

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Willis-Knighton Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2550 Kings Highway Shreveport, LA 71103	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40193</p> <p>Based on record review and interviews, the facility failed to implement the care plan for 1 (#1) out of 3 (#1, #2, #3) residents reviewed for falls. The facility failed to use a gait belt for Resident #1 during ambulation.</p> <p>Findings:</p> <p>Review of Facility's Clinical Protocol for Falls (undated) revealed: Purpose: It is the policy of ___Care that the facility shall identify patients at risk for falling and take steps to prevent future fall occurrences.</p> <p>Review of Resident #1's medical records revealed an admitted [DATE] with the following diagnoses, in part but not limited to: femoral neck fracture, neuropathy, recurrent falls, and left knee DJD (degenerative joint disease).</p> <p>Review of Resident #1's Baseline Care Plan revealed summary concerns of a fall risk and gait belt use.</p> <p>Review of Resident #1's ___Fall Risk Assessment Scale dated 12/18/2024 revealed a total score of 23 indicating a high fall risk (15 or &gt;). Further review of ___Rehab Fall Risk Care Plan revealed: mobility, in part: . gait belt when assisting patient to ambulate.</p> <p>During a telephone interview on 02/06/2025 at 8:05 a.m. S1 CNA (Certified Nurse Assistant) confirmed Resident #1 required a gait belt with ambulation. S1 CNA acknowledged on 01/17/2025 she ambulated Resident #1 without using a gait belt.</p> <p>During an interview on 02/06/2025 at 10:48 a.m. S1 ADON (Assistant Director of Nursing) reported the staff are to use a gait belt when assisting residents to ambulate. S1 ADON acknowledged Resident #1 was ambulated without a gait belt and should not have been.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 195622	If continuation sheet Page 1 of 1