STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195557	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health Care Facility	7119 Highway 1 South Marksville, LA 71351

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** 44844 Based on interview and record review, the facility failed to ensure a resident's right to be free from staff to resident verbal abuse, for 1 (Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for abuse. Resident #3, a cognitive resident, experienced mental anguish and psychosocial harm as a result of the verbal abuse by staff. This deficient practice resulted in an actual harm for Resident #3 on 02/27/2025 at 12:54 p.m., when Resident #3 reported to the Administrator that while in the activity room, S3 LPN confronted her (Resident #3), engaged in a verbal altercation with her, and shouted at her to shut her mouth. Resident #3, who had a BIMS score of 15 (cognitively intact), stated she was tearful, scared, and nervous during and after the verbal altercation with S3 LPN. As a result of the verbal abuse, Resident #3 was referred for, and received individual psychotherapy to address incident and improve anxiety. Findings: Review of the facility policy on 03/10/2025 at 1:00 p.m., and titled, Abuse-Prevention and Prohibition Policy and Procedure, with an effective date of 03/25/2023, revealed in part .Purpose: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. No one shall abuse a resident. Policy: To provide a safe, abuse-free environment for all residents .I. Types of Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Verbal abuse, sexual abuse, physical abuse, and mental abuse includes abuse facilitated or enabled through the use of technology . Our policy presumes that abuse of any resident, even in a coma, causes physical harm, pain, or mental anguish. 1. Verbal Abuse is 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 or sight, regardless of the resident's age, ability to comprehend, or disability .Examples: a. Name calling, cursing, or yelling at a resident in anger. b. Threats of harm; saying things to frighten a resident . Review of Resident #3's medical record revealed she was admitted to the facility on [DATE], with diagnoses that included: Type II Diabetes Mellitus with Diabetic Polyneuropathy, Major Depressive Disorder recurrent moderate, Obsessive Compulsive Behavior, Generalized Anxiety Disorder, and Insomnia. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #3's Quarterly MDS with an ARD of 12/10/2024, revealed Resident #3 had a BIMS score of 15, which indicated cognition was intact. The MDS revealed Resident #3 required set up supervision for bed mobility, transfers, and eating, and one person physical assistance with toileting. The MDS revealed Resident #3 used a walker for ambulation and exhibited no behaviors. Review of Resident #3's Care Plan with a review date of 03/25/2025, read in part . The resident has Anxiety related to Anxiety Disorder, with interventions that included: approach the resident in a calm manner. Review of a Psychiatric Progress note dated 03/07/2025 at 1:00 p.m., read in part .Psych services were due to an incident with an employee. The patient had a verbal altercation with a particular nurse multiple times. The most recent incident the patient was verbally abused by this particular nurse. During today's assessment, the patient is sitting with peers in dining room, and getting ready to play bingo. She is cooperative, with an anxious mood and affect. She was able to recall events and states she felt this particular nurse was out to get her, and made comments towards her in front of other residents, and a hospice employee. She stated this made her scared and anxious. She feels that the symptoms are better today, but began to become tearful and anxious again when talking about it. Treatment plan: Referred for individual psychotherapy to address incident and improve Anxiety. Patient having difficulty processing this event. Review of a facility report dated 02/28/2025 at 12:40 p.m., revealed in part . on 02/27/2025 at 12:54 p.m., Resident #3 reported to S4 ADON that she wanted to file a complaint against S3 LPN. Resident #3 indicated that while she was in the activity room, S3 LPN came into the room and confronted her in front of other residents. Resident #3 reported that S3 LPN told her she was being sarcastic for making a comment to other residents. Interview with S1 Administrator on 03/11/2025 at 9:04 a.m., revealed Resident #3 was involved in two verbal altercations with S3 LPN. S1 Administrator revealed the first incident occurred on 