STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195508	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Francisville Nursing and Rehab, LLC	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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to consult with a resident's physician when the resident experienced a change in ambulation, assistance with ADLs, and continued pain after a fall for 1 (#100) of 3 residents reviewed for falls. This deficient practice resulted in an actual harm for Resident #100, a cognitively intact resident, beginning on 05/15/2026 when Resident #100 continued to complain of left hip pain after a fall, required increased staff assistance with ADLs, and did not ambulate as normal. Prior to the fall on 05/15/2026, Resident #100 was independently ambulatory and continent. An interview with Resident #100 on 05/18/2026 revealed, after her fall on 05/15/2026, she remained in bed, required perineal care after urinary and bowel elimination, and experienced left hip pain. Staff interviews revealed Resident #100 began requiring staff assistance with ADLs, complained of pain during ADL care, and did not transfer out of bed independently after her fall on 05/15/2026. Nursing staff failed to notify Resident #100's NP/MD and/or on-call NP of Resident #100's change in condition. On the morning of 05/18/2026, S10NP was notified of Resident #100's change in condition, and Resident #100 was transferred to a local hospital. Resident #100's Computed Tomography (CT) scan at the local hospital revealed a Mildly Impacted Left Femoral Neck Fracture and Traumatic Non-displaced Fractures of the Left Superior and Inferior Pubic Rami, which required surgical intervention on 05/19/2026.Findings: Review of the facility's policy, revised December 2016, titled, Change in Resident's Condition or Status revealed the following, in part:Policy statement:Our facility shall promptly notify the resident, his or her attending physician.of changes in the resident's medical/mental condition and/or status (eg. Changes in level of care.)Policy Interpretation and Implementation:1. The nurse will notify the resident's attending physician or physician on call when there has been a (an):d. significant change in the resident's physical/emotional/mental condition;e. Need to alter the resident's treatment significantly2. A significant change of condition is a major decline or improvement in the resident's status that:a. Will not normally resolve itself without intervention by staff.b. Impacts more than one area of the resident's health status. Review of Resident #100's Clinical Record revealed an admission date of 01/25/2026 and diagnoses, which included Other Frontotemporal Neurocognitive Disorder. Review of Resident #100's Quarterly MDS with an ARD of 04/08/2026 revealed a BIMS of 15, which indicated intact cognition. Further review revealed Resident #100 was independent with toileting hygiene, transfers, and ambulation. Review of Resident #100's current Physician Orders revealed the following, in part:Assess for pain each shift. Notify NP/MD for new onset of pain or unrelieved pain and document in notes NP/MD notification twice daily. Review of Resident #100's Nurses Notes dated 05/15/2026 through 05/18/2026 revealed the following:05/15/2026 at 11:01 a.m. by S18LPN: Resident observed ambulating in the hallway when resident tripped over her shoe. Resident was witnessed by staff. Resident noted to land on right hip/buttocks after rolling from her left hip/buttocks. No head strike observed. Resident alert and responsive immediately after incident. No loss of consciousness noted. Resident reported pain to left hip/buttocks. Resident was helped off the floor by staff and rolled via wheelchair to room. Resident assisted to bed and is resting. S10NP (continued on next page)

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 0580 Level of Harm - Actual harm Residents Affected - Few	notified. X-ray ordered. Tylenol 325 mg given for pain. Responsible party notified.05/18/2026 at 9:05 a.m. by S19LPN: Resident complaining of pain to left hip. Resident had a fall on Friday, 05/15/2026. Resident seen by S10NP at bedside at 9:00 a.m. and received new order to send resident to emergency room for evaluation.Further review revealed no documentation of communication with the physician between the above listed dates/times. Review of Resident #100's current Care Plan revealed the following, in part:Problem: Risk for falls; 05/15/2026 - fallInterventions:05/15/2026: Resident assessed immediately for injury. NP notified. X-ray ordered. Tylenol 325 mg given for pain. No fracture noted to x-ray, degenerative changes noted.5/18/2026: Resident complaining of pain to left hip. Resident seen by S10NP at bedside at 9:00 a.m. and received new order to send resident to a local emergency