STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195615	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Booker T. Washington Skilled Nursing and Rehabilit	7605 Line Avenue Shreveport, LA 71106

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to provide documentation regarding the existence of any written advance directives for 3 (#4, #25, #69) of 8 residents reviewed for Advanced Directives. Findings: Review of the facility's Advance Directives policy (revised 05/31/2023) revealed in part: Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Resident #4 Review of Resident #4's record revealed an admit date of 05/07/2026 and diagnoses including: displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus with hyperglycemia, and COPD. Review of Resident #4's Advance Medical Directives form signed 05/13/2026 revealed a section of the form which read: Please note whether an Advanced Directive has been executed: was incomplete with no box checked to indicate whether or not an Advanced Directive had been executed. During an interview on 06/09/2026 at 9:15 a.m., S1ADM verified Resident #4's advanced directive was not complete and should be. Resident #25 Review of Resident #25's medical record revealed an admission date of 08/08/2024 with diagnoses that included, in part, primary generalized osteoarthritis, hereditary and idiopathic neuropathy, chronic systolic congestive heart failure, obstructive sleep apnea, anemia, atherosclerotic heat disease of native coronary without angina, and essential primary hypertension. Review of Resident #25's MDS dated [DATE], quarterly, revealed a BIMS score of 13.Review of Resident's #25's advanced medical directives form dated 08/08/2026 revealed a section of the form which read: Please note whether advanced directive has been executed. was incomplete with no box checked to indicate whether or not an advanced directive had been executed. During an interview on 06/09/2026 at 9:15 a.m., S1ADM verified Resident #25's advanced directive was not completed and should be. Resident #69 Review of Resident #69's medical record revealed an admit date of 07/02/2025 with diagnosis that included, in part, hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting left non-dominant side, aphasia following cerebral infarction, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, and unspecified systolic congestive heart failure. Review of Resident #69's quarterly MDS dated [DATE] revealed a BIMS score of 12. Review of Resident's #69's advanced medical directives form dated 08/08/2026 revealed a section of the form which read: Please note whether advanced directive has been executed. was incomplete with no box checked to indicate whether or not an advanced directive had been executed. During an interview on 06/09/2026 at 9:15 a.m., S1ADM verified Resident #69's advanced directive was not completed and should be.

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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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interviews, the facility failed to ensure Safe Smoking Assessments were completed on admit and with each subsequent MDS assessment per policy for 1 (#26) of 1 residents reviewed for smoking. Findings: Review of the facility's Smoking Policy - Residents (revised 03/08/2023) included in part:The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include the ability to smoke safely with or without supervision per a completed Safe Smoking Evaluation or equivalent form. Once a resident is determined to be a smoker, his/her ability to smoke safely will be evaluated upon admission, subsequent MDS and PRN. Based on record review and interviews, the facility failed to ensure Safe Smoking Assessments were completed on admit and with each subsequent MDS per policy for 1 (#26) of 1 residents reviewed for smoking. Findings: Review of the facility's Smoking Policy - Residents (revised 03/08/2023) included in part:The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include the ability to smoke safely with or without supervision per a completed Safe Smoking Evaluation or equivalent form. Once a resident is determined to be a smoker, his/her ability to smoke safely will be evaluated upon admission, subsequent MDS and PRN. Review of Resident #26's record revealed an admit date of 11/07/2025 and diagnoses including: conversion disorder with seizures or convulsions, COPD, epilepsy, and generalized muscle weakness. Review of the facility provided Safe Smoking List revealed Resident #26 was listed as a safe smoker. Review of Resident #26's Baseline Care Plan created 11/07/2026 revealed Resident #26 was a smoker. Review of Resident #26's Safe Smoking Assessments failed to reveal an assessment was performed on admission. Further review failed to reveal Safe Smoking Assessments were performed for Resident #26 with each subsequent MDS assessment. During an interview on 06/09/2026 at 9:48 a.m. S2 DON reviewed the facility Smoking Policy and Resident #26's Safe Smoking Assessments and confirmed Resident #26 should have had Safe Smoking Assessments performed on admission and with each subsequent MDS assessment and did not.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a significant change assessment was completed for 1 (#15) of 1 reviewed for significant change assessment. Findings: Review of Resident #15's medical record revealed an admission date of 06/13/2022 with diagnosis that included, in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia following cerebral infarction, dysphagia following cerebral infarction, acute respiratory failure with hypoxia, chronic kidney disease stage two, peripheral vascular disease with heart failure, chronic diastolic congestive heart failure, unspecified systolic congestive heart failure, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #15's MDS dated [DATE], Section C showed that a BIMS was No (resident is rarely/never understood). Resident had memory problem for short term and long term. Cognitive skills for daily decision making was marked severely impaired. Review of Resident #15's physician orders for June 2026 revealed an order of, Admit to ------- Hospice under routine home care with diagnosis of cerebral infarction, dated 04/16/2026. Review of the care plans for Resident #15 failed to reveal a care plan related to hospice care/significant change. During an interview on 06/09/2026 at 7:50 a.m., S2DON confirmed Resident #15 was admitted to hospice on 04/16/2026 and a significant change assessment was not completed for Resident #15. During an interview on 06/09/2026 at 8:10 a.m., S3MDS Nurse confirmed Resident #15 was admitted to hospice on 04/16/2026. S3MDS Nurse reported she did not complete a significant change assessment after the hospice admit for Resident #15.