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	05/11/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and an interview the facility failed to inform and provide written information to residents or resident's representative concerning the right to formulate an Advance Directive for 5 (#4, #5, #10, #36, and #53) of 5 residents reviewed for Advanced Directives. Findings: Review of facility's Advance Directive Policy with latest revision date of August 2023 revealed in part;Policy Statement: Advance Directives will be respected in accordance with state law and facility policy.Policy Interpretation and Implementation:Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical treatment and to formulate an Advanced Directive if he or she chooses to do so.2. Written information will include a description of the facility's policies to implement Advance Directives and applicable state law.3. If the resident is incapacitated and unable to receive information about his or her right to formulate an Advance Directive, the information may be provided to the resident's legal representative. 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written Advance Directives.15. In accordance with current regulatory definitions and guidelines governing Advance Directives, out facility has defined Advance Directives as preferences regarding treatment options and include, but are not limited to:a. Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized by State law, relating to the provisions of health care when the individual is incapacitated. Review of Resident #4's face sheet revealed an admission date of 03/28/2023 with the following diagnoses but not limited to specified chronic obstructive pulmonary disease, chronic diastolic (congestive) heart failure, hypertensive chronic kidney disease, atherosclerotic heart disease of native coronary artery without angina pectoris, dementia, and anxiety disorder. Review of Resident #4's medical record failed to reveal a consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission.During an interview on 05/06/2026 at 2:00 p.m. S2 Interim Assistant Administrator confirmed Resident #4 did not have a completed Advance Directive form that indicated Resident #4 was given written materials on how to formulate an Advance Directive. Review of Resident #5's face sheet revealed an initial admission date of 09/09/2025 and a reentry admission date of 4/29/2026 with the following medical diagnoses but not limited to aftercare following joint replacement surgery; displaced fracture of base of neck right femur, muscle weakness, lack of coordination abnormalities of gait and mobility, and unspecified dementia,Review of Resident #5's medical record failed to reveal a consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission.During an interview on 05/06/2026 at 4:20 p.m. S5 Corporate Nurse confirmed Resident #5's Advance Directives acknowledgment had not been obtained and should have been.Review of Resident #10's face sheet revealed an admission date of 07/10/2025 and readmission date of 03/10/2026 with following medical diagnoses but not limited sequelae of cerebral infarction; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, specified diabetes mellitus with diabetic polyneuropathy; chronic obstructive pulmonary disease, chronic kidney disease, stage 3 unspecified, and encounter for attention to ileostomy. Review of Resident #10's (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record failed to reveal a consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission. During an interview on 05/06/2026 2:00 PM S2 Interim Assistant Administrator confirmed Resident #10 did not have consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission. Review of Resident #36's face sheet revealed an admission date of 02/02/2024 with the following medical diagnoses but limited to spondylosis without myelopathy or radiculopathy, cervical region, pan lobular emphysema, type 2 diabetes mellitus with diabetic chronic kidney disease, apraxia following non-traumatic intracerebral hemorrhage, occlusion and stenosis of right carotid artery, atherosclerotic heart disease of native coronary artery without angina pectoris, spondylosis without myelopathy or radiculopathy, thoracolumbar region, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Review of Resident #36's Advance Directive Status Form dated 11/07/2023 revealed: the advance directive rights and policies been explained and written information provided to Resident and/or Responsible Party was not completed. During an interview on 05/06/2026 at 2:00 p.m. S2 Interim Assistant Administrator confirmed the Resident #36 did not have a completed advance directive form that indicated Resident #36 was given written materials on how to formulate an Advance Directive. Review of Resident #53's face sheet revealed an admission date of 12/31/2025 with the following diagnoses but not limited to Alzheimer's disease, dementia and major depressive disorder. Review of Resident #53's medical record failed to reveal a consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission.During an interview on 05/06/2026 at 2:16 PM S2 Interim Assistant Administrator confirmed Resident #53 did not have consent and/or education of Advanced Directive material given to resident/resident's responsible party upon admission.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure 3 (#9, #13, and #53) of 5 residents reviewed for unnecessary medications were free from chemical restraints by failing to: ensure Resident #9's GDR recommendations were implemented andensure Residents' (#9, #13, and #53) orders for PRN psychotropic medications did not exceed 14 days without a rational. Findings: Review of the facility's Psychotropic/Psychoactive Medication Policy revised 01/2025 revealed in part: Policy StatementA psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (I) Antipsychotic; (II) Anti-depressant; (III) Anti-anxiety; and (IV) Hypnotic. Other medications which affect brain activity will also be subject to psychotropic medication requirements if documented use is a substitution for a psychotropic medication rather than the approved or original indication.Psychotropic medications are used only when appropriate and at the lowest possible dose to enhance the residents' quality of life, maximize functional ability or promote overall well-being. Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and documented.Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review. An ongoing evaluation of need of the medication must be documented, as the resident has the right to be free of chemical restraints.Policy Implementation8. The attending physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of psychotropic medications.10. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.14. