STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195150	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Feliciana Chronic Disease	5002 Highway 10 Jackson, LA 70748

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** 42681 44965 47191 Based on observations, interviews, and record reviews, the facility failed to protect each residents' right to be free from abuse for 3 (#8, #9, and #13) of 13 (#1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12 and #13) residents reviewed for abuse. The facility failed to protect: 1. Resident #8 from mental abuse by S11CNA; 2. Resident #9 from physical abuse by Resident #10; and 3. Resident #13 from physical abuse by Resident #11. This deficient practice resulted in an actual psychosocial harm on 05/10/2024 around 6:00 p.m., when S11CNA made degrading comments about Resident #8's bowel condition loudly at the Nurses' Station with Resident #8 seated nearby. Resident #8 experienced crying, sadness, and felt degraded after S11CNA's comments about him. Findings: Review of the facility's policy titled, Abuse and Neglect Policy, with a revision date of March 2023, revealed the following, in part: Purpose: It is the policy of this facility and the state agency, to prohibit the abuse, neglect, exploitation, or extortion of patients/residents (henceforth referred to as resident). This facility is committed to preserving the right of each person receiving services to be free from abuse. All forms of abuse of residents by other residents or employees of this facility are prohibited. Definitions: Physical abuse - physical contact such as hitting, slapping, pinching, kicking, choking, scratching. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Verbal/Emotional/Psychological abuse - may be abusive because of either the manner of communication or the content of the communication; use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation; includes the use of oral, written, or gestured communication or sounds to residents, within hearing distance, regardless of age, ability to comprehend, or disability. Examples include but are not limited to: harassing a resident, mocking, insulting, ridiculing, yelling . Mental abuse/Violation of Privacy - may occur through either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. 1. Resident #8 Review of Resident #8's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Major Depressive Disorder, Generalized Anxiety Disorder, Acquired Absence of Right Leg Above Knee, and Acquired Absence of Left Leg Above Knee. Review of Resident #8's Quarterly MDS with an ARD of 06/05/2024 revealed he had a BIMS of 15, which indicated he was cognitively intact. Review of Resident #8's current Care Plan revealed the following, in part: Problem: ADLs - I need help with dressing, bathing, and personal hygiene due to my Bilateral Above Knee Amputations and Chronic Diarrhea . Problem: Alteration in bowel elimination related to I am incontinent. Review of Resident #8's Nurse's Note dated 05/15/2024 at 12:15 a.m. revealed the following, in part: Tonight I assisted Resident #8 in writing a statement regarding the way he was treated by a staff member on night shift on 05/10/2024. Resident #8 reported to me that the staff member embarrassed him by stating comments about his stomach/bowel issues in front of other residents, causing Resident #8 to get upset and cry. Resident #8 stated he was reluctant to report staff member for fear of possibly being further mistreated. Statement given to shift manager and the CNA assignment changed so the staff member is not assigned to the resident tonight. Signed: S10LPN Review of Resident #8's Incident Report revealed the following, in part: Date incident occurred: 05/10/2024 Date incident discovered: 05/15/2024 at 12:30 a.m. Type of incident: alleged abuse - emotional/verbal abuse (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Description of incident: Statement from Resident #8: On 05/10/2024, I was sitting in my wheelchair when the night shift arrived. S11CNA stated to me that she hoped I did not s*** my chair up the way that I s*** my bed up. S11CNA claimed she did not have time for that tonight. S11CNA said out in the hallway outside the day room and Nurses' Station in front of multiple other residents which was very embarrassing to me. I then rolled outside where the smoking