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	05/20/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident with an order for a psychotropic medication was not subjected to chemical restraints for 1 (#11) of 1 resident reviewed for hospice. The facility failed to ensure Resident #11's order for a psychotropic medication was limited to 14 days. Findings: Review of Resident #11's medical record, revealed Resident #11 was admitted on [DATE] with diagnoses including generalized anxiety and bipolar disorder. Review of Resident #11's physician orders revealed in part, an order dated 12/24/2025 for lorazepam 0.5 ml every 2 hours as needed for anxiety and restlessness related to generalized anxiety disorder. Further review of Resident #11's PRN lorazepam order failed to reveal a stop date or rational for continued use. During an interview on 05/20/2026 at 1:30 p.m., S2DON confirmed Resident #11 had a PRN order for lorazepam ordered on 12/24/2025 without a stop date. S2DON further confirmed there was not a documented rational for the use of lorazepam PRN for more than 14 days and should have been.

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 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 reviews and interviews, the facility failed to develop and implement an individuaized comprehensive care plan to maintain a residents highest practicable physical, mental and psychosocial well-being for 2 (#11, #65) of 2 residents reviewed. The facility failed to develop fall interventions for Resident #11 and implement restorative services for Resident #65.Findings:Resident #11Review of Resident #11's medical record revealed an admit date of 01/31/2022 with the following diagnoses including in part: Parkinson's disease, dementia, and generalized anxiety.Review of Resident #11's medical record for the past six months revealed Resident #11 had a fall on 12/15/2025, 01/08/2026, 01/26/2026, 03/09/2026, 04/02/2026, 04/03/2026, 04/12/2026, 04/13/2026 and 05/04/2026. Review of Resident #11's comprehensive care plan revealed a problem for an actual fall dated 12/09/2024. Further review of Resident #11's comprehensive care plan failed to reveal interventions had been updated for each of Resident #11's falls on 12/15/2025, 01/08/2026, 01/26/2026, 03/09/2026, 04/02/2026, 04/03/2026, 04/12/2026, 04/13/2026 and 05/04/2026. During an interview on 05/20/2026 at 8:10 a.m., S8 Case Manager, acknowledged Resident #11 had a fall on 12/15/2025, 01/08/2026, 01/26/2026, 03/09/2026, 04/02/2026, 04/03/2026, 04/12/2026, 04/13/2026 and 05/06/2026. S8 Case Manager further acknowledged interventions had not been updated on Resident #11's care plan to reflect each fall and should have been. Resident #65Review of Resident #65's medical record revealed an admit date of 01/30/2025 with the following diagnoses including in part: type 2 diabetes mellitus with diabetic neuropathy unspecified, unspecified lack of coordination, muscle weakness (generalized), other abnormalities of gait and mobility and morbid (severe) obesity due to excess calories.Review of Resident #65's MDS assessment dated [DATE] revealed a BIMS score of 15 indicating cognitively intact. Review of Resident #65's comprehensive care plan revealed the following problems and approaches: Restorative Nursing Program: Active Range of Motion related to - Active range of motion to bilateral lower extremities for 15 minutes per day. Active range of motion to bilateral upper extremities for 15 minutes per day. Restorative Nursing Program: Bed mobility related to - Resident to perform bed mobility exercises for 15 minutes for 6 days a week.Review of Resident #65's tasks for restorative services failed to reveal services were provided on the following days of: April 2nd, 4th, 8th, 9th, 24th, 27th, and 29th 2026; May 4th, 5th, 7th, and 8th 2026. During an interview on 05/18/2026 at 8:20 a.m. Resident #65 reported she is supposed to receive restorative therapy 6 days a week but sometimes only receives it 1 day a week.During an interview on 05/19/2026 at 3:35 p.m. S3 Restorative Aide reported Resident #65 receives restorative therapy 6 days a week Monday through Saturday. S3 Restorative Aide reported due to being pulled to the floor to work, the resident may only receive 1-3 days a week of therapy.During an interview on 05/20/2026 at 2:10 p.m. S2 DON acknowledged Resident #65 did not receive restorative services 6 days a week.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure 1 (#99) of 1 resident reviewed for skin conditions received treatment and services to prevent an infection and new wounds from developing. The facility failed to assess Resident #99's skin during and following heat therapy resulting in a burn.Findings:Review of Resident #99's medical record revealed an admit date of 12/13/2023 with the following diagnoses, including in part: type 2 diabetes mellitus with other circulatory problems and diabetic peripheral angiopathy without gangrene, peripheral vascular disease, unspecified open wound lower leg initial encounter, vitamin deficiency unspecified, edema unspecified anesthesia of skin, other soft tissue disorders, other skin changes, venous insufficiency (chronic) (peripheral), moderate protein-calorie malnutrition and lymphedema not elsewhere classified.Review of Resident #99's MDS assessment dated [DATE] revealed a BIMS sore of 15 indicating cognitively intact.Review of Resident #99's comprehensive care plan revealed the following problem and approach: Resident #99 has a 2nd degree burn to