #118 standing on the left side of Resident #67 pulling his penis out. S20LPN further documented Resident #118 exposed his penis to Resident #67. Further review of Resident #118's nurses notes revealed, in part, on 05/06/2024 at 1:46 p.m., Resident #118 attempted to kiss S16OT multiple times. In an interview on 05/29/2024 at 3:30 p.m., S1Administrator confirmed he was aware Resident #118 exposed himself to Resident #67 on 05/06/2024. S1Administrator further confirmed this incident was not reported due to Resident #118 being severely cognitively impaired. In an interview on 05/29/2024 at 3:40 p.m., Resident #67 confirmed Resident #118 exposed himself to her in her room on 05/06/2024. In an interview on 05/30/2024 at 10:58 a.m., S16OT confirmed Resident #118 attempted to kiss her multiple times on 05/06/2024 while she was walking with him to the therapy gym. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 05/30/2024 at 1:20 p.m., S1Administrator confirmed he had no documented evidence to present to the survey team to dispute the above mentioned findings. S1Administrator further stated he could not offer an explanation on why the above mentioned allegation of sexual abuse for Resident #118 was not reported to the state incident management system.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47327 Based on record review and interviews, the facility failed to ensure an alleged incident of sexual abuse was thoroughly investigated by the facility for 1 (Resident #118) of 1 (Resident #118) sampled resident reviewed for abuse. Findings: Review of Resident #118's record revealed, in part, an admitted [DATE] with a diagnosis of Unspecified Dementia. Review of Resident #118's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/2024 revealed, in part, Resident #118 had a Brief Interview for Mental Status (BIMS) of 1 which indicated Resident #118's cognition was severely impaired. Further review revealed Resident #118 had other behavioral symptoms directed toward others and was independent with transfers and walking. Review of Resident #118's nurse's note dated 05/06/2024 at 7:22 a.m., revealed, in part, Resident #67 was heard yelling from her room. Further review revealed when S20Licensed Practical Nurse (LPN) walked into the room to investigate the reason for yelling, she found Resident #118 was standing, in Resident #67's room, on the left side of Resident #67 and pulled out his penis and exposed his penis to Resident #67. S20LPN further documented Resident #118 exposed his penis to Resident #67. Further review of Resident #118's nurses notes revealed, in part, on 05/06/2024 at 1:46 p.m., Resident #118 attempted to kiss S16Occupational Therapist (OT) multiple times. There was no documented evidence and the facility failed to present any documented evidence that an investigation was completed to determine if Resident #118 exposed himself to Resident #67 for sexual gratification. In an interview on 05/29/2024 at 3:30 p.m., S1Administrator confirmed he was aware Resident #118 exposed himself to Resident #67 on 05/06/2024. S1Administrator acknowledged Resident #67 was interviewed after the incident but there was no further investigation completed to determine whether or not Resident #118's intention was sexual in nature. In an interview on 05/29/2024 at 3:40 p.m., Resident #67 confirmed Resident #118 exposed himself to her in her room on 05/06/2024. In an interview on 05/30/2024 at 10:58 a.m., S16OT confirmed Resident #118 attempted to kiss her multiple times on 05/06/2024 while she was walking with him to the therapy gym. In an interview on 05/30/2024 at 10:31 a.m., S12Certified Nursing Assistant (CNA) confirmed she was not interviewed about any specific behaviors of Resident #118. In an interview on 05/30/2024 at 10:38 a.m., S15LPN confirmed he was not interviewed by administration about any specific behaviors of Resident #118. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 05/30/2024 at 11:08 a.m., S17CNA confirmed she was never interviewed after the incident occurred and never wrote a statement about any specific behaviors of Resident #118. In an interview on 05/30/2024 at 11:16 a.m., S18CNA confirmed she was never interviewed after the incident occurred and never wrote a statement about Resident #118's behaviors and whether or not she thought his behaviors were sexual in nature. In an interview on 05/30/2024 at 11:39 a.m., S4Life Enrichment Director confirmed she had never been asked to write a statement, nor interviewed about Resident #118's behaviors or if she thought those behaviors were sexual in nature. In an interview on 05/30/2024 at 1:20 p.m., S1Administrator acknowledged he did not agree with the need for an investigation after he was notified that Resident #118 exposed himself to Resident #67. S1Administrator further confirmed he had no further documentation to present and he felt he had done all that he needed to do because Resident #118 was demented, and did not have the cognitive ability to know what he was doing when he was in Resident #67's room. S1Administrator indicated he did not have any documented evidence of an investigation to determine if Resident #118 had exposed himself to Resident #67 for sexual gratification. 48855

