

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER St. Francisville Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15243 LA Hwy 10 Saint Francisville, LA 70775	
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** Based on interviews and record reviews, the facility failed to protect the residents' right to be free from physical abuse by Resident #1 for 1 (#3) of 3 residents reviewed for abuse. 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. This deficient practice resulted in an actual harm for Resident #3 on 07/01/2026 when Resident #1 hit Resident #3 causing him to fall to the ground. Resident #3 was sent to a local hospital and a Computed Tomography (CT) Scan revealed a mildly displaced fracture of the intertrochanteric left hip and acute traumatic non-displaced fracture of the right seventh, eighth, and ninth ribs. Resident #3 required emergent surgical intervention on 07/01/2026. Prior to the incident with Resident #1 on 07/01/2026 Resident #3 had been independently ambulatory and able to perform (ADL's) with verbal cues from staff. After the incident on 07/01/2026 Resident #3 required a wheelchair for mobility, moderate assistance from staff with ADL's, and maximum assistance from staff with transfers. Review of the facility's policy titled, Preventing Abuse, Neglect, and Exploitation last revised 09/2022 revealed the following, in part: Abuse is the willful infliction of injury with resulting physical harm, pain, or mental anguish. Types of resident abuse: Physical abuse: Physical abuse includes any kind of intentional and aggressive physical contact such as hitting, slapping, punching. Resident to resident abuse: It is the facility's responsibility to maintain a safe environment for all residents. This can mean that residents with behaviors that provoke reactions in other residents and residents with a history of altercations with other residents are treated and supervised appropriately. Resident #3 Review of Resident #3's Clinical Record revealed an admission date of 05/13/2026 and had diagnoses of Alzheimer's and Dementia. (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 admission MDS with an ARD of 05/26/2026 revealed a BIMS of 3, which indicated he was severely cognitively impaired. Review of Resident #3's Nurses' Notes dated 07/01/2026 revealed the following, in part: On 07/01/2026 at 7:51 a.m., Resident #3 involved in an incident with Resident #1, resulting in a fall. Physical assessment completed at this time. Resident #3 unable to perform active range of motion to left lower extremity. Complained of pain to left hip. Nurse Practitioner gave order to send resident to acute care hospital for medical evaluation. Resident #3 transferred out via ambulance. Review of Resident #3's Acute Care Hospital Record dated 07/01/2026 & 07/03/2026 revealed the following, in part. X-ray of Left hip. Findings: acute traumatic comminuted proximal, intertrochanteric left femur fracture. - CT of Left Lower Extremity. Findings: acute comminuted mildly displaced fracture of the intertrochanteric left hip. - CT Chest without contrast. Findings: acute traumatic nondisplaced fracture of the right seventh, eighth and ninth ribs, located in the midaxillary line. These are singular fractures at each rib. No pneumothorax. -Left Hip Cephalomedullary Nail by Orthopedic Surgeon on 07/01/2026. Resident #1 Review of Resident #1's Clinical Record revealed an admission date of 03/24/2020 and diagnoses, which included Personal History of Traumatic Brain Injury, Paranoid Schizophrenia, Other Specified Depressive Episodes, Major Depressive Disorder-Recurrent-Severe with Psychotic Symptoms, Intermittent Explosive Disorder, and Anxiety Disorder. Further review revealed Resident #1 was transferred to a local behavioral hospital on [DATE] and did not return to the facility. Review of Resident #1's Quarterly MDS with an ARD of 07/01/2026 revealed he had BIMS of 15, which indicated intact cognition. Further review revealed he had physical and verbal behavior toward others. Review of Resident #1's Care Plan revealed the following, in part: Problem: Behavior: Socially inappropriate/disruptive behavior. Does not like loud sounds and has physically abusive behavior. History of verbal aggression toward other residents. Interventions: 07/01/2026 Resident with behaviors. He was immediately put on 1:1 observation. Resident was sent to a local hospital with a Physician's Emergency Certificate. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Nurses Notes dated 02/26/2026 through 07/01/2026 revealed Resident #1 exhibited aggressive behaviors toward other residents on 02/26/2026 and 04/17/2026. Further review revealed the following: On 05/17/2026 at 10:22 a.m. by S5LPN: Resident #1 was observed in wheelchair coming up to the nurses' station by CNA to ask for a snack. Resident #3 started screaming at Resident #1. Resident #1 stood up from his wheelchair and grabbed Resident #3's shirt. Staff immediately intervened and reoriented Resident #1 to his room. On 07/01/2026 at 8:34 a.m. by S5LPN: Resident #1 had a physical altercation with Resident #3 during breakfast. Resident #1 got out of his wheelchair after exchanging words with Resident #3. Resident #1 proceeded to slap Resident #3 twice and proceeded to try to harm Resident #3 once on the ground. This nurse broke up the altercation. Resident #1 was immediately put on 1:1 observation. Resident #1 to be PEC'd to behavioral hospital. Review of Resident #1's Physician Progress Note by S3NP dated 07/01/2026 revealed the following, in part: Today, Resident #1 physically struck another resident and attempted to hit another resident. He showed no remorse and stated he would do it again. Patient placed under PEC and sent to local Emergency Room. An interview was conducted with S5LPN on 07/28/2026 at 8:05 a.m. She stated Resident #1 had a history of verbally yelling out if another male resident yelled. She stated, on 07/01/2026, her medication cart was parked immediately outside of the dining room so she could see the dining area. She stated Resident #3 wandered into the dining room and screamed he wanted to go home. She stated she heard Resident #1 say shut up and Resident #3 replied come make me. She stated she immediately ran into the dining room. She stated before she made it to Resident #1, he ran across the dining room and hit Resident #3 twice in the face. She stated Resident #3 backed away from Resident #1 and fell. She stated Resident #1 tried to continue to hit Resident #3 while he was on the ground. She stated she physically removed Resident #1 from Resident #3 because verbal redirection was not successful. She stated Resident #1 was immediately escorted to his room. She stated once Resident #3 was put into bed, he complained of pain and was unable to straighten his left leg. She stated Resident #3 was transferred to a local hospital for imaging. She stated once Resident #1 was escorted to his room, a CNA was assigned to 1:1 and never left him until he was transported to the hospital via ambulance. She stated S3NP PEC'd Resident #1. She stated the Sheriff's Office was also notified and responded to the facility prior to Resident #1 being transferred to the hospital. She confirmed Resident #1 physically abused Resident #3 on 07/01/2026. She stated abuse training was provided after the incident. She stated the facility provided training on handling residents with behaviors, including removing them from any triggering situation, escalating situation, and monitoring them for any escalating behaviors. She stated there had been increased staff presence in the dining area for all meals. She stated 2 CNAs from each hall, the nurse, and a department head during the week were assigned to the dining room during meal times. She stated there were also two CNAs from each hall, the nurse, and the RN supervisor present in the dining room on the weekends. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with S3NP on 07/28/2026 at 10:55 a.m. She stated she received a phone call regarding the incident with Resident #1 hitting Resident #3 on 07/01/2026. She stated Resident #3 was immediately sent to the hospital for imaging. She stated Resident #1 was immediately placed on 1:1 observation. She stated when she arrived, she saw Resident #1, and Resident #1 reported he hit Resident #3 and would do it again so she PEC'd him. She confirmed Resident #3 sustained a left hip fracture which required surgical intervention and several ribs fractures from the incident. She confirmed Resident #1 physically abused Resident #3 on 07/01/2026. She stated, in response to the incident, the administrative staff had shifts of dining room duty. She stated there have been more staff present in the dining room since the incident on 07/01/2026. An interview was conducted with S2DON on 07/28/2026 at 11:21 a.m. S2DON stated Resident #1 has a history of behaviors. S2DON stated the staff were repeatedly trained on redirection and managing behaviors. S2DON stated, on 07/01/2026, she was entering the facility when she heard commotion in the dining room. S2DON stated once she arrived in the dining room, Resident #3 was on the floor with the nurse and staff caring for him. S2DON stated she immediately instructed a staff member to escort Resident #1 to his room and provide 1:1 observation. She stated Resident #1 remained on 1:1 observation until he exited the facility with ambulance personnel. S2DON stated she went to Resident #1's room, and Resident #1 reported he hurt Resident #3 and would do it again. S2DON stated Resident #1 had no remorse and was saying he would do it again with a smile on his face. S2DON stated, based on video footage and Resident #1's interview, prior to the physical contact Resident #3 was waving his arms and saying no, Resident #1 called him a p**** and stated you made me walk all the way over here, you're going to get it. She stated Resident #1 then hit Resident #3 