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	07/24/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure 1 (#165) of 5 (#5, #7, #14, #158, and #165) residents or resident's representatives reviewed for unnecessary medications were informed of risk and benefits, treatment alternatives or other options of psychotropic medications prior to administration. Findings: Review of facility's Psychotropic Medication Use and Chemical Restraints Policy dated 06/2025 revealed, in part:Purpose .This policy promotes safe, appropriate, and individualized use of psychotropic medications in nursing home residents.Policy StatementIt is the policy of this facility to prohibit the use of psychotropic medications as chemical restraints for staff convenience or disciplinary purposes. Psychotropic drugs will only be used: To treat a specific, documented condition diagnosed by a licensed practitioner, and As part of a comprehensive, person-centered care plan. Psychotropic Medication: Any drug that affects brain activity associated with mental processes and behavior. This includes but is not limited to Antipsychotics, Antidepressants, Anxiolytics (anti-anxiety agents) and Hypnotics (sedatives). The prescribing practitioner must document the resident's diagnosis or condition, risks and benefits discussed with the resident or representative, and non-pharmacological alternatives attempted.Informed ConsentObtain informed consent from the resident or legal representative.Prior to administration: Provide written and verbal education on medication purpose, potential benefits and risks, and alternatives (including non-drug interventions) Document consent in the medical record.Prohibited UsesPsychotropic medications must not be used: Without informed consent Review of Resident #165's face sheet revealed an admission date of 01/07/2025 with the following diagnoses but not limited to bipolar disorder, current episode depressed, severe with psychotic features, major depressive disorder, and altered mental status. Review of Resident #165's July 2025 Physician Orders revealed: 06/19/2025: Trazadone HCl (hydrochloride) Oral Tablet 50 MG (milligram); Give 0.5 tablet by mouth at bedtime for insomnia 06/18/2025: Cymbalta Oral Capsule Delayed Release Particles 60 MG; Give 1 capsule by mouth two times a day for major depressive disorder06/07/2025: Buspirone HCl Oral Tablet 10 MG; Give 1 tablet by mouth two times a day for generalized anxiety disorder05/27/2025: Mirtazapine Oral Tablet 30 MG; Give 1 tablet by mouth at bedtime related to major depressive disorder 03/31/2025: Anti-anxiety Medication use: Observe resident closely for significant side effect monitoring every shift 01/07/2025: Psych meds: monitor behaviors: physical aggression, yelling, cursing, biting, kicking, scratching, resisting care, exit seeking behavior or other behaviors every shift. 01/7/2025: EPS (Extrapyramidal symptoms): Monitor for EPS every shift. 01/7/2025: Psych meds: monitor side effects every shift. 01/8/2025: Hydroxyzine HCl Oral Tablet 25 MG; Give 1 tablet by mouth every 8 hours as needed for itchingReview of Resident #165's Quarterly MDS (Minimum Data Sets) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) of 10 indicating moderate impaired cognition. Review of Resident #165's MDS dated [DATE] revealed little interest or pleasure and poor appetite or overeating in doing things for 7-11 days of the look back period (over the last 2 weeks), feeling down, depressed, or hopeless for 2-6 days of look back period (over the last 2 weeks). Further review of Resident #165's MDS dated [DATE] revealed verbal behavioral symptoms directed toward others occurred for 1 to 3 days and other behavioral (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms not directed toward others occurred 1 to 3 days for the past 2 weeks of the look back period. Review of Resident #165's MDS dated [DATE] Medications section revealed Resident #165 received during the last 2 weeks of the look back period revealed Antidepressant, Anticoagulant, Antibiotic, Hypoglycemic (including insulin), Anticonvulsant, and Antipsychotic medications during the last 2 weeks of look back period. Review of Resident #165's Care Plan revealed resident uses antidepressant medication related to insomnia, depression with interventions to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given, give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness.Review of Resident #165's EHR (Electronic Health Record) failed to reveal informed consents were obtained before administration of psychotropic medications. During an interview on 07/24/2025 at 9:00 a.m. S1 Administrator presented the facility policy and confirmed informed consents were not obtained before administration of psychotropic medications.

