STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195220	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Slidell	106 Medical Center Drive Slidell, LA 70461

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion by failing to provide restorative therapy for 3 (#9, #71, and #88) of 21 residents reviewed in the final sample.Resident #9 Review of Resident #9's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Muscular Dystrophy, Right Hand Contracture, Left Hand Contracture, Right Foot Contracture, and Left Foot Contracture. Review of Resident #9's Quarterly Minimum Data Status (MDS) with Assessment Reference Date (ARD) of 07/21/2025 revealed a Brief Interview for Mental Status (BIMS) of 14, which indicated he was cognitively intact. Further review of Section GG, Functional Abilities, revealed Resident #9 had bilateral, upper and lower extremity impairment. Review of Resident #9's current Physician Orders revealed in part, the following: Restorative Nursing Program (RNP) for Dressing/Grooming, Order Date: 05/12/2025 RNP for Passive Range of Motion (PROM), Order Date: 02/19/2025 RNP for Assisted Active Range of Motion (AAROM), Order Date: 03/10/2025 Review of Resident #9's current Care Plan revealed, in part, the following: Focus: RNP: Dressing/Grooming- Resident to assist with activities of daily living (ADL) tasks with max assist. Focus: RNP: PROM to both hands for increased finger extension. Focus: RNP: AAROM to Bilateral Lower Extremities (BLEs) in supine or sitting position 10-15 reps with hip/knee exercise. Review of Resident #9's Tasks Report from 07/20/2025 to 08/19/2025, revealed staff did not document the following tasks as completed per current care plan and physician orders: Task: Restorative – AAROM (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Task: Restorative – Dressing/Grooming Training Task: Restorative – PROM On 08/19/2025 at 8:15 a.m., an interview was conducted with Resident #9. Resident #9 stated he felt his contractures were getting worse. Resident #9 further stated he received restorative nursing services for his contractures in the past, but did not recall receiving them in the past month. Resident #9 stated the previous, restorative employee had quit. Resident #9 stated his assigned CNA did not complete active or passive range of motion exercises with him. On 08/20/2025 at 10:42 a.m., an interview was conducted with S9CNA. S9CNA stated he was assigned to Resident #9's care. S9CNA stated he was not responsible for providing RNP services. S9CNA confirmed he did not provide range of motion exercises for Resident #9's hands or BLEs. On 08/20/2025 at 10:53 a.m., an interview was conducted with S4LPN. S4LPN stated she was assigned to Resident #9's care. S4LPN confirmed Resident #9 was on a RNP. S4LPN stated the previous restorative nursing assistant (RNA) had quit, and she was not aware of how RNP services were currently being handled. Resident #71 Review of Resident #71's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Dementia, Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy of Left Lower Leg, Unsteadiness on Feet, History of Falling, and Generalized Muscle Weakness. Review of Resident #71's admission MDS with ARD of 04/28/2025 revealed she had a lower extremity impairment on one side and needed partial to moderate staff assistance with ADL's. Review of Resident #71's current Physician Orders revealed, in part, the following:RNP for Ambulation, Order Date: 05/23/2025RNP for AROM, Order Date: 05/23/2025 Review of Resident #71's current Care Plan revealed the following, in part:Focus: RNP: Ambulation- Resident to ambulate with hand held assist in facility hallway 200ft.Focus: RNP: AROM- Resident to do standing exercises holding onto a steady surface/parallel bars, working on heel raise/marching/hip abduction/straight leg raises. Review of Resident #71's Tasks Report from 07/20/2025 to 08/19/2025, revealed staff did not document the following tasks as completed per current care plan and physician orders: Task: Restorative – Assistive AROM Task: Restorative – Walking Training On 08/20/2025 at 10:55 a.m., an interview was conducted with S12CNA. S12CNA stated she was assigned to Resident #71's care. S12CNA stated she was not responsible for providing RNP services. S12CNA confirmed she had never completed any active or passive range of motion exercises, nor completed any standing exercises with Resident #71. Resident #88 Review of Resident #88's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Flaccid