STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195321	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Opelousas	7941 I-49 South Service Road Opelousas, LA 70570

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, interviews, and record reviews, the facility failed to implement a comprehensive person-centered care plan for 2 (#1, #3) of 3 (#1, #2, #3) total sampled residents. This was evidenced by failing to:1.ensure physician orders to monitor a surgical incision for signs and symptoms of infection were implemented for Resident #1;2.apply palm protectors for Resident #3; and3.monitor and document the response to pain medication for Resident #3.Findings: Resident #1 1.Review of Resident #1's electronic health record revealed an admission date of 03/20/2026 with diagnoses that included, but were not limited to, status-post L2(level2)-ilium decompression and fusion, chronic kidney disease, atherosclerotic heart disease, transient ischemic attack, and cerebral infarction. Review of Resident #1's physician orders dated 03/20/2026 read in part. monitor surgery incision to back for signs and symptoms of infection. Review of Resident #1's nurses' notes revealed a note written by S11LPN on 03/20/2026 which read in part, surgical incision noted to midback. Further review of nurses' notes revealed another note written by S11LPN on 03/22/2026 which read in part, dressing to midback dry and intact. Review of S7TXN documentation dated 04/01/2026 read in part, surgical wound, new wound, present upon admission, number of staples was 36, measurement length 16.34 cm (centimeters) x 0.73 cm width x area 9.41 cm, surrounding tissue erythema redness of the skin. Further review of nurses' notes and wound care notes did not reveal further evidence of staff monitoring Resident #1's surgical incision. On 05/05/2026 at 9:36 a.m., a telephone interview was conducted with Resident #1 and his wife. Resident #1 stated staff had not been monitoring his incision. He added S7TXN had not been monitoring his surgical incision. Resident #1 stated that on 04/01/2026 was the first time S7TXN had observed his incision and completed wound care. On 05/05/2026 at 10:46 a.m., an interview was conducted with S2RNS. S2RNS stated she completed the admission assessment on Resident #1. She stated she had observed an aquacel dressing (a soft non-woven wound dressing) to the resident's lower back area. S2RNS stated she did not observe any writing on the outside of the dressing that indicated the dressing was not to be removed. She stated when residents were admitted with an aquacel dressing, staff did not remove the dressing. She stated S7TXN should have been monitoring the residents' incision. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/2026 at 11:10 a.m., an interview was conducted with S5LPN who stated she provided care to the resident while he was in the facility. S5LPN stated she remembered the resident had a physician order to monitor for signs and symptoms of infection. When asked if she had physically observed the incision on the resident's midback, she stated she had not. On 05/05/2026 at 12:50 p.m., an interview was conducted with S6LPN who stated she provided care to the resident on 03/23/2026. S6LPN stated she was aware of the physician order to monitor the surgical incision for signs and symptoms of infection. S6LPN confirmed she had not observed the surgical incision for signs and symptoms of infection. On 05/05/2026 at 3:23 p.m., a phone interview was conducted with S10PA, Resident #1's Physician Assistant, who stated when Resident #1 arrived at his post-surgical follow up appointment, he appeared pale and weak. S10PA stated when she removed the midback dressing it was awful. She stated fecal residue was observed on the surgical incision and the dressing was saturated with some brown colored substance. S10PA stated the dressing was so saturated with a brown substance that the glue from the dressing was stuck to the resident's skin and the dressing barely hung on. S10PA stated there was no writing on the dressing stating Do Not Touch. S10PA stated their office did not receive any calls from the facility to clarify the orders or request new orders for the care of the surgical incision. On 05/05/2026 at 3:45 p.m., an interview was conducted with S1DON and S5LPN. S1DON stated Resident #1's orders stated the dressing was not to be removed. When asked why she did not call the physician's office for clarification of the order, she stated the doctor should have been more specific when he wrote his orders. S1DON was asked again why she or her staff did not call the physician's office for clarification of the order, and she stated she worked with the physician for many years, and that was something he did many times before. S5LPN stated in hindsight, I should have called for clarification of the orders. She stated she did not physically observe the surgical incision for signs and symptoms of infection. Resident #3 2. Resident #3 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, aphasia following unspecified cerebrovascular disease, muscle weakness, cognitive communication deficit, delirium due to unknown physiological condition, and major depressive disorder. Review of Resident #3's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 05, indicating the resident's cognition was severely impaired. Review of Resident #3's MDS Section GG revealed Resident #3 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/ bathe self, and upper and lower body dressing. Section GG also revealed Resident #3 had impairment on both sides upper and lower extremities. Review of Resident #3's care plan revealed resident was at risk for complications to left and right hand related to weakness, impaired mobility, and