STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195603	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Vista Nursing and Rehab Center	323 Evergreen Hwy Bunkie, LA 71322

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 - Minimal harm or potential for 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** 46773 Based on interview and record review the facility failed to ensure residents' rights to be free from mental and verbal abuse, for 2 (Resident #1 and Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The facility failed to protect Resident #1 and Resident #2 from mental and verbal abuse by S3 CNA. The facility implemented corrective actions which were completed prior to the State Agency's Investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review of the facility policy on 09/18/2024, with a revision date of 09/2022 titled: Abuse, Neglect, Exploitation or Misappropriation Prevention Program, read in part Policy Statement: Residents have the right to be free from abuse. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. Mental and Verbal Abuse: 3. Examples of Mental and Verbal abuse included, but are not limited to: a. harassing a resident; b. mocking, insulting, ridiculing; c. yelling or hovering over a resident , including but not limited to, depriving a resident of care . Resident #1 Review of Resident #1's medical records revealed an admitted [DATE], with diagnoses that included: Parkinson's Disease, Unspecified Intellectual Disabilities, Unspecified Mood Disorder, Epilepsy, Type 2 Diabetes Mellitus, Unspecified Dementia, and Major Depressive Disorder. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Admission MDS with an ARD 6/19/2024, revealed a BIMS score of 04, indicating severely impaired cognition. The MDS revealed Resident #1 was dependent on staff for all ADL's due to impairment to upper and lower extremities, Interview on 09/19/2024 at 1:45 p.m. with Resident #1, revealed on 08/27/2024, S3 CAN spoke to her in a rude manner, which made her cry. Resident #2 Review of Resident #2's medical records revealed an admitted [DATE], with diagnoses that included: Dysphagia following Cerebral Infarction, Unspecified Dementia, Contraction of right and left ankle, Memory deficient following Cerebral Infarction, Schizoaffective Disorder, Bipolar Disorder, Epilepsy, and Chronic Obstructive Pulmonary Disease. Review of Resident #2 Quarterly MDS with an ARD of 08/07/2024, revealed a BIMS score of 8, indicating moderately impaired cognition. Interview on 09/18/2024 at 10:18 a.m. with Resident #2 revealed on 08/27/2024, when the incident occurred with S3 CNA and Resident #1, S3 CNA also spoke to him in a rude manner, and that it upset him. Review of video footage of the incident on 08/27/2024 at 12:24 p.m., revealed Resident #1 and Resident #2 sitting in Hall X's dining area, and S3 CNA sitting to the left side of Resident #1. Resident #1 shifted her body in the chair, and moved the pillow that had been repositioned by S3 CNA on 3 different occasions. S3 CNA was again observed to put the pillow back in position. S3 CNA was heard telling Resident #1 you aren't going to get a diet coke if you keep moving the pillow, and go ahead and take that pillow off, but you are not getting any coke. At 12:25:45 seconds, the video footage revealed that Resident #1 moved her pillow, and S3 CNA grabbed Resident #1's arm and pushed it up in order to put the pillow in place, then placed Resident #1's arm back down, while telling Resident #1, you don't need a coke, you need to keep that pillow under your arm. At this point Resident #2 was heard telling S3 CNA You're going to get fired. S3 CNA aggressively replied, that doctor put that in her chair, and want it with her. Yes, that's my job to keep her safe. I'm not being fired; I'm being safe and cautious. S3 CNA asked Resident #2 are you okay over there? Resident #2 replied, my back hurts. S3 CNA stated do you want to go to bed? S3 CNA then shook her head and said, You going to have to wait until someone else comes right here. Interview on 09/18/2024 at 1:45 p.m. with S4 ADON, revealed she was in her office located directly across from Hall X's dining area, when she heard Resident #2 tell S3 CNA, you need to stop that, or you are going to get fired. S4 ADON stated she immediately walked over and asked S3 CNA what was going on. S3 CNA stated Resident #1 kept throwing her pillow on the floor. S4 ADON stated that at that point, Resident #1 looked back at me and stated She (S3 CNA) hit me. S4 ADON stated she assisted Resident #1 away from S3 CNA, and notified S1 Administrator and S2 DON of the allegation. During an interview on 09/19/2024 at 12:45 p.m., S1 Administrator stated from observing the video footage of the incident that occurred on 08/27/2024, S3 CNA spoke to Resident #1 and Resident #2 in an aggressive, antagonizing manner. S1 Administrator stated S3 CNA taunted Resident #1 by telling her that if she moved her pillow, she would not get a coke; and deprived Resident #2's request to go back to bed in an aggressive manner, when he complained of back pain. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility has implemented the following actions to correct the deficient practice: 1. S3 CNA was terminated on 08/27/2024 due to Abuse. 2. Body Audit was conducted on Resident #1 and Resident #3 on 08/27/2024. 3. Body Audits were completed on all residents being care for on the hall that S3 CNA worked on 08/27/2024. 4. Life safety rounds completed on all residents in the facility on 08/27/2024 with 2 questions: Do you feel safe living here? Have you felt threatened by anyone here? 5. In-servicing on Abuse policy and PTSD for all staff began on 08/27/2024 and was completed on 09/03/2024. 6. Post Traumatic Stress Disorder psychiatric evaluations completed for Resident #1 and Resident #2 by Psychiatric Nurse Practitioner on 08/29/2024. 7. Resident Council meeting held on 08/29/2024, where residents were educated on Abuse/Neglect, Exploitation/Misappropriation Prevention. 8. QAPI/PIP initiated on 08/27/2024 for Abuse, and is ongoing. Facility correction Date of 09/03/2024