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	01/29/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received a reasonable accommodation of their needs by failing to ensure the call light was accessible to a resident for 1 (Resident #59) of 48 sampled residents.Review of facility policy titled Call Light/Bell with revision date of 01/2024, revealed in part. Purpose: to provide the resident a means of communication with staff members. Procedure: 1. Ensure resident has call light in reach when in resident room or in bathroom/shower room. 7. Leave the resident comfortable. Place the call light within the residents reach before leaving the room.Review of Resident #59's medical record revealed an admission date of 02/27/2025, with diagnoses that included, in part,. Cerebrovascular Disease Unspecified, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left dominant side, Major Depressive Disorder, and Generalized Anxiety Disorder.Review of Resident #59's Quarterly MDS with ARD 11/20/2025 revealed the resident had a BIMS score of 13, indicating intact cognition. Resident #59 was dependent on staff for toileting hygiene and transfers. Resident #59 required moderate assistance from staff for personal hygiene.Review of Resident #59's care plan initiated on 02/27/2025 with next review date of 02/18/2026 revealed the resident was at risk for falls related to impaired mobility and hemiplegia affecting the left side. Intervention included in part. Call light is within reach, and encourage the resident to use it for assistance as needed.On 01/28/2026 at 8:48 a.m., observation revealed Resident #59 lying in bed. The call bell was observed tucked between the mattress and bedframe, not within reach for the resident.On 01/28/2026 at 8:52 a.m., observation from outside of Resident #59's door revealed Resident #59 to be yelling Ma'am from her room several times, attempting to get the attention of staff members to request a cold wet washcloth.On 01/28/2026 at 11:56 a.m., observation revealed Resident #59 lying in bed. The call bell was observed to be located on the floor next to the resident's bed, not within reach for the resident.On 01/28/2026 at 4:16 p.m., observation revealed Resident #59 lying in bed, awake and alert. The resident was requesting a new diaper from the surveyor. The call bell was observed on the floor next to the resident's bed, not within reach for the resident.On 01/29/2026 at 8:54 a.m., observation revealed Resident #59 positioned upright in bed, eating breakfast. The call bell was observed hanging off the right side of the resident's bed, out of reach for the resident.On 01/29/2026 at 9:10 a.m., S3LPN accompanied surveyor to Resident #59's bedside. S3LPN confirmed the resident's call bell was not within reach for the resident, and should have been.On 01/29/2026 at 1:45 p.m., the above findings were discussed with S1ADM and S2DON. S1ADM and S2DON acknowledged that the call bell was not within reach for Resident #59, and should have been.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety. The facility failed to ensure food was properly sealed and stored in the stand-alone freezer, walk-in cooler, and walk-in freezer area of the facility's kitchen. This had the potential to affect 108 residents who were served from the kitchen. Findings:Review of the facility's policy, titled, Storage of Refrigerated Food, with a revised date of 09/25, revealed, in part.No food is left uncovered. Review of the facility's policy titled, Storage of Frozen Food, with a revised date of 09/22, revealed, in part.No food is left uncovered. An initial tour of the kitchen was conducted on 01/27/2026 at 8:50 a.m. with S4DM. Observations were made of the following items:Stand-Alone Freezer:An opened cardboard box of rolls with the inside plastic liner opened and unsecured.An opened cardboard box of biscuits with the inside plastic liner opened and unsecured.Walk-in Cooler:An opened cardboard box of bacon with the inside plastic liner opened and unsecured.Walk-in Freezer:An opened carboard box of pork chops with the inside plastic liner opened and unsecured. Interview with S4DM on 1/27/2026 at 9:15 a.m. confirmed that the inner plastic liners of the opened boxes of food should have been closed or secured but had not been.