

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Heritage Manor South		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>30669</p> <p>Based on record review and interview the facility failed to inform in writing 1 (#151) of 3 residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification of changes in their liability.</p> <p>Findings:</p> <p>Review of the facility's SNF Beneficiary Protection Notification Review revealed the facility initiated Resident #151's discharge from Medicare Part-A Services when the benefit days were not exhausted. A written NOMNC (Notice of Medicare Non-Coverage) or ABN (Advance Beneficiary Notice) was not given to Resident #151 or his RP (responsible party).</p> <p>Review of the facility's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage read in part the following: Beginning on 10/10/2024 you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.</p> <p>Additional Information: On 10/28/2024 at 1:08 p.m., you _____ (the Resident Representative's name) were contacted by telephone at _____ Contact#, by S5 Account Manager to discuss details of this notice.</p> <p>During an interview on 10/28/2024 at 4:30 p.m., S5 Account Manager reported a written NOMNC or ABN were not provided to Resident #151 or his RP. S5 Account Manager reported she should have notified Resident #151 or his RP earlier in October and she did not.</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record review, observations and interviews the facility failed to develop and implement a comprehensive person-centered care plan for 2 (#62, #81) out of 30 sampled residents reviewed. The facility failed to develop a care plan for Resident #62's diabetic wound and failed to obtain a physician order for Resident #81 to receive oxygen therapy.</p> <p>Findings:</p> <p>Resident #62</p> <p>Review of Resident #62's medical record revealed an admitted [DATE] with diagnoses that included, in part, type 2 diabetes mellitus, diabetic ulcer, absence of right leg below knee, dementia, essential (primary) hypertension, impetigo, and peripheral vascular disease.</p> <p>Review of Resident #62's Physician Orders revealed an order dated 08/30/2024 to cleanse diabetic ulcer to left great toe with wound cleanser, pat dry, apply medi-honey and cover with bandage every Tues, Thurs, and Sat until resolved. May be changed as needed for soilage/dislodgement - every day shift every Tue, Thu, Sat and every 1 hour as needed.</p> <p>Review of Resident #62's 08/20/2024 Quarterly MDS (Minimum Data Set) revealed Resident #62 had a BIMS (Brief Interview Mental Status) of 07, which indicated severe cognitive impairment.</p> <p>Review of Resident #62's medical record revealed weekly wound assessments had been conducted for a diabetic wound to left dorsum-1st digit (Hallux) that was acquired in-house.</p> <p>Review of Resident #62's care plan failed to reveal a care plan had been developed for Resident #62's diabetic foot ulcer-left dorsum-1st digit (Hallux).</p> <p>During an interview on 10/30/2024 at 3:13 p.m. S4 MDS Coordinator reviewed Resident #62's care plan and acknowledged a care plan for Resident #62's diabetic wound had not been developed and should have been.</p> <p>40193</p> <p>Resident #81</p> <p>Review of Resident #81's medical record revealed an admitted [DATE] with the following diagnoses, including in part: chronic pulmonary obstructive disease/unspecified, edema/unspecified, and shortness of breath.</p> <p>Review of Resident #81's Physicians Orders failed to reveal an order for continuous oxygen via nasal cannula at 3 liters per minute (LPM).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #81's Nurse Practitioner Progress Note dated 10/10/2024 revealed a history of present illness: .He is dependent on oxygen at 3 Liters .</p> <p>Observation on 10/28/2024 at 8:15 a.m. revealed Resident #81 sitting up in wheelchair in room and noted nasal cannula with continuous oxygen in progress at 3LPM. Further observation revealed humidifier bottle and tubing dated 10/28/2024.</p> <p>During an interview on 10/29/2024 at 2:45 p.m. Resident #81 reported he does wear his oxygen.</p> <p>Observation on 10/30/2024 at 8:55 a.m. revealed Resident #81 lying in bed with continuous oxygen via nasal cannula in place at 3LPM.</p> <p>During an interview on 10/30/2024 at 1:00 p.m. S6 Licensed Practical Nurse (LPN) confirmed Resident #81 does wear his oxygen.</p> <p>During an interview on 10/30/2024 at 10:25 a.m. S2 DON (Director of Nursing) confirmed Resident #81 does use oxygen sometimes and did not know why he did not have an order for oxygen but should have.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record review and interview the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (#62) of 30 sampled residents by failing to administer a full course of antibiotic as ordered by the physician.</p> <p>Findings:</p> <p>Review of Resident #62's medical record revealed an admitted [DATE] with diagnoses that included, in part, type 2 diabetes mellitus, diabetic ulcer, absence of right leg below knee, dementia, essential (primary) hypertension, impetigo, and peripheral vascular disease.</p> <p>Review of Resident #62's 08/20/2024 Quarterly MDS (Minimum Data Set) revealed Resident #62 had a BIMS (Brief Interview Mental Status) of 07, which indicated severe cognitive impairment.</p> <p>Review of Resident #62's physician orders revealed a 09/20/2024 order, with an end date of 09/27/2024 for Amoxicillin-Pot Clavulanate Tablet 875-125mg (milligram) - give 1 tablet by mouth every 12 hours for wound infection for 7 days.</p> <p>Review of Resident #62's September 2024 MAR (Medication Administration Record) revealed:</p> <p>Amoxicillin-Pot Clavulanate Tablet 875-125mg (1 tablet every 12 hours) - 8:00 p.m. doses for 9/20, 09/21, and 09/22/2024 and 8:00 a.m. doses for 09/21 and 09/22/2024 were left blank, indicating 5 missed doses of the medication.