STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195408	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor South	9712 Mansfield Road Shreveport, LA 71118

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews the facility failed to ensure a grievance investigation and resolution had been conducted and documented as per facility policy for 1 (#1) of 3 (#1, #2, #3) sampled residents. Review of facility Grievances - Residents policy with latest revision date of 05/2024 revealed, in part:All residents are to be encouraged and assisted (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff and other resident's and other concerns regarding their facility stay, in the event that they have a need to make a concern known. The following outlines the process: . Family members, visitors or others may also present grievances on behalf of residents. Grievances may also be made anonymously using the suggestion box. The facility shall make prompt efforts to resolve the grievances. The Social Worker or Social Service Designee has been appointed by the Administrator to . to receive concerns, grievances and recommendations by residents, or any group or individual designated by the resident and his/her representative. Concerns which cannot be promptly resolved shall be treated as a grievance. These grievances shall be directed to the appropriate Department Head and/or Administrator for investigation and follow-up according to the following procedure:o Upon receipt of a grievance/complaint the staff receiving the complaint will report to their supervisor, grievance official, or will initiate the Grievance/Complaint Form NS-795. An investigation led by the Administrator based on the allegations will be set forth. NS-795 will be completed electronically in the electronic health record.o The Administrator and his/her designees will conduct an impartial investigation of the allegations and will discuss the findings and recommendations within five (5) work days of receiving the complaint, with the complainant, The Resident has the right to review the grievance and obtain a written decision regarding the grievance.o In all grievance cases, the resident and/or legal representative will be informed of the result of the investigation, the recommendations made by the investigating parties, and of the action(s) contemplated by the Administrator. Reports shall be maintained electronically for a minimum of 3 years. Review of Resident #1's medical record revealed an initial admission date of 12/03/2024 with diagnoses including, in part, rheumatoid arthritis, type 2 diabetes mellitus, essential hypertension, Alzheimer's disease unspecified, anxiety disorder unspecified, bipolar disorder, atherosclerotic heart disease of native coronary artery without angina pectoris, and mood disorder due to known physiological condition with mixed features. Review of 06/13/2025 Significant Change MDS (Minimum Data Set) revealed BIMS (Brief Interview for Mental Status) should not have been conducted as resident is rarely/never understood. Review of a 04/01/2025 at 11:25 a.m. grievance/complaint report revealed a family member had reported: (1) Resident #1's sheets looked dirty, even when they are clean; (2) Had received a call from the 2pm to 10pm nurse on 3/31/2025 at 4pm with report that Resident #1's stomach hurt and the nurse reported being unsure if Resident #1 had eaten or not and family member brought food and reported Resident #1 ate as if starving; and (3) Resident #1 was soaking wet and had to change him and today Resident #1 still had on the same clothing Resident #1 was put in yesterday. Further review of the Grievance/Complaint report failed to reveal evidence an investigation had been conducted and resolution communicated. During an interview on 07/16/2025 at 3:55 p.m. S1 DON (Director of Nursing) reviewed the 04/01/2025 grievance/complaint form and confirmed an investigation and resolution had not been documented. During an interview on 07/17/2025 at 11:57 a.m. S2 SSD (Social Services Director) reported she had recorded the 04/01/2025 complaint from Resident #1's family member, forwarded the complaint to nursing and laundry and did not document any investigation or resolution. S2 SSD further confirmed there was no evidence an investigation for the 04/01/2025 complaint had been done and no evidence the complainant had been notified of the resolution.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a comprehensive person-centered care plan had been developed and implemented for 1 (#3) of 3 (#1, #2, #3) sampled residents. The facility failed to ensure a care plan had been developed and implemented to reflect Resident #1/Resident #1's RP's (Responsible Party) wishes for code status of DNR (Do Not Resuscitate). Review of Resident #3's medical record revealed an admission date of [DATE] with diagnoses including, part, chronic obstructive pulmonary disease (COPD), unspecified severe protein-calorie malnutrition, anemia unspecified, essential (primary) hypertension, anxiety disorder, depression unspecified, and pain unspecified. Review of Resident #3's [DATE] Significant Change MDS (Minimum Data Set) revealed a BIMS (Brief Interview Mental Status) of 99, which indicated Resident #3 was unable to complete the interview. Review of Resident #3's physician orders revealed a [DATE] order for Do Not Resuscitate. Review of Resident #3's medical record revealed a [DATE] Advance Directive Consent obtained from Resident #3's RP with selection of DNR code status.Review of Resident #3's current care plan revealed a care plan initiated on [DATE] for Full code with interventions that included: if cardiac arrest occurs, initiate CPR; respect resident/family wishes; and review and update code status with resident/family as needed. During an interview on [DATE] at 8:11 a.m. S3 MDS (Minimum Data Set) Nurse and S4 MDS Nurse reviewed Resident #3's medical record and care plan and reported Resident #3 was care planned for full code and should have been care planned for DNR.