Hemiplegia Affecting Left Non-dominant Side, Age-Related Physical (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Debility, and Unspecified Sequelae of Cerebral Infarction. Review of Resident #88's Quarterly MDS with ARD of 07/18/2025 revealed a BIMS of 15, which indicated she was cognitively intact. Further review of Section GG, Functional Abilities, revealed Resident #88 had upper and lower extremity impairment on one side. Review of Resident #88's current Physician Orders revealed, in part, the following: Restorative Nursing Program (RNP) for Splinting, Order Date: 08/08/2024 RNP for Passive Range of Motion (PROM), Order Date: 08/08/2024 RNP for Active Range of Motion (AROM), Order Date: 08/08/2024Review of Physician Notes, dated April 2025 to current, revealed, in part, the following: Past Medical History: Brain aneurysm CVA History of Present Illness: [AGE] year old female with history of prior CVA with residual left hemiplegia. She is complaining today of left ankle pain. States her ankle rolled last night while being transferred into bed. Some swelling. Took Tylenol this morning with no relief. Plan: Functional quadriplegia: Requires Hoyer for transfers. Continue strict offloading, careful incontinence care. Continue restorative therapy. Signed, S6NP on 08/12/2025 at 12:19 P.M. Review of Resident #88's current Care Plan revealed, in part, the following: Focus: Resident requires restorative nursing program related to hemiplegia: Active Range of Motion to bilateral upper extremities (BUEs) with 2-3lb weight for 30 repetitions to all planes of motion, arm bike and rickshaw. Focus: Resident requires restorative nursing program related to hemiplegia: Passive Range of Motion to left upper extremity (LUE) for 15 minutes. Focus: Resident requires restorative nursing program: Resident has a splint/brace, apply splint to left lower extremity, Ankle-Foot Orthosis (AFO), in A.M. and remove in P.M. Check skin integrity Q2 hours and after removing. Review of Resident #88's Tasks Report from 07/20/2025 to 08/19/2025, revealed staff did not document the following tasks as completed per current care plan and physician orders: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Task: Restorative –AROM Task: Restorative – Brace/Splint Task: Restorative – PROM On 08/19/2025 at 1:58 p.m., an interview was conducted with Resident #88. Resident #88 stated she did not wear a brace today. Resident #88 stated she was supposed to wear a brace on her left lower leg, during the day. Resident #88 stated she had not refused the brace and she did not recall the last time anyone applied the brace. Resident #88 stated the therapist had been putting on her brace but quit. Resident #88 stated no other facility staff had attempted to put the brace on her. On 08/20/2025 at 10:41 a.m., an observation was made of Resident #88 without a brace on her left lower extremity. On 08/20/2025 at 10:53 a.m., an interview was conducted with S7LPN. S7LPN stated she was assigned to Resident #88's care. S7LPN confirmed Resident #88 was on a RNP. S7LPN confirmed Resident #88 did not have on her brace today. S7LPN stated she was not responsible for applying Resident #88's brace. S7LPN stated the RNA would apply Resident #88's brace in the morning and the nurse would remove and check her skin in the evening. On 08/20/2025 at 10:55 a.m., an interview was conducted with S8CNA. S8CNA stated she was assigned to Resident #88's care. S8CNA stated she was not responsible for providing RNP services. S8CNA confirmed she had never applied a brace to Resident #88's left leg, completed any active or passive range of motion exercises with Resident #88, nor completed any exercises utilizing a 2-3 pound weight with Resident #88. On 08/20/2025 at 11:03 a.m., an interview was conducted with S3CN. S3CN stated the facility certified nursing assistants should provide coverage for RNP services when the contracted therapy department did not employee a RNA. S3CN confirmed any residents with orders and care plans to include RNP services should have received those services and been documented as complete in the electronic health record. On 08/20/2025 at 11:41 a.m., an interview was conducted with S6NP. S6NP stated she provided care to the aforementioned residents. S6NP confirmed if the resident had RNP services ordered, she expected those services to be provided. S6NP further confirmed she expected Resident #88's AFO brace to be applied in the morning and removed at night. On 08/20/2025 at 2:35 p.m., an interview was conducted with S5TD. S5TD stated the therapy department was a contracted company and responsible for the facility's RNP. S5TD stated the aforementioned residents were not currently receiving skilled therapy services. S5TD stated the aforementioned residents should have received RNP services and were not. S5TD stated her company had not employed a RNA since 07/19/2025. S5TD stated the facility was responsible for providing those services when her company did not employ an RNA. S5TD confirmed there were no restorative progress notes for Resident #9 from 07/20/2025 to 08/19/2025.