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 45877 48855 Based on interviews, observations, and record reviews, the facility failed to ensure a person-center plan of care consisted of individualized interventions, that was reflective of a resident's status was developed and/or implemented, for a resident whose cognition was severely impaired and assessed as being at high risk for falls. This deficient practice was identified for 1 (Resident #69) of 3 (Resident #21, Resident #26, and Resident #69) sampled residents reviewed for falls. Findings: Review of Resident #69 record revealed Resident #69's current admitted was 03/18/2024, and had the following diagnoses, in part: Stroke, Hemiplegia, Aphasia, and Post Traumatic Head Trauma. Review of Resident #69's Re-entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/2024 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 2 which identified Resident #69's cognition as being severely impaired. Further review revealed Resident #69 required assistance with ambulation and transfers. Review of Resident #69's Facility Fall Risk assessment dated [DATE] revealed, in part, a score of 18, which identified Resident #69 as being at high risk for falls. Review of Resident #69's current care plan with a goal date of 07/09/2024 revealed, in part, Resident #69 was at risk for falls due to having decreased safety awareness and generalized weakness. Further review revealed, Resident #69's interventions included: Resident #69 was to have a call light within reach, and to be reminded by staff to call for assistance; Resident #69 was to be reminded by staff to ask for assistance for all ambulation and transfers; Resident #69 was to have bright signage in his room to remind to him to call for assistance; Resident #69 was to have bright tape on his wheelchair brakes/extenders to remind him to lock his wheelchair. Review of Resident #69's Physician Progress Note dated 03/05/2024, revealed, in part, Resident #69 had short term memory loss. Review of Resident #69's Nurse's Progress Note dated 03/22/2024 reveled, in part, Resident #69 displayed multiple attempts to self-transfer without assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observation on 05/28/2024 at 9:19 a.m. revealed Resident #69 lying in bed sleeping. Further observation revealed no colored signage on Resident #69's walls in his room and bright colored tape on his wheelchair extenders/brakes on his wheelchair. Observation on 05/28/2024 at 2:20 p.m. revealed, Resident #69 was at the nursing station, visibly confused, and was unable to answer questions appropriately. In an interview on 05/28/2024 at 2:26 p.m. S10Registered Nurse indicated Resident #69 had difficulty making his needs known. In an interview on 05/28/2024 at 2:36 p.m., S9Licensed Practical Nurse (LPN) indicated Resident #69 was cognitively impaired, and was not able to use the call bell to ask for assistance. In an interview on 05/29/2024 at 11:50 a.m. S8MDC/LPN indicated Minimum Data Set (MDS) nurses were responsible for updating care plans. S8MDC/LPN further indicated care plan interventions were based upon resident's capability, and whether a resident can be educated, can perform the intervention and/or the activity, and according to their cognitive ability. S8MDC/LPN indicated bright colored signage, colored tape on wheelchair extenders, using a call bell to call for assistance, reminding Resident #69 to use the call bell to ask for assistance were all interventions that were not appropriate for Resident #69 who had a BIMS score of 2 due to his cognitive impairment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 22609 41461 45877 Based on record reviews, observations, and interviews, the facility failed to: 1.) Ensure staff handled soiled towels appropriately for 1 (Resident #1) of 2 (Resident #1 and Resident #58) residents reviewed for urinary catheter (a tube inserted into the bladder to allow urine to drain) care; and, 2.) Ensure a resident's urinary catheter