department for evaluation.Initiated 01/12/2026 Problem: Risk for impaired urinary elimination.Interventions: monitor for new incontinence; Notify provider immediately if any voiding abnormalities. Review of Resident #100's Left Hip with Pelvis X-Ray Report dated 05/15/2026 at 2:54 p.m. revealed the following, in part:Clinical Information: Fall rule out fracture.Findings:No acute fracture or dislocation. Impression: Degenerative change of the left hip without acute osseous abnormality.Caveat: Up to 10% of hip fractures may be occult on radiographs. If clinical concern persists or the patient fails to bear weight, consider short interval follow-up radiographs versus MRI, the gold standard of hip interrogation. Review of Resident #100's Physician Progress Note by S10NP dated 05/18/2026 revealed the following, in part:Resident seen today for fall.Assessment/Plan:Fall, Subsequent Encounter:Resident had a fall on Friday and was complaining of left hip pain. Left hip x-ray negative. Today, she continues to complain of pain and is unable to ambulate. Transferring to local hospital for advanced imaging. Review of Resident #100's CNA & Nursing Assignments dated 05/15/2026 through 05/18/2026 revealed the following:05/15/2026:6:00 a.m. to 6:00 p.m.: S18LPN and S22CNA6:00 p.m. to 6:00 a.m.: S6LPN and S23CNA05/16/2026:6:00 a.m. to 6:00 p.m.: S20LPN and S24CNA6:00 p.m. to 6:00 a.m.: S7LPN and S23CNA05/17/2026:6:00 a.m. to 6:00 p.m.: S8LPN and S26CNA6:00 p.m. to 6:00 a.m.: S7LPN and S23CNA05/18/2026:6:00 a.m. to 6:00 p.m.: S19LPN and S25CNA Review of Resident #100's Hospital Record dated 05/18/2026 revealed the following, in part:History and Physical: Patient seen and evaluated by me with left hip fracture after fall on Friday.History of present illness: .resident presented to the emergency room after a mechanical fall on Friday at the nursing home after tripping on her right shoe. She landed on her left hip. She has since not able to bear weight. She was sent for further evaluation today.Treatment given in emergency room: Morphine injection 2 mg and Orphenadrine injection 60 mg intravenously.Physical Exam:Musculoskeletal: tenderness, deformity, and signs of injury present; Comments: left hip with pain, left lower extremity externally rotated.Assessment and Plan:Closed Displaced Fracture of Left Femoral Neck:Admit for surgical repair in the morning; andOrthopedics consulted in emergency department.Vital Signs:05/18/2026 at 10:25 a.m. Pain adult numerical scale level 9.CT lower extremity left without contrast:Impression:Mildly impacted left femoral neck fracture; andTraumatic Non-displaced fractures of the left superior and inferior pubic rami.Orthopedic Consult note dated 05/18/2026:Chief complaint: fallPlan: Percutaneous screw fixation left hip per CT result tomorrow once cleared by hospital medicine. Physical Exam:Musculoskeletal: tenderness to palpation pain with internal/external rotation of hip only. Decision for surgery: After extensive discussion regarding risks, benefits and alternatives to surgery, the patient elected to proceed with surgery. Plan for operating room as soon as possible. An observation and interview was conducted of/with Resident #100 on 05/18/2026 at 9:02 a.m. She was lying in bed. She stated she had a fall on 05/15/2026 in the hallway. She stated her left hip had been hurting since her fall. She stated the nurses had given her something for pain, which was mildly effective but not completely effective. She explained she had been staying in the bed since the fall and was having to use a brief for urinary and bowel elimination. She stated she normally could transfer and ambulate to the bathroom independently but it hurt too bad to get up. An interview was conducted with S22CNA on 05/19/2026 at 3:27 p.m. She confirmed she was assigned to Resident #100 from 6:00 a.m. to 6:00 p.m. on 05/15/2026. She stated she did not witness (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Resident #100's fall on 05/15/2026 but was notified of the fall. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated, after the fall, Resident #100 did not get out of bed and required incontinence care. She stated, after the fall, Resident #100 said she was in pain and could not walk. She stated, during care for Resident #100 on 05/15/2026, Resident #100 was taking deep breaths and had facial grimaces when she would move. She stated Resident #100 had to stop multiple times during care and take a breath because she was in pain. She stated she notified S18LPN at least twice during her shift of Resident #100's change in condition and pain. She stated Resident #100 was requesting pain medication, and she notified the nurse. A telephone interview was conducted with S18LPN on 05/19/2026 at 4:00 p.m. She confirmed she was assigned to Resident #100 when she fell on [DATE]. She stated Resident #100 was independently ambulatory and was walking in the hallway when she lost her footing, tripped, and fell. She stated Resident #100 initially complained of pain to her left hip. She stated S1DON was present in the facility and assisted with the assessment. She stated S1DON immediately notified S10NP via phone, and S10NP ordered an x-ray of the left hip. She stated the x-ray was performed immediately and revealed no acute findings. She stated she administered two 325 mg Tylenols to Resident #100 for pain. She stated she assessed Resident #100's pain after administration of the Tylenol, and it was effective. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated Resident #100 not getting out of the bed, urinating in an incontinence brief, and requiring staff assistance with incontinence care was a change in condition for Resident #100. She stated she was not notified of a change in condition for Resident #100. She stated if she had been notified of the change in condition, she would have performed an additional assessment and notified the NP or on-call NP of the change in condition. A telephone interview was conducted with S6LPN on 05/20/2026 at 9:19 a.m. She confirmed she was assigned to Resident #100 on 05/15/2026 from 6:00 p.m. to 6:00 a.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated Resident #100 would get up once or twice through the night and would independently ambulate to the nurses' station and request different things. She confirmed Resident #100 required incontinence care in the early morning of 05/16/2026, which was a change in condition. She stated that morning, Resident #100 ambulated to the bathroom with staff. She stated Resident #100 was not ambulating and toileting herself independently, which was as change in condition, and the NP should have been notified. A telephone interview was conducted with S23CNA on 05/20/2026 at 11:14 a.m. She confirmed she was assigned to Resident #100 on 05/15/2026, 05/16/2026, and 05/17/2026 from 6:00 p.m. to 6:00 a.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated, prior to Resident #100's fall, Resident #100 was up and out of bed nightly when she would arrive for her shifts. She stated on 05/15/2026, 05/16/2026, and 05/17/2026, Resident #100 was in bed when she arrived for her shifts and was having incontinent episodes. She stated she notified S7LPN Resident #100 was having incontinent episodes, which was a change in condition. A telephone interview was conducted with S7LPN on 05/20/2026 at 3:39 p.m. She stated she was assigned to Resident #100 on 05/16/2026 and 05/17/2026 from 6:00 p.m. to 6:00 a.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated, on 05/16/2026 and 05/17/2026, Resident #100 was rubbing her leg and saying she had a fall. She stated Resident #100 was not getting out of bed as normal and was calling the CNAs to change her incontinence brief. She stated Resident #100 said she was not getting up because of her fall. She stated she did not assess Resident #100 for pain and did not ask Resident #100 if she was hurting anywhere. She stated she should have assessed and asked Resident #100 if she was in pain. She explained she assumed Resident #100 was not getting out of bed because of fear from falling. She confirmed she did not notify the NP or on-call of Resident #100's change in condition. An interview was conducted with (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	S26CNA on 05/20/2026 at 7:55 a.m. She confirmed she was assigned to Resident #100 on 05/17/2026 from 6:00 a.m. to 6:00 p.m. She explained 05/17/2026 was her first day working with Resident #100 so S12RCNA assisted her. She stated Resident #100 required incontinence care three times during her shift. She stated Resident #100 complained of pain to her left hip during movement. She stated Resident #100 guarded at her hip and said, ow, ow, ow during care. She stated each time Resident #100 complained of pain, S12RCNA reported it to the nurse. She stated S21RN was also at the facility as the supervisor that day, and S12RCNA reported it to S21RN. An interview was conducted with S12RCNA on 05/20/2026 at 8:38 a.m. She confirmed she provided care for Resident #100 on 05/17/2026 on the day shift. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated, on 05/17/2026, Resident #100 did not get out of bed and was utilizing an incontinence brief for urination and bowel movements. She stated, during care on 05/17/2026, Resident #100 was yelling and saying she was in so much pain, which was a change in condition. She stated she summoned S21RN. She stated S21RN observed Resident #100's care and pain. She stated S21RN stated Resident #100 received an x-ray, which was negative. She stated Resident #100 had never stayed in bed all day like she did on 05/17/2026. A telephone interview was conducted with S21RN on 05/20/2026 at 10:27 a.