</p> <p>During an interview on 10/30/2024 at 1:30 p.m. S2 DON (Director of Nursing) reviewed Resident #62's September 2024 MAR and reported the Amoxicillin-Pot Clavulanate doses for 8:00 p.m. on 09/20, 09/21, and 09/22/2024 and doses for 8:00 a.m. on 09/21 and 09/22/2024 were blank and the full course was not administered.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure residents were free of accident hazards by failing to ensure bed rails were securely attached to the bed for 5 (#70, #54, #49, #40, and #8) of 6 (#70, #54, #49, #40, #8, and #201) residents reviewed for accident hazards.</p> <p>Findings:</p> <p>Resident #70</p> <p>Review of Resident #70's record revealed an admitted [DATE] and diagnoses including: unspecified dementia unspecified severity with other behavioral disturbance, post-traumatic stress disorder, unspecified mood disorder, bipolar disorder current episode manic severe with psychotic features, edema, and pain. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #70's most currently completed MDS (Minimum Data Set) Assessments with an ARD (Assessment Reference Date) of 08/13/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) Score of 9 out of 15 indicating moderately impaired cognition. Further review revealed the resident was independent requiring no set up or physical help from staff for bed mobility, transfer, eating, and toilet use.</p> <p>Observation on 10/28/2024 at 9:35 a.m. revealed Resident #70 lying in bed with bilateral quarter metal bed rails in place on the upper half bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 9:35 a.m., Resident #70 stated he used the rails to help position himself and to help himself sit up.</p> <p>Observation on 10/29/2024 at 10:18 a.m. revealed Resident #70's bed had bilateral quarter metal bed rails attached to the upper half of the bed. The right rail was loose when moved toward and away from the mattress. The left rail was very loose when moved toward and away from the mattress and freely moved toward the foot of the bed so that it turned a full 90 degrees.</p> <p>During an interview on 10/29/2024 at 10:18 a.m., Resident #70 asked the surveyor what they were doing. When told the surveyor was looking at the rails on his bed, and told him they were kind of loose, he replied yeah I know. That's why I don't use them, I'm afraid I'll fall.</p> <p>Resident #54</p> <p>Review of Resident #54's most recently completed comprehensive MDS assessments with ARD of 08/06/2024 revealed the resident had a BIMS score of 15 out of 15 indicating he was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/28/2024 at 10:25 a.m. revealed Resident #54 had bilateral quarter metal bed rails in place on the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 10:25 a.m. Resident #54 reported he used the rails to help position himself in the bed.</p> <p>Observation on 10/29/2024 at 10:30 a.m. revealed resident lying in his bed. Further observation revealed the resident's bed had bilateral quarter metal bed rails attached to the upper half of the bed. Both rails were loose and freely moved back and forth and toward and away from the mattress.</p> <p>During an interview on 10/29/2024 at 10:30 a.m. Resident #54 reported he used the rails to pull himself up in the bed, but they were pretty loose. Resident #54 further indicated the staff only checked on the rails at his request, but it had been a while since he had mentioned the rails being loose to any staff member.</p> <p>Resident #49</p> <p>Review of Resident #49's record revealed an admitted [DATE] and diagnoses including: neuroleptic induced parkinsonism, vascular dementia severe with mood disturbance, depression, unspecified mood disorder, alcohol dependence with alcohol-induced persisting dementia, insomnia, idiopathic peripheral autonomic neuropathy, generalized muscle weakness, anxiety disorder, impulse disorder, unspecified pain, unspecified abnormalities of gait and mobility, unspecified lack of coordination. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #49's most recently completed comprehensive MDS assessments with ARD of 08/06/2024 revealed the resident had a BIMS score of 10 out of 15 indicating moderately impaired cognition. Further review revealed Resident #49 was independent with setup help only for eating, required supervision with one person physical assist for toilet use; supervision with one person physical assist for bed mobility and transfer.</p> <p>Observation on 10/28/2024 at 9:33 a.m. revealed Resident #49's bed had bilateral quarter metal bed rails in place on the upper half of the bed in the raised position. The rail to the right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 9:33 a.m., Resident #49 reported he used the rails to help position himself in the bed.</p> <p>Observation on 10/29/2024 at 10:14 a.m. revealed Resident #49's bed had bilateral quarter metal bed rails attached to the upper half of the bed. Both rails were loose and freely moved back and forth and toward and away from the mattress.</p> <p>Resident #40</p> <p>Review of Resident #40's record revealed an admitted [DATE] and diagnoses including: neurocognitive disorder with Lewy Bodies, vascular dementia, bipolar disorder, and generalized muscle weakness. The resident resided on the facility's secure memory care unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #40's most recently completed comprehensive MDS assessments with ARD of 09/18/24 revealed the resident's BIMS interview was not conducted due to the resident being rarely/never understood. Further review revealed the resident had a short-term memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Observation on 10/28/2024 at 9:41 a.m. revealed Resident #40's bed had bilateral quarter metal bed rails in place to the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>Observation on 10/29/2024 at 10:20 a.m. revealed Resident #40's bed had bilateral quarter metal bed rails attached to the upper half of the bed. The left rail was in the down position. The right rail was loose and moved freely toward and away from the mattress and moved back and forth toward the head and foot of the bed when pulled on.