

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195615	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Booker T.Washington Skilled Nursing and Rehabilita		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414</p> <p>Based on record review and interview, the facility failed to ensure a Discharge Minimum Data Set (MDS) assessment was completed timely for 1 (Resident #32) out of 18 (Resident #9, #13, #15, #20, #30, #32, #34, #40, #43, #44, #53, #56, #59, #60, #69, #70, #72, and #73) sampled residents investigated.</p> <p>Findings:</p> <p>Review of Resident #32's medical record revealed Resident #32 was admitted on [DATE] and discharged from the facility on 10/23/2023.</p> <p>Review of Resident #32's Discharge MDS dated [DATE] revealed a completion date of 02/22/2024 and a transmission date of 02/29/2024.</p> <p>Review of Resident #32's medical record failed to reveal a Discharge MDS assessment was completed and transmitted within 14 days after the resident was discharged from the facility.</p> <p>During an interview on 03/06/2024 at 11:20 a.m., S5MDS Coordinator acknowledged Resident #32's 10/23/2023 Discharge MDS was not completed and transmitted within 14 days of discharge and should 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

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a plan of care had been developed for 4 (#56, #69, #70 and #72) residents. The facility also failed to ensure a plan of care had been implemented for 1 (#40) resident. This was out a total of 24 sampled residents whose plan of care had been reviewed. The facility failed to:</p> <ol style="list-style-type: none"> 1. Develop a plan of care for Residents #56, #69, #70 and #72. 2. Implement the plan of care for Resident #40. <p>Findings:</p> <p>Resident #56</p> <p>Review of Resident #56's medical record revealed an admitted [DATE] with the following diagnoses in part: end stage renal disease, diabetes mellitus type 2 with diabetic chronic kidney disease, dependence on renal dialysis, and congestive heart failure.</p> <p>Review of Resident #56's Quarterly MDS (Minimum Data Set) dated 01/19/2024 revealed Resident #56 had a BIMS (Brief Interview for Mental Status) score of 7 indicating severely impaired cognition.</p> <p>Review of Resident #56's Physician Orders dated 02/29/2024 revealed an order for Clindamycin 300mg (milligrams), give 1 capsule PO (by mouth) tid (three times a day) for an infection for 5 days.</p> <p>Review of Resident #56's MAR (Medication Administration Record) revealed an order for the antibiotic, Clindamycin 300 mg, three times a day for an infection for 5 days with a start date of 02/29/2024.</p> <p>Review of Resident #56's Nurses Notes dated 03/05/2024 revealed Resident #56 was seen on 02/29/2024 with left arm infection and was started on Clindamycin.</p> <p>Review of Resident #56's Comprehensive Care Plan failed to reveal a care plan had been developed for antibiotic use and an infection to left arm.</p> <p>Observation on 03/06/2024 at 12:00 p.m. revealed Resident #56 with a dressing to her left arm.</p> <p>During an interview on 03/04/2024 at 1:22 p.m. Resident #56 reported she was on antibiotics for an infection on her left arm.</p> <p>During an interview on 03/06/2024 at 1:50 p.m. S5 MDS Coordinator, reported Resident #56 was not care planned for antibiotic use or skin/wound/infection and should have been.</p> <p>Resident #69</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #69's medical record revealed an admitted [DATE] with the following diagnoses, in part: type 2 diabetes mellitus without complications, major depressive disorder/single episode/unspecified, bipolar disorder/unspecified, other schizoaffective disorders, chronic obstructive pulmonary disease (COPD) and non-traumatic ischemic infarction of muscle/left upper arm/right upper arm.</p> <p>Review of Resident #69's MDS assessment dated [DATE] revealed medications received: 7/7 days of Insulin injections, received during the last 7 days antipsychotic, antidepressant, and diuretic.</p> <p>Review of Resident #69's Comprehensive Care Plan failed to reveal problem and approaches for type 2 diabetes mellitus, bipolar disorder/medication, depression/medication, hypertension, chronic obstructive pulmonary disease and anticoagulant therapy.