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews the facility failed to act promptly to concerns presented in the resident council meetings. The deficient practice affected 4 (#37, #139, #170, #178) of 7 (#37, #45, #139, #170, #173, #174, #178) residents interviewed for resident care and life in the facility. The deficient practice had the potential to affect the total census of 176 residents in the facility. Findings:Review of the facility's grievance policy with a revision date of 6/2025 revealed:INTENT: It is the policy of the facility to allow the resident and or legal representative to voice a grievance in such a manner to acknowledge and respect resident rights.PROCEDURE:1. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC (Long Term Care) facility stay.2. The resident has the right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.4. The designated professional will maintain the facility Grievance Program.5. All residents, staff, and visitors will have access to the professional designated to manage the Grievance Program, Grievance Officer. 8. The facility will establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights.9. Upon request, the facility will give a copy of the grievance policy to the resident. The grievance policy must include:a. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number, a reasonable expected time frame for completing the review of the grievance, the right to obtain a written decision regarding his or her grievance, and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; b. Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;c. As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;d. Consistent with 5483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider, and as required by State law;e. Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;f. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility.Review of the Resident Council Meeting Minutes held on [DATE], [DATE], [DATE], and [DATE] revealed discussions of missing clothes among the residents with no resolution.During (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on [DATE] at 2:12 p.m. Resident #178 reported missing items such as missing clothes to the facility and no one will do anything. Review of Resident #178's record revealed a Quarterly MDS dated [DATE] with a BIMS score of 12 indicating moderate cognition.During an interview on [DATE] at 2:13 p.m. Resident #139 reported hair grease going missing to the nurses and CNAs (Certified Nursing Assistant) and nothing gets done. Resident #139 further reported it does not do any good to report things missing because nothing gets done about it and there is no resolution and no replacements.nothing. Resident #139 further reported she will see other resident's wearing her clothes and she can't just go take it off of them. Resident #139 reported pants and shirts missing in the last 6 months and no one does anything about it. Resident #139 reported feeling aggravated. Review of Resident #139's record revealed a Quarterly MDS dated [DATE] with a BIMS score of 12 indicating moderate cognition.During an interview on [DATE] at 2:14 p.m. Resident #37 reported underwear missing within the last 2 months and they were never replaced. Resident #37 reported the missing items to S26 Social Service and S25 Laundry Supervisor.Review of Resident #37's record revealed a Quarterly MDS (Minimum Data Sets) dated [DATE] with a BIMS (Brief Interview of Mental Status) score of 15 indicating intact cognitionDuring an interview on [DATE] at 2:15 p.m. Resident #170 reported laundry goes missing all the time. Resident #170 further reported within the last 3 months he reported his laundry missing to CNAs and the nursing staff and the facility will not resolve the issue. Review of Resident #170's record revealed a Quarterly MDS dated [DATE] with a BIMS score of 15 indicating intact cognition. During an interview on [DATE] at 2:21 p.m. S27 Housekeeping reported the laundry was horrible and unorganized, residents clothing items go missing all the time. S27 House Keeping has observed CNAs gather laundry from residents' rooms and take them to the laundry area. S27 Housekeeping reported the laundry was so unorganized and that was why residents' laundry was missing. An observation on [DATE] at 2:00 p.m. revealed at least 4 large unorganized racks of laundry and blankets and a barrel with large amounts of laundry piled up over the top. During an interview on [DATE] at 2:00 p.m. S25 Housekeeping and Laundry Supervisor reported items should be labeled before being sent to the laundry. S25 Laundry Supervisor reported if items were washed and not labeled, they were placed in the missing clothes section. S25 Housekeeping and Laundry Supervisor reported some resident families donate their deceased family member's clothes and they were also placed in the same pile as the missing clothes pile. S25 Housekeeping and Laundry Supervisor reported if a resident needed a shirt, they pulled from the missing clothes pile and a shirt would be picked out for them to wear. S25 Housekeeping and Laundry Supervisor confirmed he was not aware of Resident #37's missing underwear, Resident #139's, Resident #170's and Resident #178's missing any clothing. S25 Housekeeping and Laundry Supervisor reported there was not a list of missing clothing items which included a date the items went missing. S25 Housekeeping Laundry Supervisor reported the donated pile of clothes was mixed with the missing clothes pile. During an interview on [DATE] at 2:24 p.m. S26 Social Service reported the CNAs and nursing staff should label all clothing upon admit and as they receive personal items. S26 Social Service reported items should be found in a reasonable amount of time which is about 3 days. S26 reported if missing items are not found, a Grievance form should be filled out with missing items listed and the facility will replace the missing items. S26 Social Service was not aware of missing items from Resident #37, Resident #139, Resident #170, or Resident #178.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews the facility failed to provide a safe, clean, comfortable and homelike environment for 4 (#50, #88, #91, #110) of 11 (#35, #50, #56, #68, #88, #91, #110, #128, #158, #179 #189) residents reviewed for environment. The facility failed to: 1. provide a clean room and a closet door for Resident #110.2. provide linens that were in good repair for all residents. (This had the ability to affect 176 residents residing in the facility.)3. provide the required furnishings in each resident room. The facility failed to provided a chair for Resident #88 and #91.4. provide a clean uncluttered room for Resident #50, Resident #50's clothes were stored on the floor. Findings: Resident #50 Review of Resident #50’s medical record revealed an admit date of 06/26/2025 with the following diagnoses, including in part: unspecified fracture of upper end of right humerus/subsequent encounter with routine healing, unsteadiness on feet, and cognitive communication deficit. Observation on 07/21/2025 at 8:05 a.m. revealed Resident #50's clothing in a box on the floor next to the bed and on clothing on the bathroom floor. During an interview on 07/21/2025 at 8:25 a.m. S6 CNA (Certified Nursing Assistant) acknowledged the clothes in the box and on the bathroom floor should not be there. Resident #91 Review of Resident #91’s medical record revealed an admit date of 09/13/2023 with the following diagnoses, including in part: Hypertension, depression, respiratory failure, and nutrition malnutrition. Further observation revealed a Quarterly MDS (Minimum Data Set) dated 06/19/2025 with a BIMS (Brief Interview for Mental Status) score of 14 indicating intact cognition. An observation on 07/23/2025 at 1:00 p.m. revealed Resident #91 shared a room with one other resident and had one metal fold out chair in her room labeled with her roommate’s name. Further observation failed to reveal Resident #91 had a chair to sit in or for visitors to sit in. During an interview on 07/23/2025 at 1:00 p.m. Resident #91 reported when her daughter visited, she had to sit on the edge of Resident #91's bed during the visit because there was not a chair for her to sit in. Resident #88 Observation on 07/21/2023 at 9:30 a.m. revealed Resident #88 was in a shared room with no chairs for residents or visitors to sit. During an interview on 07/21/2023 at 9:30 a.m. Resident #88 acknowledged there were no chairs to sit in the resident shared room and reported sitting on the side of the bed when wanting to sit up. Resident #88 reported his mother stood up during a visit with him and his grandmother sat on the foot of his bed. Review of Resident #88's face sheet revealed an admission date of 02/22/2023 with the following (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses but not limited to major depressive disorder, history of falling, pyogenic arthritis, polyneuropathy, contracture of left knee, and pain in left knee. Review of Resident #88's Quarterly MDS (Minimum Data Sets) dated 05/15/2025 revealed a BIMS (Brief Interview of Mental Status) of 14 indicating cognitively intact. Resident #110 Observation on 07/21/2025 at 8:30 a.m. revealed Resident #110's floor was sticky with dark brown colored dirt and residue in the corners and on the base boards of the room, further review revealed Resident #110's closet did not have a door in place. Review of Resident #110's Quarterly MDS (Minimum Data Set) dated 05/22/2025 revealed Resident #110 was assessed to have a BIMS score of 8 indicating moderately impaired cognition. During an interview on 07/21/2025 at 9:16 a.m. Resident #110 reported the closet did not have a door when he was admitted to the facility several months ago and he did not know when the floor was mopped last. During an interview on 07/22/2025 at 2:45 p.m. S22 Maintenance Director confirmed Resident #110 should have had a closet door in place and Resident #110's floor should have been cleaned daily. During an interview on 07/24/2025 at 3:00 p.m. S1 Administrator confirmed each resident should have had a chair in their room. Observations on 07/22/2025 at 11:50 a.m. during a tour of the laundry completed with S25 Housekeeping and Laundry Supervisor revealed bed sheets, pillowcases are worn thin and discolored (yellowish and tan stains). Further observation of the facility’s blankets revealed they were in very poor condition thin, discolored, felt scratchy.