02/23/2025, and was not reported by Resident #3 until 02/27/2025. S1 Administrator revealed on 02/23/2025 Resident #3 reported there were residents sitting at the entry of the activity room, so Resident #3 went around them. S3 LPN confronted Resident #3 and told Resident #3 she had been rude to the other residents. S1 Administrator revealed Resident #3 indicated that during the confrontation, S3 LPN told Resident #3 to shut her mouth in front of everyone. S1 Administrator revealed he asked Resident #3 why hadn't she reported the incident, and Resident #3 replied if it happened again she was going to report S3 LPN. S1 Administrator stated on 02/27/2025 at 1:10 p.m., Resident #3 reported to S4 ADON that she was ambulating to the activity room and a resident was sitting close to the entrance of the door, so Resident #3 stated I better go around the other way, I don't want to get into trouble again. S1 Administrator revealed Resident #3 entered the activity room and sat at the table. S1 Administrator revealed S3 LPN entered the activity room, and approached Resident #3 and called her sarcastic in front of the other residents. S1 Administrator revealed a hospice employee was in the activity room and witnessed the incident. S1 Administrator revealed he watched the video surveillance (no audio), for both incidents and witnessed interactions between Resident #3 and S3 LPN. S1 Administrator revealed Resident #3 was crying and upset during interview. S1 Administrator revealed S3 LPN was terminated on 02/28/2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/11/2025 at 11:15 a.m. with Resident #3, revealed that on 02/23/2025 (no time), she went to the activity room to play bingo. Resident #3 revealed there were several other residents seated near the entrance, and she said Oh my goodness, I better go around the other way. Resident #3 revealed S3 LPN entered the activity room, and confronted her, and told her she had been rude to the other residents. Resident #3 stated she attempted to explain what happened, and S3 LPN told her to shut her mouth. Resident #3 revealed she did not report this incident to anyone. Resident #3 revealed the second incident was on 02/27/2025, when she went to play bingo in the activity room. Resident #3 revealed there were several residents at the entrance door to the activity room, and she said I better go around before I get into trouble again. Resident #3 revealed S3 LPN confronted her at this time and yelled at her you're sarcastic. Resident #3 stated that she became tearful and afraid, and asked S3 LPN Why are you treating me like this? What have I done to you? Resident #3 stated S3 LPN replied everyone else might be scared to stand up to you, but I'm not. Resident #3 stated she repeatedly asked S3 LPN to go away and leave her alone; however, S3 LPN continued badgering her. Resident #3 revealed S3 LPN looked at her as if she (S3 LPN) could have killed her, and she (Resident #3) was very scared. Resident #3 revealed R1 and a Hospice Volunteer Coordinator witnessed the verbal altercation. Resident #3 stated she told S3 LPN that she was going to report her to S1 Administrator. S3 LPN then laughed in her face and replied No, you're not because he (S1 Administrator) is not here. Resident #3 stated she was fearful. Resident #3 was observed visibly upset, nervous, and shaking throughout the interview. Resident #3 stated that she was afraid that S3 LPN might come through her window at night and kill her. Interview on 03/11/2025 at 12:05 p.m. with S4 ADON revealed that on 02/27/2025 at approximately 1:00 p.m. , Resident #3 reported to her that she walked to the activity room to play bingo, and a resident's foot blocked the entrance way. Resident #3 stated she went around the other resident so she wouldn't get into trouble. Resident #3 stated S3 LPN, who was sitting at the nurses' station, walked into the activity room, and yelled at Resident #3 that she was being sarcastic. S4 ADON stated that Resident #3 said she's (S3 LPN) after me and was tearful and anxious. S4 ADON stated that Resident #3 then reported an incident that occurred o02/23/2025, when S3 LPN told her to shut her mouth. S4 ADON stated Resident #3 informed her that she had not reported the 02/23/2025 incident to anyone. Interview with S5 CNA/Unit Coordinator on 03/11/2025 at 12:12 p.m., revealed she was in the day room attending to a resident after lunch on 02/27/2025. S5 CNA/Unit Coordinator revealed she observed Resident #3 walk through the TV room to enter the activity room. Resident #3 stated, I don't want to get into trouble again. S5 CNA/Unit Coordinator