</p> <p>Resident #8</p> <p>Review of Resident #8's record revealed an admitted [DATE] and diagnoses including: unspecified dementia with behavioral disturbance, unspecified convulsions, bipolar disorder, persistent mood disorder, major depressive disorder, insomnia, generalized muscle weakness, anxiety disorder. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #8's most recently completed comprehensive MDS assessments with ARD of 10/08/2024 revealed the resident's BIMS interview was not conducted due to the resident being rarely/never understood. Further review revealed Resident #8 had a short-term memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Observation on 10/28/2024 at 9:25 a.m. revealed Resident #8 lying in bed with bilateral quarter metal bed rails in place to the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>Observation on 10/29/2024 at 10:16 a.m. revealed Resident #8 lying in her bed with bilateral quarter metal bed rails attached to the upper half of the bed. The resident's upper body was leaning up against the right bed rail. Further observation revealed both rails were loose and moved toward and away from the mattress, and moved back and forth toward the head and foot of the bed when pulled on.</p> <p>Observations beginning on 10/29/2024 at 3:58 p.m. with S7 CNA (Certified Nursing Assistant) on the secure dementia care unit revealed Resident #70, #49, #40, and #8's bed rails were loose and freely moveable.</p> <p>During an interview on 10/29/2024 beginning at 3:58 p.m. S7 CNA confirmed Resident #70, #49, #40, and #8's bed rails were loose and should not be.</p> <p>Observations beginning on 10/29/2024 at 4:00 p.m. with S8 CNA revealed Resident #54's bed had had bilateral quarter metal side rails attached to the upper half of the bed that were loose and freely moveable.</p> <p>During an interview on 10/29/2024 at 4:00 p.m. S8 CNA confirmed Resident #54's bed rails were loose and should not be.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations beginning on 10/29/2024 at 4:04 p.m. with S3 ADON (Assistant Director of Nursing) revealed Resident #70, #49, #40, #8 and #54's beds had had bilateral quarter metal bed rails attached to the upper half of the bed that were loose and freely moveable.</p> <p>During an interview on 10/29/2024 beginning at 4:04 p.m. S3 ADON confirmed Resident #70, #49, #40, #8 and #54's bed rails were loose and freely moveable and should not be.</p> <p>During an interview on 10/29/2024 at 4:08 p.m. S2 DON (Director of Nursing) reported the maintenance department was responsible for checking the bed rails to ensure they were firmly attached and functioning properly. S2 DON further reported she did not know if maintenance checks were done on a routine basis or only when problems were reported.</p> <p>During an interview on 10/29/2024 at 4:33 p.m. S9 Maintenance reported he only inspected bed rails when staff turned in a work order reporting an issue. S9 Maintenance reported he did not conduct regular routine maintenance on the bed rails.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867</p> <p>Based on record reviews, observations and interviews, the facility failed to ensure correct use and maintenance of bed rails. The facility failed to ensure: residents were assessed for risks associated with the use of bed rails (side rails) and/or safety devices, informed consent was obtained from resident/resident representative prior to installation of bed rails, evidence of monitoring and supervision during the use of bed rails, and/or scheduled maintenance was conducted according to manufacturer's recommendations for any bed rails in use for 12 (#5, #8, #14, #29, #31, #40, #49, #54, #57, #64, #70, #201) of 12 residents reviewed for bed rails.</p> <p>Findings:</p> <p>Review of the facility's Restraints and Safety Devices policy with a revision date of October of 2022 revealed in part:</p> <p>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 resident's medical symptoms. Restraints may not be used for the convenience of the nursing staff or as punishment to the resident.</p> <p>Physical Restraint Definition</p> <p>Any 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.</p> <p>Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This is not determined by a type of device or method, but can only be determined on an individual basis by evaluating the effect it has on the resident. Do not focus on the type, intent or the reason behind the use to determine if it should be classified as a restraint, focus on the effect. The Restraint Device Worksheet helps to make the determination of whether the device is a restraint or not. If it is determined not to be a restraint, it is a device. If the device being used could be considered a restraint, the Device/Physical Consent shall be completed.</p> <p>Residents must be screened for use of approved restraints to meet their particular needs. Side rail usage should also be reviewed. If necessary, use side rail covers or bolster to prevent the resident's body from going under or through side rails if side rails are used.</p> <p>The facility must attempt to use an appropriate alternatives prior to installing a side rail. If used, the facility must assess the resident for risk of entrapment, review the risks and benefits with the resident or resident representative, obtain informed consent prior to installation, ensure bed dimensions are appropriate for the resident's size and weight, and follow manufacturer's directions for installing and maintaining side rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #5</p> <p>Review of Resident #5's medical record revealed an admitted [DATE] with diagnoses including but not limited to: quadriplegia unspecified, communicating hydrocephalus, morbid (severe) obesity due to excess calories, muscle weakness (generalized), aphasia, cerebral palsy, spastic quadriplegia, cerebral palsy, and profound intellectual disabilities.