STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195313	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Agnes Healthcare and Rehab Center	606 Latiolais Road Breaux Bridge, LA 70517

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to identify and correct situations that could possibly result in actual or suspected abuse by failing to immediately report a complaint made by a resident to the Administrator or designee for 1 (#92) resident out of 30 sampled residents. Findings: Review of the facility's policy titled, Grievance, with a last revised date of 11/24/2025, read in part: Grievance or complaint is filed, if staff has received the complaint, he/she is to notify administrator or his designed as soon as possible.Prevention- identify and correct situations that could possibly result in abuse. Encourage staff to report actual or suspected abuse without fear of retribution.Identification- C) any staff person receiving a complaint of abuse, neglect, or an injury of unknown origin whether it is from the resident, a family member of staff, should listen to the complaint, writing down the date, and time complaint is being received time, and any details given. Review of Resident #92's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] and had diagnosis of incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic. Review of Resident #92's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating that his cognition was intact.On 05/05/2026 at 12:56 p.m., an interview was conducted with Resident #92. He stated he began having right shoulder pain after S10CNA pulled his wrist and arm. He was unable to remember the exact date. He stated he was sitting on the edge of bed, facing the window, and asked S10CNA to assist him with getting out of bed. S10CNA grabbed his wrist area and arm and in the process of helping him to stand, she pulled his whole arm out of socket. He reported the incident to the S9LPN the following week. Review of an x-ray report dated 10/09/2025 revealed in part: - Impression: Moderate osteoarthritis glenohumeral joint.Chronic rotator cuff tear. Review of facility's grievance log from October 2025 to May 2026 did not reveal a grievance was filed for Resident #92. On 05/05/2026 at 1:50 p.m., an interview was conducted with S9LPN. She stated Resident #92 complained to her that his right shoulder and arm started hurting after S10CNA pulled his arm when helping to get him out of bed. She stated she was unsure of when it exactly happened because when he reported it to her, S10CNA was not employed at the facility. She stated that when Resident #92 reported this to her, she reported it to either S4AsstADM/MDS/IP or S6DON, but she was not completely sure. However, she was sure she reported this complaint to a superior. An x-ray was ordered for the resident, because on 10/09/2025, he complained of right shoulder pain while in therapy. On 05/05/2026 at 2:45 p.m., an interview was conducted with S7QA who was responsible for quality assurance. S7QA stated that sometime in December, the resident told her that his shoulder was injured when a CNA pulled his arm while moving him. S7QA stated that she did not further investigate to determine which CNA pulled his arm or when the incident actually occurred. On 05/06/2026 at 9:55a.m., a joint interview was conducted with S6DON, S4AsstADM/MDS/IP, S7QA, and S9LPN. S6DON confirmed that on 10/09/2025, the resident had an x-ray that revealed a chronic rotator cuff tear. S6DON and S4AsstADM/MDS/IP stated they were not aware of Resident #92's complaint that S10CNA pulled his arm out of the socket and caused the injury to his arm until the surveyor brought it to their attention. S7QA stated that a couple of (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	months after the resident was confirmed to have a chronic rotator cuff tear, he began to complain of right shoulder pain again, and told her She's the reason my shoulder is hurt in an accusatory manner. S7QA was unable to recall the exact date the resident told this to her and was unable to recall which CNA the resident was referring to. S7QA confirmed she did not report this complaint to S6DON or the Administrator and she should have so that the CNA could have been identified and they could have investigated the concern. S9LPN confirmed the resident complained that his arm was manipulated in some manner by S10CNA while helping him to sit up and remembered that she reported this to S11ADON who no longer works at the facility. S6DON confirmed that S11ADON should have notified her of the resident's complaint and also confirmed there was no documentation of the resident's complaint to S9LPN, S11ADON, or S7QA. S10CNA and S11ADON were unavailable for interview at the time of the survey. On 05/06/2026 at 11:37 a.m., an interview was conducted with S8ADM. He stated that on 10/09/2025, Resident #92 informed him that a CNA moved him improperly and he conducted an investigation, but he was not aware of any other claims of possible mistreatment by staff members resulting in injury to his shoulder after 10/09/2025. He also did not follow up with the resident to confirm which CNA moved him improperly. He confirmed that he was not informed that the resident complained to two different staff members that a CNA injured his arm and if he would have known, he would have investigated the complaint. He also confirmed that S11ADON and S7QA nurse, should have reported the resident's claims to S6DON or himself.