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She confirmed, on 05/17/2026, she was notified Resident #100 was complaining of pain. She stated she observed the staff changing Resident #100's incontinence brief, and Resident #100 reported she was unable to bear weight on her left leg. She stated she thought Resident #100 pulled a muscle since her x-ray was negative. She stated she assessed Resident #100's leg, and there were no outward signs of a fracture. She confirmed Resident #100 did not get out of bed on 05/17/2026. She confirmed Resident #100 requiring incontinence care was a change in condition. She stated the change in condition happened after Resident #100 fell. She stated the NP/MD and/or on-call provider should have been notified of Resident #100's change in condition. Multiple attempts were made to contact S20LPN, S24CNA, and S8LPN throughout the survey, which were unsuccessful. S15ADON was notified during the survey of the attempted interviews and was also unsuccessful in reaching the aforementioned employees. An interview was conducted with S25CNA on 05/19/2026 at 3:39 p.m. She stated she provided care for Resident #100 on the morning of 05/18/2026. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated, on 05/18/2026, Resident #100 required incontinence care in her bed, which was a change in condition. She stated Resident #100 was complaining of pain during care, was guarding her hip and saying, ouch. She sated S19LPN was aware of Resident #100's condition and had contacted the ambulance. An interview was conducted with S19LPN on 05/19/2026 at 2:29 p.m. She confirmed she was assigned to Resident #100 on 05/18/2026 beginning at 6:00 a.m. She stated, on the morning of 05/18/2026, Resident #100 was complaining of pain to her left leg, was not getting out of bed, and was requiring an incontinence brief and the staff to change her, which was a change in condition. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated she notified S10NP and S10NP assessed Resident #100. She stated S10NP ordered Resident #100 to go to a local emergency room for evaluation via ambulance related to needing a CT. She stated Resident #100 was transported to a local hospital via ambulance. An interview was conducted with S1DON on 05/19/2026 at 12:00 p.m. She confirmed Resident #100 had a fall on the morning of 05/15/2026. She stated x-rays were immediately ordered and obtained. She stated the x-ray results were negative. She stated Resident #100 was unable to bear weight on 05/18/2026 so the nurse contacted the NP and received orders to transfer the resident to the hospital. She stated the hospital performed a CT, which revealed a left hip fracture. An interview was conducted with S10NP on 05/19/2026 at 2:20 p.m. She confirmed she was notified of Resident #100's fall on 05/15/2026 at the time of her fall, and she ordered a left hip x-ray. She stated (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	the x-ray was negative. She stated she assessed Resident #100 on the morning of 05/18/2026, and Resident #100 was in pain. She stated Resident #100 did not rate her pain but said her thigh was hurting. She explained Resident #100's thigh pain was referred pain from her hip. She stated Resident #100 did perform active range of motion of the left leg at that time but would not allow S10NP to touch her leg. She stated she ordered Resident #100 be transferred to the hospital for a CT. She stated the hospital CT showed Resident #100 had a left hip fracture. She stated Resident #100 had left hip surgery this morning. She stated she would expect Resident #100 to be in pain with a hip fracture. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated Resident #100 requiring incontinence care and not ambulating was a change in condition. She confirmed the nurses did not contact the on-call NP this weekend related to continued pain or change in condition for Resident #100. She stated if Resident #100 had a change in condition, the nurses should have contacted the on-call NP. She stated if she had been notified or the on-call NP had been notified, they would have ordered Resident #100 be sent to the hospital for a CT at that time. An interview was conducted with S1DON on 05/20/2026 at 3:10 p.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She was made aware of staff interviews revealing Resident #100 not getting out of the bed as usual over the weekend, requiring an incontinence brief, and requiring changing by the staff. She confirmed this was a change in condition for Resident #100. She stated she would have expected the nurses to contact the physician when Resident #100 had a change in condition to obtain new orders.