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, observation, and interviews, the facility failed to ensure nurse staffing data requirements were documented on daily postings. This deficient practice had the potential to affect any of the 103 residents residing in the facility.Findings:Review of the facility's policy titled Posting of Nurse Staffing Information, dated 04/2006, revealed the following:The facility must post the following information on a daily basis.4. Resident Census Posting Requirements: The facility shall post nurse staffing information on a daily basis at the beginning of each shift. At the beginning of the day shift, the facility will initiate by entering the facility name, date, resident census, and shift times. An observation was made on 08/18/2025 at 4:00 p.m. of the nurse staffing data sheet dated 08/18/2025. Review of the nurse staffing data sheet revealed no documentation of the facility census. An interview was conducted on 08/18/2025 at 4:05 p.m. with S3CN. She reviewed the nurse staffing data sheet dated 08/18/2025. She confirmed the facility census was not documented on the nurse staffing data sheet and should have been. An interview was conducted on 08/20/2025 at 9:30 a.m. with S10CNAS. She stated she was responsible for completing the nurse staffing data sheet. She reviewed the nurse staffing data sheet dated 08/18/2025 and confirmed the facility census was not documented and should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure staff routinely disinfected shared resident care equipment for 4 (#33, #95, #104 and #108) of 4 (#33, #95, #104 and #108) sampled residents observed during medication administration. Review of a Center for Disease Control and Prevention (CDC) article dated 2008, updated 06/12/2024, and titled Recommendations for Disinfection and Sterilization in Healthcare Facilities revealed the following, in part:Guideline for Disinfection and Sterilization in Healthcare Facilities A. RationaleThe ultimate goal of the Recommendations for Disinfection and Sterilization in Health-Care Facilities is to reduce rates of health-care associated infections through appropriate use of both disinfection and sterilization. Each recommendation is categorized according to scientific evidence, theoretical rationale, applicability, and federal regulations. 4. c. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly). Resident #33Review of Resident #33's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Essential Hypertension and Chronic Obstructive Pulmonary Disease.Review of Resident #33's Medical Record Administration (MAR) dated August 2025 revealed resident's vital signs were obtained every day shift.Resident #95Review of Resident #95's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Essential Hypertension and Atherosclerotic Heart Disease.Review of Resident #95's MAR dated August 2025 revealed resident's vital signs were obtained every day shift.Resident #104Review of Resident #104's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Essential Hypertension.Review of Resident #104's MAR dated August 2025 revealed resident's vital signs were obtained every day shift.Resident #108Review of Resident #108's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Essential Hypertension.Review of Resident #108's MAR dated August 2025 revealed resident's vital signs were obtained every day shift.An observation was made on 08/19/2025 at 8:43 a.m. of an automatic wrist blood pressure monitor cuff made of a soft porous cloth fabric.An observation was made on 08/19/2025 at 8:45 a.m. during residents' medication administration with S4LPN. S4LPN entered Resident #104's room and obtained Resident #104's blood pressure with an automatic wrist blood pressure monitor and pulse oxygen saturation with the fingertip pulse oximeter. Then, Resident #104 