STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195507	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Ville Platte	2020 W. Main Street Ville Platte, LA 70586

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47004 Based on record review and interview, the facility failed to ensure a resident's right to be free from sexual abuse and psychosocial harm (#1), by another resident (#2), in a total sample of 6 residents (#1, #2, #3, #R1, #R2, and #R3). The facility implemented corrective actions which were completed prior to the State Agency's Investigation, thus it was determined to be a Past Noncompliance citation. This failed practice resulted in an actual harm situation on 09/06/2024 at approximately1:42 p.m., when S4 Housekeeper walked by Resident #1's room, and observed Resident #2 remove his hand from beneath Resident #1's covers near her bottom. S4 Housekeeper immediately informed S3 LPN of her observation. S3 LPN immediately went to Resident #1's room, and observed Resident #2 pull back Resident #1's covers, and slide his hand from Resident #1's thigh area into her brief. S3 LPN immediately intervened, and removed Resident #2 from Resident #1's room. Resident #1 had diagnoses that included in part .Cerebral Palsy, Dysphagia, Aphasia, Quadriplegia, and Unspecified Intellectual Disabilities. A reasonable person in Resident #1's situation would have experienced severe psychosocial harm and humiliation, as a result of this inappropriate, unwanted sexual contact/abuse. Findings: Review of the facility's Incident Investigation and Reporting policy with review date of 05/2024, revealed in part . Each resident residing in this facility has the right to be free from any type of abuse including: verbal, sexual, mental, physical abuse, neglect, exploitation, misappropriation of resident property. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual Abuse: Is nonconsensual sexual contact of any type with a resident. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1 Review of Resident #1's medical record revealed an admitted [DATE]. Resident #1 had diagnoses that included in part . Cerebral Palsy, Unspecified Convulsions, Dysphagia, Aphasia, and Unspecified Intellectual Disabilities. Review of Resident #1's Quarterly MDS with an ARD of 07/04/2024, revealed a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. Review of the MDS revealed Resident #1 was dependent on staff for all ADL's. Review of Resident #1's CPOC with a target date of 10/04/2024, revealed she was Dependent with ADL's. Interventions included: Total assist for all ADL's due to Cerebral Palsy, and Quadriplegia. She is unable to make needs and wants known. She does not speak. Aphasic. Review of Resident #1's nurses' notes documented by S2 DON, revealed the following in part . 09/06/2024 at 1:42:55 p.m. - S4 Housekeeper notified S3 LPN of Resident #2 being in the room of Resident #1. Above nurse (S3 LPN) immediately went to Room A, where she saw the bathroom door open. When she got past the bathroom door, she saw male resident (Resident #2) pull blankets back, off of female resident (Resident #1), and put his hand in her brief at the groin. Resident #2 Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE]. Resident #2 had diagnoses that included in part . Cerebral Infarction, Unspecified Lack of Coordination, Difficulty in Walking, Generalized Muscle Weakness, Dysphagia following Cerebral Infraction, COPD, Foot Drop Right foot, Contracture of Right Shoulder, Right Elbow, and Right Hand. Review of Resident #2's Quarterly MDS with ARD of 08/15/2024, revealed Resident #2 had a BIMS of 13 (cognition intact). Review of Resident #2's nurses' notes documented by S2 DON revealed the following in part . 09/06/2024 at 1:42:55 p.m. - S4 Housekeeper notified S3 LPN of Resident #2 being in the room of Resident #1. S3 LPN immediately went to Room A, where she saw the bathroom door open. When S3 LPN got past the bathroom door she saw Resident #2 pull blankets back, off of Resident #1, and put his hand into her brief at the groin. S3 LPN immediately removed Resident #2 from Resident #1's room, and reported to S2 DON and S1 Administrator. Per video footage, Resident #2 was observed entering Resident #1's room at 1:42 p. m. S4 Housekeeper went by Resident #1's room at 1:42:55 p.m. S3 LPN entered Resident #1's room at 1:43:47 p.m., and escorted Resident #2 out of Resident #1's room. Interview on 09/16/2024 at 10:00 a.m. with S1 Administrator revealed the facility had substantiated sexual abuse that occurred on 09/06/2024 by Resident #2 to Resident #1, when a staff member witnessed Resident #2's hand in Resident #1's brief. S1 Administrator stated Resident #1 was unable to consent to the inappropriate touch. