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	05/14/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews, the facility failed to ensure residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing for 2 (#1and #3) residents of 3 sampled residents. The facility failed to ensure:1. Resident #1's right lateral ankle pressure injury remained free of moisture and 2. EBP signage was in place for Resident #1 and Resident #3. Findings: Review of the facility's undated Enhanced Barrier Precautions policy revealed in part: Enhanced Barrier Precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing.All residents with any of the following conditions should use enhanced barrier precautions:2. Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides. Resident #1 Review of Resident #1 's medical record revealed an admit date of 03/03/2025 with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Type 2 Diabetes, and mild protein-calorie malnutrition. Review of Resident #1's Annual MDS assessment dated [DATE] revealed a BIMS was not conducted as Resident #1 was never understood. Resident #1 was totally dependent on staff and required physical assistance for bathing and transfers. Review of Resident #1's Comprehensive Care Plan revealed in part, Resident #1 was care planned for EBP for wounds. Review of Resident #1's medical record revealed the following wound assessments and treatment recommendations by S2Wound Care NP in part: 04/07/2026 Stage 3 right lateral ankle pressure injury with a status of stable and measured 2.5 cm x 3 cm x 0.2 cm. Treatment Recommendations: Clean with 0.125% Dakin's solution, apply Calcium alginate, Collagen with silver (Ag) and Silicone super-absorbent dressing. Change 3 times per week, Tuesday/Thursday/Saturday and as needed if dislodged, saturated, or soiled. 4/14/2026 Stage 3 right lateral ankle pressure injury with a status of subsequent-worsening and measured 3 cm x 2.5 cm x 0.2 cm with Undermining from 12 o'clock to 3 o'clock, 0.7 cm. Treatment Recommendations: Clean with 0.125% Dakin's solution, apply Collagen with silver (Ag), Calcium Alginate with Silver (Ag) and Silicone super-absorbent dressing. Change 3 times per week, Tuesday/Thursday/Saturday and as needed if dislodged, saturated, or soiled. Review of S2Wound Care NP's 04/14/2026 progress note revealed an addendum related to the decline of Resident #1's right lateral ankle injury which revealed in part: An addendum has been made to the existing progress note due to documented events that occurred after this morning's assessment. I was contacted by S1Administrator who stated one of Resident #1's family members had concerns regarding wound, deterioration, and status of Resident #1's current wounds. At this morning's assessment, it was noted Resident #1 had a wound deterioration to the right lateral ankle as the granulation tissue appeared frail. The granulation tissue to Resident #1's right lateral ankle was noted to be less robust beefy red tissue and overall less healthy. A change in Resident #1's plan of care was made. Silver collagen was added to stimulate the wound bed and to decrease any bioburden. This afternoon, a conference call was held with Resident (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's family member. During the call, I (S2Wound Care NP) explained to Resident #1's family member the characteristics of the right lateral ankle wound deterioration. Please note prior to the call it was reported that Resident #1's family member had assisted Resident #1 to shower over the weekend. During the call, I explained to Resident #1's family member that excess moisture from showering can cause a tissue change or wound deterioration. An observation on 05/11/2026 at 11:00 a.m. revealed Resident #1's room failed to have EBP signage in place. During an interview on 05/11/2026 at 11:05 a.m., S3CNA acknowledged Resident #1's room did not have EBP signage in place and should have. During an interview on 05/11/2026 at 11:10 a.m., S4LPN acknowledged Resident #1's room did not have EBP signage in place and should have had. During an interview on 05/12/2026 at 9:30 a.m., S2Wound Care NP reported the wound assessment on 04/14/2026 revealed Resident #1's right lateral ankle pressure injury had changes she could not understand. S2Wound Care NP reported Resident #1's right lateral ankle pressure injury was mushy and frail. S2Wound Care NP further reported on the afternoon, 04/14/2026 she was notified by the facility Resident #1's family member had showered Resident #1 over the weekend. S2Wound Care NP further reported the changes to Resident #1's right lateral ankle were consistent with getting wet. S2Wound Care NP confirmed moisture to a wound bed could causes frailness and a decline. S2Wound Care NP acknowledged residents with pressure injuries should not be showered. During an interview on 05/12/2026 at 3:30 p.m., S5RN reported the shower incident occurred on 04/05/2026 around 2:00 p.m. S5RN reported Resident #1's family member wanted Resident #1 to have a shower. S5RN reported she brought the shower chair into Resident #1's room and she and Resident #1's family member transferred Resident #1 to the shower chair. S5RN reported Resident #1's wounds did not have dressings in place and she secured a plastic bag only to Resident #1's right lateral ankle wound. S5RN reported she proceeded to take Resident #1 into the shower room and showered Resident #1. S5RN reported after the shower she transported Resident #1 back to the room and applied wound care cleaner and a dry dressing to all of Resident #1's wounds. S5RN acknowledged the plastic bag around Resident #1's right ankle had collected a little water. S5RN reported she did not report or document the shower incident and stated she did not think showering Resident #1 was a big deal. S5RN further reported she did not know a major decline could result by a wound getting wet. During an interview on 05/12/2026 at 4:10 p.m., S1Administrator reported S5RN should not have showered Resident #1 with open wounds. During a telephone interview on 05/13/2026 at 11:40 a.m., S2Wound Care NP stated Bottom line, Resident #1 should have never been put in the shower. This set Resident #1 up for bacteria. Resident #3Review of Resident #3 's medical record revealed an admit date of 02/20/2024 with a diagnosis including in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS was not conducted as Resident #3 was never understood. Resident #3 was totally dependent on staff and required physical assistance for bathing and transfers. Review of Resident #3's Comprehensive Care Plan revealed Resident #3 was care planned for EBP for wounds. An observation on 05/11/2026 at 11:50 a.m. revealed Resident #3 awake and lying in bed resting with visible wound care bandages to heels bilaterally. Further observation failed to reveal EBP signage was in place. During an interview on 05/11/2026 at 11:05 a.m., S3CNA acknowledged Resident #3 was on EBP related to his wounds. S3CNA furthered acknowledged there was no EBP signage on Resident's #3 door and should have been. During an interview on 05/11/2026 at 11:10 a.m., S4LPN confirmed Resident #3 was on EBP. S4LPN further confirmed no EBP signage was in place and should have been.