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	195350	A. Building B. Wing	07/24/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide the required documents to 1 (#110) of 1 (#110) resident and or resident representative who was transferred out of the facility for treatment. The facility failed to provide Resident #110 a copy of the facility's bed hold policy when transferred out of the facility. Findings: Review of Resident #110's medical record revealed an initial admit date of 11/06/2025 and a re-admission date of 02/16/2025 with diagnoses of but not limited to hyperkalemia, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic kidney disease, essential hypertension and osteoarthritis.Review of Resident #1's medical record revealed Resident #110 was transferred to a hospital for treatment of hyperkalemia on 01/16/2025 and 02/13/2025.Review of Resident #110's medical record failed to reveal any documentation of the bed hold policy being provided to Resident #110 or Resident #110's representative when transferred to a hospital for treatment on 01/16/2025 and 02/13/2025. During an interview on 07/23/2025 at 2:15 p.m. S1 Administrator confirmed the facility's bed hold policy had not been provided to Resident #110 or Resident #110's representative when transferred to the hospital for treatment on 01/16/2025 and 02/13/2025.

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	195350	A. Building B. Wing	07/24/2025

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facitiy failed to ensure resident assessments were encoded, transmitted and completed for 1 (#81) of 3 (#81, #130, #183) residents reviewed for resident assessments.Findings: Review of Resident #81's medical records revealed an admit date of 02/05/2025 and discharge date of 03/14/2025 with the following diagnoses, including in part: heart failure unspecified and type 2 diabetes mellitus without complications. Review of Resdient #81's MDS (Minimal Data Set) Assessments failed to reveal a discharge assessemnt. During an interview on 07/23/2025 at 2:30 p.m. S3 MDS Nurse acknowledged Discharge MDS Assessment was not completed until today.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop and implement a baseline care plan for 2 (#110, #188) out of 63 total sampled residents reviewed. Findings: Resident #110 Review of Resident #110’s medical record revealed an initial admit date of 11/06/2025 and a re-admission date of 02/16/2025 with diagnoses of but not limited to hyperkalemia, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic kidney disease, essential hypertension and osteoarthritis. Review of Resident #110's medical record failed to reveal a baseline care plan had been completed when Resident #110 was admitted on [DATE] and re-admitted on [DATE]. During an interview on 07/22/2025 at 1:00 p.m. S3 MDS (Minimum Data Set) Nurse confirmed a baseline care plan was not completed when Resident #110 was admitted on [DATE] and re-admitted on [DATE] and should have been. Resident #188 Review of Resident #188’s medical record revealed an admit date of 07/11/2025 with the following diagnoses, including in part: malignant neoplasm of upper lobe/left bronchus or lung, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and unspecified pleural effusion not elsewhere classified. Review of Resident #188’s medical records failed to reveal the baseline plan of care was completed upon admission. During an interview on 07/24/2025 at 2:30 p.m. S3 MDS Nurse acknowledged a baseline care plan was not developed for Resident #188 and should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to provide services according to the written plan of care for 1 (#14) of 5 (#5, #7, #14, #158, and #165) reviewed for unnecessary medications. The facility failed to ensure Resident #14's lab were obtained as ordered by the physician. Findings: Review of Resident #14's face sheet revealed an initial admission date of 12/15/2023 and a re-entry admission date of 02/10/2025 with the following diagnoses, but not limited to schizoaffective disorder, bipolar type, dementia without behavioral disturbances, psychophysiological insomnia, and anxiety disorder. Review of Resident #14's July 2025 Physician Orders revealed an order dated 06/02/2025: biannual labs: CBC (complete blood count), CMP (comprehensive metabolic panel), hemoglobin A1C, TSH (thyroid stimulating hormone), lipid, B12, folate, Vitamin D, Magnesium, Thiamine and Iron panel with ferritin for June and December.Review of Resident #14's Quarterly MDS (Minimum Data Sets) dated 04/30/2025 revealed a BIMS (Brief Interview of Mental Status) score of 15 indicating cognitively intact. Further review of Resident #14's MDS review of medications received during the last 7 days of the look back period revealed administration of antipsychotic, antidepressant, antiplatelet, hypoglycemic and anticonvulsant. Review of Resident #14's EHR (Electronic Health Record) failed to reveal lab for TSH (thyroid stimulating hormone), lipid, B12, folate, Vitamin D, Magnesium, Thiamine and Iron panel with ferritin were obtained as ordered. During an interview on 07/22/2025 at 10:30 a.m. S1 Administrator confirmed lab for TSH (thyroid stimulating hormone), lipid, B12, folate, Vitamin D, Magnesium, Thiamine and Iron panel with ferritin were obtained as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews, observations and interviews, the facility failed to ensure residents who were unable to complete their activities of daily living received the necessary services to maintain grooming and hygiene for 4 (#50, #68, #74, #187) out of 4 (#50, #68, #74, #187) residents reviewed for activities of daily living. The facility failed to:1. Ensure Resident #50 received baths, washed hair and toenails were trimmed,2. Ensure Resident #68 received baths, oral care and nail care,3. Ensure Resident #74 received proper peri-care for MASD (moisture-associated skin damage)4. Ensure Resident #187 received baths. Findings: Review of Facility's Activities of Daily Living (ADLs)/Maintain Abilities (undated) revealed: Procedure: 2. The facility will ensure a resident is given the appropriate amount of treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. hygiene - bathing, dressing, grooming, and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . Review of Facility's fingernails/Toenails, Care of Policy and Procedure dated 06/2025 revealed: Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed to prevent infections. Review of Facility's Hair, Shampooing Policy and Procedure dated 06/2025 revealed Purpose: The purpose of this procedure is to clean the hair and scalp. Review of the Facility’s Mouth Care Policy and Procedure dated 06/2025 revealed: Purpose: The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. Resident #50 Review of Resident #50’s medical record revealed an admit date of 06/26/2025 with the following diagnoses, including in part: unspecified fracture of upper end of right humerus/subsequent encounter with routine healing, polyneuropathy unspecified, unsteadiness on feet, and cognitive communication deficit. Review of Resident #50’s MDS (Minimum Data Set) assessment dated [DATE] revealed functional status: impairment on one side upper extremity; eating/oral hygiene setup; toileting/ shower/bathe/upper and lower dressing/bed mobility/toilet transfer partial/moderate. Review of shower schedule posted in nurse's station revealed: women shower days are Monday-Wednesday-Friday. Observation on 07/21/2025 at 8:05 a.m. revealed Resident #50 sitting on side of bed with hair disheveled and toenails long and curled over on both feet. During an interview on 07/21/2025 at 8:05 a.m. Resident #50 reported she has not been getting a (continued on next page)