area was and actually cried thinking this is how I have to live and I don't want to inconvenience anyone, but at the same time I have never been rude to S11CNA before. My feelings were hurt and I was embarrassed. When I rolled back into the building, I then told my nurse that I was ready to go to bed. I can put myself back to bed on my own. My nurse, S10LPN, then stuck her head out the smoking area door and stated to S11CNA that I would like to go to bed and would she please go and ensure that my bed was ready and that I was not soiled. At this time, S11CNA yelled at S10LPN, he can put himself to bed, she didn't have time to be bothered with my a**, and that I shouldn't be up in my chair anyway. S10LPN then came back into the building, and S12CNA came with her and ensured I was in bed and dry. Signed: Resident #8. Signature of person completing this form: S8RNM 05/15/2024 Supervisor review: do you suspect abuse or neglect? yes. On 06/04/2024 at 10:08 a.m., an interview was conducted with Resident #8. He stated, on 05/10/2024, he was by the medication cart outside the Nurses' Station at shift change, around 6:00 p.m. when S11CNA came out of the Nurses' Station and said something like, I hope you don't mess up the chair because you're hard enough to clean already. He stated S9LPN and S10LPN were at the medication cart giving report and heard the comments S11CNA made. He stated the comment made him feel bad, he went by the big window in the front of the facility, and cried and wondered what he did to end up here in this position. He stated after some time, he came back inside and asked for assistance getting back in bed. He stated S10LPN and S11CNA had words, S11CNA refused to assist him back to bed, and S10LPN and S12CNA assisted him back to bed. He stated he had chronic diarrhea for a long time and struggled with Depression because he never saw himself being in a place like this. He stated after the incident, he was sad for a few days. On 06/04/2024 at 10:35 a.m., an interview was conducted with S13CNA. She confirmed she was assigned to Resident #8 today. She stated she was aware of the incident that occurred on 05/10/2024 with Resident #8 and S11CNA. She stated following the incident, Resident #8 was sad about the situation and did not get out of the bed for a couple days. On 06/04/2024 at 1:34 p.m., a telephone interview was conducted with S8RNM. She stated an incident occurred between Resident #8 and S11CNA on 05/10/2024, and she was made aware of the incident on the night shift of 05/14/2024. She stated Resident #8 was very [NAME] and quiet. She stated Resident #8 was tearful when he explained to her that S11CNA said I hope you don't s*** your chair like you s*** your bed. She stated Resident #8 reported the incident occurred in front of other residents, S10LPN and S9LPN. She confirmed the above described incident was verbal and emotional abuse and when S11CNA was removed from Resident #8's unit, he began coming out of his room and engaging with other residents and staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 06/05/2024 at 9:32 a.m., a telephone interview was conducted with S9LPN. She stated Resident #8 was always very pleasant, friendly, and never had any behaviors. She stated, on 05/10/2024 at shift change, in a very loud in frustrated tone, S11CNA complained that Resident #8 was still up and every time he gets back in bed, he gets s*** everywhere and she did not want to clean it up. She stated Resident #8 was up in his wheelchair at the time the statement was made but was unsure of his exact location. She stated Resident #8 would have been able to hear the statements made by S11CNA if he was seated outside the Nurses' Station. She explained if Resident #8 overheard S11CNA, he would be very upset because he was generally very bothered and emotional related to his chronic diarrhea. She confirmed the statements made by S11CNA were very disrespectful. On 06/05/2024 at 2:04 p.m., a telephone interview was conducted with S11CNA. She confirmed Resident #8 had frequent diarrhea. She stated she never had a conversation with anyone about Resident #8's bowel movements. She stated she did not recall ever making a comment about Resident #8's bowel movements or him having a bowel movement in his chair or his bed. She stated if she had, that would have been abuse. Telephone