Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195486	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Stratmore Nursing & Rehab Ctr	530 Stratmore Drive Shreveport, LA 71115

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 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. 36665 Based on record review, observations, and interviews the facility failed to ensure individual resident's narcotic records were maintained and reconciled for 2 of 3 medication carts reviewed. The facility failed to ensure an accurate count of controlled medications was maintained. Findings: Review of the facility's Drug-Controlled Substances Policy dated 11/17 revealed the following: Controlled medications are to be signed out on Form NS-618--Individual Residents Narcotic Record at the time they are to be administered. RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) only will sign out for and/or administer controlled medications, recording the date, time, resident's name, and signature of the administering nurse on the narcotic count sheet. The administering nurse will also check for the accuracy of the remaining count. Observation of the medication cart for 800 hall on 03/05/2025 at 8:15 a.m. with S2 LPN revealed resident #50's medication card for Norco 10/325 mg (milligrams) had a count of 6. Observation of medication pass on 03/05/2025 at 8:15 a.m. revealed S2 LPN administered resident #50's Norco 10/325 mg one tablet for pain without signing it out on resident #50's Individual Residents Narcotic Record. Observation on 03/05/2025 at 8:17 a.m. of resident #50's Individual Residents Narcotic Record for Norco 10/325 mg with S2 LPN revealed a count of 5, failing to reconcile with the count of 6 on resident #50's medication card for Norco 10/325 mg. During an interview on 03/05/2025 at 8:17 a.m. S2 LPN reported she had signed out resident #50's Norco 10/325 mg prior to administering it and confirmed it should have signed out at the time of administration. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/06/2025 at 8:05 a.m. with S3 LPN of the medication cart for 1000 hall revealed resident #121's medication card for Modafinil 200 mg had a count of 4, and resident #121's Individual Resident Narcotic Record had a count of 5 and failed to reconcile. Further observation revealed a medication cup on the top of the medication cart with 5 tablets inside that included a white oval pill that S3 LPN identified as resident #121's Modafinil 200 mg tablet. During an interview on 03/06/2025 at 8:05 a.m. S3 LPN reported, she had already pulled resident #121's Modafinil 200 mg up, and pointed to a cup of tablets on the top of the medication cart. S3 LPN stated, I just hadn't signed it out. S3 LPN confirmed resident #121's medication should not have been pre-pulled up and resident #121's Modafinil 200 mg should have been removed and signed out of locked narcotic stock at the time of administration and not before. During an interview on 03/06/2025 at 11:30 a.m. S1 DON (Director of Nurses) confirmed controlled medications, including resident #50's Norco 10/325 mg and resident #121's Modafinil 200 mg should have been signed out on each residents Individual Narcotic Records at the time of administration. S1 DON further confirmed the count of resident #50 and resident #121's controlled medications should have reconciled.