in the face. S2DON stated Resident #1 was PEC'd, sent to a local hospital, and was admitted to a behavioral health unit. S2DON stated Resident #3 sustained a hip, femur, and rib fractures. S2DON confirmed, since the incident on 07/01/2026, she had been monitoring the dining room during meal service per the new department head schedule. An interview was conducted with S1ADM on 07/28/2026 at 11:21 a.m. S1ADM stated, based on the video footage, it was difficult to determine if Resident #3 fell from Resident #1's hit or if he was backing away from Resident #1 and fell. S1ADM confirmed Resident #3 made gestures to Resident #1 that he did not want to fight. S1ADM stated Resident #1 reported Resident #3 verbally told him he did not want to fight. An interview was conducted with S1ADM on 07/28/2026 at 12:37 p.m. She stated the facility immediately put protections in place after the incident with Resident #1 on 07/01/2026. She stated Resident #1 was removed from the facility for a psychiatric stay, and ultimately, due to his behaviors at the psychiatric hospital, was involuntarily discharged from the facility. She stated all staff had been re-educated on abuse, redirection, and how to approach residents when they become aggressive. She stated monitoring was increased in the dining room for all meals and for large group activities. She stated monitoring was in place to identify if any residents were having any outbursts or behaviors. She stated the facility changed the dining schedule so that instead of residents going by hallway, it was first come first served. She stated there was a department head assigned to the dining room for each meal during the week. She stated on the weekends, the RN supervisor monitored the meal service. She stated one CNA remained on the hall to pass trays and all other CNAs responded to the dining room for the meal service. She stated she monitored the dining room to (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	ensure the staff were where they were supposed to be for that given meal. Review of the facility's in-service records revealed all staff had been re-educated on abuse, redirection, and how to approach residents when they are becoming aggressive. Review of the facility's meal service assignment schedule revealed a department head was assigned to observe each meal in the facility. The facility had implemented the following actions to correct the deficient practice: Corrective action accomplished for Resident #1, resident was removed from the dining room and placed one on one with staff until the ambulance arrived to transport to the hospital on a PEC for his aggressive behaviors. All residents have the potential to be affected by the residents' aggressive behaviors. All staff have been educated on abuse, redirection and how to approach residents when they are becoming aggressive. Continuing corrective action is to increase monitoring in the dining room and at large group activities. In order to monitor theses corrective actions, the facility has changed the dining schedule. Instead of the residents eating by hall, the residents will eat first come first serve. A department head will be assigned to monitor a specific meal on a specific day of the week. The department head will be monitoring for any outbursts or aggressive behaviors. Also, there will be one aide on each hall to pass the hall trays and the others will be in the dining room directing the residents to the table and passing out trays. The administrator/designee will monitor the dining room to ensure the staff are where they should be every day for 1 week, then 5 times a week for 2 weeks, the 3 times a week for 2 weeks, then once a week for 2 weeks. Then randomly thereafter. Completion date: 07/13/2026. Throughout the survey from 07/27/2026 to 07/29/2026, observations, interviews, and record reviews revealed the above listed actions were implemented. Observations were made of the facility's bingo activity in the main dining room on 07/27/2026 at 10:00 a.m. and the meal services on 07/27/2026 at 11:18 a.m., 07/28/2026 at 7:24 a.m., and 07/29/2026 at 7:20 a.m. with multiple CNAs, one nurse, and one administrative personnel present. Staff interviews revealed staff received training on the facility's abuse policy and procedure, redirection, and how to approach residents when they are becoming aggressive. Observations were made throughout the survey with no abuse identified. Observations, interviews, and record review, revealed monitoring had begun with no further issues identified.