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	07/24/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bath. During an interview on 07/23/2025 at 9:50 a.m. Resident #50 reported she has not gotten a bath today. Observation on 07/23/2025 at 9:58 a.m. revealed Resident #50 with hair greasy and toenails long and curled. During an interview on 07/23/2025 at 10:54 a.m. S1 Administrator confirmed Resident #50 did not have bathing added as a task for staff and there is no documentation that a bath or shower was received. During an interview on 07/23/2025 at 1:45 p.m. S1 Administrator acknowledged Resident #50's toenails needed to be trimmed. During an interview on 07/23/2025 at 2:15 p.m. S6 CNA (Certified Nursing Assistant) acknowledged resident needs a bath and toenails need trimming. S6 CNA confirmed Resident #50's hair is greasy. Resident #68 Review of Resident #68’s medical record revealed an initial admit date of 06/30/2011 with a re-entry date of 05/12/2024 with the following diagnoses, including in part: Encounter for attention to tracheostomy, gastrostomy, anoxic brain damage, cerebral aneurysm, acquired absence of left and right leg above the knee, contracture of muscle, multiple sites. Review of Resident #68’s MDS (Minimum Data Set) assessment dated [DATE] revealed functional abilities: Functional limitation in range of motion – impairment on both sides with upper and lower extremities. Further review revealed Resident #68 was dependent with oral hygiene, toileting, shower/bathe, and personal hygiene. Review of Resident #68’s medical record revealed for the month of July 2025 CNA Task For oral hygiene: Failed to document oral care was done or coded was Not Applicable (-97) on the following dates: Day shift: July 2nd-6th, 9th-12th, 14th, 16th, 17th, and 19th-23rd. Evening shift: July 2nd, 3rd, 6th-8th, 12th, 13th, 14th, 16th-21st. Night shift: July 1st, 3rd-8th, 11th-20th.Record review revealed for the month of July 2025 CNA Task For Shower on Tuesdays-Thursdays-Saturdays 11-7 shift failed to document as done on the following scheduled dates: July 2025: 1st, 5th, 17th and 19th. An observation on 07/21/2025 at 9:15 a.m. revealed debris build up on Resident #68's teeth and dirty nail beds. During an observation on 07/22/2025 at 12:34 p.m. heavy build-up of debris was noted on top and bottom teeth of Resident #68’s teeth. Further observation with S9 CNA revealed Resident #68 had gold front top teeth, but the gold was barely visible due to the heavy build up on his teeth. Further observation revealed a thick light grayish build up behind his bottom front teeth. An observation revealed black and brown build-up under the nail beds of Resident #68. S9 CNA looked under the nail bed and retrieved dark brown debris out from under the left thumb nail with a gloved hand. (continued on next page)

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	195350	A. Building B. Wing	07/24/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/22/2025 at 12:34 p.m. S9 CNA could not find any oral hygiene supplies in Resident #68’s room and acknowledged there should be. S9 CNA reported further Resident #68 should get oral hygiene care three times a day and nails should be cleaned with bath. S9 CNA agreed Resident #68's had heavy build up on teeth and nail beds were dirty and was in need of ADL care. Resident #74 Review of Resident #74’s medical record revealed an initial admit date of 02/24/2017 with a re-entry date of 01/22/2023 with the following diagnoses, including in part: Spastic diplegic cerebral palsy, type 2 diabetes, chronic pain syndrome, muscle wasting and atrophy – right and left upper arms and right and left lower legs. Review of Resident #74’s physician orders dated 05/12/2025 revealed an order for: Sacrum (including buttocks) apply house barrier cream every shift every day until resolved for MASD (Moisture-associated skin damage). During an observation on 07/22/2025 at 2:59 p.m. with S16 CNA revealed Resident #74 had bright red moist skin breakdown to the buttocks area with a large amount of caked on white/yellow/gray substance. Further observation revealed large white and yellowish flakes of the substance was in Resident #74’s brief. During an interview on 07/22/2025 at 2:59 p.m. S16 CNA reported Resident #74 had skin breakdown for a while and a house barrier cream was applied to her buttocks area. S16 CNA further reported not being able to get the cream completely off and the house barrier cream was reapplied with peri-care or bowel movement. During an interview on 07/22/2025 at 3:05 p.m. S8 Wound Care Nurse reported Resident #74 had MASD and house barrier cream was applied after every incontinent episode. Resident #74 should have the buttocks completely cleaned after her bath, her wound should be cleaned with gauze and wound cleanser. During a phone interview on 07/23/2025 at 9:37 a.m. S18 Wound Care NP, reported when residents have MASD the house barrier cream should not be caked up on the resident’s buttocks. The area should be cleaned off after incontinent episodes and cream reapplied. Resident #187 Review of resident #187 records revealed an admit date of 07/16/2025. Review of resident #187’s records revealed diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, weakness, contractures of the right and left knee, muscle weakness, atrophy of the right and left arms, gangrene to all toes to right and left foot. During an interview on 07/21/2025 at 11:00 a.m. resident #187 reported he had not had a bath since he was admitted to the facility 5 days ago. Resident #187 reported he had not been offered a bath. During an interview on 07/23/2025at 2:15 p.m. S1 Administrator reported there was no Task documented including bath for resident #187 to reveal ADL (activity of daily living) care was provide (continued on next page)

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	195350	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the facility’s CNAs (certified nursing assistant). S1 Administrator reported if a bath was provided for resident #187 it should had been documented on the Task form and it was not. S1 Administrator reported she was informed that the CNAs are to document on the Task form what ADL care they had provided for the resident. During an interview on 0723/2025 at 2:20 p.m. resident #187 still reported he had not been given a bath. During an interview on 07/23/2025 at 2:40 p.m.S21 CNA Supervisor reported the Task form for ADL care should be completed at the end of each shift by the CNAs revealing what care was provided for the resident.