bag was not touching the floor for 3 (Resident #58, Resident #89, and Resident #169) of 4 (Resident #1, Resident #58, Resident #89, and Resident #169) sampled residents with urinary catheters. Findings: 1. Review of the facility's undated Perineal Care Policy and Procedure revealed, in part, soiled linen should be discarded appropriately. Review of Resident #1's Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) of 05/03/2024, revealed Resident #1 had an indwelling urinary catheter. Observation on 05/29/2024 at 4:08 p.m. revealed S14Certified Nursing Assistant (CNA) wiped Resident #1's urinary catheter from the urinary meatus (opening to the bladder) and then placed the soiled towel on Resident #1's bedside table. Further observation revealed S14CNA wiped Resident #1's urinary catheter from the urinary meatus outward with another towel and placed the soiled towel on Resident #1's bedside table. S14CNA was then observed taking another towel, and wiped Resident #1's catheter from the urinary meatus outward and placed the soiled towel on Resident #1's bedside table. Observation on 05/29/2024 at 4:18 p.m. revealed S14CNA provided incontinent care to Resident #1 after she had a bowel movement. Observation further revealed S14CNA wiped Resident #1's genital area with a wet towel and placed the visibly soiled towel on Resident #1's bedside table. In an interview on 05/29/2024 at 4:32 p.m., S14CNA confirmed she placed the above mentioned soiled towels on Resident #1's bedside table and should not have. In an interview on 05/29/2024 at 4:49 p.m., S2Director of Nursing (DON) confirmed towels used for catheter care and/or incontinence care should nog have been placed on Resident #1's bedside table. In an interview on 05/30/2024 at 1:41 p.m., S3Assistan Director of Nursing (ADON)/Infection Preventionist (IP) indicated towels used for catheter care and incontinence care that were placed on Resident #1's bedside table was an infection control problem. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #58 Review of Resident #58's record revealed, in part, a diagnosis of neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). Review of Resident #58's Minimum Data Set with an Assessment Reference Date of 05/13/2024 revealed, in part, Resident #58 had an indwelling urinary catheter. Review of Resident #58's record revealed, in part, Resident #58 had a history of urinary tract infections. Observation on 05/27/2024 at 9:10 a.m. revealed Resident #58 lying in bed. Further review revealed Resident #58's uncovered urinary catheter bag was attached to the right side of the bed frame with the bottom of the urinary catheter bag touching the floor. In an interview on 05/29/2024 at 10:30 a.m., S2DON indicated Resident #58's uncovered urinary catheter bag should not be touching the floor. Resident #89 Review of Resident #89's record revealed, in part, a diagnosis of neurogenic bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). Review of Resident #89's Minimum Data Set with an Assessment Reference Date of 03/13/2024 revealed, in part, Resident #89 had an indwelling urinary catheter. Observation on 05/24/2024 at 9:55 a.m. revealed Resident #89's lying in bed. Further review revealed Resident #89's uncovered urinary catheter bag was attached to the bed frame with the bottom of the urinary catheter bag touching the floor. In an interview on 05/29/2024 at 10:30 a.m., S2DON indicated Resident #89's uncovered urinary catheter bag should not be touching the floor. Resident #169 Review of Resident #169's record revealed, in part, a diagnosis of neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). Review of Resident #169's current Physician Orders dated 05/2024 revealed, in part, Resident #169 had an indwelling urinary catheter connected to a urinary bag. Review of Resident #169's Minimum Data Set with an Assessment Reference Date of 05/16/2024 revealed, in part, Resident #169 had an indwelling urinary catheter. Review of Resident #169's Care Plan revealed, in part, a review date of 08/10/2024, and Resident #169 will have no infections from catheter use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/30/2024 at 8:15 a.m., revealed Resident #169's urinary catheter bag was hanging down and touching the floor. In an interview on 05/30/2024 at 8:18 a.m., S1Administrater indicated he observed Resident #169's urinary catheter bag hanging down and touching the floor and it should not be. In an interview on 05/30/2024 at 9:00 a.m., S2DON indicated Resident #169's indwelling urinary catheter should not be touching the floor due to the possible transmission of infections.