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	12/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure residents received adequate supervision to prevent elopement for 1 (#1) of 3 (#1, #2, #3) sampled residents at risk for elopement. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 12/09/2025. It was determined to be a Past noncompliance Citation. Findings: Review of Resident #1's record revealed an admission date of 10/27/2025 and a discharge to a behavioral hospital on [DATE]. Diagnoses included, in part, Parkinson's disease without dyskinesia without mention of fluctuations, dementia, depression, Alzheimer's disease unspecified, essential hypertension, atherosclerotic heart disease, and delusional disorders. Review of Resident #1's 11/03/2025 admission MDS (Minimum Data Set) revealed Resident #1 had a BIMS (Brief Interview Mental Status) score of 06, indicating a severe cognitive impairment. Review of Resident #1's Care Plan revealed Resident #1 was care planned for security bracelet which was initiated on 11/11/2025 and an actual elopement on 11/30/2025 when Resident #1 left the facility through a window in an office that had a malfunctioning door lock. Interventions included an admission to ___ _____ Behavioral on 12/01/2025, a change in lock codes of offices with window access, one on one supervision, and resident was moved to the secure memory care unit on 12/01/2025. Review of Resident #1's progress notes revealed:-11/30/2025 at 2:51 p.m. - . Resident was not in her room, CNA (unspecified Certified Nursing Assistant) states that she just walked with her about 10-15 minutes ago down the hall. Writer walked to Hall E to see if resident was on Hall B or Hall E hall and she was not. CNA's found resident's walker on Hall E smoking patio. Writer reviewed the cameras and at 1:21 p.m. writer noted resident going into the MDS office then 5-10 minutes later the CNA checked in the office for the resident and did not see her. Writer never seen resident come back out of the MDS office. CNA was driving searching for resident and found resident at _____ (convenience store) at 2:07 p.m. on _____ Rd. CNA brought resident back. Full head to toe assessment complete and only skin tear noted to right arm with steri strips in place and another skin tear to right arm with bandage in place, these were old skin tears. Writer asked resident how she got out and she began smiling and stated I'm not going to tell you my secret. Resident was placed on the Memory care unit for safety.-12/01/2025 at 1:56 p.m. - New order to send resident to ___ _____ Behavior.-12/01/2025 at 4:42 p.m. - Left facility ambulating with walker, left in ___ ____ Behavior van at 2:15 p.m. Review of 11/30/2025 facility video footage with S2 ADON (Assistant Director of Nursing) revealed:From Hall A hall camera:-1:19 p. m. - Resident #1 was initially seen on Hall A near the staff breakroom hugging S12 CNA and S12 CNA and Resident #1 proceeded to walk away from the camera, all the way down to the far end of Hall A door which led to door that entered Hall E where MDS office was located. S12 CNA seen going into a room on the left at the end of the Hall A while Resident #1 continued on down the hallway.-1:20 p.m. - Resident #1 seen going through door at the far end of Hall A to Hall E where the MDS office was located. From Hall E camera:-1:20 p. m. - Resident #1 was seen coming through door from Hall A to Hall E and attempted to open the door to outside across from the Hall A door without success, then attempted to open mechanical closet door next to the outside door and it was locked, then attempted to open the door to outside again, but was unable to open it. -1:21 p.m. - Resident #1 proceeded past 3 windows and turned toward the MDS office and was able to open the door, without any difficulty, and entered the office. Resident #1 did not exit the MDS office door. During an interview on 12/10/2025 at 9:55 a.m. S3 DON (Director of Nursing) reviewed Resident #1's record and confirmed Resident #1's wanderguard was initiated on 11/11/2025. During an interview on 12/10/2025 at 10:43 a.m. S3 DON confirmed the windows in offices with windows leading outside the facility and the windows in therapy gym did not have stops to limit how far the windows would open before the 11/30/2025 incident. Further reported she had worked the day of the 11/30/2025 incident and upon check of the MDS office lock right after the incident, the keypad door lock was found to be unlocked. During an interview on 12/10/2025 at 11:53 a.m. S2 ADON reported when she went to give Resident #1's medications on 11/30/2025 at 1:30pm, Resident #1 was not in her room and upon review of video footage, Resident #1 was seen entering the MDS office at 1:21 p.m. S2 ADON further confirmed Resident #1 was found and returned to the facility on [DATE] at 2:07 p.m During an interview on 12/11/2025 at 12:50 p.m. S1 Administrator confirmed she had been made aware on 11/30/2025 that Resident #1 had exited the building through a window in the MDS office on a Sunday when the office would have been locked and the MDS nurse reported she had locked the door. S1 Administrator further reported a system was already in place that had been