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	195350	A. Building B. Wing	07/24/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure residents received care and services that are resident centered, in accordance with professional standards of practice for 2 (#74, #110) of 63 sampled residents. The facility failed to: 1.provide a splint for Resident #74 as ordered.2.complete all admission lab test ordered Resident #110.3.revise/update Resident #110's plan of care to reflect a diagnosis of hyperkalemia.4.complete Resident #110's admission lab in a timely manner. Findings: Resident #74 Review of Resident #74’s medical record revealed an initial admit date of 02/24/2017 with a re-admission date of 01/22/2023 with the following diagnoses, in part: Spastic diplegic cerebral palsy, chronic pain syndrome, muscle wasting and atrophy, not elsewhere classified, left and right upper arms, and contracture, unspecified joint. An observation on 07/21/2025 at 12:32 p.m. revealed one hand splint on the bed side table of Resident #74. During an interview on 07/23/25 at 9:16 a.m. S31 COTA (Certified Occupational Therapy Assistant) Rehab Director reported Resident #74 was discharged from OT (Occupational Therapy) services with a left hand splint and restorative nursing to apply the splint. S31 COTA Rehab Director reported the left hand split should continue to be part of restorative, which does not stop unless OT was notified of an issue. S31 COTA Rehab Director, reported she had not been notified of Resident #74 not using her left hand splint and should have been. An observation on 07/23/2025 at 10:40 a.m. revealed one hand splint on the bed side table. No hand splint was in Resident #74's left hand. During an interview on 07/23/2025 at 11:37 a.m. S17 Restorative CNA (Certified Nursing Assistant) reported Resident #74 was not on the list to receive restorative service for hand splint placement. S17 Restorative CNA reviewed Resident #74’s record and confirmed Resident #74 was discharged from OT on 11/25/2024 and should have received restorative care for hand splint placement. During an interview on 07/24/2025 at 9:32 a.m. S31 COTA Rehab Director confirmed Resident #74 was discharged in 11/2024 with the use of a left hand splint. Resident #110 Review of Resident #110’s medical record revealed an initial admit date of 11/06/2025 and a re-admission date of 02/16/2025 with diagnoses of but not limited to hyperkalemia, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic kidney disease, essential hypertension and osteoarthritis. Review of Resident #110’s medical record revealed Resident #110 was transferred to a hospital on [DATE] and 02/13/2025 and returned to the facility with a diagnosis of hyperkalemia. (continued on next page)

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	195350	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's Comprehensive Care Plan failed to reveal a problem and approach for hyperkalemia. During an interview on 07/22/2025 at 1:00 p.m. S3 MDS (Minimum Data Set) Nurse confirmed Resident #110 failed to have a comprehensive plan of care initiated for the diagnosis of hyperkalemia. Review of Resident #110's November 2024 physician's orders revealed the following orders: Admit to Skilled Services 11/06/2024, Admit lab: CBC (complete blood count), CMP(comprehensive metabolic panel, TSH (thyroid stimulating hormone), Hgb A1C (hemoglobin A1C), HIV (human immunodeficiency virus) , hepatitis C, vitamin D level, RPR (Rapid Plasma [NAME]), and a urinalysis with culture and sensitivity 11/07/2024, Need admit labs 11/26/2024. Review of Resident #110’ medical record failed to reveal any results for HIV, Hepatitis C and RPR. Further review revealed CBC, CMP, TSH, HgbAIC, and Vitamin D level were not done until 11/26/2024 and were ordered on 11/07/2024. Review of Resident #110’s Nurse Practitioner progress notes dated 11/25/2025 revealed the following documentation: There is still limited information for admission labs. Administration and floor nurse made aware to draw admission labs in the morning. During an interview on 07/22/2025 at 3:30 p.m. S1 Administrator confirmed all lab tests ordered for Resident #110 when admitted were not completed as ordered. S1 Administrator further confirmed Resident #110’s admission labs that were completed were not done in a timely manner. Resident #110’s admission lab (partial completion) was completed on 11/26/2025 but was originally ordered on 11/07/2025.

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	195350	A. Building B. Wing	07/24/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure a resident environment remains as free of accident hazards for 1 (#158) reviewed for accidents. The facility did not maintain resident #158's wheelchair in safe operating condition. Findings:Review of the Accident and Incident Prevention, Reporting, and ResponseAdministrative Policies (7/2025) revealed in part:Purpose: To ensure a safe environment for all residents by minimizing accidents hazards, providing adequate supervision and assistive devices, and implementing a proactive and systematic approach to preventing, investigating, and mitigating accidents and incidents in accordance with federal regulations, facility policies, and resident-centered care principles.Policy StatementThe facility is committed to:Maintaining a resident environment that is as fee as possible from accident hazards while meeting individual resident needs.Observation on 07/21/2025 at 11:36 a.m. revealed resident #158's wheelchair was in need of repair. Resident #158's wheelchair locks did not lock, the right wheel was loose and unstable and the wheelchair did not have footrest.During an interview on 07/22/2025 at 2:00 p.m. S20 DON reported when a wheelchair or some other equipment needs repair a work order is completed and given to Maintenance. S20 DON reported if the wheelchair needs parts, then they will contact the company to get parts. S20 DON they will get the resident in another wheelchair until the part come in.During an interview on 07/22/2025 at 2:30 p.m. S22 Maintenance Director reported of has been on the job for three months. S22 Maintenance Director reported the process for completing a work order and getting it to his department is by using TELS (The Equipment Lifecycle System) the workplace reporting system. S22 Maintenance Director reported all staff has excess to the TELS system. S22 Maintenance Director reported when they create a work order in the TELS systems it hits the telephone of the two guys that work under him, DON, Administrator, and Corporate letting maintenance know the location, priority and issues. S22 Maintenance Director reported they can even take pictures. Reviewed S22 Maintenance Director phone with him, he entered resident #158's name and room number and her name or room number never came up in the TELS system. S22 Maintenance Director reported a work order had not been completed.Review of resident #158 records revealed diagnoses that include morbid (severe) obesity due to excess calories, effusion right knee and muscle weakness. Review of resident #158's 5-day MDS (minimum data set) dated 05/29/2025 revealed functional ability, she uses a manual wheelchair for mobility.

