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	12/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure an allegation of verbal abuse was reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency for 1 (Resident #1) of 3 sampled Residents reviewed for abuse. Findings: Review of the facility policy with last review date of 05/2024 titled: Incident Investigation and Reporting read in part. To provide guidance to the facility for investigation and reporting incidents of abuse, neglect, exploitation, misappropriation of property and/or other reportable incidents to LDH, Health Standards Section. 1. Each resident residing in this facility has the right to be free from any type of abuse. Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of the age, ability to comprehend, or disability. 3. Abuse, Neglect, Misappropriation of Resident Property and Exploitation are crimes and shall be reported to proper authorities as such. In the event of any incident involving an allegation or suspicion of mistreatment, exploitation, neglect, abuse, misappropriation or other crime, as well as injuries of unknown origin, elopement, and/or adverse events, each occurrence will be reported immediately to the Administrator of the facility, who will immediately notify the Corporate Compliance Officer and Regional Supervisor. The administrator will begin an investigation. The administrator shall report to the State Survey Agency and local law enforcement entities in which the facility is located, any allegation or reasonable suspicion of a crime against any resident. The administrator shall report not later than 2 hours after forming the suspicion, if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not involve abuse or result in serious body injury. Review of the medical record for Resident # 1 revealed she was admitted to the facility on [DATE]. Resident #1 had diagnoses that included in part . Alzheimer's disease, Unspecified Mood Affective Disorder, Conversion Disorder with Seizures or Convulsions, Schizophrenia, Anxiety Disorder, Major Depressive Disorder, Dissociative and Conversion Disorder, and Pain. Review of Resident #1's Quarterly MDS with an ARD of 09/16/2025 revealed a BIMS score of 99, which indicated the resident could not complete the interview due to severe cognitive impairment. Review of the facility's Incident Log dated 09/01/2025-11/30/2025, revealed Resident #1 had an alleged abuse incident, with incident report created 09/08/2025 at 8:50 a.m. Review of Resident #1's departmental progress notes revealed an incident progress note by S3 Previous DON on 09/08/2025 8:50 a.m. that read in part.S5 CNA reported on 09/08/2025 to S1 Administrator, S6 ADON, and myself (S3 Previous DON) that at the end of her shift on 09/06/2025 she reported S4 CNA for foul language towards Resident #1. S5 CNA reported S4 CNA to S7 LPN and S8 LPN. S5 CNA reported that S4 CNA stated to Resident #1, What the f*ck you still doing up? and S4 CNA also stated to Resident #1 b*tch. S5 CNA reported it occurred at shift change on 09/06/2025 at 10:00p.m. S5 CNA and S9 CNA both stated they reported it to assigned nurses at time of incident. S4 CNA, S5 CNA, S9 CNA, and S8 LPN were unavailable for interview at time of survey. Interview on 12/08/2025 at 1:51 p.m. with S7 LPN revealed he recalled the alleged verbal abuse incident back in September between S4 CNA and Resident #1. S7 LPN stated on approximately 09/06/2025, S5 CNA reported to him that she overheard S4 CNA cursing at Resident #1. S7 LPN revealed S5 CNA reported to him she heard S4 CNA say to Resident #1 something to the effect of B*tch what are you still doing up? Or, B*tch why are you not sleeping? S7 LPN revealed he was not the assigned nurse of Resident #1, so he immediately informed S8 LPN who was Resident #1's assigned nurse, so that she (S8 LPN) could complete the incident report. S7 LPN stated he was unaware that S8 LPN had not completed the incident report at that time. S7 LPN confirmed all allegations of abuse should be reported immediately to administration and an incident report completed. Review of a SIMS report completed by the facility revealed there was an alleged verbal abuse allegation by S4 CNA to Resident #1. The facility entered the discovered date as 09/08/2025 10:00 p.m. The facility entered the allegation into SIMS reporting system on 09/10/2025 8:36 a.m. Review of written statement dated 09/11/2025 by S1 Administrator read in part. On 09/08/2025 right before 9:00 a.m. meeting with department heads S5 CNA informed S3 Previous DON, S6 ADON, and S1 Administrator of an incident that occurred in the memory care unit. Accused CNA was suspended pending investigation and inservicing of staff was started. On 09/09/2025 prior to 8:00 a.m. a SIMS was initiated. On 09/10/2025 at 8:20 a.m. the SIMS system was opened to start adding information into the report, but the initial report could not be found. Another report was opened on 09/10/2025 at 8:36 a.m. Interview on 12/08/2025 at 3:30 p.m.