STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195323	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Health & Rehab	2575 Airline Drive Bossier City, LA 71111

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure 2 (#3, #5) out of 5 sampled residents were free from abuse resulting in resident to resident interactions. The facility failed to develop and implement ongoing monitoring to ensure resident safety.Findings:Review of Resident #3's medical records revealed an admit date of 12/05/2022 with the following diagnoses, in part: personal history of traumatic brain injury.Review of Resident #3's facility initiated investigation in part, revealed event occurred on12/03/2025 and type of injury was sexual assault. Further review revealed during the investigation, Resident #5 reported to Social Services Director (SSD) two weeks prior the accused tried to touch her but didn't report it because he stopped. The iknvestigation failed to include plans to conduct ongoing monitoring following the incident.Review of Resident #3's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitively intact.During an interview on 12/16/2025 at 10:15 a.m. Resident #3 reported Resident #4 touched her private parts in the cafeteria and made her feel uncomfortable. Review of Resident #5's medical records revealed an admit date of 01/17/2025 with the following diagnoses, in part: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, cognitive communication deficit, vascular dementia severe with agitation and metabolic encephalopathy. Review of Resident #5's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating cognitively intact. During an interview on 12/16/2025 at 9:15 a.m. S5 SSD (Social Services Director) confirmed when conducting interviews, Resident #5 reported Resident #4 had come into her room and tried to put his hand down her diaper.During an interview on 12/16/2025 at 10:20 a.m. Resident #5 reported Resident #4 was coming in her room all the time and talking to her. Resident #5 further reported Resident #4 would grab her legs and run his hands up her leg making her feel uncomfortable. During an interview on 12/16/2025 at 2:30 p.m.S1 Administrator acknowledged Resident #4 was accused by Resident #3 and Resident #5 of making sexual advances. S1 Administrator further acknowledged the facility had not developed plans for ongoing monitoring following the incident of abuse.The investigation revealed a current level of non-compliance due to not implementing ongoing monitoring.The facility's plan included the following: Resident #4 was immediately separated from the other residents and placed on 1 on 1 monitoring in his roomPolice were notified and report filed.Resident #4 was discharged to behavioral health hospital on [DATE] and did not return to the facility.In-serviced conducted on 12/08/2025 staff on abuse and sexual inappropriate behavior.All female residents in the facility were interviewed on 12/05/2025.A trauma screen was conducted on Resident #3 and Resident #5.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The facility failed to document 1 (#1) out of 2 residents discharge from the facility.Findings:Review of Resident #1's medical records revealed an admit date of 10/09/2025 and a discharge date of 10/13/2025 with the following diagnoses, in part: chronic obstructive pulmonary disease unspecified, essential (primary) hypertension, other bipolar disorder, chronic kidney disease stage 3 unspecified, unspecified atrial fibillation, displaced subtrochanter fracture of right femur, displace transverse fracture of shaft of left ulna, displace fractureof medial condyle of left tibia, non-displced fracure of body of scapula left shoulder and contusion of lung unilateral subsequent encounter.Review of the facility census failed to reveal Resident #1 was in the facility.Review of Resident #1's medical record failed to reveal date, time, and events of discharge from the facility. Further review failed to reveal a discharge summary.During an interview on 12/16/2025 at 10:20 a.m. S2 ADON (Assistant Director of Nursing) acknowledged Resident #1 did not have a discharge note indicating date, time, and events of discharge from the facility and should have. S2 ADON reported Resident #1 was transferred to another nursing home facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to develop a baseline care plan for 1 (#1) out of 5 sampled residents reviewed.Findings:Review of Resident #1's medical records revealed an admit date of 10/09/2025 with the following diagnoses, in part: chronic obstructive pulmonary disease unspecified, essential (primary) hypertension, other bipolar disorder, chronic kidney disease stage 3 unspecified, unspecified atrial fibillation, displaced subtrochanter fracture of right femur, displace transverse fracture of shaft of left ulna, displace fractureof medial condyle of left tibia, non-displced fracure of body of scapula left shoulder and contusion of lung unilateral subsequent encounter. Review of Resident #1's medical record failed to reveal a baseline care plan. During an interview on 12/16/2025 at 10:25 a.m. S4 MDS (Minimum Data Set) nurse confirmed Resident #4 did not have a baseline care plan developed and should have.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and interviews, the facility failed to provide needed care and services, in accordance with the resident's goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. The facility failed to ensure 1 (#4) out of 5 sampled residents received medication ordered upon re-ademission to the facility.Findings:Review of Resident #4's medical record revealed an admit date of 04/04/2022 with the following diagnoses, in part: major depressive disorder recurrent and unspecified and anxiety disorder.Review of Resident #4's hospital psychiatric evaluation revealed an admit date of 10/23/2025, date of evaluation 10/24/2025 and discharge date of 10/30/2025. Further review, in part revealed: .admitted for unstable mood and cannabis use disorder. Discharge goal: He needs to have a stable mood, be free of any agitation, maintain sobriety, and improve coping skills. Discharge medication summary included, in part: Divalproex Sodium DRT (delayed release time) 250 mg (milligarm) by mouth daily 9:00 a.m. and 9:00 p.m. - indication mood.Review of Resident #4's Physician's orders failed to reveal an order for Divalproex Sodium DRT 250 mg by mouth daily 9:00 a.m. and 9:00 p.m. - mood.During an interview on 12/16/2025 at 10:05 a.m. S3 Psych NP (Nurse Practitioner) reported when Resident #4 returned from the behavioral hospital the discharged psychotropic medications should have been ordered and administered to Resident #4 once returning to the facility.During an interview on 12/16/2025 at 10:30 a.m. S2 ADON (Assistant Director of Nursing) acknowledged Resident #4 did not have an order entered for Divalproex Sodium DRT 250 mg by mouth daily 9:00 a.m. and 9:00 p.m. for mood and should have.