</p> <p>Review of Resident #69's Physician's Orders revealed the following orders:</p> <p>02/28/2024 - Lantus subcutaneous solution 100unit/ml (milliliter) inject 28 unit subcutaneously at bedtime</p> <p>02/02/2024 - Insulin Aspart injection solution inject as per sliding scale .</p> <p>12/21/2023 - Trazadone HCL (hydrochloride) tablet 50mg give 1 tablet by mouth at bedtime - bipolar disorder</p> <p>11/27/2023 - Coreg oral tablet 6.25mg give 1 tablet by mouth two times a day - hypertension</p> <p>11/02/2023 - Metformin HCL oral tablet 100mg give 1 tablet orally two times a day</p> <p>10/30/2023 - Monitor for side effects of antidepressant medication every shift. Monitor for edema related to diuretic therapy every shift. Document 0=none, 1=trace, 2=2+, 3=+3, 4=pitting edema. Notify MD (Medical Director) of 3+ or greater.</p> <p>Monitor for behaviors every shift.</p> <p>10/26/2023 - Sertraline HCL oral tablet 25mg give 1 tablet by mouth one time a day - major depressive disorder. Seroquel oral tablet 400mg give 1 tablet by mouth one time a day - bipolar disorder. Lasix oral tablet 40mg give 1 tablet by mouth one time a day - COPD. Spironolactone oral tablet 25mg give 1 tablet by mouth one time a day - COPD. Entresto oral tablet 24-26mg give 1 tablet by mouth two times a day - hypertension. Amlodipine Besylate oral tablet 10mg give 1 tablet by mouth one time a day - hypertension.</p> <p>During an interview on 03/06/2024 at 9:30 a.m. S5 MDS Coordinator acknowledged Resident #69 was not care planned for diabetes, major depressive disorder receiving antidepressant, bipolar disorder and other schizoaffective disorders receiving antipsychotics, receiving anticoagulant therapy, chronic obstructive pulmonary disease, and hypertension and should be.</p> <p>Resident #70</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #70's medical record revealed an admitted [DATE] with the following diagnoses, in part: cardiovascular accident, essential hypertension, weakness, lack of coordination and abnormalities in gait and mobility.</p> <p>Review of Resident #70's MDS revealed a BIMS score of 14 indicating intact cognition.</p> <p>During an interview on 03/04/2024 at 9:13 a.m., Resident #70 stated, I am doing good except for the pain in my left knee; they have been giving me Ibuprofen but it is not working.</p> <p>During an interview on 03/06/2024 8:30 a.m., S6 LPN (licensed practical nurse) reported Resident #70 had chronic pain to her left knee and had just completed a 5 day regimen of Ibuprofen 600 mg routinely for 5 days and she routinely gets Voltaren gel for left knee pain.</p> <p>Review of Resident #70's Comprehensive Care Plan failed to reveal a problem or approaches related to Resident #70's left knee pain.</p> <p>During an interview on 03/06/2024 at 9:30 a.m., S6 MDS Coordinator reported being made aware of Resident #70's left knee pain. S6 MDS Coordinator confirmed failing to include a problem and approaches in Resident #70's plan of care that addressed Resident #70's left knee pain.</p> <p>Resident #72</p> <p>Review of Resident #72's medical records revealed an admitting diagnosis of COPD dated 02/01/2024.</p> <p>Review of Resident #72's Physician Orders revealed an order dated 02/01/2024 for O2 (Oxygen) 2L (liters) per NC (nasal cannula).</p> <p>Review of Resident #72's Comprehensive Care Plan revealed an initiated date of 03/05/2024 for emphysema/COPD.</p> <p>Observation on 03/05/2024 at 9:00 a.m. revealed Resident #72 with O2 at 2L per NC.</p> <p>During an interview on 03/06/2024 at 9:50 a.m. S5 MDS Coordinator confirmed Resident #72 had an admitting diagnosis of COPD and should have developed a care plan for COPD and oxygen use on admit and was not.</p> <p>Resident #40</p> <p>Review of Resident #40's medical record revealed an admitted [DATE] with a diagnosis of but not limited to stage 4 pressure ulcer to sacrum, type 2 diabetes, diabetic neuropathy, cognitive communication deficit, unspecified dementia, muscle wasting and atrophy, and gastrostomy.</p> <p>Review of Resident #40's Quarterly MDS dated [DATE] revealed Resident #40 had a BIMS score of 6 indicating severely impaired cognition.