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	195350	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record reviews and interviews, the facility failed to provide care and services to maintain acceptable parameters of nutritional status for 1 (#62) resident reviewed for nutrition. The facility failed to consult a Registered Dietician for Resident #62 diagnosed with a pressure ulcer.Findings:Review of Facility's Pressure Ulcer Treatment Policy and Procedure dated 06/2025 revealed: Purpose: The purpose of this procedure is to provide guidelines for the treatment of pressure ulcers to facilitate healing and to prevent further deterioration. 3. Consult Dietary as needed/ordered. Review of Resident #62's medical records revealed an admit date of 05/02/2025 with the following diagnoses, including in part: other ulcerative colitis without complications, paraplegia complete, other idiopathic peripheral autonomic neuropathy and pressure ulcer of sacral region, stage 4. Review of Resident #62's medical records failed to reveal Resident #62 receiving supplements for wound healing.Review of Resident #62's weights revealed on 05/02/2025, the resident weighed 181 lbs. (pounds). On 06/02/2025, the resident weighed 171 lbs. which is a -5.52% loss.Review of Resident #62's medical records failed to reveal a consult was completed for a Registered Dietician since admission.During an interview on 07/23/2025 at 12:55 p.m. S4 Registered Dietician reported she has not received a consult for Resident #62.During an interview on 07/23/2025 at 2:17 p.m. S8 WCN (Wound Care Nurse)/LPN (Licensed Practical Nurse) confirmed Resident #62 was admitted with a stage 4 pressure ulcer.S8 WCN/LPN acknowledged Resident #62 is not receiving supplements for wound healing and the Registered Dietician has not been consulted.During an interview on 07/24/2025 at 10:20 a.m. S2 CNO (Chief Nursing Officer) acknowledged a consult for Registered Dietician was not completed.

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	195350	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interview, the facility failed to provide residents necessary respiratory care and services in accordance with accepted professional standards of practice for 5 (#2, #35, #109, #128, #188) out of 6 (#2, #35, #109, #128, #186 and #188) residents reviewed for respiratory. The facility failed to store hand held nebulizer equipment in a covered bag and change and date oxygen tubing and humidification bottles weekly.Findings:Procedure Guidelines: Oxygen Administration -3. [NAME] bottle with date and initials upon opening.4. Change prefilled humidifier when water level becomes low.5. Change oxygen cannulas and tubing every 7 days and date. Resident #2Review of Resident #2's face sheet revealed an initial admission date of 02/20/2024 with a re-entry date of 05/07/2024 with the following diagnoses chronic respiratory failure with hypoxia. Review of Resident #2's July 2025 Physician orders revealed dated 07/03/2025: oxygen at 2L (liters) via NC (nasal cannula), every 8 hours as needed for shortness of breath Review of Resident #2's Quarterly MDS (Minimum Data Sets) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) was not conducted as resident was rarely/never understood. Review of Resident #2's Care Plan failed to reveal focus with measurable goals and appropriate interventions related to Resident #2's diagnoses of chronic respiratory failure with hypoxia and use of oxygen. Observation of Resident #2's oxygen concentrator on 07/21/2025 at 10:00 a.m. revealed oxygen administered at 2L via NC. Further observation revealed Resident #2's oxygen tubing was not dated/labeled and humidification bottle was empty. During an interview on 07/21/2025 at 11:30 a.m. S23 LPN (Licensed Practical Nurse) confirmed Resident #2's oxygen tubing was not dated/labeled and humidification bottle was empty. S23 LPN reported Resident #2's oxygen tubing should have been dated, labeled and humidification bottle should have been replaced. Observation of Resident #2's oxygen concentrator on 07/23/2025 at 11:40 a.m. revealed oxygen administered at 2L via NC. Further observation revealed Resident #2's oxygen tubing was not dated/labeled and humidification bottle was empty. During an interview on 7/23/2025 at 11:40 a.m. S24 LPN confirmed Resident #2's oxygen tubing was not dated/labeled and humidification bottle was empty. S24 LPN reported Resident #2's oxygen tubing should be dated, labeled and humidification bottle should have been replaced. During an interview on 07/23/2025 at 3:00 p.m. S3 MDS Nurse reviewed Resident #2's care plan and confirmed the care plan did not include a focus with measureable goals and appropriate interventions related to diagnoses chronic respiratory failure with hypoxia and use of oxygen. Resident #35Review of Resident #35's medical record revealed in part, a readmission date of 06/02/2025 with diagnoses including, but not limited to, chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #35's cognition was intact. Review of Resident #35's physician orders revealed, in part, order dated 06/02/2025 for oxygen at 3 liters (L) continuously per mask or nasal cannula. An observation on 07/21/2025 at 8:14 a.m. revealed Resident #35 lying in bed with oxygen per nasal cannula at 3L. Further observation on 07/21/2025 at 8:14 a.m. revealed oxygen tubing was not dated. During an interview on 07/21/2025 at 12:30 p.m., S29 Licensed Practical Nurse (LPN) observed Resident #35's oxygen tubing and confirmed Resident #35's tubing was not dated and should have been. Resident #109Review of Resident #109's medical records revealed an admit date of 04/01/2025 with the following diagnoses, including in part: acute respiratory failure with hypoxia and chronic obstructive pulmonary disease unspecified. Review of Resident #109's Physician's orders revealed an order dated 05/14/2025 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligram/3 ml (milliliter); 3ml inhale orally every 6 hours as needed for wheezing and 3 ml inhale orally four times a day for shortness of breath. Further review revealed an order dated 04/01/2025 for oxygen at (2) liters per mask or nasal cannula continuously every shift and change and date all respiratory supplies and tubing . Observation on 07/21/2025 at 8:10 a.m. (continued on next page)

