STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195325	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivian Healthcare Center	912 South Pecan Street Vivian, LA 71082

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** 36921 Based on record reviews, observations, and interviews the facility failed to ensure a plan of care had been developed for 4 (#13, #37, #50, #52) of 8 (#13, #18, #32, #37, #38, #50, #52, #168) residents reviewed for accidents. The facility failed to ensure a plan of care for side rail assist bars had been developed for Residents #13, #37, #50, and #52. Findings: Review of the facility's PSDs (Personal Safety Devices)-Enablers-Side Rails & Restraints policy with a revision date of February 2025 revealed in part, these devices require evaluation, resident and/or responsible party notification, an order, care planning, and routine monitoring for effectiveness and restraining effect. Resident #13 Review of Resident #13's medical record revealed in part, an original admitted [DATE] with diagnoses including, but not limited to Parkinson's without dyskinesia and dementia with agitation. Review of Resident #13's annual and state MDS (Minimum Data Set) assessments dated 12/13/2024 revealed in part, a BIMS (Brief Interview for Mental Status) score of 9 indicating moderately impaired cognition. Further review of Resident #13's annual and state MDS assessments dated 12/13/2024 revealed Resident #13 required limited assistance by one person with bed mobility and toilet use and required supervision by one person with transfers. Review of Resident #13's current physician orders revealed in part, an order dated 02/08/2024 for SRA (Side Rail Assist) bar times two for bed mobility and transfers. Review of Resident #13's comprehensive care plan failed to reveal a focus for the use of side rail assist bars and appropriate interventions. Multiple observations throughout the day on 03/17/2025 revealed Resident #13 in and out of her bed. Further observations revealed Resident #13's bed with side rail assist bars in a raised positon to each side of the HOB (Head of Bed). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 03/18/2025 at 11:55 a.m. revealed Resident #13's bed with side rail assist bars in a raised positon to each side of the HOB. During an interview on 03/18/2025 at 11:55 a.m., Resident #13 reported she does use the assist bars to reposition herself while in bed and to get out of bed. During an interview on 03/19/2025 at 1:27 p.m., S4 MDS Nurse confirmed Resident #13's comprehensive care plan did not include a focus for side rail assist bars. During an interview on 03/19/2025 at 3:31 p.m., S2 DON (Director of Nursing) and S3 Corporate Nurse confirmed Resident #13's care plan did not include a focus on side rail assist bars. Resident #37 Review of Resident #37's medical record revealed in part, an admitted [DATE] with diagnoses including, but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #37's quarterly and state MDS assessments dated 12/13/2024 revealed in part, Resident #37 required supervision with set up assist for bed mobility. Review of Resident #37's current physician orders revealed in part, an order dated 02/08/2024 for SRA bar times two for bed mobility and transfers. Review of Resident #37's comprehensive care plan failed to reveal a focus for the use of side rail assist bars and appropriate interventions. An observation on 03/18/2025 at 8:58 a.m. revealed Resident #37's bed with side rail assist bars in a raised positon to each side of the HOB. During an interview on 03/19/2025 at 9:28 a.m., S2 DON confirmed Resident #37's care plan should have a focus with appropriate interventions for side rail assist bars and did not. Resident #50 Review of Resident #50's medical record revealed in part, a readmitted [DATE] with diagnoses including, but not limited to other sequelae of cerebral infarction and dementia without behavioral disturbance. Review of Resident #50's annual MDS assessment dated [DATE] revealed in part, a BIMS score of 3 indicating severely impaired cognition. Further review of Resident #50's annual MDS dated [DATE] revealed Resident #50 required supervision or touch assist with chair/bed to chair transfers and toilet transfers. Review of Resident #50's current physician orders revealed in part, an order dated 02/07/2024 for SRA bar times two for transfers and bed mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's comprehensive care plan failed to reveal a focus for the use of side rail assist bars and appropriate interventions. Multiple observations throughout the day on 03/17/2025 revealed Resident #50 in her bed with side rail assist bars in a raised positon to each side of the HOB. During an interview on 03/19/2025 at 1:27 p.m., S4 MDS Nurse confirmed Resident #50's comprehensive care plan did not include a focus for side rail assist bars. During an interview on 03/19/2025 at 3:31 p.m., S2 DON and S3 Corporate Nurse confirmed Resident #50's care plan did not include a focus for side rail assist bars. Resident #52 Review of Resident #52's medical record revealed in part, an admitted [DATE] with diagnoses including, but not limited to spinal stenosis of lumbar region with neurogenic claudication and dorsalgia. Review of Resident #52's quarterly and state MDS assessments dated 02/27/2025 revealed in part, Resident #52 required limited physical assistance by one person with bed mobility. Review of Resident #52's current physician orders revealed in part, an order dated 11/20/2024 for SRA bar times two. Review of Resident #52's comprehensive care plan failed to reveal a focus with appropriate interventions for the use of side rail assist bars and appropriate interventions. An observation on 03/17/2025 at 11:33 a.m. revealed Resident #52's bed with side rail assist bars in a raised positon to each side of the HOB. During an interview on 03/19/2025 at 9:28 a.m., S2 DON confirmed Resident #52's care plan should have a focus with appropriate interventions for side rail assist bars and did not.