decline in dexterity: Notify MD of any change; Palm protector to left and right hand during the day, may have off at night. On 05/05/2026 at 9:23 a.m., an observation was conducted in Resident #3's room with her husband present. The resident's hands were contracted with fingers turned into her palms. Resident #3 had a piece of cloth in the palm of each of her hands, no palm protector was observed. On 05/05/2026 at (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:30 a.m., an interview, review of Resident #3's medical record, and observation of Resident #3 was conducted with S5LPN. S5LPN reviewed the resident's care plan and confirmed Resident #3 should have palm protectors in her hands. S5LPN then observed Resident #3's right and left hands. S5LPN confirmed there was a piece of cloth inside the palms of Resident #3's hands. S5LPN confirmed Resident #3 did not have palm protectors in her hands. On 05/05/2026 at 11:05 a.m., an interview and observation of Resident #3 was conducted with S1DON. S1DON confirmed there was a piece of cloth in the palms of Resident #3's hands. S1DON confirmed Resident #3 should have palm protectors in her hands. 3. Review of Resident #3's care plan revealed the resident was on a pain medication (Opioid): Administer analgesic medications as ordered by physician. Monitor/ document side effects and effectiveness q (every) shift, ask physician to review medication if side effects persist. Review of the Resident #3's electronic medical record physicians orders revealed an order for oxycodone HCL oral table 20 mg(milligrams) *controlled drug*; give one tablet by mouth three times a day for generalized pain with an order date of 03/30/2026. Review of Resident #3's medication administration record revealed the resident received oxycodone oral tablet 20 mg three times a day during the review period of 04/01/2026 through 05/04/2026. There was no evidence of monitoring for side effects and effectiveness q shift. On 05/05/2026 at 10:30 a.m., an interview and review of Resident #3's medical record was conducted with S5LPN. S5LPN confirmed Resident #3's care plan stated monitor/ document side effects and effectiveness every shift for Opioid medications and ask physician to review medication if side effects persist. S5LPN reviewed the electronic health record for Resident #3. S5LPN confirmed there was no documented evidence that Resident #3 was monitored/ documented for side effects and effectiveness of opioid medications that were given three times per day. On 05/05/2026 at 12:50 p.m., an interview and review of Resident #3's medical record was conducted with S1DON and S12CN. S1DON reviewed the electronic health record for Resident #3 and confirmed Resident #3 was administered opioid medication three times per day. S1DON confirmed there was no documentation of monitoring for side effects and effectiveness Q shift for Resident #3. S12CN reviewed Resident #3's electronic medical record and confirmed the care plan for Resident #3 read: Resident is on pain medication (Opioid): Administer analgesic medications as ordered by physician. Monitor/ document side effects and effectiveness every (Q) shift, ask physician to review medication if side effects persist. S12CN confirmed Resident #3's care plan should have been followed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a resident who was unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good personal hygiene and grooming for 2 (Resident#1, Resident#3) of 3 residents reviewed for ADLs. The facility failed to:1. provide personal hygiene for Resident #1, and2. Provide personal hygiene and nail care for Resident #3 Findings:Resident #1 Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE] and had diagnoses of chronic pain syndrome, atherosclerotic heart disease, Bradycardia, status post L2 ilium decompression and fusion. Further review revealed a discharge date of 04/04/2026. Review of Resident #1's physician orders dated 03/20/2026 read in part, monitor surgery incision to back for signs and symptoms of infection, do not remove dressing every shift. Review of a facility document with no title, which recorded Certified Nursing Assistant (CNA) staff task performed for residents dated 03/01/2026 – 04/06/2026. Review of a section on the task document read in part bath day (Tuesday, Thursday, Saturday) partial/moderate assist. Further review of the document revealed no documented evidence Resident #1 was given a bath on 03/27/2026, 03/28/2026 and 03/30/2026. Review of Resident #1's admission MDS (Minimum Data Set) dated 03/27/2026 read in part.BIMS (Brief Interview for Mental Status) score was 12 which indicated his cognition was moderately intact, only moderate problems with thinking and memory. Functional Abilities: shower/bathe – partial/moderate assistance Personal hygiene – partial/moderate assistance On 05/05/2026 at 9:31 a.m., a phone interview was conducted with Resident #1 and his wife. Resident #1 stated during his stay in the facility, he did not receive bed baths or showers regularly. Resident #1 stated during his two weeks stay in the facility, he received a total of three baths. On 05/05/2026 at 10:25 a.m., a record review of the CNA task log and an interview was conducted with S3CNASUP. S3CNASUP stated when an X was documented on the task log, it meant the task was not completed. Further review of the task log revealed an X on 03/27/2026 and 03/30/2026. On 05/05/2026 at 10:30 a.m., an interview and record review was conducted with S4CNA. She stated she did not know Resident #1, and she had not provided any personal care to the resident during his stay in the facility. Further review of the bath log revealed S4CNA initials on 03/28/2026 and 04/04/2026. S4CNA stated she did not know how her initials were documented on the resident's task log because she had not provided any care to the resident. On 05/05/2026 at 1:00 p.m., a follow up interview was conducted with S3CNASUP. S3CNASUP was asked how she was ensuring that residents in the facility were receiving baths on their assigned days and as needed. She stated she believed staff were performing the tasks that they were documenting (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as complete. S3CNASUP was asked for more monitoring interventions, but she did not provide any further monitoring interventions prior to survey exit. Resident #3 Review of the facility's policy and procedure titled, Resident Quality of Care with a review date of 08/2024, revealed in part: 2. a. Bathing: iii. At the time of bath, all residents shall also receive, nail care, . 