</p> <p>Review of Resident #5's comprehensive care plan revealed Resident #5's current safety devices and special equipment included approaches of quarter bed rails X 2 and wheelchair.</p> <p>Review of Resident #5's medical record failed to reveal documentation of monitoring and supervision provided during use of bed rails.</p> <p>Observation on 10/29/2024 at 8:07 a.m. revealed Resident #5 was awake in bed with head of bed slightly elevated and bed rails were up on both sides of upper bed.</p> <p>Observation on 10/29/2024 at 1:19 p.m. revealed Resident #5 was asleep in bed with head of bed elevated and bed rails were up on both sides of upper bed.</p> <p>During an interview on 10/29/2024 at 3:48 p.m. S11 LPN (Licensed Practical Nurse) observed Resident #5's bed rails and reported the rails were always up when she was in bed.</p> <p>Resident #8</p> <p>Review of Resident #8's record revealed an admitted [DATE] and diagnoses including: unspecified dementia with behavioral disturbance, unspecified convulsions, bipolar disorder, persistent mood disorder, major depressive disorder, insomnia, generalized muscle weakness, anxiety disorder. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #8's most recently completed comprehensive MDS (minimum data set) assessments with ARD (assessment reference date) of 10/08/2024 revealed the resident's BIMS (brief interview mental status) interview was not conducted due to the resident being rarely/never understood. Further review revealed Resident #8 had a short-term memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Review of Resident #8's record failed to reveal a consent for the use of bed rails.</p> <p>Observation on 10/28/2024 at 9:25 a.m. revealed Resident #8 lying in bed with bilateral quarter metal side rails in place to the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>Observation on 10/29/2024 at 10:16 a.m. revealed Resident #8 lying in her bed with bilateral quarter metal side rails attached to the upper half of the bed. The resident's upper body was leaning up against the right side rail. Further observation revealed both rails were loose and moved toward and away from the mattress, and moved back and forth toward the head and foot of the bed when pulled on.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/30/2024 at 8:15 a.m. S2 DON (Director of Nursing) confirmed a consent for the use of bed rails had not been obtained for Resident #8 prior to the use of the rails and should have been.</p> <p>Resident #14</p> <p>Review of Resident #14's medical record revealed an admitted [DATE] with following diagnoses, including but not limited to: acquired absence of left leg below knee, acquired absence of right leg above knee, hereditary and idiopathic neuropathy, morbid (severe) obesity, chronic systolic (congestive) heart failure, primary generalized (osteo) arthritis, other lack of coordination, and muscle wasting and atrophy of unspecified site.</p> <p>Review of Resident #14's comprehensive care plan revealed:</p> <p>Potential for injury related to the use of quarter side rails. Bed rails up X2 when in bed for bed mobility and positioning. Quarter side rails up X 2 when in bed, and safety device/restraint assessment quarterly and prn (as needed).</p> <p>Review of Resident #14's medical record failed to reveal documentation of monitoring and supervision had been provided during use of bed rails.</p> <p>Observation on 10/28/2024 at 3:06 p.m. revealed Resident #14's bed rails were up on both sides of upper bed.</p> <p>Observation on 10/29/2024 at 3:48 p.m. with S11 LPN revealed Resident #14 was in bed with head of bed elevated and bed side rails were up on both sides of upper bed.</p> <p>During an interview on 10/29/2024 at 3:48 p.m. S11 LPN reported Resident #14 usually had both upper bed rails up and preferred them to stay up.</p> <p>Resident #29</p> <p>Review of Resident #29's medical record revealed an admitted [DATE] with the following diagnoses, including but not limited to: spondylosis of the lumbar region, delusional disorder and anxiety disorder.</p> <p>Review of Resident #29's comprehensive care plan revealed, in part:</p> <p>Resident #29 had a potential for injury related to the use of quarter side rails up X 2 when in bed for bed mobility and repositioning.</p> <p>Review of Resident #29's medical record revealed an incomplete Device/Physical Restraint Consent dated 09/03/2024, which failed to indicate whether the resident consented to side rails.</p> <p>Further review of Resident #29's medical record failed to reveal documentation of monitoring and supervision provided during the use of side rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/28/2024 at 8:15 a.m. revealed Resident #29 asleep in bed with bilateral upper quarter side rails in use.</p> <p>Observation on 10/28/2024 at 11:15 a.m. revealed Resident #29 awake in bed with bilateral upper quarter side rails in use.</p> <p>During an interview on 10/28/2024 at 11:15 a.m. Resident #29 reported she uses the left side rail to help get out of bed.</p> <p>During an interview on 10/29/2024 at 3:50 p.m. S10 LPN reported Resident #29's upper quarter side rails are kept in a raised position.</p> <p>During an interview on 10/29/2024 at 4:30 p.m. S2 DON acknowledged Resident #29's Device/Physical Restraint Consent was incomplete.