</p> <p>Review of Resident #40's comprehensive plan of care revealed a resolved problem of: I have an unstageable pressure ulcer to my right heel (resolved 11/02/2023).</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Review of Resident #40's March 2024 Physician Orders revealed an order dated 10/30/2023: Heel Protectors to both feet while in bed.</p> <p>Observation on 03/06/2024 at 8:50 a.m. with S6 LPN revealed Resident #40 did not have on heel protectors while in bed and Resident #40's heels were touching. Further observation revealed Resident #40's heel protectors were in the closet.</p> <p>During an interview on 03/06/2024 at 8:50 a.m. S6 LPN reported the certified nursing assistants should have put Resident #40's heel protectors on while Resident #40 was in bed.</p> <p>During an interview on 03/06/2024 at 10:00 a.m. S2 DON (Director of Nursing) confirmed Resident #40 should have had heel protectors put on while in bed as ordered by the physician.</p> <p>36665</p> <p>40193</p>		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193</p> <p>Based on record review and interview, the facility failed to ensure residents were free of unnecessary medications for 1 (#15) out of 6 (#15, #20, #30, #34, #40, #69) sampled residents reviewed for unnecessary medications. The facility failed to monitor Resident #15 for edema while receiving a diuretic.</p> <p>Findings:</p> <p>Review of Resident #15's Medical Records revealed an admitted [DATE] with the following diagnoses, in part: type 2 diabetes mellitus without complications, congestive heart failure, other symptoms and signs involving the genitourinary system, obstructive and reflux uropathy/unspecified other viral pneumonia.</p> <p>Review of Resident #15's Physician's Orders revealed orders dated 01/05/2024 - Bumetanide oral tablet 1mg (milligram) give 1 tablet by mouth one time a day and Spironolactone oral tablet 100mg give 1 tablet by mouth one time a day.</p> <p>Review of Resident #15's January - March 2024 Medication Administration Records and Treatment Administration Records failed to reveal monitoring for edema.</p> <p>During an interview on 03/06/2024 at 10:35 a.m., S2 DON (Director of Nursing) acknowledged edema was not monitored for Resident #15 for January, February and March while receiving a diuretic.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>Based on record reviews and interviews, the facility failed to ensure a resident's medical record was complete and accurately documented in accordance with accepted professional standards and practices for 3 (Resident #9, #43, #60) of 4 (Resident #9, #40, #43, and #60) residents reviewed for wounds.</p> <p>Findings:</p> <p>Review of facility's Wound Care policy with a revision date of November 2017 revealed in part:</p> <p>Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.</p> <p>Documentation:</p> <p>The following information should be recorded in the resident's medical record:</p> <ol style="list-style-type: none"> 1. They type of wound care given. 2. The date and time the wound care was given. 3. The name and title of the individual performing the wound care. 8. The signature and title of the person recording the data. <p>Resident #9</p> <p>Review of Resident #9's medical record revealed an admitted d of 03/31/2023 with the following medical diagnoses, in part: restlessness and agitation, mild protein-calorie malnutrition, muscle weakness, and pain.</p> <p>Review of Resident #9's physician order revealed in part:</p> <p>02/24/2024 Right buttock: order to cleanse with wound cleanser pat dry, apply Medihoney and calcium alginate, and cover with dry dressing once daily and as needed until resolved.</p> <p>02/20/2024 Pro-Stat oral liquid, give 30ml (milliliters) by mouth, one time a day, to promote healing.</p> <p>Review of Resident #9's January 2024 TAR (Treatment Administration Record) revealed wound care to right buttock was not documented on the following days: 01/01/2024, 01/06/2024, 01/08/2024, 01/15/2024, 01/17/2024, 01/19/2024, 01/23/2024, 01/26/2024, 01/29/2024, and 01/30/2024.