interviews were unsuccessful with S10LPN on 06/04/2024 at 12:17 p.m., 06/04/2024 at 2:45 p.m., 06/05/2024 at 8:15 a.m., 06/0 5/2024 at 10:41 a.m., 06/05/2024 at 1:07 p.m., and 06/05/2024 at 2:51 p.m. Review of the State Agency Investigator's Report for Resident #8 revealed the following, in part: Incident date: 05/10/2024 Discovered: 05/15/2024 Alleged Victim: Resident #8 Statement by S10LPN: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 05/10/2024, I was working the night shift, Resident #8 was in his wheelchair outside of the Nurses' Station, as well as S11CNA. I could not really make out what was being said, but voices were raised and then all residents along with S11CNA went out to the smoking area. When I walked out back to this area, Resident #8 was in his wheelchair and had rolled down the sidewalk away from everyone else. Resident #8 appeared to be upset and possibly had been crying. After ten minutes, Resident #8 came back inside the building and stated he was ready to get in his bed. I went to get S11CNA, and informed her Resident #8 was ready to get into his bed. S11CNA began to yell at me outside in front of other residents. She said I don't have time to fool with him right now, he shouldn't even be up right now. I then came back into the building and was assisted by S12CNA to get Resident #8 in bed. I then asked the resident while in his room what was wrong and if something had happened. Resident #8 told me he didn't understand why staff were mean because he was never mean to anyone. He also told me how he can't help he has bad diarrhea, does not want to be like this, and surely doesn't do it on purpose. I encouraged the resident to report staff when they are mean and explained to him that is abuse. Resident stated that he was afraid to make anything worse but that he would think about it and let me know if he decided to report anything. When I came back to work, my RN Manager came to me and told me to go and help Resident #8 do a statement since he can't write. Statement done and signed by resident. Even though I did not hear exactly what S11CNA said to the resident, the attitude she had toward myself and the resident was not therapeutic and not conducive to patient care. Whatever S11CNA did say to the resident upset him enough that his demeanor changed to very sad and he obviously had been crying as it appeared he had tears in his eyes. On 06/05/2024 at 12:45 p.m., an interview was conducted with S6APS. He confirmed he investigated an allegation S11CNA emotionally abused Resident #8. He confirmed he interviewed S10LPN during his investigation. He stated S10LPN reported she did not hear S11CNA say anything directly to Resident #8 but when she went outside there were a lot of other residents outside and they were laughing and Resident #8 appeared to be crying. He stated S10LPN reported S11CNA was yelling at her as well. He stated S10LPN explained based on how Resident #8 reacted and S11CNA acted, she believed Resident #8 was abused by S11CNA. On 06/05/2024 at 4:00 p.m., an interview was conducted with S2DON. She stated Resident #8 had never made false reports against staff and was a very pleasant resident. She stated if S11CNA said what Resident #8 accused her of, that was abuse. On 06/05/2024 at 12:30 p.m., an interview was conducted with S5AA. He confirmed a state agency investigator investigated the allegation S11CNA abused Resident #8. He stated he reviewed the state agency investigator's report and investigation. He confirmed he substantiated the allegation because there was enough evidence to show S11CNA mentally abused Resident #8. 2. Resident #10 Review of Resident #10's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction and Unspecified Psychosis. Review of Resident #10's quarterly MDS with an ARD 04/18/2024 revealed a BIMS of 3, which indicated resident had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #10's Nurse's Notes dated 05/18/2024 at 11:34 a.m. by S14RN revealed Resident #9 was bumping into Resident #10's Gerichair several times, Resident #9 grabbed Resident #10 and scratched Resident #10's nose. On 06/04/2024 at 1:22 p.m., an interview was conducted with S16LPN. S16LPN stated Resident #10 does not like noise and will curse at others when agitated. S16LPN stated if you are close enough to Resident #10 he will grab at you. Resident #9 