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs, safely and as appropriate. Resident #9Review of Resident #9's medical record revealed an admission date of 08/28/2011 and diagnoses including Parkinson's disease, major depressive disorder, and dementia. Review of Resident #9's physician orders revealed an order dated 01/28/2025 for Quetiapine (Seroquel) Fumarate Oral Tablet 25 milligrams; Give 0.5 tablet [12.5 milligrams] by mouth two times a day related to major depressive disorder. Further review revealed Resident #9 had a PRN psychotropic medication order start date 11/18/2023 for Hydroxyzine (Vistaril) HCL Tablet 25 milligram; Give 1 tablet by mouth every 6 hours as needed for anxiety and/or itching. Further review failed to reveal a rational or a stop date of PRN psychotropic medication order over 14 days. Review of Resident #9's most recent GDR dated 01/14/2026 revealed a dose reduction recommendation for Seroquel to 12.5 milligrams once at night.Review of Resident #9's discontinued and completed orders for dates 01/14/2026 through 05/11/2026 failed to reveal implementation from GDR recommendation dated 01/14/2026 to decrease Seroquel 12.5 milligrams from twice daily to once at night. During an interview on 05/11/2026 at 10:20 a.m. S3 DON confirmed Resident #9's GDR dated 01/14/2026 recommended a decrease in Seroquel 12.5 milligrams from twice daily to once at night. S3 DON reported there was no documentation of a GDR attempt from 01/14/2026 or rational why GDR attempt was not made. Resident #13Review of resident #13's medical record revealed an admission date of 10/31/2025 and diagnoses including unspecified dementia, anxiety disorder, and altered mental status. Review of Resident #13's physician orders revealed Resident #13 had a PRN psychotropic medication order start date 10/13/2025 for Ativan (Lorazepam) Oral Tablet 0.5 milligrams; Give 1 tablet by mouth every 12 hours as needed for agitation related to anxiety disorder, unspecified. Further review failed to reveal (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a rational or a stop date of PRN psychotropic medication order. Resident #53Review of Resident #53's medical record revealed an admission date of 12/31/2025 and diagnoses including Alzheimer's disease, unspecified dementia, and major depressive disorder. Review of Resident #53's physician orders revealed Resident #53 had a PRN psychotropic medication order start date 01/15/2026 for Vistaril Oral Capsule 50 milligrams (Hydroxyzine Pamoate); Give 1 capsule by mouth every 4 hours as needed for anxiety related to anxiety disorder, unspecified. Further review failed to reveal a rational or a stop date of PRN psychotropic medication orders.During an interview on 05/08/2026 at 11:26 a.m., S3 DON reported PRN psychotropic medications should be reordered every 14 days or have as stop date with rational for an order lasting longer than 14 days. S3 DON confirmed residents #9, #13, and #53 had PRN psychotropic medication orders which lasted longer than 14 days without a stop date or rational for an order lasting longer than 14 days.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to: 1. Provide written notice to residents and/or their RP which specified the reason for transfer, effective date, location and statement of the resident's appeal rights and duration of the bed hold for 3 (#6, #10, and #56) of 3 residents reviewed for hospitalizations, and 2. Update the emergency transfer log (Notice of Discharge to the Ombudsman) for 2 (#6 and #10) of 3 residents reviewed for hospitalizations. Findings: Resident #6 Review of Resident #6's medical record revealed an admission date on 11/21/2025 and diagnoses including acute respiratory failure with hypoxia and dependence on renal dialysis. Review of Resident #6's medical record revealed emergency transfers to an acute care hospital on [DATE], 12/16/2025, 03/05/2026, 03/31/2026 and 04/18/2026. Further review failed to reveal documentation Resident #6 or Resident #6's RP was given written notification of the facility's bed hold policies at the time of his transfer's to the hospital on [DATE], 12/16/2025, 03/05/2026, 03/31/2026 or 04/18/2026. Review of the facility's Ombudsman Emergency Transfer Log for dates 04/01/2025 through 03/31/2026 failed to reveal documentation the Ombudsman was notified of Resident #6's transfer to the hospital on [DATE]. Resident #10 Review of Resident #10's medical record revealed an admission date on 07/10/2025 and diagnoses including other sequelae of cerebral infarction, specified diabetes mellitus with diabetic polyneuropathy, chronic obstructive pulmonary disease, and chronic kidney disease. Review of Resident #10's progress notes for dates 03/02/2026 through 03/10/2026 revealed Resident #10 was sent to the hospital on [DATE] per Resident #10's request and returned to the facility 03/10/2026. Further review failed to reveal a documentation of the bed hold notification was given to Resident #10 and/or RP on 03/02/2026 at time of transfer. Review of the facility's Ombudsman Emergency Transfer Log for dates 04/01/2025 through 03/31/2026 failed to reveal documentation the Ombudsman was notified of Resident #10's transfer to the hospital on [DATE]. Resident #56 Review of Resident #56's medical record revealed an admission date of 02/24/2026 and a discharge date of 03/20/2026 with diagnoses including chronic kidney disease and unspecified dementia. Review of Resident #56's medical record revealed Resident #56 was transferred to an acute care hospital on [DATE]. Further review failed to reveal Resident #56's RP was given written notification of the facility's bed hold policies at the time of his transfer to the hospital on [DATE]. During an interview on 05/08/2026 at 8:50 a.m., S4 Business Office Manager reported she was not responsible for bed hold documentation at the time of transfer. During an interview on 05/08/2026 at 8:55 a.m., S6 Social Services reported she was not responsible for bed hold documentation at the time of transfer. During an interview on 05/08/2026 at 8:59 at a.m., S3 DON reported she was not sure who was responsible for bed hold documentation at the time of transfer. During an interview on 05/08/2026 at 9:44 a.m., S5 Corporate Nurse reported there was no documentation of the bed hold policy/notification at transfer for Residents #6, #10, and #56.During an interview on 05/08/2026 at 9:45 a.m., S1 Regional Operation Manager/Interim Administrator reported there was not documentation in the medical record of the bed hold policy/notification at time of transfer for Residents #6, #10, and #5.During an interview on 05/08/2026 at 11:00 a.m., S6 Social Services confirmed the Ombudsman was not notified of Resident #6's transfer on 03/05/2026 and Resident #10's transfer on 03/02/2026 and should have been.