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received an assistive device to maintain and/or improve hearing for 1 (Resident #6) out of 1 resident investigated for communication-sensory.Findings:Review of Resident #6's admission Record revealed she was admitted to the facility on [DATE] with diagnoses that included, in part, major depressive disorder, cognitive communication deficit, and anxiety disorder.Review of Resident #6's Quarterly MDS (Minimum Data Set) with an ARD of 02/26/2026, under Section C, revealed she had a BIMS score of 15 which indicated her cognition was intact. Further review of the MDS revealed, under Section B, that Resident #6 had minimal difficulty hearing and no hearing aid or other appliance was used.Review of Resident #6's Progress notes revealed a note dated 02/26/2026 written by S5SSD which stated the following: No hearing aids noted for assist device. Is slightly HOH however was able to hear when spoken to in a louder tone. Is on wait list for free hearing aids with (Social Services Organization). Further review of the progress notes revealed a note dated 12/04/2025 written by S5SSD which stated: No hearing aids noted for assist device. Is slightly HOH however was able to hear when spoken to in a louder tone. Is on wait list (Social Services Organization) for free hearing aids.On 05/04/2026 at 10:44 a.m., an interview was conducted with Resident #6 and she stated she had trouble hearing. Resident #6 stated the facility was aware that she had trouble hearing and she was on a waiting list for hearing aids. She stated she was told the list was long and she had not heard anything else regarding her hearing aids.On 05/05/2026 at 3:30 p.m., an interview was conducted with S5SSD. S5SSD confirmed that Resident #6 was on the (Social Services Organization) waiting list for hearing aids. S5SSD stated the waiting list was long and it usually takes about 6-9 months for a resident to receive hearing aids.On 05/05/2026 at 3:35 p.m., a record review and interview was conducted with S5SSD. A review of a progress note in Resident #6's chart revealed an entry written by S5SSD dated 09/30/2024 at 8:30 a.m. which revealed the following: No hearing aid noted for assist device. Offered assist device.phoned (Social Services Organization).Resident #6 placed on wait list for free hearing aids. S5SSD confirmed that Resident #6 had been on the (Social Services Organization) waiting list for hearing aids since 09/30/2024.On 05/05/2026 at 3:55 p.m., an interview was conducted with S5SSD. S5SSD stated that if it was taking long for a resident to receive their hearing aids, and a resident has not received their hearing aids, she would call the (Social Services Organization) to follow up. S5SSD stated she did not realize that Resident #6 was on the (Social Services Organization) waiting list for hearing aids since 09/30/2024 until present. S5SSD stated she supposed it was her responsibility to follow up with the (Social Services Organization) regarding Resident #6's hearing aids, since the resident had been on the waiting list for hearing aids longer than 6-9 months.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and record review, the facility failed to store food in accordance with professional standards for food service and failed to ensure sanitary conditions were maintained in the kitchen by failing to:Appropriately store, label and date frozen food items, and Ensure kitchen staff used good hygienic practices while preparing and serving food to residents.This had the potential to affect 93 residents who consumed foods from the facility's kitchen.Findings:1.On 05/05/2026, a review of the facility's policy titled, Food Storage with a last reviewed date of 11/24/2025, read in part . 14. Frozen Foods .c. All foods should be covered, labeled and dated .All foods will be checked to assure that foods will be consumed by their use by dates or discarded . On 05/04/2026 at 8:53 a.m., an observation of the facility's freezer with S2DMT revealed the following:- 1/2 a plastic bag of frozen meat patties which was tied at the opening. The bag had a small hole in the plastic bag, was not labeled with the contents, and did not have a used by dated.- 4 mid-sized plastic bags with frozen brown substance. The bags were not labeled with the contents and used by date.-2 large frozen plastic bags with a brown substance. The bags were not labeled with the contents and/or used by date. S2DMT confirmed the above findings. She stated each of the items were supposed to be labeled with the contents and used by date when they were removed from their original container. She also stated the bag with the meat patties should not have had a hole. 2.On 05/05/2026, a review of the facility's policy titled, Bare Hand Contact with Food and Use of Plastic Gloves with a last reviewed date of 11/24/2025, read in part .Procedure: 1. Staff will use good hygienic practices and techniques .2. Staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling food. 3. Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task such as working with ready-to-eat food ., used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation .5. Clean gloves are to be used when: a. Handling ready-to-eat foods . On 05/04/2026 at 10:50 a.m., an observation was made of S3Cook preparing pureed vegetables to serve the resident's for lunch. S3Cook wore the same pair of single use plastic gloves during the process. S3Cook was observed wearing single use plastic gloves to retrieve a food processer and a scooper, scooped vegetables from a pot on the stove, placed the vegetables in the food processer, then touched the food processer wearing the same pair of single use plastic gloves to turn on the food processor. S3Cook was then observed using her gloved right hand to scoop the pureed vegetables from the food processer into a pan. She did not change her gloves or use a food utensil. S3Cook stated she should have used a spoon and not her contaminated glove to remove the pureed vegetables from the food processer. S3DM, who was also observing the process, stated S3Cook should have used a food utensil to remove the vegetables from the food processer. On 05/04/2026 at 11:45 a.m., an observation was made of S3Cook serving resident's lunch from the steam table. S3Cook was wearing a pair of single use plastic gloves. She picked up a thermometer to check food temperatures, touched the steam table several times, picked up plates to serve the food and touched the scoopers for each food item each time she placed food on a plate. S3Cook was observed cutting meat with a knife that she held in her gloved right hand as she held the meat with her gloved left hand. S3Cook did not change her gloves or used a utensil to hold the meat. She confirmed the above findings and stated she should have used a fork. On 05/04/2026 at 2:48 p.m., an interview was conducted with S4AsstADM/MDS/IP. She stated S3Cook should not have touched the residents' food with her gloved hands after touching another surface, because she could transfer contaminants from that surface to the residents' food. On 05/05/2026 at 10:38 a.m., an interview was conducted with S1DM. S1DM stated S3Cook should not have touched all those non-food items with her gloved hand and then go back and touch the residents' food with the same contaminated glove. She stated S3Cook should have gotten a spoon and used it to scoop the vegetables out of the food processer and used a fork to hold the meat while cutting it.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's plan of care was implemented as ordered for 2 (Resident #3, Resident #7) out of a total sample of 30 residents by failing to:follow physician's order for assessing Resident #3's dialysis site; andfollow physician's order for monitoring of right hand splint; administering enteral feed; and administering enteral flush for Resident #7.Findings:1.Review of Resident #3's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage renal disease, atherosclerotic heart disease, and diabetes mellitus.Review of Resident #3's February 2026 physician's order and Hall TAR (Treatment Administration Record) revealed the following order dated 09/27/2022: Dialysis Access Site-observe daily for bleeding or signs of infection. Notify dialysis center/MD (medical doctor) if noted every shift. The resident's Hall TAR failed to include nurses' initials or evidence that the resident's dialysis access was observed for bleeding or signs of infection on 02/27/2026, day and evening shift. Review of Resident #3's April 2026 physician's order and Hall TAR revealed the following order dated 09/27/2022: Dialysis Access Site-observe daily for bleeding or signs of infection. Notify dialysis center/MD (medical doctor) if noted every shift. The resident's Hall TAR failed to include nurses' initials or evidence that the resident's dialysis access was observed for bleeding or signs of infection on 04/07/2026 evening, 04/13/2026-evening, 04/16/2026-evening, 04/18/2026-day, 04/22/2026-evening, and 04/29/2026-night.On 05/06/2026 at 11:48 a.m., an interview and record review was conducted with S4AsstADM/MDS/IP. She reviewed Resident #3's February 2026 and April 2026 Hall TARs and confirmed there was no evidence the nurses were monitoring the resident's dialysis access site for the above dates. S4AsstADM/MDS/IP confirmed the resident's monitoring was not done as ordered in February 2026 and April 2026.2.Review of Resident #7's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis, muscle wasting and atrophy, encounter for attention to gastrostomy, dysphagia, and aphasia.Review of Resident #7's January 2026 physician's order and Hall TAR revealed the following order dated 01/30/2025: Check right hand splint-color of limb, movement ability, sensation when touched, and temperature of skin on feel every shift for monitoring. Document plus or minus. Minus must be reported to the physician. The Hall TAR failed to include nurses' initials or evidence that the resident's dialysis access was observed for bleeding or signs of infection on the date of 01/21/2026-evening, 01/26/2026-day, and 01/29/2026-day.Review of Resident #7's February 2026 physician's order and Hall TAR revealed the following