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #9's February 2024 TAR revealed wound care to right buttock was not documented on the following days: 02/02/2024, 02/04/2024, 02/06/2024, 02/06/2024, 02/07/24, 02/17/2024, and 02/23/2024.</p> <p>Review of Resident #9's March 2024 TAR revealed wound care to right buttock was not documented on the following days: 03/01/2024, 03/02/2024, and 03/03/2024.</p> <p>During an interview on 03/05/2024 at 3:55 p.m., after reviewing January, February, and March 2024 TARs, S3Corporate Nurse confirmed dates were missing from Resident #9's TAR of Wound Care being performed and the nurses should have documented on the TAR.</p> <p>Resident #43</p> <p>Review of Resident #43's medical record revealed an admitted [DATE] with the following medical diagnoses, in part: contracture of muscles, multiple sites, type 2 diabetes mellitus, pressure ulcer of left hip, stage 4 and pressure ulcer of sacral region, stage 4.</p> <p>Review of Resident #43's physician orders revealed in part:</p> <p>02/14/2024 Sacrum: Cleanse wound with wound cleanser, pat dry, apply Bactroban, apply wet to dry Dakin's and cover with dry dressing once daily and as needed until resolved.</p> <p>01/31/2024 Left Hip: Cleanse wound with wound cleanser, pat dry, apply calcium alginate and collagen, cover with dry dressing once daily and as needed until resolved.</p> <p>Review of Resident #43's January 2024 TAR revealed wound care to sacrum and left hip was not documented on the following days: 01/06/2024, 01/08/2024, 01/15/2024, 01/17/2024, 01/19/2024, 01/23/2024, 01/26/2024, 01/29/2024 and 01/30/2024.</p> <p>Review of Resident #43's February 2024 TAR revealed wound care to sacrum and left hip was not documented on the following days: 02/02/2024, 02/03/2024, 02/04/2024, 02/06/2024, 02/07/2024, 02/14/2024, 02/17/2024, and 02/23/2024.</p> <p>Review of Resident #43's March 2024 TAR revealed wound care to sacrum and left hip was not documented on the following days: 03/01/2024, 03/02/2024 and 03/03/2024.</p> <p>During an interview on 03/05/24 at 3:55 p.m., S3Corporate Nurse confirmed there was missing documentation of wound care for Resident #43 and wound care should have been documented on the TAR.</p> <p>During an interview on 03/06/2024 at 9:00 a.m. S4Treatment Nurse and S1Administrator reviewed and Resident #43's January - March 2024 TARs and acknowledged wound care had not been documented daily and should have been.</p> <p>Resident #60</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Review of Resident #60's medical record revealed admitted [DATE] with the following medical diagnoses, in part: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus without complications, peripheral vascular disease/unspecified, congestive heart failure and moderate protein-calorie malnutrition.</p> <p>Review of Resident #60's physician's orders revealed in part:</p> <p>02/21/2024 - right heel: paint with betadine, wrap foot with dressing once daily and as needed unit resolved one time a day and as needed if dressing is soiled.</p> <p>02/09/2024 - side of right stomp: cleanse with wound cleanser, pat dry, apply xeroform to side of stomp over bone cover with dry gauze once daily and as needed until resolved one time a day and as needed. Top of right stump: wet to dry with betadine over open area to top of stomp, cover with dry gauze once daily and as needed until resolved one time a day and as needed.</p> <p>02/06/2024 - sacrum: cleanse with wound cleanser, pat dry, apply collagen and calcium alginate and cover with dry dressing once daily and as needed until resolved.</p> <p>01/18/2024 - sacrum: cleanse with wound cleanser, pat dry, apply Santyl and calcium alginate and cover with dry dressing once daily and as needed until resolved one time a day.</p> <p>Review of Resident #60's January - March 2024 TARs revealed wound care was not documented on the following days: 01/15/2024, 01/17/2024, 01/23/2024,01/25/2024, 01/26/2024, 01/29/2024, 01/30/2024, 02/02/2024, 02/04/2024, 02/04/2024, 02/06/2024, 02/07/2024, 02/14/2024 and 02/17/2024.</p> <p>During an interview on 03/06/2024 at 1:00 p.m. S3Corporate Nurse acknowledged the documentation for wound care was missing for Resident #60.</p> <p>40193</p> <p>44414</p>		