</p> <p>Resident #31</p> <p>Review of Resident #31's medical record revealed an admitted [DATE] with diagnoses including but not limited to: type 2 diabetes mellitus with diabetic chronic kidney disease, acute systolic (congestive) heart failure, atherosclerotic heart disease, muscle wasting and atrophy of unspecified site, insomnia, other lack of coordination, secondary Parkinsonism unspecified, history of falling, and bipolar disorder.</p> <p>Review of Resident #31's comprehensive care plan revealed Resident #31's current safety devices and special equipment included approaches of quarter side rails X 2 and wheelchair.</p> <p>Review of Resident #31's medical record failed to reveal documentation of monitoring and supervision provided during use of bed rails.</p> <p>Observation on 10/28/2024 at 3:23 p.m. revealed Resident #31 was lying in bed with head of bed slightly elevated and bed rails were up on both sides of the upper bed.</p> <p>During an interview on 10/29/2024 at 3:48 p.m. S11 LPN observed Resident #31's side rails and confirmed bed rails were up on both sides of upper bed and Resident #31 preferred them to stay up.</p> <p>Resident #40</p> <p>Review of Resident #40's record revealed an admitted [DATE] and diagnoses including: neurocognitive disorder with Lewy Bodies, vascular dementia, bipolar disorder, and generalized muscle weakness. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #40's most recently completed comprehensive MDS assessments with ARD of 09/18/2024 revealed the resident's BIMS interview was not conducted due to the resident being rarely/never understood. Further review revealed the resident had a short-term memory problem and severely impaired cognitive skills for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #40's Nurse Data Collection and Screening dated 09/18/2024 revealed in part: section B. Restraint Necessity/Positioning Device: device in use=yes, device=side/bed rail, alteration in safety awareness, severe impairment of mental status, bed mobility=independent with an enabler; type of bed/side rail-quarter bed rail/assist bed rail. Further review revealed section #3 Bed/side rails have been inspected and evaluated to identify and remove potential fall, entrapment, or entanglement hazards and is appropriate for resident needs after considering all relevant risk factors was left blank.</p> <p>Observation on 10/28/2024 at 9:41 a.m. revealed Resident #40's bed had bilateral quarter metal side rails in place to the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>Observation on 10/29/2024 at 10:20 a.m. revealed Resident #40's bed had bilateral quarter metal side rails attached to the upper half of the bed. The left rail was in the down position. The right rail was loose and moved freely toward and away from the mattress and moved back and forth toward the head and foot of the bed when pulled on.</p> <p>During an interview on 10/30/2024 at 8:15 a.m. S2 DON confirmed Resident #40's bed rail assessment dated [DATE] did not include an inspection and evaluation to identify and remove potential fall, entrapment, or entanglement hazards and should have.</p> <p>Resident #49</p> <p>Review of Resident #49's record revealed an admitted [DATE] and diagnoses including: neuroleptic induced parkinsonism, vascular dementia severe with mood disturbance, depression, unspecified mood disorder, alcohol dependence with alcohol-induced persisting dementia, insomnia, idiopathic peripheral autonomic neuropathy, generalized muscle weakness, anxiety disorder, impulse disorder, unspecified pain, unspecified abnormalities of gait and mobility, unspecified lack of coordination. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #49's most recently completed comprehensive MDS assessments with ARD of 08/06/2024 revealed the resident had a BIMS score of 10 out of 15 indicating moderately impaired cognition. Further review revealed Resident #49 was independent with setup help only for eating, required supervision with one person physical assist for toilet use; supervision with one person physical assist for bed mobility and transfer.</p> <p>Review of Resident #49's record failed to reveal a consent for the use of bed rails.</p> <p>Review of Resident #49's comprehensive care plan failed to reveal any interventions related to the use of side rails.</p> <p>Review of Resident #49's Nurse Data Collection and Screening form dated 08/06/2024 revealed in part: Restraint Necessity/Positioning device: The question Does the resident currently have a device in use of being considered? Devices may include but not limited to bed/side rails, lap buddy, table, recliner, seatbelt, mittens, position change alarm etc. was marked No. Further review revealed no assessment of risks associated with the use of the bed rails had been completed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/28/2024 at 9:33 a.m. revealed Resident #49's bed had bilateral quarter metal side rails in place on the upper half of the bed in the raised position. The rail to the right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 9:33 a.m., Resident #49 reported he used the rails to help position himself in the bed.</p> <p>Observation on 10/29/2024 at 10:14 a.m. revealed Resident #49's bed had bilateral quarter metal side rails attached to the upper half of the bed. Both rails were loose and freely moved back and forth and toward and away from the mattress.</p> <p>During an interview on 10/30/2024 at 8:43 a.m. S2 DON confirmed Resident #49 did not have a consent for the use of bed rails, was not care planned for the use of bed rails, and had not been evaluated for the risks associated with the use of bed rails. S2 DON further reported Resident #49 had bed rails in use and should not have.</p> <p>Resident #54</p> <p>Review of Resident #54's most recently completed comprehensive MDS assessments with ARD of 08/06/2024 revealed the resident had a BIMS score of 15 out of 15 indicating he was cognitively intact.