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	07/24/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #109's humidifier via nasal cannula at 2 liters per minute undated. Further observation revealed a hand held nebulizer tubing and mouth piece lying on bed side table not stored in a bag and undated. During an interview on 07/21/2025 at 10:15 a.m. S7 LPN reported oxygen tubing, humidifier bottles and hand held nebulizer equipment should be changed weekly and dated. S7 LPN further acknowledged the hand held nebulizer tubing and mouth piece should be placed in a bag. Resident #128Review of Resident #128's medical records revealed an admit date of 07/03/2025 with the following diagnoses, including in part: combined systolic (congestive) and diastolic (congestive) heart failure, and chronic obstructive pulmonary disease unspecified. Review of Resident #128's Physician's orders dated 07/03/2024 for change and date all respiratory supplies and tubing weekly .every day shift every Tuesday and as needed and oxygen at (2) liters per nasal cannula continuously every shift. Observation on 07/21/2025 at 8:50 a.m. revealed Resident #128's hand held nebulizer tubing observed on bed side table undated and not stored in a covered bag. During an interview on 07/21/2025 at 10:15 a.m. S7 LPN reported hand held nebulizer tubing is changed weekly. S7 LPN acknowledged Resident #128's hand held nebulizer is undated and should be stored in a covered bag. Resident #188Review of Resident #188's medical record revealed an admit date of 07/11/2025 with the following diagnoses, including in part: malignant neoplasm of upper lobe/left bronchus or lung, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and unspecified pleural effusion not elsewhere classified. Review of Resident #188's Physician's orders revealed an order dated 07/21/2025 for change and date all respiratory supplies and tubing weekly on Monday .one time a day every Monday. Further review revealed an order dated 07/12/2025 for oxygen at 2 liters per nasal cannula continuously every shift. Observation on 07/21/2025 at 8:40 a.m. revealed Resident #188 wearing continuous oxygen via nasal cannula at 2 liters per minute. Further observation failed to reveal the oxygen tubing and humidifier bottle dated. During an interview on 07/21/2025 at 10:15 a.m. S7 LPN reported oxygen tubing and humidifier bottles are changed weekly. S7 LPN acknowledged Resident #188's oxygen tubing and humidifier bottle were undated.

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	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. Based on interviews and record review the facility failed to provide specialized rehabilitation services for 1 of 1 (#158) sample resident as required by the resident's plan of care. Resident #158 was not provided restorative services. Findings:During an interview on 7/21/2025 at 11:18 a.m. resident #158 reported she had therapy for three days and she had not had any therapy since then. Resident #158 reported she was told by therapy she would be seen by Restorative, and she had not been seen.Review of resident 158's Physical Therapy Restorative Referral dated 05/27/2025 revealed restorative service was to start dated 06/05/2025 for six weeks.During an interview on 07/22/2025 at 1:30 p.m. S17 Restorative CNA (certified nursing assistant) reported they did not provide restorative services for resident #158. S17 Restorative CNA reported there is only two Restorative CNAs for the entire facility. S17 Restorative CNA reported they obtain the referrals for restorative services from physical therapy then they give the referral to their supervisor. S17 Restorative CNA reported their supervisor will schedule the resident for restorative services. S17 Restorative CNA reported resident #158 was never put on their schedule by their supervisor.Review of resident #158's records revealed diagnoses that include morbid (severe) obesity due to excess calories, effusion, right knee and muscle weakness. Review of resident #158's 5-day MDS (minimum data set) dated 05/29/2025 revealed a BIMS (brief interview for mental status) score of 15 which indicate cognitively intact. Functional abilities indicate she uses a manual wheelchair. Related to mobility resident #158 requires substantial/maximal assistance with rolling left to right, lying to sitting on the side of the bed. Dependent with sitting to stand, chair/bed-to-chair transfers and toilet transfers.Review of resident #158's Comprehensive Plan of Care revealed an ADL self-care performance deficit related to weakness. Resident requires fluctuating assist times 1-2 with ADL. Resident #158 requires two person assist with transfers.

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	195350	A. Building B. Wing	07/24/2025

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to electronically submit accurate direct care staffing information based on payroll to Centers for Medicare and Medicaid Services (CMS) as required. Findings:Record review of the PBJ (Payroll Based Journal) Report for FY (Fiscal Year) Quarter 2 2025 (January 1 - March 31) revealed triggers for the following: One Star Staffing Rating and Excessively Low Weekend Staffing. Review of staffing pattern forms for weekends of FY 2025 quarter 2 ([DATE]- March 31) revealed the facility provided more hours than required and failed to reveal any days in which the facility did not provide enough hours. During an interview on 07/23/2025 at 4:35 p.m. S1Administrator reported corporate submitted the information for the PBJ and did not submit correct information. During an interview on 07/24/2025 at 8:55 a.m. S2Chief Nursing Officer reported she did not know why the information submitted by corporate to PBJ was not accurate.

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	195350	A. Building B. Wing	07/24/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record reviews, observations, and interviews the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to effect 176 residents residing at the facility at time of entrance on 07/21/2025 as reported by the Administrator. The facility failed to:1. maintain an up to date monthly tracking and trending for infection prevention and control, 2. ensure resident care equipment, dirty linens and briefs were handled in a sanitary manner. Findings: Observations on 07/22/2025 at 11:50 a.m. during a tour of the laundry completed with S25 Housekeeping and Laundry Supervisor revealed bed sheets, pillowcases are worn thin and discolored (yellowish and tan stains). Further observation of the facility’s blankets revealed to be in very poor condition thin, discolored, felt scratchy. During an interview on 07/23/2025 at 10:30 a.m. S20 DON (Director of Nursing) present the facility's infection control surveillance binder. Observation with the S20 DON revealed infection surveillance was not done which included, monthly trend and tracking of antibiotic therapy and treatment. Review of Resident #50’s medical record revealed an admit date of 06/26/2025 with the following diagnoses, including in part: unspecified fracture of upper end of right humerus/subsequent encounter with routine healing, acute kidney failure unspecified and cognitive communication deficit. Observation on 07/21/2025 at 8:05 a.m. revealed 2 bath basins and a bedpan on Resident #50's bathroom shower floor not stored in bags or labeled. Observation on 07/22/2025 at 10:00 a.m. revealed 2 bath basins and 2 bedpans on Resident #50's bathroom shower floor not stored in bags or labeled. Observation on 07/23/2025 at 9:58 a.m. revealed 2 bath basins and a bedpan on Resident #50's bathroom shower floor not stored in bags or labeled. During an interview on 07/23/2025 at 9:58 a.m. S1 Administrator and S2 Chief Nursing Officer acknowledged 2 bath basins and 2 bedpans on the bathroom shower floor were not stored in bags and labeled and should be. Observation on 07/21/2025 at 11:21 a.m. revealed S30 CNA (Certified Nurse Assistant) exit a resident room. Observation of shared resident room revealed dirty linen and briefs were on the floor. Further observation revealed S30 CNA return to resident room with a white trash bag. During an interview on 07/21/2025 at 11:21 a.m. S30 CNA reported dirty linen and briefs should not have been on the floor. S30 CNA reported a clear trash bag should be used for dirty briefs and blue bags are used for dirty linen. S30 CNA reported leaving the room to retrieve a clear trash bag since there was not any trash bags in the trash can in the room. During an interview on 07/23/2025 at 2:30 p.m. S21 CNA Supervisor confirmed dirty linens and briefs should not have been placed on the floor.