order dated 01/30/2025: Check right hand splint-color of limb, movement ability, sensation when touched, and temperature of skin on feel every shift for monitoring. Document plus or minus. Minus must be reported to the physician. The Hall TAR failed to include nurses' initials or evidence that the resident's right hand splint was checked for the above on the date of 02/04/2026-evening, 02/14/2026-night, and 02/18/2026- night, and 02/27/2026-day.Review of Resident #7's March 2026 physician's order and MAR (Medication Administration Record) revealed the following in part:Order dated 12/30/2024: Enteral Feed Order, every shift enteral formula feedings of Diabetasource 60 cc/hr (cubic centimeters per hour) continuously. The MAR failed to include nurses' initials or evidence that the treatment was administered for the resident on the date of 03/20/2026--evening.Order dated 01/02/2025: Enteral Flush-Check placement and residual prior to administering water flush. Hold if residual is > (greater than) or = (equal to) 100 ml (milliliters). Recheck in 1 hour and/or notify MD if unresolved. The MAR failed to include nurses' initials or evidence that the treatment was administered for the resident on the date of 03/20/2026 at 1030.Review of Resident #7's April 2026 physician's order and MAR (Medication Administration Record) revealed the following in part:Order dated 12/30/2024: Enteral (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Feed Order, every shift enteral formula feedings of Diabetasource 60 cc/hr (cubic centimeters per hour) continuously. The MAR failed to include nurses' initials or evidence that the treatment was administered for the resident on the date of 04/02/2026-evening.Order dated 01/02/2025: Enteral Flush-Check placement and residual prior to administering water flush. Hold if residual is > (greater than) or = (equal to) 100 ml (milliliters). Recheck in 1 hour and/or notify MD if unresolved. The MAR failed to include nurses' initials or evidence that the treatment was administered for the resident on the date of 04/02/2026 at 1030.Review of Resident #7's April 2026 physician's order and Hall TAR revealed the following order dated 01/30/2025: Check right hand splint-color of limb, movement ability, sensation when touched, and temperature of skin on feel every shift for monitoring. Document plus or minus. Minus must be reported to the physician. The Hall TAR failed to include nurses' initials or evidence that the resident's right hand splint was checked for the above on the date of 04/07/2026-evening, 04/13/2026-night, and 04/16/2026-night, and 04/18/2026-day, 04/22/2026-evening, and 04/29/2026-night.On 05/06/2026 at 11:56 a.m., an interview and review of Resident #3 and Resident #7's physician orders and Hall TAR was conducted with S4AsstADM/MDS/IP. She reviewed Resident #7's January 2026, February 2026, and April 2026 Hall TAR and confirmed that the TARs failed to include nurses' initials or evidence that the nurses the resident's right hand splint was checked for the above dates. S4AsstADM/MDS/IP also reviewed Resident #7's March 2026 and April 2026 MAR, and confirmed that the MARs failed to include nurses' initials or evidence that the treatments of enteral feed or enteral flush were administered for the above dates. S4AsstADM/MDS/IP confirmed the resident's right hand splint was not checked and enteral feed and enteral flush were not done as ordered in January 2026, February 2026, March 2026 and April 2026.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that a resident's care plan was accurately updated to reflect the resident's current code status for 1 (Resident #3) out of 30 sampled residents. This deficient practice had the potential to affect a total census of 95 residents.Findings: Review of Resident #3's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage renal disease, atherosclerotic heart disease, and diabetes mellitus.Review of Resident #3's electronic medical record revealed she was a DNR (Do Not Resuscitate).Review of Resident #3's electronic medical record revealed a Louisiana Physician Orders For Scope of Treatment (LaPOST) that read in part:.A. Do Not Attempt Resuscitation (DNR).F. Summary of Goals: Discussed with: Personal Health Care Representative. The basis for these orders is: Patient's Personal Health Care Representative (Qualified Patient without capacity), signed by physician and signed by Personal Health Care Representative on [DATE]. Review of Resident #3's [DATE] physician's orders revealed the following order dated [DATE]: Do Not Resuscitate-No CPR (cardiopulmonary resuscitation). Review of Resident #3's care plan read in part.I am a Full Code and want CPR done on me. On [DATE] at 11:42 a.m., an interview and record review was conducted with S4AsstADM/MDS/IP who stated that she was responsible for completing and updating care plans for residents in the facility. S4AsstADM/MDS/IP confirmed Resident #3's record revealed the LaPOST form that indicated the resident had a DNR status and was signed on [DATE]. A review of resident's care plan was conducted with S4AsstADM/MDS/IP, who confirmed that the resident's care plan had not been updated and/or revised to reflect the code status to DNR status and was not.