</p> <p>Observation on 10/28/2024 at 10:25 a.m. revealed Resident #54 had bilateral quarter metal side rails in place on the upper half of the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 10:25 a.m. Resident #54 reported he used the rails to help position himself in the bed.</p> <p>During an interview on 10/29/2024 beginning at 4:04 p.m. S3 ADON (Assistant Director of Nursing) confirmed Resident #54's bed rails were loose and freely moveable and should not be.</p> <p>Resident #57</p> <p>Review of Resident 57's medical record revealed a re-entry date of 04/05/2024 with the following diagnoses, including but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, vascular dementia, severe with other behavioral disturbance, and general anxiety disorder.</p> <p>Review of Resident #57's comprehensive care plan on 10/29/2024 revealed in part:</p> <p>Resident #57s current safety devices and special equipment included bolster device and quarter bed rails x 2.</p> <p>Review of Resident #57's medical record failed revealed an undated Device/Physical Restraint Consent.</p> <p>Review of Resident #57's medical record revealed the Quarterly Nurse Data Collection and Screening assessment dated [DATE] failed to assess Resident #57 for the use of a bolster device.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #57's medical record failed to reveal documentation of monitoring and supervision provided during use of side rails.</p> <p>Observation on 10/28/2024 at 8:30 a.m. revealed Resident #57 asleep in bed with bilateral upper quarter bed rails in use with bolster devices strapped to the resident side of each rail.</p> <p>Observation on 10/28/2024 at 11:00 a.m. revealed Resident #57 asleep in bed with bilateral upper quarter bed rails and bolster devices in use.</p> <p>Observation on 10/29/2024 at 10:30 a.m. revealed Resident #57 asleep in bed with bilateral upper quarter bed rails and bolster devices in use.</p> <p>During an interview on 10/29/2024 at 3:50 p.m., S10 LPN reported Resident #57's upper quarter bed rails stay up and she was not sure why both bed rails and bolsters were in use.</p> <p>During an interview on 10/29/2024 at 4:30 p.m. S2 DON acknowledged Resident #57's Device/Physical Restraint Consent was not dated and was incomplete.</p> <p>During an interview on 10/30/2024 at 8:45 a.m. S2 DON reviewed Resident #57's 09/16/2024 Assessment for Restraint Necessity dated 09/16/2024 and acknowledged Resident #57 had not been assessed for bolster device usage. S2DON acknowledged Resident #57 had a bolster device in use and should not have.</p> <p>Resident #64</p> <p>Review of Resident #64's medical record revealed an admitted [DATE] with diagnoses that included, in part, unspecified diastolic (congestive) heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic obstructive pulmonary disease, iron deficiency anemia, primary generalized (osteo) arthritis, unspecified dementia, post-traumatic stress disorder, chronic kidney disease stage 4, muscle weakness (generalized), other lack of coordination, and unspecified pain.</p> <p>Review of Resident #64's comprehensive care plan revealed:</p> <p>Resident #64's current safety devices and special equipment included approaches of quarter bed rails X 2 and wheelchair.</p> <p>Review of Resident #64's medical record failed to reveal documentation of monitoring and supervision provided during use of bed rails.</p> <p>Observation on 10/28/2024 at 12:02 p.m. revealed Resident #64 was in bed with head of bed elevated and bed rails were up on both sides of upper bed.</p> <p>Observation on 10/29/2024 at 1:17 p.m. revealed Resident #64 was lying in bed with head of bed elevated and bed rails were up on both sides of upper bed.</p> <p>During an interview on 10/29/2024 at 3:44 p.m. S11 LPN observed Resident #64 and reported Resident #64 usually kept his both of his upper bed rails up and preferred them to stay up to make it easier to maneuver in bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #70</p> <p>Review of Resident #70's record revealed an admitted [DATE], and diagnoses including: Unspecified dementia unspecified severity with other behavioral disturbance, post-traumatic stress disorder, unspecified mood disorder, bipolar disorder current episode manic severe with psychotic features, edema, and pain. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #70's most currently completed MDS Assessments with an ARD of 8/13/2024 revealed the resident had a BIMS (Brief Interview for Mental Status) Score of 9 out of 15 indicating moderately impaired cognition. Further review revealed the resident was independent requiring no set up or physical help from staff for bed mobility, transfer, eating, and toilet use.</p> <p>Review of Resident #70's comprehensive care plan failed to reveal any interventions related to the use of bed rails.</p> <p>Review of Resident #70's Nurse Data Collection and Screening form dated 08/13/2024 revealed in part: Restraint Necessity/Positioning device: The question Does the resident currently have a device in use of being considered? Devices may include but not limited to bed/side rails, lap buddy, table, recliner, seatbelt, mittens, position change alarm etc. was marked No. Further review revealed no assessment of risks associated with the use of the bed rails had been completed.</p> <p>Observation on 10/28/2024 at 9:35 a.m. revealed Resident #70 lying in bed on the locked dementia care unit. Bilateral quarter metal side rails were in place on the bed in the raised position. The rail to right side was loose and moved back and forth and side to side when pulled.</p> <p>During an interview on 10/28/2024 at 9:35 a.m., Resident #70 stated he used the rails to help position himself and to help himself sit up.</p> <p>Observation on 10/29/2024 at 10:18 a.m. revealed Resident #70's bed had bilateral quarter metal bed rails attached to the upper half of the bed. The right rail was loose when moved toward and away from the mattress. The left rail was very loose when moved toward and away from the mattress and freely moved toward the foot of the bed so that it turned a full 90 degrees.