STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195350	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Place Rehab and Nursing Center	1736 Irving Place Shreveport, LA 71101

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 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. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the provider failed to ensure a plan of care had been developed and implemented for 2 (#1 and #5) of 6 (#1, #2,#3,#4 #5 #6) residents whose care plans were reviewed by:1. Failing to develop a plan of care for the use of a PICC (peripheral inserted central catheter) line for Resident #1 and Resident #5.2. Failing to administer Resident #1 intravenous antibiotic medication as ordered and failing to provide restorative care for Resident #5 as ordered.Findings: 1.Resident #1Review of Resident #1's medical record revealed an admit date of 09/17/2025 with a diagnosis of but not limited to sepsis unspecified organism, Bacterial infection, type 2 diabetes with other circulatory problems, polyneuropathy, and non-pressure chronic ulcer of the feet.Review of Resident #1's MDS (Minimum Data Set) dated 09/23/2025 revealed a BIMS (Brief Interview Mental Status) score of 15 indicating intact cognition. Review of Resident 1's medical record revealed Resident #1 was admitted to the facility with a PICC line in his left arm. Review of Resident #1's Comprehensive Care Plan failed to reveal a problem and approaches reflecting use of a PICC line for the administration of IV (intravenous) antibiotics. During an interview on 12/20/2025 at 3:15p.m. S5 MDS Director confirmed Resident #1's Comprehensive Care Plan failed to have a problem and approaches reflecting the use of a PICC line for the administration of IV antibiotics. Resident #5Review of Resident 5's medical record revealed an admit date of 10/07/2025 with a diagnosis of but not limited to muscle wasting and atrophy, right shoulder non-surgical orthopedic/muscle, cachexia, moderate protein-calorie malnutrition, other pleural conditions, other disorders of lung pulmonary cavity lesion, shortness of breath, other specified disorders of the bladder and dysphagia oropharyngeal phase.Review of Resident #5's admission MDS (Minimum Data Set) dated 10/13/2025 revealed a BIMS (Brief Interview Mental Status) score of 15 indicating intact cognition. Review of Resident 5's medical record revealed Resident #5 was admitted to the facility with a PICC line was located in his left jugular vein and had to be sent back out to the transferring facility for replacement to his right upper inner arm. Review of Resident #1's Comprehensive Care Plan failed to reveal a problem and approaches reflecting use of a PICC line for the administration of IV (intravenous) antibiotics. During an interview on 12/02/2025 at 3:30 p.m. S5 MDS Director confirmed Resident #5's Comprehensive Care Plan failed to have a problem and approaches reflecting the use of a PICC line for the administration of IV antibiotics.2.Resident #1Review of Resident #1's September 2025 Physician's Orders revealed an order for Cefepime HCL intravenous solution 2 GM (grams)/100 ml (milliliters) every 8 hours intravenously for osteomyelitis until 10/22/2025.Review of Resident #1's September 2025 Medication Administration Record failed to reveal documentation of the administration of Cefepime IV solution on 09/19/2025 10 p.m. dose and 09/24/2025 2:00 p.m. dose. During a phone interview on 12/02/2025 at 9:00 a.m. Resident #1 reported the nurses at the facility did not administer IV antibiotic medication properly. Further reported Resident #1 was not given the IV antibiotics three times a day.During an interview on 12/02/2025 at 2:00 p.m. S2 DON (Director of Nursing) confirmed Resident #1's IV antibiotics were not documented as administered 09/19/2025 10 p.m. dose and 09/24/2025 2:00 p.m. dose. S2 DON confirmed Resident #1's IV antibiotics should have been administered as ordered by the physician. Resident #5 Review of resident #5 current Physician's orders revealed an order dated 11/20/2025, Resident to attend restorative nursing program for active/ active assist range of motion to bilateral upper and lower extremities 6 times a week for a minimum of 15 minutes for session as tolerated. During an interview on 12/01/2025 at 1:30 p.m. resident #5 reported he had not received restorative services. During an interview on 12/02/2025 at 3:20 p.m. S6 Restorative Aide reported restorative services for resident #5 had not been started. S6 Restorative Aide reported the MDS nurses place a resident on the restorative aide schedule so that they can be seen and resident #5 was not placed on their schedule.During an interview on 12/02/2025 at 3:30 p.m. S5 MDS Director confirmed Resident #5 did not have restorative services, she reported it had been overlooked.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed ensure a resident's Percutaneous Endoscopic Gastrostomy (PEG) tube (a soft, plastic feeding tube that goes into the stomach used to provide nutrition when oral intake is inadequate) feeding was not administered while a resident was in a flat position for 1 (#4) of 6 (#1, #2, #3, #4, #5 and #6) sampled residents. Findings: Review of the facility's Feeding Systems (Artificial) policy dated 06/2025 revealed in part:Purpose: The purpose of this procedure is to provide guidelines for the safe administration of tube feedings.Procedure Guidelines2. Continuous Feeding:b. If not contraindicated, elevate the head of the bed thirty to forty-five degrees (30-45 degrees) for duration of feeding and for one (1) hour after administration. Review of Resident #4's medical record revealed an admit date of 04/17/2025 with diagnoses including in part focal traumatic brain injury with loss of consciousness of unspecified duration and attention to gastrostomy. Review of Resident #4's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part a BIMS (Brief Interview of Mental Status) was not