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident's involuntary discharge notice met the requirement for discharge for 1 (#1) of 3 residents reviewed for transfer and/or discharge by failing to ensure the notice:Was made as soon as practicable before discharge; and Contained the mailing address, email address, and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.Findings: Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Personal History of Traumatic Brain Injury, Paranoid Schizophrenia, Other Specified Depressive Episodes, Major Depressive Disorder-Recurrent-Severe with Psychotic Symptoms, Intermittent Explosive Disorder, and Anxiety Disorder. Further review revealed Resident #1 was discharged from the facility on 07/20/2026. Review of Resident #1's Quarterly MDS with an ARD of 07/01/2026 revealed he had a BIMS of 15, which indicated intact cognition. Further review of the MDS revealed he had physical and verbal behavior toward others. Review of Resident #1's Discharge summary dated [DATE] revealed the following:Hospital Course:Diagnoses and all orders for this visit:History of Traumatic Brain Injury (Primary)Overview: He has remained in a room by himself at the facility. Unfortunately, due to his TBI he continues to have outbursts and behaviors that put others at risk. On 07/01/2026, he had an unprovoked altercation with another resident and showed no remorse. He was admitted to BHU at a local hospital under PEC. Resident is unable to return to the nursing facility due to ongoing aggressive behavior in which he needs a higher level of care to meet his needs. The safety of individuals in the facility is in danger due to the behavior status of Resident #1.Schizophrenia, Unspecified TypeOverview: . He has a history of impulsive and aggressive behaviors. On 07/01/2026, he physically struck another resident and attempted to hit another resident. He showed no remorse and stated he would do it again. Patient was placed under PEC and sent to a local hospital. He is being discharged from [Facility]. Review of the facility's Emergency Transfer Log dated July 2026 revealed Resident #1 was emergently transferred to a local hospital on [DATE] for behaviors and was emergently discharged from the facility while in the hospital. Review of the facility's Notification of Involuntary Discharge for Resident #1 dated 07/17/2026 revealed the following:Re: IMMEDIATE Involuntary Discharge pursuant to S483.15(c)(1)(i)(C) and (D), pursuant to S483.15(c)(4)(ii). Specific to S483.15(c)(1)(i)(C)-(D): The health and safety of individuals, particularly other residents in the facility, is endangered due to the clinical or behavioral status of the resident.Dear Resident #1, The [Facility] issues to you, Resident #1, this written notice of involuntary discharge pursuant to S483.15(c)(1)(i)(A), (C), and (D) and S483.15(c)(4)(ii). (i) Your immediate discharge is warranted pursuant to S483.15(c)(1)(i)(A),(C), and (D) and S483.15(c)(4)(ii) because your actions, behaviors, and misconduct endangered and continues to endanger both the health and safety of individuals in the Facility. (ii) In accordance with 42 C.F.R. S483.15(c)(4)(ii), the effective date of your discharge is immediate; thus, your discharge is effective 07/01/2026, the date of your actual immediate transfer, notice being provided on the date above.Further review revealed the discharge notice did not contain the mailing, email address, and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. Review of Resident #1's BHSF-142 revealed the following:Approved for admission by Level II authority effective 12/29/2015.OBH-PASRR Level II Evaluation Summary & (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Determination Notice: The individual has a serious mental illness. Review of documentation for receipt of the above discharge notice letter revealed the following parties received the notification letter on the following dates: Resident #1 - 07/20/2026; Resident #1's RP - 07/24/2026; Ombudsman's office - 07/28/2026; and Administrative Law Judge - 07/25/2026. A telephone interview was conducted with Resident #1's RP, on 07/27/2026 at 4:27 p.m. She stated she received Resident #1's involuntary discharge notice via email from the facility on 07/24/2026, which was after the date of discharge. An interview was conducted with S3NP on 07/28/2026 at 10:55 a.m. She stated she officially discharged Resident #1 on 07/20/2026 due to him needing a higher level of care and his behavior status being a danger to other residents in this facility. An interview was conducted with S1ADM on 07/28/2026 at 3:00 p.m. She confirmed Resident #1's involuntary discharge notice reflected a discharge date of 07/01/2026. She stated Resident #1 was discharged from the facility on 07/20/2026. She confirmed Resident #1's involuntary discharge notice was received by Resident #1 on 07/20/2026 via hand delivery, Resident #1's RP on 07/24/2026 via email, Administrative Law Judge on 07/25/2026 via certified mail, and the Ombudsman's Office on 07/28/2026 via certified mail. She confirmed the mailing address, email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act was not listed on the discharge notice. An interview was conducted with S1ADM on 07/29/2026 at 12:35 p.m. She confirmed Resident #1's involuntary discharge notice was issued to the required parties after the date of discharge listed in the notice.		