2. a. Bathing: iv. Partial bath – by resident, if able, assisted by staff, or performed completely by staff daily or as often as indicated by the physical condition of the resident. This shall include: washing face, hands,. nail care, skin care,. Review of Resident #3's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to aphasia following unspecified cerebrovascular disease, muscle weakness, cognitive communication deficit, delirium due to unknown physiological condition, and major depressive disorder. Review of Resident #3's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/11/2026, revealed the resident's Brief Interview for Mental Status (BIMS) score was 05, indicating her cognition was severely impaired. Further review of the MDS revealed that the resident was dependent on staff for personal hygiene. Review of Resident #3's care plan revealed in part, resident needs assist with ADLs (Activities of Daily Living): bathing: resident is dependent on staff for bathing/ showering; personal hygiene: resident is dependent on staff for personal hygiene. Review of resident #3's care plan did not reveal interventions for nail care. On 05/05/2026 at 9:23 a.m., an observation was made of Resident #3's nails and palms on both hands. The resident had long, untrimmed thumb fingernails with a black substance caked underneath the thumb fingernails. The other fingers and fingernails were curled into the palm of her hand. The fingers curled into the palm of her hands had a yellow film on them. The nails curled into the palm of her hands were yellow and brown and untrimmed. Resident #3's hands smelled of a foul and sour odor. Resident #3 was not interviewable. On 05/05/2026 at 10:30 a.m., an interview and observation of Resident #3 was conducted with S5LPN. S5LPN confirmed Resident #3's thumb fingernails were coated with a black cakey substance under the nails. S5LPN confirmed the other fingers and fingernails were yellow and brown. S5LPN confirmed that both hands smelled of a foul and sour odor. S5LPN confirmed resident #3's fingernails were long and untrimmed. Resident #3's thumb fingernail measured 1/4 of an inch in length. On 05/05/2026 at 11:05 a.m., an interview and observation of Resident #3 was conducted with S1DON. S1DON confirmed Resident #3's thumb fingernails were coated with a black cakey substance under the nails. S1DON confirmed the other fingers and fingernails curled into her palm were yellow and brown. S1DON confirmed both of Resident #3's hands smelled of a foul and sour odor. S1DON confirmed Resident #3's nails were long and untrimmed. Review of Resident #3's task log revealed that Resident #3 was given a bath on 05/01/2026 and on 05/04/2026 by S11CNA. On 05/05/2026 at 2:15 p.m., an interview was conducted with S11CNA. S11CNA confirmed that she (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathed Resident #3 on 05/01/2026 and 05/04/2026 and she did not clean inside the resident's hands, clean under her nails, or provide nail care. On 05/05/2026 at 12:10p.m., an interview was conducted with S13RNS. S13RNS stated wound care nurses performed nail care for residents that are diabetic. S13RNS stated that if a resident is not diabetic, the certified nursing assistants would provide nail care when baths were given. Reviewed Resident #3's EHR. Resident #3 does not have a diagnosis of diabetes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices by failing to ensure staff accurately documented baths for 1 (Resident #1) of 3 (#1, #2, #3) residents sampled for Activities of Daily Living (ADL) care. Findings:Review of Resident #1's electronic health record revealed an admission date of 03/20/2026 with diagnoses that included, but were not limited to, status-post L2(level2)-ilium decompression and fusion, and cerebral infarction. Further review of the electronic health record revealed the resident was discharged from the facility on 04/04/2026 at 5:26 p.m. Review of a facility task document with no title dated 03/01/2026 - 04/06/2026 revealed CNA (Certified Nursing Assistant) staff recorded the completion of specific task(s) performed for residents during the CNA staff's shifts. Review of a section on the task document read in part, bath day (Tuesday, Thursday, Saturday) partial/moderate assist. Further review of the document revealed S9CNA documented on 04/05/2026 and 04/06/2026 she had completed activities of daily living and provided care for Resident #1 when the resident had been discharged home. On 05/05/2026 at 10:55 a.m., an interview was conducted with S8SS. She confirmed Resident #1 had been discharged from the facility on 04/04/2026 at 5:26 p.m. On 05/05/2026 at 1:00 p.m., a record review and interview was conducted with S3CNASUP. She stated S9CNA worked the night shift. She added that S9CNA should not have documented that she provided care for Resident #1 when the resident was discharged from the facility on 04/04/2026. She confirmed this was inaccurate documentation.