performed as Resident #4 was rarely/never understood. Review of Resident #4's quarterly MDS revealed Resident #4 had a feeding tube in place.Review of Resident #4's physician orders revealed in part:08/21/2025 Enteral feed every shift, Jevity 1.5 at 55 cc (cubic centimeter) per hour per peg pump continuously.11/28/2025 Tube: elevate head of bed 30-45 degrees at all times during feeding and one hour after feeding is stopped. Review of Resident #4's current care plan revealed in part, Resident #4 required peg tube feedings and to elevate the head of bed 30-45 degrees at all times during feeding and one hour after feeding is stopped. An observation on 12/01/2025 at 2:55 p.m. revealed Resident #4 lying supine in bed with Jevity 1.5 infusing at 55 cc per hour per peg pump. Further observation revealed Resident #4's head of bed was in a flat position and not elevated. During an interview on 12/01/2025 at 3:00 p.m., S2DON (Director of Nursing) and S1Administrator acknowledged Resident #4 was lying on her back and the head of bed was not elevated while tube feeding was in process. S2DON reported the head of bed should be elevated at 30 degrees during tube feeding infusion and was not.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to follow procedures to ensure a resident received pain medication to be administered as ordered for 1 (Resident #2) of 6 sampled residents. The facility failed to provide effective pain management due to the resident's scheduled morphine not being available. The deficient practice resulted in an actual harm for Resident #2 on 11/27/2025 at 8:10 p.m. when Resident #2 received a prn (as needed) dose of Oxycodone-acetaminophen 10-325 mg (milligram) po (by mouth) for a pain level of 10 which had a follow-up status of ineffective. The facility had ran out of Resident #2's Morphine Sulfate (controlled substance) narcotic pain medication ordered for the administration of 30 mg 2 tablets for a total of 60 mg po q (every) eight hours. Resident #2's last documented dose of scheduled Morphine was on 11/26/2025 at 2:00 p.m. S3Unit Manager failed to follow up on the narcotic medication refill request for Resident #2's Morphine prior to and after Resident #2 ran out of scheduled Morphine. Resident #2 missed 3 consecutive doses of scheduled Morphine prior to transfer to a local ER (Emergency Room). Resident #2 received Oxycodone-acetaminophen 10-325 mg on 11/26/2025 at 8:55 p.m. for pain for a pain level of 9 which included a follow-up status of effective and on 11/27/2025 at 6:22 a.m. for pain for a pain level of 7 which included a follow-up status of effective. Resident #2 received Tylenol 650 mg po on 11/27/2025 at 5:40 p.m. with no pain level documented which included a follow-up status of ineffective. Resident #2 received an additional dose of prn oxycodone-acetaminophen 10-325 mg po on 11/27/2025 at 8:10 p.m. for a pain level of 10 which included a follow-up status of ineffective. Resident #2 reported he needed his Morphine for chronic pain and the alternate pain medications were not working. Resident #2 reported his body takes some time to feel the effects of not getting his scheduled Morphine and stated the pain was worsening, so I had to go to the ER. Reported when he left for the ER his headache pain level was a 7 out of 10. Resident #2 was transferred to the ER on [DATE] at 9:21 p.m. for complaints of severe headache, nausea and ineffective pain control. Findings: Review of the facility's Pain Management policy dated 09/2025 revealed in part:Policy: The intent of the facility to ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan and the resident's choices, related to pain management.Procedure: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.Review of the facility's Pain Documentation in eMAR (Electronic Medication Administration Record) for PRN Pain Medications policy dated 09/2025 revealed in part: Policy: It is the policy of this center to review pain needs by asking the resident for the verbal pain scale .Procedure:1. Explain to the resident/resident representative that the purpose of the documentation and pain rating scale is to aid the nurses and physicians in controlling and managing the resident's current pain level.2. Explain to the resident to rate the current pain level on a scale from 0 to 10, where 0 is no pain and 10 is the worst pain imaginable. (Remember the resident's report of pain is subjective; their pain rating is what they say it is. Ask the resident to select a number that best describes how they feel at the time of observation.)4. Pain should be observed and recorded in eMAR prior to PRN pain intervention and after pain intervention, to ensure pain interventions are managing pain.Note: Both pharmacological and non-pharmacological considerations should be made for pain.Pharmacological: When considering drug therapy for managing pain, there are three basic concepts to review:1. By mouth (most convenient and cost-effective route of administration).2. By the clock (rather than PRN or as needed) allows each analgesic dose to achieve constant pain control.3. By the ladder:a. Start with non-opioid analgesic drugs such as acetaminophen, aspirin or other non-steroidal anti-inflammatory drugs.b. If pain remains unrelieved, opioids may be added. These include codeine, hydrocodone, oxycodone and low dose morphine. c. For severe pain unrelieved by above steps, consider opioids such as morphine, oxycodone, hydromorphone and fentanyl.Review of the facility's Ordering and Receiving Controlled Medications policy dated 01/2023 revealed in part: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the nursing care center, in accordance with federal and state laws and regulations. Review of Resident #2's medical record revealed an admit date of 09/08/2022 with a re-admit date of 09/09/2025. Further review of Resident #2's medical record revealed diagnoses which included in part, other incomplete lesion at T7-T10 level of thoracic spinal cord