STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195321	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Opelousas	7941 I-49 South Service Road Opelousas, LA 70570

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a resident who was unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 1 (#78) out 2 (#1 and #78) resident investigated for ADLs. Findings: Review of Resident #78's clinical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but not limited to, Parkinsonism unspecified and muscle weakness (generalized). Review of Resident #78's care plan read in part, resident needs assist with ADLs. Interventions included. Oral hygiene: resident needs supervision with oral hygiene. Review of the CNA's (Certified Nursing Assistant) electronic personal hygiene task charting for Resident #78 revealed that oral care should be provided q (every) shift (three times a day).On 09/23/2025 at 11:30 a.m., Resident #78 was observed lying in bed. An observation of the resident's oral cavity was conducted and revealed a white residue on her teeth and food particles were observed between her teeth.On 09/24/2025 at 11:00 a.m., an observation was made of Resident #78's oral cavity and revealed a white residue on her teeth and food particles were observed between her teeth. Resident #78 stated no one had brushed her teeth today. On 09/24/2025 at 11:21 a.m., an observation of Resident #78's oral cavity was conducted with S1DON (Director of Nursing). She agreed that Resident #78's teeth had a white residue and food particles between her teeth. S1DON asked Resident #78 had her teeth been cleaned today and the resident answered No.

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the resident's physician timely addressed the resident's RP (Representative) and/or resident's request for pain medication for 1 (#78) of 1 resident out of final sample of 38 residents. Findings:Review of the facility's policy titled, Physician Responsibilities read in part, Physician Services.A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the resident's immediate care needs. Review of Resident #78's clinical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but not limited to, intervertebral disc disorders with radiculopathy, lumbar region, other intervertebral disc degeneration, lumbar region with discogenic back pain only, low back pain, unspecified. Further review of the resident's medical record revealed that she had a Stage 3 sacral pressure ulcer. Review of Resident #78's admission MDS (Minimum Data Set) dated 09/09/2025 under Section J-Health Conditions revealed that the resident occasionally experienced pain. Further review under Section M-Skin Conditions revealed that the resident had an unstageable pressure ulcer. Review of Resident #78's care plan revealed the resident was care planned for pain with interventions that include in part, notify physician as needed of any complications.observe the effectiveness of pain intervention as needed.Review of Resident #78's physician orders revealed an order dated 08/31/2025 for Acetaminophen (Tylenol) oral table-give 1000 mg (milligram) by mouth every 6 hours as needed for pain.Review of Resident #78's MAR (medication Administration Record) revealed from 09/02/2025 to 09/23/2025, the resident requested pain medication for an average pain of 6 to 7 out of 10. Further review of the MAR revealed that on 09/17/2025, the resident received pain medication for pain 9 out of 10. Review of the nurse's note dated 09/17/2025 read, Resident complains of pain and refused PRN (as needed) Tylenol. Resident stated that doesn't work. I need something else please. RP aware and voices concern. Notified (resident physician name) nurse, will notify MD (medical doctor) and return call. RP made aware. On 09/23/2025 at 11:15 a.m., an interview was conducted with S3LPN (Licensed Practical Nurse). She stated that today she talked with the resident's physician nurse to follow up on the resident's complaint of Tylenol being ineffective for the resident's sacral pain. S3LPN contacted the resident's physician office 3-4 times in the last 2 weeks to address the resident's pain management, but she had not received a call from the resident's physician. On 09/23/2025 at 11:32 a.m., Resident #78 was observed lying in bed with guests present. The female guest stated that she was the resident's former caregiver. She stated that the family had been trying to get a meeting with Resident #78's physician to address her lack of pain management. On 09/23/2025 at 12:00 p.m., a phone interview was conducted with resident's daughter. She stated that she had been trying to get a meeting with Resident #78's physician to discuss several issues, but no meeting was set up. She stated that she had been asking for something better than Tylenol for her mother since September 5th for her complaint of pain to her sacral wound, but the resident was still receiving Tylenol. She stated that she finally sent an email to the nursing home intake staff on 09/22/2025 to address the resident's ineffective pain management. On 09/23/2025 at 1:25 p.m., an interview was conducted with S1DON (Director of Nursing). S1DON stated that she was made aware of the resident's daughter's concerns. She confirmed that the resident's daughter sent an email on 09/22/2025 requesting that the resident's physician order something different than Tylenol for the resident's pain. She confirmed she was made aware that Resident #78's physician had not addressed the resident's daughter and/or the resident's pain management request. She stated that she became aware about two days ago. She stated that in the past, the facility has had conversation about the resident's physician not returning calls timely and lack of (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicating when they need him. On 09/23/2025 at 1:45 p.m., an interview was conducted with Resident #78's physician nurse. She confirmed that she sent a message to the resident's physician today regarding that the Tylenol was not effective to manage the resident's pain. She confirmed they received a fax from the nurse at the nursing home on [DATE] stating that the resident's daughter requested a non-narcotic medication for the resident's pain. She stated that she was not sure if the fax received on 09/17/2025 was addressed by the physician. On 09/23/2025 at 2:11 p.m., a phone call received from Resident #78's physician's Office Manager. She stated that the resident's physician was requesting to speak with the surveyor.There was no call received from Resident #78's physician by exit of the survey.

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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. Based on observation, interviews, and record review, the facility failed to store and process linens to prevent the spread of infection as evidenced by failing to ensure clean items were not stored in the soiled linen area of the laundry department. Findings: Review of the facility's policy titled, Infection Control Laundry Department, with a last reviewed date of 08/2021, read in part: Sorted linens must be kept in a designated area separate from clean linen. Review of the facility's policy titled, Laundry Instructions, with a last reviewed date of 07/2025, read in part: 6. Keep soiled linens separate from clean linens, in their proper place. On 09/24/2025 at 11:37 a.m., an observation was made of the laundry department with S6Laun (Laundry). S6Laun stated that no soiled linens could be stored in the clean area of the laundry department and no clean linens can be stored in the soiled linen area. An observation was then made of the soiled linen area of the laundry department. A shelf, next to the washing machines, was observed with the following items: 2 geri (geriatric) chair cushions, a pair of heel lift boots, 4 pairs of shoes, and 2 Hoyer lift pads. S6Laun stated that these items had been washed today and were clean. She stated that they allowed them to air dry in the soiled linen area because they had space to dry them there. On 09/24/2025 at 11:45 a.m., an interview and observation was conducted with S4HskSup (Housekeeping Supervisor). She stated that the above listed items were clean, but they stored them on the shelf in the soiled area because they did not have a place in the clean area to store the items. S4HskSup confirmed that clean items or linens were not supposed to be stored in the soiled linen area of the laundry department. On 09/24/2025 at 12:30 p.m., an interview was conducted with S5ADON/IP (Assistant Director of Nursing/Infection Preventionist). S5ADON/IP was asked if she was familiar with infection control practices regarding the storage of clean linens and items. She stated she was not familiar with laundry processes.