Review of Resident #9's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Moderately Intellectual Disabilities, Epilepsy, Schizophrenia and Extrapyramidal Movement Disorder. Review of Resident #9's quarterly MDS with an ARD of 05/09/2024 revealed a BIMS of 3, which indicated severe cognitive impairment. Review of Resident #10's Nurse's Notes dated 05/18/2024 at 9:38 a.m. by S17LPN revealed Resident #9 bumped into Resident#10's Geri chair several times, Resident #10 then grabbed Resident #9's face and scratched the right side of Resident #9's nose. Upon exam slight bleeding to right side, cleansed TAO applied. On 06/04/2024 at 1:58 p.m., an observation of the surveillance video was made with S18APD. On 05/18/2024 at approximately 9:38 a.m. both Resident #9 and Resident #10 were in the day room. Resident #9 backed up his wheelchair next to Resident #10's Geri chair, Resident #9 then leaned over Resident #10 and raised her right arm, Resident #10 immediately swatted his left arm and grabbed at Resident #9's face. Security immediately stepped in and separated both residents. On 06/04/2024 at 1:59 p.m., an interview was conducted with S18APD. S18APD confirmed Resident #10 grabbed Resident #9's face and it was considered physical abuse. 06/05/2024 at 10:00 a.m., an interview was conducted with S3CRO. S3CRO stated he was responsible for completing incident reports. S3CRO and S18APD reviewed surveillance of the incident that occurred between Resident #9 and Resident #10. S3CRO confirmed physical abuse occurred. 3. Resident #11 Review of Resident #11's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses which included Unspecified Intracranial Injury with Loss of Consciousness, Dementia, Major Depressive Disorder, Other Frontotemporal Neurocognitive Disorder, and Amnestic Disorder due to Known Physiological Condition. Review of Resident #11's Quarterly MDS with an ARD of 02/29/2024 revealed a BIMS of 1, which indicated severe cognitive impairment. Resident #13 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #13's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Personal History of Other Mental and Behavioral Disorders. Review of Resident #13's annual MDS with an ARD of 02/29/2024 revealed a BIMS of 15, which indicated he was cognitively intact. Review of Resident #13's Nurse's Note dated 05/19/2024 at 5:17 p.m. by S4RN revealed I heard yelling in the hallway by the dining room door. I saw Resident #13 on the floor next to his rollator walker. Resident #13 reported he could not get out of Resident #11's way, and Resident #11 pushed him to the floor. On 06/04/2024 at 10:54 a.m., an interview was conducted with Resident #13. He stated a few weeks ago Resident #11 pushed him to the floor while he was waiting to go into the dining area. He denied any pain or injuries as a result of this incident. On 06/04/2024 at 11:51 a.m., an interview was conducted with S4RN. She stated she recalled the incident that took place between Resident #11 and Resident #13. She stated she was in the hallway when she heard a lot of noise and commotion. She stated upon assessment of the noise, she observed Resident #13 sitting on the floor with his rollator walker next to him. She stated Resident #13 was cognitively intact, and when she asked him what happened, he stated, I couldn't get out of Resident #11's way fast enough so he pushed me out the way. On 06/05/2024 at 1:34 p.m., an interview was conducted with S3CRO. S3CRO confirmed he reviewed the video footage from 05/19/2024 involving Resident #11 and #13. He stated Resident #11 grabbed Resident #13 and pushed him to the floor with force. He confirmed he considered the altercation physical abuse. On 06/05/2024 at 2:01 p.m., an observation of the facility's surveillance footage was conducted with S2DON. On 05/19/2023 at 5:19 p.m., Resident #13 was observed standing in the hallway near the exit of the dining room door when Resident #11 forcefully shoved Resident #13 to the floor with both hands. Immediately following the observation, and interview was conducted with S2DON. S2DON stated Resident #11 grabbed Resident #13 and pushed him to the floor with force. She confirmed she considered the altercation physical abuse.