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 09/17/2024 at 08:09 a.m. with S4 Housekeeper, revealed on 09/06/2024 at approximately 1:45 p.m., she was making a round on Hall X. S4 Housekeeper stated when she passed Resident #1's room (Room A), she noticed Resident #2 in the room and found it strange, as he should not have been in there. S4 Housekeeper stated Resident #2 jumped when she asked him what he was doing in Resident #2's room. S4 Housekeeper stated she then observed Resident #2 removing his hand from beneath Resident #1's covers near her bottom. S4 Housekeeper stated she saw S3 LPN on the hall (Hall X), and informed S3 LPN of what she observed, and S3 LPN went to the room (Room A) right away. S4 Housekeeper revealed Resident #1 could normally be observed moving around, and playing in bed. S4 Housekeeper stated what caught her attention was the fact that she (Resident #1) was not doing this. S4 Housekeeper revealed Resident #1 was not displaying her normal behavior. S4 Housekeeper stated Resident #1 wasn't her normal jolly self, she had a frown, she looked uncomfortable, and just wasn't her normal self when Resident #2 was in there. Interview on 09/17/2024 at 8:22 a.m., with S3 LPN, revealed on 09/06/2024 at approximately 1:45 p.m., S4 Housekeeper reported to her that Resident #2 was in Resident #1's room. S3 LPN stated she knew Resident #2 did not visit with Resident #1, so she immediately went to Resident #1's room. S3 LPN stated when she entered, she observed Resident #2 pulling back Resident #1's covers, and as she was walking up to him, she observed Resident #2 slide his hand from Resident #1's thigh area and into her brief. S3 LPN stated she immediately removed Resident #2 from Resident #1's room, and asked him why he had his hand in Resident #1's brief. S3 LPN stated Resident #2 revealed he was tickling her. S3 LPN revealed she stated to Resident #2 well you don't tickle anyone in that area, so what were you doing? S3 LPN revealed Resident #2 got angry and began cursing at her. Interview on 09/17/2024 at 2:40 p.m. with Resident #1's responsible party revealed, although Resident #1 was not able to express herself, if she could, she felt Resident #1 would be very upset that Resident #2 touched her inappropriately. Resident #1's responsible party stated I can only imagine she would feel angry, upset, and not trustful of people. Resident #1's responsible party revealed she was thankful that due to Resident #1's cognition, she was not able to recall the incident, because that would be traumatic for her. The facility implemented the following actions to correct the deficient practice: 1. Resident #1 and Resident #2 were immediately separated and placed on 1:1 monitoring on 09/06/2024. 2. A body audit was performed for Resident #1, and had negative findings. 3. Law enforcement notified. Resident #2 was sent to a behavioral hospital on 09/06/2024, and did not return to the facility after discharge from the behavioral hospital. 4. Resident interviews and assessments conducted related to feeling safe or abuse by anyone in the facility began on 09/06/2024. All residents interviewed and assessed had negative findings. 5. Abuse policy was reviewed with no changes required to the facility's Abuse policy. 6. Facility in-services completed by S2 DON were started on 09/06/2024 concerning the facility's Abuse Policy and completed on 09/13/2024. All staff employed by the facility have received training on the above policy as of 09/17/2024. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	7. QA committed met on 09/06/2024 to discuss resident to resident sexual abuse that occurred on 09/06/2024. Resident Abuse will be monitored by the DON as part of the facility's QAPI. Monitoring began on 09/06/2024. Monitoring will occur 3 times a week for 90 days. 8. There have been no other incidences of abuse in the facility, and monitoring continues as noted above. Facility correction date of 09/13/2024. Throughout the survey, observations, interviews, record reviews revealed staff had received training on the abuse policy, regarding resident to resident abuse, and that monitoring had begun. Random staff and resident interviews revealed there had been no other incidences of resident to resident abuse.