STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195389	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Baton Rouge II	9301 Oxford Place Ave Baton Rouge, LA 70809

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 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 observations, interviews, and record reviews, the facility failed to ensure that residents who were unable to carry out activities of daily living (ADLs) received assistance with incontinent care for 2 (#7 and #85) of 4 residents reviewed for ADLs. Review of the facility's policy titled Toileting Resident, with a revision date of 01/24, revealed the following, in part: PurposeResidents are toileted safely on a routine basis in a timely manner according to their individual plan of care. Resident #7Review of Resident #7's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Dementia and Generalized Muscle Weakness. Review of Resident #7's Significant Change MDS with an ARD of 01/20/2026 revealed she had a BIMS of 12, which indicated she was moderately cognitively impaired. Further reviewed revealed she required partial/moderate assistance with toileting. Review of Resident #7's current Care Plan revealed the following, in part:Focus: Resident #7 has bowel incontinence related to dementia.Interventions: Check resident every two hours and assist with toileting as needed; Provide peri-care after each incontinent episode. Review of the facility's Grievance Log revealed Resident #7's family filed grievances on 02/04/2026, 02/17/2026, and 02/23/2026 related to Resident #7 not being changed in a timely manner. On 03/03/2026 at 12:00 p.m., an interview was conducted with Resident #7's family member. She stated she had concerns with staff not changing Resident #7 in a timely manner. On 03/04/2026 from 8:30 a.m. to 3:15 p.m., an observation was made of the residents on Unit 1. Resident #7 sat in the dining room of Unit 1, without being checked for incontinence, changed, or toileted until 1:50 p.m. On 03/04/2026 at 1:50 p.m., an observation was made of S8CNA and S9CNA bringing Resident #7 to her bathroom. Resident #7 was able to pivot from the wheelchair onto the toilet with assistance from S8CNA and S9CNA. Resident #7's brief was observed to be saturated with urine. There was a golf ball sized wet spot on the back of Resident #7's pants and wet residue in the center of Resident #7's wheelchair. At that time, S8CNA confirmed this observation. On 03/04/2026 at 3:12 p.m., an interview was conducted with S8CNA. She stated she was assigned to Resident #7 today. S8CNA stated Resident #7 was incontinent at times, but could use the restroom sometimes if brought to sit on the toilet. She confirmed from 8:30 a.m. to 1:50 p.m., Resident #7 was not changed, checked to see if she needed to be changed, or put on the toilet. She confirmed residents should be checked for incontinence every two hours and changed at least every two hours if needed. Resident #85Review of Resident #85's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which include Dementia and Muscle Atrophy and Wasting. Review of Resident #85's Quarterly MDS with an ARD of 02/09/2026 revealed she was unable to complete the BIMS interview. Further reviewed revealed she was dependent on staff for toileting. Review of Resident #85's current Care Plan revealed the following, in part:Focus: Resident #85 has bowel incontinence related to dementia.Interventions: Check resident every two hours and assist with toileting as needed; Provide peri-care after each incontinent episode. On 03/04/2026 from 8:30 a.m. to 3:15 p.m., an observation was made of the residents on Unit 1. Resident #85 sat in the dining room of Unit 1, without being checked for incontinence or changed, until 2:58 p.m. On 03/04/2026 at 2:58 p.m., an observation was made of S8CNA providing incontinence care to Resident #85. Resident #85 was observed to be (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wearing gray sweat pants which were observed to be saturated in the front and in the back. On 03/04/2026 at 3:00 p.m., an interview was conducted with S8CNA. S8CNA confirmed the observation above and confirmed Resident #85 had not been checked for incontinence or changed every two hours and should have been. On 03/05/2026 at 12:13 p.m., an interview was conducted with S2DON. S2DON stated staff should check to see if residents needed to be changed or toileted every two hours and as needed. She was notified of the above observations of Unit 1 and confirmed residents should have been checked for incontinence and changed every two hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record review, the facility failed to ensure controlled drugs were accurately reconciled for 2 of 2 (Medication Cart A and Medication Cart B) medication carts observed for controlled drug reconciliation. Review of the facility's policy titled, Drug-Controlled Substances with a revision date of 09/2025 revealed the following:Controlled medications are to be signed out on Individual Resident Narcotics