</p> <p>During an interview on 10/30/2024 at 8:43 a.m. S2 DON confirmed Resident #70's care plan did not include the use of bed rails/safety device. S2 DON further confirmed Resident #70 had not been assessed quarterly for the risks associated with the use of the bed rails and should have been.</p> <p>Resident #201</p> <p>Review of Resident #201's record an admitted [DATE] and diagnoses including: fracture of unspecified parts of lumbosacral spine and pelvis subsequent encounter for fracture with routine healing, schizoaffective disorder bipolar type, depression, muscle wasting and atrophy unspecified site, cognitive communication deficit, mood disorder, unspecified abnormalities of gait and mobility, lack of coordination, generalized muscle weakness, unspecified dementia. The resident resided on the facility's secure memory care unit.</p> <p>Review of Resident #201's most recently completed comprehensive MDS assessments with ARD of 08/20/2024 revealed the resident had a BIMS score of 6 out of 15 indicating severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/29/2024 at 10:12 a.m. revealed Resident #201 lying in bed with bilateral quarter metal side rails attached to the upper half of the bed.</p> <p>Observation on 10/29/2024 at 3:58 p.m. revealed Resident #201's bed had bilateral quarter metal side rails attached to the upper half of the bed.</p> <p>During an interview on 10/29/2024 at 4:08 p.m. S2 DON reported a consent should be obtained from all residents or the residents' responsible parties prior to the installation or use of bed rails or other safety devices, even if not considered a restraint. S2 DON further reported a resident/device assessment should be conducted at least quarterly, and the use of the device should be included in the resident's care plan. S2 DON also reported the maintenance department was responsible for checking the bed rails to ensure they were firmly attached and functioning properly, but she did not know if checks were done on a routine basis or only when problems were reported.</p> <p>During an interview on 10/29/2024 at 4:33 p.m. S9 Maintenance reported he only inspected bed rails when staff turned in a work order reporting an issue. S9 Maintenance reported he did not conduct regular routine maintenance on the bed rails. S9 Maintenance further reported he did not know what the manufacturer recommendations were regarding the maintenance of the rails but he could look them up.</p> <p>During an interview on 10/30/2024 at 9:26 a.m. S9 Maintenance reported he did not have the manufacturer's recommendations for the installation and/or maintenance of the metal side rails. S9 Maintenance stated the rails come loose all the time. S9 Maintenance further confirmed he did not conduct regular scheduled maintenance checks on the bed rails, but only inspected them when staff reported an issue to him.</p> <p>During an interview on 10/30/2024 at 1:30 p.m. S1 Administrator reported he did not have the manufacturer's information and guidance for the metal bed rails in use at the facility, and did not know what the manufacturer's recommendations were for the scheduled maintenance of the rails.</p> <p>During an interview on 10/30/2024 at 4:10 p.m. S2 DON and S12 Corporate Nurse reported no residents with side rails up were being monitored for the use of side rails.</p> <p>40015</p> <p>44414</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193</p> <p>Based on record reviews and interviews, the facility failed to ensure residents were free from unnecessary medications for 4 (#28, #34, #79, #87) out of 6 (#28, #34, #49, #70, #79, #87) residents review for unnecessary medications. The facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor Resident #28 for edema, 2. Monitor Resident #34 for edema and bleeding, 3. Monitor Resident #79 for edema and bleeding, and 4. Monitor Resident #87 for bleeding. <p>Findings:</p> <p>Resident #28</p> <p>Review of Resident #28's medical record revealed an admitted [DATE] with the following diagnoses, including in part: acute on chronic congestive heart failure (CHF), essential (primary) hypertension, end stage renal disease, chronic kidney disease/stage 3 unspecified, and dependence on dialysis.</p> <p>Review of Resident #28's Physician's Orders revealed an order dated 08/01/2024 for Bumetanide tablet 1 mg (milligram) give 1 tablet by mouth one time a day related to CHF.</p> <p>Review of Resident #28's October 2024 tasks in electronic health record failed to reveal edema was monitored every shift on the following days: 1-5, 7, 9-13, 15-20, 24, 25, 26, 28, and 29th.</p> <p>During an interview on 10/30/2024 at 11:50 a.m. S2 DON (Director of Nursing) acknowledged Resident #28 was not monitored every shift for edema and should have been.</p> <p>Resident #34</p> <p>Review of Resident #34's medical record revealed an admitted [DATE] with the following diagnoses, including in part: chronic obstructive pulmonary disease/unspecified, CHF, and edema/unspecified.</p> <p>Review of Resident #34's Comprehensive Care Plan revealed: Resident is on diuretic therapy related to CHF - monitor/document/report prn (as needed) adverse reactions to diuretic therapy .Potential for altered blood pressure - monitor for and document any edema. Notify MD (Medical Director). Potential for abnormal bleeding and bruising - observe for signs and symptoms of abnormal bleeding - tarry stool, coffee ground emesis, nose bleed, excessive/unexplained bruising .</p> <p>Review of Resident #34's Physician's Order dated 08/01/2024 for Torsemide oral tablet 20 mg give 20 mg by mouth one time a day for edema and Apixaban tablet 5 mg give 1 tablet orally two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #34's October 2024 tasks in the electronic health record failed to reveal edema was monitored every shift on the following days: 1-5, 7, 9-14, 16-20, 22-26, 28 and 29th. Further review of the tasks failed to reveal bleeding was monitored every shift on the following days: 1-5, 7, 9-14, 16-20, 22-26, 28 and 29th.