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 Based on record review, observation, and interviews, the facility failed to ensure that a resident who required dialysis received services consistent with professional standards of practice for 1 (#37) of 1 resident reviewed for dialysis by failing to assess Resident #37 upon return to the facility from dialysis treatment. Findings: Review of Resident #37's March 2025 physician orders revealed: 01/22/2025: Resident to receive dialysis 3 days a week on Monday-Wednesday-Friday at ____ dialysis center. 12/05/2025: Monitor AV (Arteriovenous) shunt pressure dressing to left arm for excessive bleeding every shift upon return from dialysis and remove dressing morning after dialysis. 12/05/2025: Monitor AV shunt site left arm for signs and symptoms infection q (every) shift. Palpate pulse(s) distal to shunt. Note changes in skin color and temp. Report changes to physician. 12/05/2025: AV shunt to left arm. Assess & palpate AV shunt q shift for thrill and bruit. Report concerns to physician. Review of Resident #37's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) of 12 out of 15; indicating cognitively intact. During an interview on 03/18/2025 at 9:47 a.m. Resident #37 reported upon return to the facility the nurse does not assess dialysis access site and/or obtain vital signs. Resident #37 further reported he removed his own dressing from dialysis. Observation on 03/18/2025 at 9:47 a.m. revealed Resident #37's dialysis access was in the left forearm with no dressing in place. During an interview on 03/19/2025 at 2:25 p.m. S5 RN (Registered Nurse) reported upon return from dialysis Resident #37 is not assessed and vital signs are not obtained unless Resident #37 complained of feeling bad, fatigue, weak or a headache. S5 RN reported the transport driver will leave the communication binder at the desk and S5 RN was not made aware of Resident #37's return from dialysis treatments. During an interview on 03/19/2025 at 3:00 p.m. S2 DON (Director of Nursing) reported the nursing staff should complete the dialysis checklist by assessing the resident according to the dialysis communication form and vital signs should be obtained upon return from dialysis. S2 DON reported not being aware if the facility had a policy for assessment of a resident upon return from dialysis and instructions for completing the dialysis communication form.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 Based on record review, observation, and an interview, the facility failed to ensure correct use of bed rails as evidence by failing to obtain a written a physician order for side rail assist bars, obtain an informed consent from resident or resident's responsible party prior to installation, and ensure a care plan was initiated with a focus for side rail assist bars for 1 (#168) out of 8 (#13, #18, #32, #37, #38, #50, #52, and #168) residents investigated for accidents. Findings: Review of the facility's PSDs (Personal Safety Devices) -Enablers-Side Rails & Restraints Policy with a revision date of February 2025 revealed in part, These devices require evaluation, resident and/or responsible party notification, an order, care planning, and routine monitoring for effectiveness and restraining effect. Protocols for PSD-Enablers-Side Rails and Restraints I. When a resident is admitted with or is prescribed a personal safety, enabler and/or a type of side rail. The IDT (Interdisciplinary Team) will: notify resident and/or responsible party of device use and purpose in plan of care obtain and write an order update care plan and Kardex/POC (Plan of Care) to include appropriate monitoring device Review of Resident #168's face sheet revealed an admitted [DATE] with the following diagnoses but not limited to intractable epilepsy, dementia, and mild cognitive impairment. Review of Resident #168's March 2025 physician orders failed to reveal an order for hand assist rails. Review of Resident #168's care plan failed to reveal a focus on side rails/assist rails with appropriate interventions. S2 DON (Director of Nursing) presented surveyor with an electronic copy of Resident #168's Side Rail/ Assist Bar Informed Consent obtained by verbal consent on 03/18/2025. Observation on 03/17/2025 at 9:30 a.m. revealed Resident #168 had side rail assist bars to both sides of the bed. During an interview on 03/19/2025 at 9:28 a.m. S2 DON confirmed Resident #168 should have a physician order for side rail assist bars, care plan should have a focus with interventions for side rail assist bars and an informed consent should have been signed prior to installation and was not.