right lower leg - medial and lateral (05/04/2026 changed to 3rd degree full thickness burns status post debridement) date initiated: 04/23/2026.Review of Resident #99's physician's orders revealed the following:05/04/2026 - burn to right lower leg (medial) - cleanse with wound cleanser, pat dry, apply Santyl, collagen silver and gel fiber to wound fiber to wound bed, cover with dry dressing daily until healed every day shift and as needed for soilage/dislodgment.05/04/2026 - burn to right lower leg (lateral) - cleanse with wound cleanser, pat dry, apply Santyl, collagen silver and gel fiber to wound fiber to wound bed, cover with dry dressing daily until healed every day shift and as needed for soilage/dislodgment.05/01/2026 - Cephalexin oral tablet 500 mg by mouth three times a day related to unspecified open wound, unspecified lower leg, initial encounter.05/01/2026 - consult ____wound care to evaluate and treat one time only for 1 dayObservation on 05/18/2026 at 8:10 a.m. revealed Resident #99's right medial calf and right lateral shin with dressings intact with purplish red discoloration of the lower extremity.During an interview on 05/18/2026 at 8:10 a.m. Resident #99 reported therapy applied a heating pad on his right lower leg for muscle tightness and the pad burned him. Resident #99 further reported later in the evening he noticed there was a blister filled with fluid hanging off his right leg.During an interview on 05/19/2026 at 11:08 a.m. S4 PT reported Resident #99 received moist heat therapy and would tell her if he was having any problems. S4 PT reported if a resident has diagnoses of PVD or circulation issues an assessment of the skin should be done more frequently. S4 PT further reported all resident's skin should be assessed and documented during and after a procedure. S4 PT acknowledged she did not assess Resident #99's skin because she was busy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interviews, the facility failed to ensure a resident's indwelling urinary catheter was flushed with normal saline every shift according to physician's orders for 1 (Resident #94) of 2 sampled residents reviewed for catheter use. Findings: Review of Resident #94's medical record revealed an admit date of 05/07/2025 with a diagnosis in part of neuromuscular dysfunction of the bladder. Review of Resident #94's physician orders revealed in part an order dated 06/17/2025: Flush catheter with normal saline every shift. Review of Resident #94's medical record failed to reveal documentation Resident #94's indwelling urinary catheter had been flushed every shift with normal saline as ordered for the month of May, 2026. During an interview on 05/20/2026 at 8:15 a.m., S6LPN acknowledged Resident #94 had a physician order to flush Resident #94's catheter with normal saline every shift. S6LPN further acknowledged no documentation of the flushes could be found in Resident #94's medical record for the month of May, 2026. S6LPN reported Resident #94's catheter flushes should be documented on the MAR and were not. During an interview on 05/20/2026 at 10:40 a.m., S2DON acknowledged Resident #94 had a physician order to flush Resident #94's indwelling urinary catheter with normal saline every shift. S2DON reported she could not produce documentation Resident #94's catheter flushes had been completed for the month of May, 2026.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's MDS were transmitted within the required timeframe for 1 (#8) of 2 (#8, #121) residents reviewed for assessments. Review of Resident #8's medical record revealed in part resident was admitted to the facility on [DATE] and left the facility with a Discharge Return Anticipation MDS on 12/22/2025.Review of Resident #8's MDS dated [DATE] revealed status was not accepted.During an interview on 05/20/2026 at 11:45 a.m. S5 Case Manager confirmed that Resident #8's MDS was not sent and should have been.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews the facility failed to ensure residents who required respiratory care received the care and services consistent with professional standards by failing to properly store CPAP face device for 1 (#122) of 1 residents reviewed for respiratory care. Review Resident #122's medical diagnosis included, but not limited to obstructive sleep apnea, dementia with anxiety, asthma and depression.Review of Resident #122's physician's orders dated 03/26/2026 revealed the following: CPAP setting 10 cm with H2O at bed time and remove CPAP every morning.Review of Resident #122's MDS dated [DATE] revealed the following:BIMS score 04 severe cognitive impairmentDuring an observation on 05/18/2026 at 9:30 a.m. in Resident # 122's room revealed a CPAP mask and machine on the bedside table. The CPAP face mask was sitting on top of the CPAP machine and not stored in any type of container.During an observation on 05/19/2026 at 9:20 a.m. in Resident #122's room revealed CPAP face mask sitting on top of a plastic bag, on top of CPAP machine, not stored in any type of container.During an observation on 05/20/2026 at 7:40 a.m. in Resident #122's room revealed CPAP face mask sitting on top of CPAP machine, not stored in any type of container.During an interview on 05/19/2026 at 9:20 a.m. S7 LPN acknowledged Resident #122's CPAP mask should have been stored in a bag or container and was not.During an interview on 05/20/2026 at 7:35 a.m. S2 DON acknowledged that when a resident's CPAP mask is not in use, the CPAP mask should be stored in a container or bag.