touched the automatic wrist blood pressure monitor cuff with her other hand and contacted her shirt. S4LPN returned to the medication cart with the above equipment. S4LPN entered Resident #33's room and obtained Resident #33's blood pressure with the same automatic wrist blood pressure monitor and pulse oxygen saturation with the fingertip pulse oximeter and returned to the medication cart with the above equipment. Further observation revealed, S4LPN entered Resident #108's room and obtained Resident #108's blood pressure with the same automatic wrist blood pressure monitor and pulse oxygen saturation with the fingertip pulse oximeter and returned to the medication cart with the above equipment. S4LPN entered Resident #95's room and obtained Resident #95's blood pressure with the same automatic wrist blood pressure monitor and pulse oxygen saturation with the fingertip pulse oximeter. The blood pressure cuff came in contact with the bedside table as Resident #95 rested his arm. S4LPN returned to the medication cart with the above equipment. S4LPN did not sanitize the above equipment used to obtain residents' vital signs between each resident's use.An interview was conducted on 08/19/2025 at 9:10 a.m. with S4LPN. S4LPN stated the wrist (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure monitor and the fingertip pulse oximeter were to be sanitized with the facility's disposable disinfectant cloth wipes between each resident. S4LPN confirmed she did not sanitize the wrist blood pressure monitor and the fingertip pulse oximeter in between and/or after the above residents' vital signs were obtained and should have.An interview was conducted on 08/20/2025 at 4:45 p.m. with S2DON. S2DON confirmed she did not expect the nursing staff to sanitize the automatic wrist blood pressure monitor and the fingertip pulse oximeter in between each resident. S2DON further confirmed the automatic wrist blood pressure monitor and the fingertip pulse oximeter should only be sanitized if the equipment became visibly soiled. An interview was conducted on 08/20/2025 at 4:45 p.m. with S3CN. S3CN confirmed she did not expect the nursing staff to sanitize the automatic wrist blood pressure monitor and the fingertip pulse oximeter in between each resident. S3CN stated there was no scheduled routine cleaning for the automatic wrist blood pressure monitor and the fingertip pulse oximeter. S3CN further confirmed per individual nurses' judgement the automatic wrist blood pressure monitor and the fingertip pulse oximeter should only be sanitized if the equipment became visibly soiled.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on record review, observations, and interviews, the facility failed to ensure electrical equipment was maintained in safe operating condition for 1 of 1 (#97) sampled residents reviewed for call light safety.Findings: Review of the maintenance log from April 2025 to present revealed no documented request for repair as it related to Resident #97's call light electrical wires being exposed. On 08/18/2025 at 9:30 a.m., an observation was made in Resident #97's room of the call light pulled off the wall with multiple electrical wires exposed. On 08/19/2025 at 11:20 a.m., an observation was made in Resident #97's room of the call light pulled off the wall with multiple electrical wires exposed. On 08/20/2025 at 9:30 a.m., an observation was made in Resident #97's room of the call light pulled off the wall with multiple electrical wires exposed. On 08/20/2025 at 11:35 a.m., an observation was made in Resident #97's room of the call light enclosure box and it had been repaired. On 08/20/2025 at 11:50 a.m., an interview was conducted with S11MS. He stated no staff member had reported to him the need for Resident #97's call light repair. On 08/20/2025 at 12:20 p.m., an interview was conducted with S1ADMIN. He stated while assisting a staff member in Resident #97's room, he observed the call light enclosure box being pulled away from the wall with multiple wires exposed. He stated he repaired the call light and secured the call light enclosure box against the wall. S1ADMIN was informed of the numerous observations made of the call light being unsecured with wires exposed. He stated he would have expected his staff to recognize the need for repair and place a request for repair in the maintenance binder. S1ADMIN stated the call light should have been secured to the wall, and should not have been hanging with wires exposed.