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681 Based on interviews and record review, the facility failed to ensure a resident received necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive care plan by failing to implement and document increased behavior monitoring for 1 (#9) of 5 (#3, #4, #5, #6, and #9) residents reviewed for increased monitoring for behaviors. Findings: Review of facility's policy titled, Observation Precautions, dated 08/08/2023, revealed, in part: Purpose: Observation precautions are instituted for situations where the resident's condition/behavior presents as a clear and present risk to himself, others or the environment. Definitions: Increased Observation-staff members are assigned to observe an individual resident more frequently than traditional rounds. Increased observation may be completed in 15 minute intervals. Procedure: Documentation and Reporting: a. A form specific to the documentation of observation precautions shall be maintained with entries noted every 15 minutes by assigned staff and every 2 hours by a nurse. b. Documentation completion is required to the end of the assigned employee's shift. Review of Resident #9's clinical record revealed an admitted [DATE] with diagnoses which included Moderate Intellectual Disabilities, Schizophrenia and Extrapyramidal Movement Disorder. Review of Resident #9's quarterly MDS with ARD 05/09/2024 revealed a BIMS of 3, which indicated severe cognitive impairment. Review of the Physician Order dated 05/18/2024 for Resident #9 revealed, in part: Increased observations every 15 minutes monitor for behavior. Review of Observation Precaution sheets dated 05/18/2024 through 06/04/2024 revealed on the following days the monitoring was not conducted: 1. 05/18/2024-no q15 minute documentation at 5:45 p.m. 2. 05/19/2024-no q15 documentation at 6:00 p.m. through 6:00 a.m. 3. 05/20/2024-no q2 hour nurse documentation at 6:00 p.m. through 6:00 a.m. 4. 05/21/2024-no q15 minute documentation at 6:00 a.m. through 6:00 p.m. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. 05/21/2024-no q15 documentation at 6:00 p.m. through 6:00 a.m. 6. 05/22/2024-no q15 documentation at 6:00 a.m. through 6:00 p.m. 7. 05/22/2024-no q15 documentation at 6:00 p.m. through 6:00 a.m. 8. 05/23/2024-no q15 documentation at 8:45 a.m. through 9:45a.m. and 10:15 a.m. through 11:15 a.m. 9. 05/23/2024-no q15 minute documentation at 6:00 p.m. through 6:00 a.m. 10. 05/24/2024-no q 2 hour nurse documentation at 6:00 p.m. through 6:00 a.m. 11. 05/25/2024-no q15 minute documentation at 6:00 a.m. through 6:00 p.m. 12. 05/26/2024-no q15 minute documentation at 6:00 a.m. through 6:00 p.m. 13. 05/27/2024-no q15 minute documentation at 6:00 a.m. through 6:00 p.m. 14. 05/28/2024-no q15 minute documentation at 6:00 p.m. through 6:00 a.m. 15. 05/29/2024-no q15 minute documentation at 6:00 p.m. through 6:00 a.m. 16. 06/03/2024-no q15 minute documentation at 3:15 p.m. through 5:45 p.m. On 06/04/2024 at 1:22 p.m., an interview was conducted with S16LPN. S16LPN stated Resident #9 was on increased observations for behaviors since 05/18/2024. S16LPN stated rounding and documentation should occur every 15 minutes, and confirmed if the documentation was not completed, then the observation was not done. On 06/05/2024 at 9:16 a.m., an interview was conducted with S19LPN. S19LPN stated residents on increased observations required observations every 15 minute. S19LPN reported she had not completed an Observation Precaution sheet on Resident #9 in a month or two. S19LPN confirmed if documentation was not completed on the resident, then observations were not done. On 06/05/2024 at 10:00 a.m., an interview was conducted with S3CRO. S3CRO stated residents placed on increased observations for behaviors should be documented and rounded on every 15 minutes. S3CRO confirmed if the documentation was not completed, then the observation was not done. On 06/05/2024 at 11:29 a.m., an interview was conducted with S2DON. S2DON stated increased observations could be conducted by security or a medical professional. S2DON reported all observations precautions should be documented on rounding sheets. S2DON verbalized the expectation was that the nurse documented observations every 2 hours and the CNA documented every 15 minutes. S2DON stated the above documents were not completed correctly. S2DON confirmed if the observation for behaviors was not documented on the Observation Precaution sheet, it was not done.