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents' code status wishes for emergency basic life support were consistent and accurate across all areas of residents' medical records for 2 (#4, #78) of 8 residents reviewed for Advanced Directives. The facility failed to ensure the residents' records reflected the residents' wishes to be a DNR. Findings:Review of the facility's Advance Directives policy (revised [DATE]) revealed in part: 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive11. The resident has the right to refuse treatment, whether or not he or she has an advance directive. A resident will not be treated against his or her own wishes. 15. Our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: e. Do Not Resuscitate - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. 20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. 21. The Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. Resident #4 Review of Resident #4's medical record revealed an admit date [DATE] and diagnoses including: displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus with hyperglycemia, COPD, major depressive disorder, PTSD, schizoaffective disorder bipolar type, long term (current) use of insulin, and generalized anxiety disorder. Review of Resident #4's 5-Day MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 15 indicating the resident was cognitively intact. Review of Resident #4's __POST document signed by Resident #4 on [DATE] and by the physician on [DATE] revealed Resident #4 had chosen DNR/Do Not Attempt Resuscitation (Allow Natural Death), Comfort focused treatment, and no artificial nutrition by tube. Review of Resident #4's electronic medical record revealed the home page displayed a Code Status of Full Code. Review of Resident #4's face sheet revealed the Advance Directive section was marked Full Code. Review of Resident #4's physician orders in the electronic record revealed an order dated [DATE] - Full Code. Review of Resident #4's comprehensive care plan revealed Resident #4 had elected a full code status (date initiated [DATE] revision on [DATE]) with approaches including - inform all care givers of full code status, notify MD and family as soon as possible begin CPR and call 911. During an interview on [DATE] at 8:35 a.m. Resident #4 reported she remembered having a conversation with someone about her code status but did not remember who it was with. Resident #4 reported they had signed a yellow piece of paper indicating they had chosen to be a DNR and did not want anyone to do CPR on them. During an interview on [DATE] at 10:43 a.m., S2 DON reported the facility did not have an actual policy for carrying out a resident's expressed wishes for code status or implementing the choices selected on the __POST document. S2 DON further reported the customary procedure on admission was for the Social Worker to let the DON or ADON know if a resident had chosen to be a DNR so they could follow up with the MD and enter the DNR order. S2 DON reported if a resident was transferred to the Emergency Room, a copy of the resident's face sheet and a copy of their __POST document was sent with them. During an interview on [DATE] at 10:55 a.m., S1 Administrator and S2 DON reviewed Resident #4's signed __POST document and agreed the resident had chosen DNR/Do Not Attempt Resuscitation (Allow Natural Death), Comfort focused treatment, and no artificial nutrition by tube. S1 Administrator and S2 DON further reviewed Resident #4's face sheet and physician orders and confirmed they showed the resident to be a full code. S1 Administrator and S2 (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON agreed Resident #4's expressed code status wishes were not consistent across all documents and should be. Resident #78 Review of Resident #78's record revealed an admit date of [DATE] and diagnoses including COPD, Type 2 Diabetes Mellitus, epilepsy, infection and inflammatory reaction due to unspecified internal joint prosthesis, peripheral vascular disease, congestive heart failure, and major depressive disorder. Resident #78's admission MDS assessment including the resident's BIMS score had not yet been completed. Review of Resident #78's electronic record revealed a __POST document electronically signed by Resident #78 on [DATE] and not signed by physician. Further review revealed Resident #78 chose DNR/Do Not Attempt Resuscitation (Allow Natural Death), Comfort focused Treatment, and no artificial nutrition by tube. Review of Resident #78s Advanced Directive acknowledgment signed by the resident on [DATE] revealed a section of the form which read Please note whether an Advanced Directive has been executed had I have a DNR Order selected. Review of Resident #78's hard copy __POST physically signed by Resident #78 on [DATE] and by the physician on [DATE] revealed Resident #78 chose CPR/Attempt Resuscitation (requires full treatment in section B); Section B - chose Comfort focused treatment; section C - chose no artificial nutrition by tube. Review of Resident #78's electronic medical record revealed the home page displayed a Code Status of Full Code Review of Resident #78's face sheet revealed the Advance Directive section was marked Full Code. Review of Resident #78's physician orders in the electronic record revealed an order dated [DATE] for a Full Code. Review of Resident #78's comprehensive care plan revealed Resident #78 was care planned for a full code with approaches including notify MD and family as soon as possible begin CPR and call 911. During an interview on [DATE] at 9:05 a.m., Resident #78 reported they had a conversation with someone when they were admitted about their code status wishes but did not remember who it was with. Resident #78 reported they had told the staff member they did not want anyone trying to resuscitate them, and wanted to be allowed to die naturally and be left alone if they coded. Resident #78 reported they did not remember all of the papers they signed on admission but did remember having the conversation. During an interview on [DATE] at 10:55 a.m., S1 Administrator and S2 DON reviewed Resident #78's printed __POST document showing CPR, Comfort focused treatment, and no artificial nutrition by tube and confirmed it did not match the resident's electronic __POST indicating DNR/Do Not Attempt Resuscitation (Allow Natural Death) or Resident #78's Advance Directive form stating the resident had a DNR order. S1 Administrator and S2 DON further reviewed Resident #78's face sheet and electronic physician orders and confirmed they showed Resident #78 was a full code. S1 Administrator and S2 DON agreed Resident #78's wishes for DNR or full code were not consistent across all documents and should be.