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	05/29/2026

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to report alleged/witnessed physical and verbal abuse to the state survey agency within two hours for 2 (Resident #77, Resident #128) of 2 sampled residents investigated for abuse reporting. Findings:Review of the facility's undated Abuse and Neglect Policy and Procedure revealed, in part, each resident had the right to be free from abuse. Further review revealed residents must not be subjected to abuse by anyone, including other residents. Further review revealed instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain, or mental anguish. Further review revealed verbal abuse included the use of oral or gestured communication regardless of a resident's age, ability to comprehend, or disability. Further review revealed physical abuse included hitting, slapping, or kicking. Further review revealed, a facility employee, who became aware of abuse, shall immediately report the matter to the facility's Administrator or Director of Nursing (DON). Further review revealed the facility's Administrator or designee shall complete a report to the mandated stated agency. Further review revealed if the allegation involved abuse, immediately would have been defined as not later than 2 hours after the allegation is made. Review of Resident #128's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/2025 revealed, in part, Resident #128 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Review of Resident #77's incident report dated 01/25/2026 revealed, in part, Resident #77 had a verbal altercation with another resident when Resident #77 called Resident #128 a dirty f***ing b***h. Further review revealed Resident #128 then slapped Resident #77. Further review revealed the altercation was heard by multiple staff members. Further review revealed Resident #77 indicated that they (he and Resident #128) were arguing and Resident #128 slapped him. Review of Resident #128's incident report dated 01/25/2026 revealed, in part, Resident #128 got into an altercation with Resident #77. Further review revealed Resident #77 had come up and started arguing with Resident #128 and then called her a dirty f***ing b***h. Resident #128 then slapped Resident #77. Further review revealed staff witnessed Resident #128 and Resident #77's altercation.Review of Resident #77's progress note dated 01/25/2026, revealed, in part, Resident #77 called another resident a b***h. Further review revealed Resident #77 was then slapped according to witnesses. Review of Resident #128's progress note dated 01/25/2026 revealed, in part, Resident #128 was involved in an altercation with another resident. Further review revealed Resident #128 was called a b***h and then slapped the other resident per witnesses. Further review revealed Resident #128 denied slapping the other resident and indicated she had just kicked at the other resident's wheelchair. Review of S3Licensed Practical Nurse's (LPN) Incident/Accident Witness Statement dated 01/25/2026 revealed, in part, S3LPN wrote she saw Resident #128 slap Resident #77 across the face and Resident #77's head snapped back. Review of S4Certified Nursing Assistant's (CNA) Incident/Accident Witness Statement dated 01/25/2026 revealed, in part, S4CNA wrote she was standing at the nurse's station when she heard you dirty f***ing b***h then a slap. Review of S5LPN's Incident/Accident Witness Statement dated 01/25/2026 reveled, in part, S5LPN wrote she heard residents screaming at each other, Resident #77 loudly called Resident #128 a dirty f***ing (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	b***h, and then she heard a loud slap. Further review revealed S5LPN wrote she immediately went to the scene and Resident #77 appeared visibly angry. Further review revealed S5LPN wrote, when questioned, both residents (Resident #77 and Resident #128) reported kicking each other and Resident #128 reported slapping Resident #77. There was no documented evidence the above mentioned allegations/observations of physical and verbal abuse were reported to the state agency as required within 2 hours as required. In an interview during entrance conference on 05/26/2026 at 9:02AM, S1Administrator indicated he did not have any State Incident Management System (SIMS) reports for the last 6 months. In an interview on 05/29/2026 at 10:44AM, S7Activities Director indicated Resident #77 and Resident #128 had verbal disagreements with each other at times, and she had told Resident #77 and Resident #128 to remain distant from each other, but Resident #77 and Resident #128 always wanted to sit together anyway. In a telephone interview on 05/29/2026 at 11:48AM, S3LPN indicated she had witnessed Resident #128 slap Resident #77 in the face, and the hit was intentional because she saw Resident #128 swing to hit Resident #77's face.In an interview on 05/29/2026 at 11:52AM, S1Administrator indicated he did not consider the above mentioned incident that occurred between Resident #128 and Resident #77 verbal or physical abuse because Resident #128's BIMS score was low, she hit Resident #77 out of frustration, and Resident #128 did not even remember slapping him. S1Administrator further indicated he had not reported this incident into the SIMS because Resident #128 did not have the mental ability to make decisions. S1Administrator offered no further information that disputed the above mentioned deficient practice. In a telephone interview on 05/29/2026 at 12:11PM, S4CNA indicated on 01/25/2026, she was standing by the nursing station, and Resident #77 had cursed and she saw Resident #77 said something like you b***h to Resident #128. S4CNA further indicated she witnessed Resident #128 and Resident #77 kicking each other's wheelchairs.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a referral was made to the Louisiana Office of Behavioral Health's Preadmission Screening and Resident Review (PASRR) program for a resident with a serious mental disorder for 1 (Resident #108) of 1 sampled resident investigated for PASRR. Findings: Review of Resident #108's electronic medical record (EMR) revealed, in part, Resident #108 was admitted to the facility on [DATE]. Further review revealed Resident #108 did not have a serious mental disorder at the time of admission. Review of Resident #108's Form 142 dated 07/14/2021 revealed, in part, Resident #108 did not have a serious mental disorder. Review of Resident #108's diagnosis information list dated 06/24/2024 revealed Resident #108 had diagnoses, of in part, Psychosis, Major Depressive Disorder, and Anxiety. Further review revealed there was no diagnosis of Dementia or Alzheimer's disease. Review of Resident #108's medical record revealed there was no documented evidence a PASRR Level II evaluation was completed for Resident #108, which indicated Resident #108 had a serious mental disorder. Review of Resident #108's most recent MDS with an ARD of 04/02/2026 revealed, in part, Resident #108 had diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder. In an interview on 05/28/2026 at 1:44PM, S2Social Worker indicated Resident #108's serious mental disorder occurred after Resident #108's admission to the facility. S2Social Worker further indicated Resident #108 required a referral to the Louisiana Office of Behavioral Health's PASRR program due to a serious mental disorder diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder, and it was not completed as required. In an interview on 05/28/2026 at 1:45PM, S1Administrator indicated a submission to the Office of Behavioral Health program to evaluate Resident #108 for a Level II PASRR due to Resident #108's serious mental disorders was not completed, and should have been completed as required.