</p> <p>During an interview on 10/30/2024 at 11:50 a.m. S2 DON acknowledged Resident #34 was not monitored every shift for edema and bleeding and should have been.</p> <p>Resident #79</p> <p>Review of Resident #79's medical record revealed an admitted [DATE] with the following diagnoses, including in part: anxiety disorder, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and acute kidney failure.</p> <p>Review of Resident #79's Physician's Orders revealed an order dated 08/28/2024 for Eliquis tablet 5 mg by mouth two times a day and Furosemide tablet 40 mg by mouth one time a day.</p> <p>Review of Resident #79's October 2024 tasks in electronic health record failed to reveal edema was monitored every shift on the following days: 1, 4, 6-11, and 13-29th. Further review of the tasks failed to reveal bleeding was monitored every shift on the following days: 1, 4, 6-11, and 13-29th.</p> <p>During an interview on 10/30/2024 at 2:35 p.m. S3 ADON (Assistant Director of Nursing) acknowledged Resident #79 had not been monitored every shift for edema and bleeding and should have been.</p> <p>Resident #87</p> <p>Review of Resident #87's medical record revealed an admitted [DATE] with the following diagnoses, including in part: dyskinesia, neurocognitive disorder with lewy bodies, and major depressive disorder,</p> <p>Review of Resident #87's Physician's Orders revealed an order dated 10/14/2024 for Eliquis tablet 5 mg by mouth two times a day.</p> <p>Review of Resident #87's October 2024 tasks in electronic health record failed to reveal bleeding was monitored every shift on the following days: 1-2, 4, 6, 9-11, 13-20, 23, and 25-28th.</p> <p>During an interview on 10/30/2024 at 2:35 p.m. S2 ADON acknowledged Resident #87 had not been monitored every shift for bleeding and should have been.</p> <p>44414</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193</p> <p>Based on record reviews and interviews, the facility failed to ensure residents were free from unnecessary psychotropic medications for 3 (#34, #79, #87) out of 6 (#28, #34, #49, #70, #79, #87) residents review for unnecessary medications. The failed to monitor Residents #34, #79, and #87 for psychotropic side effects and behaviors.</p> <p>Findings:</p> <p>Resident #34</p> <p>Review of Resident #34's medical record revealed an admitted [DATE] with the following diagnoses, including in part: anxiety disorder due to known physiological condition, mood disorder due to known physiological condition/unspecified, insomnia/unspecified, and major depressive disorder/recurrent/moderate.</p> <p>Review of Resident #34's Physician's Orders dated 09/13/2024 for Zoloft oral tablet give 150 mg (milligram) by mouth one time a day for major depressive disorder (MDD), 09/10/2024 for Busprione HCL (hydrochloride) tablet give 7.5 mg orally three times a day for anxiety, 08/01/2024 for Duloxetine HCL enteric coated pellets capsule 60 mg orally two times a day for behavior - withdrawn, and 08/01/2024 for Bupropion HCL tablet ER (extended release) 24 hr (hour) 150 mg give 1 tablet orally one time a day for behavior - withdrawn.</p> <p>Review of Resident #34's October 2024 tasks in the electronic health record failed to reveal side effects were monitored every shift on the following days: 1-5, 7, 9-14, 16-20, 22-26, 28 and 29th. Further review of the tasks failed to reveal behaviors were monitored every shift on the following days: 1-5, 7, 9-14, 16-20, 22-26, 28 and 29th.</p> <p>During an interview on 10/30/2024 at 11:50 a.m. S2 DON (Director of Nursing) acknowledged Resident #34 was not monitored every shift for psychotropic side effects and behaviors and should have been.</p> <p>Resident #79</p> <p>Review of Resident #79's medical record revealed an admitted [DATE] with the following diagnoses, including in part: anxiety disorder, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and acute kidney failure.</p> <p>Review of Resident #79's Physician's Orders revealed an order dated 08/28/2024 for Buspirone tablet 5 mg by mouth two times a day and Trazadone tablet 50 mg by mouth at bedtime. Further review revealed an order dated 10/15/2024 for Mirtazapine tablet 7.5 mg by mouth at bedtime for depression</p> <p>Review of Resident #79's October 2024 tasks in electronic health record failed to reveal side effects and behaviors were monitored every shift on the following days: 1, 4, 6-11, and 13-29th.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Heritage Manor South		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/30/2024 at 2:35 p.m. S3 ADON (Assistant Director of Nursing) acknowledged Resident #79 had not been monitored every shift psychotropic side effects and behaviors and should have been.</p> <p>Resident #87</p> <p>Review of Resident #87's medical record revealed an admitted [DATE] with the following diagnoses, including in part: dyskinesia, neurocognitive disorder with lewy bodies, and major depressive disorder.</p> <p>Review of Resident #87's Physician's Orders revealed orders dated 10/17/2024 for Sertraline tablet 100 mg by mouth one time a day, 05/21/2024 Alprazolam tablet 0.25 mg by mouth one time a day and 07/30/2024 Quetiapine Fumarate tablet 150 mg by mouth at bedtime.</p> <p>Review of Resident #87's October 2024 tasks in electronic health record failed to reveal side effects and behaviors were monitored every shift on the following days: 1-2, 4, 6, 9-11, 13-20, 23, and 25-28th.</p> <p>During an interview on 10/30/2024 at 2:35 p.m. S3 ADON acknowledged Resident #87 had not been monitored every shift for psychotropic side effects and behaviors and should have been.</p> <p>44414</p>