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	195350	A. Building B. Wing	07/24/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview the facility failed to maintain and follow policies and procedures for immunization for 4 (#55, #84, #87, #186) of 5 (#55, #77, #84, #87 and #186) sampled residents for influenza, pneumococcal disease and COVID-19. The facility failed to educate and offer residents and/or their representative immunizations of pneumonia, influenza and coronavirus disease (COVID-19), and failed to allow them to refuse and/or agree to either of the vaccines.Findings:Pneumonia Vaccine for Residents (Nursing Policy Manual 06/2025) revealed in part:Policy: Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.Pneumococcal Vaccine/Diseasea. Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization.b. The resident or the resident's legal representative has the opportunity to refuse immunization.Influenza Vaccine for Residents (Nursing Policy Manual 06/2025) revealed in part:Policy: Each resident is offered an influenza immunization October 1 through March 31st annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period, (may give with consent as soon as available and up until pharmacy supply is depleted). Influenza.1. Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization.2. The resident or the resident's legal representatives has the opportunity to refuse immunizations.Coronavirus Disease (COVID-19) Vaccination of Residents (@2001 MED PASS Revised June 2022) revealed in part:Policy Statement: Each resident is offered the COVID-19 vaccine unless the immunization is medically contradicted or the resident has already been immunized.Policy Interpretation and Implementation1. Resident who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so.2. The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision.During an interview on 07/23/2025 at 10:50 a.m. S1 Administrator reported immunizations are offered during the admission process and documentation should be in the admission records.Review of resident #55's admission records revealed an admission date of 05/01/2025 to this facility. Further review of admission records failed to reveal any documentation that indicated the residents and/or their representative had been educated or offered the pneumonia, influenza and/or coronavirus disease (COVID-19 immunizations).Review of resident #84's admission records revealed an admission date of 05/01/2025 to this facility. Further review of admission records failed to reveal any documentation that indicated the residents and/or their representative had been educated or offered the pneumonia, influenza and/or coronavirus disease (COVID-19 immunizations).Review of resident #87's admission records revealed an admission date of 05/01/2025 to this facility. Further review of admission records failed to reveal any documentation that indicated the residents and/or their representative had been educated or offered the pneumonia, influenza and/or coronavirus disease (COVID-19 immunizations).Review of resident #186's admission records revealed an admission date of 05/01/2025 to this facility. Further review of admission records failed to reveal any documentation that indicated the residents and/or their representative had been educated or offered the pneumonia, influenza and/or coronavirus disease (COVID-19 immunizations).

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	195350	A. Building B. Wing	07/24/2025

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based of observations and interview the facility failed to have the most recent annual survey results of the facility posted in a place readily accessible to the residents, family members or anyone to review. Findings:During an observation on 07/21/2025 at 11:30 a.m., review of the survey results binder near the front door failed to reveal the annual survey from 2024.During an interview on 07/21/2025 at 12:05 p.m. S1 Administrator acknowledged that the previous years' annual survey results were not in the survey binder and should have been.

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	195350	A. Building B. Wing	07/24/2025

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to accommodate 1 (#165) out of 1 resident reviewed for personal privacy. The facility failed to ensure Resident #165 had a privacy curtain in a shared room. Findings:Observation on 07/21/2025 at 10:00 a.m. of Resident #165's room revealed was in a shared with a roommate. Further observation revealed Resident #165 did not have privacy curtain. During an interview on 07/21/2025 at 10:00 a.m. Resident #165 and visitor reported Resident #165 did not have a privacy curtain.Review of Resident #165's face sheet revealed an admission date of 01/07/2025 with the following diagnoses bipolar disorder, current episode depressed and altered mental status. Review of Resident #165's Quarterly MDS (Minimum Data Sets) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 10 indicating moderately impaired cognition. During an interview on 07/23/2025 at 11:30 a.m. S19 CNA (Certified Nurse Assistant) observed Resident #165's room and confirmed there was no privacy curtain around bed A.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on record reviews and interview the facility failed to develop an individualized person centered care plan for 1 (#14) of 2 (#5, #14) residents with measurable goals and appropriate interventions to address the care and treatment for a resident with dementia. Findings: Review of Resident #14's face sheet revealed an initial admission date of 12/15/2023 and a re-entry admission date of 02/10/2025 with diagnosis of dementia. Review of Resident #14's July 2025 Physician Orders revealed an order dated 05/10/2024: Memantine HCl (hydrochloride) oral tablet 5 MG (milligram); Give 1 tablet by mouth two times a day related to dementia and anxiety. Review of Resident #14's Care Plan failed to reveal a focus of dementia with measurable goals and appropriate interventions. During an interview on 07/23/2025 at 3:00 p.m. S3 MDS (Minimum Data Sets) Nurse confirmed Resident #14's care plan did not include a focus of dementia with measurable goals and appropriate interventions.

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	195350	A. Building B. Wing	07/24/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, and interviews the facility failed to maintain electrical equipment in safe operating condition for 1 (#35) of 11 (#35, #50, #56, #68, #88, #91, #110, #128, #158, #179, #189) residents reviewed for environment. The facility failed to ensure that Resident #35's bed control was properly maintained and in safe working order. Findings:Review of Resident #35's medical record revealed, in part, a readmission date of 06/02/2025 with diagnoses including, but not limited to chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #35's cognition was intact. An observation on 07/21/2025 at 8:14 a.m. revealed Resident #35's bed remote had exposed wires. During an interview on 07/21/2025 3:28 p.m., S28Maintenance confirmed Resident #35's bed control had exposed wires. During an interview on 07/21/2025 at 3:35 p.m., S20Director of Nursing (DON) confirmed Resident #35's bed control had exposed wires and should not have.