STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195323	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Health & Rehab	2575 Airline Drive Bossier City, LA 71111

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 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 review and interviews, the facility failed to develop a Comprehensive Person Centered Care Plan, which met the needs of 1 (#1) of 3 sampled residents. The facility failed to ensure physician recommendations were followed and interventions were in place for a subacute-chronic olecranon fracture. Findings:Review of the facility's Comprehensive Care Plans undated policy revealed in part:Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Policy Explanation and Compliance Guidelines:3. The comprehensive care plan will describe, at a minimum, the following:a. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.b. any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. Review of Resident #1's medical record revealed an admit date of 08/08/2024 with diagnoses including in part, type 2 diabetes and chronic pain syndrome. Review of Resident #1's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part a BIMS (Brief Interview of Mental Status) score of 06, indicating severe cognitive impairment. Review of Resident #1's interdisciplinary notes revealed in part, Resident #1 returned from a local emergency department (ED) on 12/12/2025 at 6:21 p.m. after evaluation of a fall. Resident #1's left arm had a splint with a sling which was to stay in place until seen for follow-up. Resident #1's discharge instructions included orthopedic follow-up to be scheduled by the facility for a subacute-chronic left elbow fracture. Review of Resident #1's hospital records revealed in part, a CT (Computed Tomography) scan performed on 12/12/2025 revealed Resident #1 had a subacute to chronic appearing olecranon fracture with distraction and mild rotation of the olecranon fracture fragment. Further review of Resident #1's hospital records revealed a splint had been placed on Resident #1's left arm and Resident #1 was discharged back to the facility with an order to follow-up with an orthopedic physician. Review of Resident #1's physician orders failed to reveal orders had been entered for the management or follow-up of Resident #1's left subacute-chronic olecranon fracture. Review of Resident #1's Comprehensive care plan failed to reveal interventions had been put into place for the management or follow-up of Resident #1's left subacute-chronic olecranon fracture. Review of Resident #1's medical record failed to reveal Resident #1 received a follow-up appointment with an orthopedic physician. During an interview on 01/05/2026 at 12:25 p.m. Resident #1 reported he had rolled out of bed and landed on his left side. Resident #1 reported he went to the ED and the doctor applied a splint and a sling to his left elbow. Resident #1 further reported he had not been back to a doctor to have his elbow checked. During an interview on 01/06/2026 at 10:30 a.m. S4MDS Nurse reported she was not aware Resident #1 returned (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the ED with a splint and sling to his left elbow with an order for orthopedic follow-up. S4MDS Nurse reported she was responsible for updating residents' care plans and acknowledged Resident #1's care plan had not been updated to reflect management of a subacute-chronic left elbow fracture. During an interview on 01/06/2025 at 11:45 a.m., S3ADON (Assistant Director of Nursing) acknowledged physician orders had not been entered for care and follow-up of Resident #1's subacute-chronic left elbow fracture. S3ADON further acknowledged Resident #1's care plan had not been updated and should have been. During an interview on 01/06/2026 at 1:20 p.m., S2DON (Director of Nursing) acknowledged Resident #1 failed to receive follow-up orthopedic care and care plan interventions were not updated.