Record(Form NS-618) at the time they are to be administered. An observation of Medication Cart A on 03/03/2026 at 10:30 a.m. with S3LPN revealed Resident #46's Alprazolam 0.5 mg medication packet contained 55 tablets. Review of the Individual Resident Narcotics Record showed on 03/03/2026 at 7:00 a.m., S3LPN documented administration of one tablet with a remaining balance of 54 tablets. On 03/03/2026 at 10:31 a.m., an interview was conducted with S3LPN. S3LPN confirmed Resident #46's narcotic record showed 54 tablets remaining while the medication packet contained 55 tablets. S3LPN stated she signed out the medication during morning medication pass but forgot to administer it. S3LPN stated controlled medications should be prepared and administered at the time they are signed out. An observation of Medication Cart B on 03/03/2026 at 10:54 a.m. with S4LPN revealed Resident #86's Lorazepam 0.5 mg medication packet contained 47 tablets while the Individual Resident Narcotics Record indicated a remaining balance of 48 tablets. Further observation revealed Resident #117's Tramadol 50 mg medication packet contained 24 tablets while the Individual Resident Narcotics Record indicated a remaining balance of 25 tablets. On 03/03/2026 at 10:55 a.m., an interview was conducted with S4LPN. S4LPN confirmed the narcotic counts for Residents #86 and #117 were discrepant between the narcotic record and the medication packets. S4LPN stated she forgot to sign the medications out at the time of administration during morning medication pass and acknowledged controlled medications should be signed out when prepared for administration, stating, I should know better. On 03/04/2026 at 2:35 p.m., an interview was conducted with S2DON. S2DON stated the Individual Narcotic Record should accurately display the quantity of controlled medications available at all times. S2DON confirmed the above mentioned controlled medications should have been signed out on the resident's Individual Narcotic Record at the time they were administered to the residents.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were not imposed for the purpose of staff convenience and were used to treat a resident's medical symptoms for 1 (#113) of 2 residents reviewed for restraints. Review of the facility's policy titled Restraints and Safety Devices, with a revision date of 10/22, revealed the following, in part:It is the philosophy of this facility that a resident has the right to be free from any physical or chemical restraints not required to treat the residents' medical symptoms. Physical Restraint DefinitionAny manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove, restricts freedom of movement or normal access to one's body. Review of Resident #113's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Dementia and Frequent Falls. Review of Resident #113's Annual MDS with an ARD of 01/19/2026 revealed she had a BIMS of 4, which indicated severe cognitive impairment. Further review revealed she had no impairment of the lower extremity, and she required partial/moderate assistance for transfers. Review of Resident #113's current Physician's Orders revealed no order for restraints. Review of Resident #113's current Care Plan revealed the following, in part: Problem: The resident has had an actual fall with (no injury) Poor Balance, Unsteady gaitInterventions: 02/02/2026-Soft waist self-release belt applied while in wheelchair to reduce fall probability Review of Resident #113's Nurse's Notes revealed the following, in part:-02/02/2026 at 6:53 p.m. - Resident #113 was observed attempting to ambulate independently. Resident did not strike her head. Resident was immediately assessed. Resident able to move all extremities. No injuries noted at this time. Resident educated on the importance using her ambulatory device when ambulating. Will continue to monitor. -Signed, S3LPN-02/02/2026 at 7:07 p.m.- New fall intervention as followed -(1)Soft waist self-release belt applied while in wheelchair to reduce fall probability - floor nurse and staff assigned aware of new fall intervention - plan of care revised. -Signed, S6LPN Further review of Resident #113's Clinical Record revealed no Physical Restraint Assessment was completed. On 03/04/2026 at 8:28 a.m., an observation was made of Resident #113. She was sitting at the dining room table in her wheelchair on Unit 1. A soft seatbelt was observed fastened at her waist. On 03/05/2026 at 9:36 a.m., an observation was made of Resident #113. She was sitting at the dining room table in her wheelchair on Unit 1. A soft seatbelt was observed fastened at her waist. On 03/05/2026 at 1:24 p.m., an interview was conducted with S3LPN. S3LPN stated Resident #113 was able to stand and pivot. S3LPN stated she was assigned to Resident #113 and witnessed her fall on 02/02/2026. She stated on 02/02/2026, Resident #113 stood up in her wheelchair then fell before staff could get to her. She stated Resident #113 sustained no injuries. S3LPN stated the seatbelt was the intervention