revealed S3 LPN was at the nurse's station and overheard Resident #3's comment. S5 CNA/Unit Coordinator revealed S3 LPN entered the activity room, then Resident #3 and S3 LPN passed words. S5 CNA/Unit Coordinator stated that she didn't remember the words that were spoken, and Resident #3 was very upset at that time. Telephone interview on 03/11/2025 at 1:37 p.m. with the Hospice Volunteer Coordinator revealed the following: She was at the facility after lunch on 02/27/2025 to call bingo for the residents. Resident#3 came into the activity room and sat down. S3 LPN entered the activity room, approached Resident #3, and said, I heard the smart comment you made when you passed the nurse's station. Resident #3 said I didn't say that, and S3 LPN replied to Resident #3, I heard you, you're mad because you've met someone that's going to stand up to you. Resident #3 then asked S3 LPN to go away and leave her alone; but, S3 LPN continued to make comments to Resident #3. Resident #3 asked S3 LPN, Why are you so mean to me?, and repeatedly pleaded with S3 LPN to leave her alone. Resident #3 was tearful and very upset. S3 LPN's voice became loud and aggressive as S3 LPN continued talking to Resident #3. Hospice Volunteer Coordinator revealed Resident #3 became too upset to play bingo. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/11/2025 at 3:12 p.m. with R1 who had a BIMS score of 13, (which indicated intact cognition), revealed Resident #3 was seated in the activity room when S3 LPN entered, and yelled at Resident #3 that she was sarcastic. R1 revealed another incident happened the previous weekend when S3 LPN told Resident #3 to shut her mouth. R1 stated Resident #3 was shaking, crying, and asked R1 for help. R1 revealed she accompanied Resident #3 when she reported the incident to S4 ADON. R1 revealed on 02/27/2025, as they were waiting to speak with S4 ADON, S3 LPN exited S4 ADON's office and told Resident #3, I guess you're happy now. R1 stated that Resident #3 was still nervous and upset after the incident occurred. Interview on 03/11/2025 at 3:51 p.m. with S1 Administrator, confirmed that S3 LPN did verbally abuse Resident #3 on 02/23/2025 and 02/27/2025. Telephone Interview on 03/12/2025 at 11:41 a.m. with S3 LPN, revealed on 02/23/2025 there were residents waiting to play bingo, and she heard a commotion. S3 LPN revealed she left the nurse's station to see what was going on. S3 LPN revealed two other residents said that Resident #3 had said something to them, and they were upset. S3 LPN revealed she approached Resident #3 in the activity room, and asked her if she said anything ugly to the two residents, and if she had said something ugly, not to do it again. S3 LPN revealed Resident #3 became upset, and wouldn't stop talking. S3 LPN confirmed she told Resident #3 to shut it. S3 LPN revealed Resident #3 said, So you want me to shut my mouth? and she replied to Resident #3, Yes. S3 LPN revealed that on 02/27/2027, she overheard from the nurse's station Resident #3 say, I'll go around the other way, I don't want to get accused again. S3 LPN revealed she went into the activity room and told Resident #3 she shouldn't have made that remark, and that it was unnecessary. S3 LPN stated, I shouldn't have said anything to Resident #3, and I should have just let it go. S3 LPN confirmed that Resident #3 was still upset and witnessed Resident #3 cry after the verbal altercation that occurred on 02/27/2025.

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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 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. 44844 Based on interview and record review the facility failed to ensure an allegation of staff to resident verbal abuse was reported to the State Survey Agency immediately, but not later than 2 hours after the staff to resident verbal abuse was discovered, for 1 (Resident #3) of 3 (Resident #1, Resident #2 and Resident #3) sampled residents. Interview on 03/11/2025 at 3:51 p.m. with S1 ADM revealed on 02/27/2025 at 12:45 p.m., Resident #3 was verbally abused by S3 LPN. S1 ADM revealed this incident of staff to resident verbal abuse was witnessed by a Hospice Volunteer Coordinator and R1. Review of the SIMS (Statewide Incident Management System) report dated 03/06/2025 revealed the discovery date and time of verbal abuse for Resident #3 was on 02/27/2025 at 12:54 p.m. The SIMS entry time was documented as 02/28/2025 at 12:40 p.m. Interview on 03/11/2025 at 3:51 p.m. with S1 ADM confirmed a SIMS report was not entered immediately or within 2 hours after discovery of abuse.