put into place for Resident #113 on 02/02/2026 for fall prevention. On 03/05/2026 at 10:20 a.m., an interview was conducted with S7CNA. She stated Resident #113 was a one person assist for transfers. She stated she did not know why Resident #113 had a seatbelt in place. She stated the seatbelt was fastened around Resident #113's waist while she was in her wheelchair. S7CNA stated she did not know if Resident #113 was able to release the seatbelt on her own. On 03/05/2026 at 10:25 a.m., an interview was conducted with S5LPN. S5LPN stated she was assigned to Resident #113 today. She stated Resident #113 was a one person assist for transfers and toileting. She stated after Resident #113's last fall, the seatbelt was the fall intervention that was initiated. She stated the seatbelt was in place to prevent Resident #113 from having another fall. She stated Resident #113 was to wear the seatbelt at all times while up in her wheelchair. She stated did not know if Resident #113 could remove the seatbelt by herself. On 03/05/2026 at 10:34 a.m., an observation was made of S5LPN asking Resident #113 to release her seatbelt. S5LPN asked Resident #113 to release the seatbelt four times. The fourth time, Resident #113 was observed putting her (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingers on the release button, but did not release the belt. On 03/05/2026 at 10:36 a.m., a follow up interview was conducted with S5LPN. She confirmed Resident #113 was unable to release the seatbelt. S5LPN stated if a resident was unable to release a seatbelt, the seatbelt was considered a restraint. On 03/05/2026 at 11:02 a.m., an interview was conducted with S6LPN. S6LPN stated she was responsible for investigating falls and initiating fall care plans and interventions. She stated Resident #113 was a one person assist. She stated Resident #113 had an intervention initiated for a seatbelt on 02/02/2026. She stated the purpose for the seatbelt was to prevent Resident #113 from falling out of her wheelchair. She stated Resident #113's seatbelt was to be worn while she was up in her wheelchair. She stated Resident #113's seatbelt was not a restraint, but a safety device. She stated Resident #113 was not supposed to be able to remove the seatbelt, because if she were able to, it would not have been an effective safety device. She stated there had been no restraint assessment completed for Resident #113's seatbelt. On 03/05/2026 at 12:13 p.m., an interview was conducted with S2DON. S2DON stated seatbelts served as a safety device to remind residents on Unit 1 to stay seated and not get up without assistance. She stated seatbelts were not considered restraints for residents who resided on Unit 1 because the residents were non-ambulatory, so the seatbelts were not restricting their movements. S2DON further stated no restraint assessments were completed by the facility for residents who had seatbelts initiated. On 03/05/2026 at 1:51 p.m., a follow up interview was conducted with S2DON. She reviewed Resident #113's Nurse's Notes dated 02/02/2026 indicating Resident #113 had a fall after attempting to ambulate independently. S2DON confirmed Resident #113's seatbelt would restrict her from standing up.

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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 reviews, observations, and interviews, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (#91) of 2 residents reviewed for enteral feedings. The facility failed to ensure the enteral feeding bag was appropriately labeled.Findings: Review of the facility's policy titled, Tube Feeding, and dated 12/2015 revealed the following: Procedures for administering tube feedings are in place and address:e. Labeling of the container. Review of the clinical record for Resident #91 revealed he was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction due to Thrombosis of Left Middle Cerebral Artery, Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia following Cerebral Infarction, Dysphagia, Oropharyngeal Phase, Encounter for attention to Gastrostomy, unspecified, Cerebral Infarction. Review of the current Physician Orders for Resident #91, revealed, in part, the following: Start date: 03/02/2026 tube feeding formula: Diabetasource AC at 75 ml/hour, continuous. 03/03/2026 9:12 a.m., an observation of Resident #91's tube feeding bag with no name, date, time or rate noted on bag of Diabetasource AC running 75ml/hour per pump. 03/03/2026 9:14 a.m., an interview was conducted with S4LPN. S4LPN stated she would spike a new bag of the proper tube feeding formula, label the bag with Resident's name, the date, time, rate of infusion. S4LPN stated if she found the tube feeding bag unlabeled she would discontinue the present bag and hang a new bag of feeding after labeling it properly. 03/03/2026 9:23 a.m., an observation of Resident #91's tube feeding was conducted with S2DON. S2DON confirmed Resident #91 tube feeding was unlabeled with his name, date and time initiated and should have been.