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide pain management consistent with professional standards of practice and the comprehensive care plan by failing to adequately assess and intervene when a resident experienced pain after a fall for 1 (#100) of 3 residents reviewed for falls. This deficient practice resulted in an actual harm for Resident #100, a cognitively intact resident, beginning on 05/15/2026 when Resident #100 continued to complain of left hip pain after a fall, required increased staff assistance with ADLs, and did not ambulate as normal. An interview with Resident #100 on 05/18/2026 revealed, after her fall on 05/15/2026, she remained in bed and required perineal care after urinary and bowel elimination due to new left hip pain. Staff interviews revealed Resident #100 began requiring staff assistance with ADLs, complained of pain during ADL care, and did not transfer out of bed after her fall on 05/15/2026. Nursing staff failed to notify Resident #100's NP/MD and/or on-call NP of Resident #100's increased pain. Nursing staff also failed to administer pain medications as ordered to alleviate pain. On the morning of 05/18/2026, S10NP was notified of Resident #100's pain, and Resident #100 was transferred to a local hospital. Resident #100's Computed Tomography (CT) scan at the local hospital revealed a Mildly Impacted Left Femoral Neck Fracture and Traumatic Non-displaced Fractures of the Left Superior and Inferior Pubic Rami, which required surgical intervention on 05/19/2026.Findings: Review of the facility's policy, revised June 2023, titled, Pain - Clinical Protocol revealed the following, in part:Assessment and Recognition: 2. The nursing staff will assess each individual for pain.whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain.4. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example.ambulation or repositioning.Monitoring:1. The staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain.a. For example, review frequency and intensity of pain, ability to perform ADLs.3. The staff will discuss significant changes in levels of comfort with the attending physician who will consider adjusting interventions accordingly. Review of the facility's Standing Physician Orders, revised 01/10/2020, revealed the following, in part:Common symptoms/complaints:9. Paina. Tylenol 650 mg by mouth every four hours as needed. Review of Resident #100's Clinical Record revealed an admission date of 01/25/2026 and diagnoses, which included Other Frontotemporal Neurocognitive Disorder and Polyneuropathy. Review of Resident #100's Quarterly MDS with an ARD of 04/08/2026 revealed a BIMS of 15, which indicated intact cognition. Further review revealed Resident #100 was independent with toileting hygiene, transfers, and ambulation. Review of Resident #100's current Care Plan revealed the following, in part:Problem: Resident has chronic pain related to lower back and bilateral knees.Interventions (initiated 01/06/2026): Administer pain medication per order; Determine resident's satisfactory pain level; Evaluate effectiveness of pain-relieving interventions (non-medication and medication); Evaluate for non-verbal indicators of pain; Evaluate mood/behavior Review of Resident #100's current Physician Orders revealed the following, in part:Start date: 01/06/2026 - Assess for pain each shift. Notify NP/MD for new onset of pain or unrelieved pain and document in notes NP/MD notification BID;Start date: 01/05/2026 - Pregabalin 75 mg PO TID at 7:30 a.m., 2:00 p.m., and 7:30 p.m.; andStart date: 02/19/2026 - Voltaren external gel 1% apply to bilateral knees topically two times daily for pain.Further review of Resident #100's current Physician orders revealed no additional order for pain medication. The facility's standing order for Tylenol was not transcribed into Resident #100's Physician Orders. Review of Resident #100's Nurses Notes dated 05/15/2026 revealed the following:05/15/2026 at 11:01 a.m. by S18LPN: Resident observed ambulating in the hallway when resident tripped over her shoe. Resident reported pain to left hip/buttocks. S10NP notified. X-ray ordered. Tylenol 325 mg given for pain. Review of Resident #100's Left Hip with Pelvis X-Ray Report (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	dated 05/15/2026 at 2:54 p.m. revealed the following, in part:Impression: Degenerative change of the left hip without acute osseous abnormality.Caveat: Up to 10% of hip fractures may be occult on radiographs. If clinical concern persists or the patient fails to bear weight, consider short interval follow-up radiographs versus MRI, the gold standard of hip interrogation. Review of Resident #100's MAR dated May 2026 revealed the following, in part:Assess for pain each shift. Notify MD/NP for new onset of pain or unrelieved pain and document in notes NP/MD notification two times a day. 05/18/2026 day shift - pain level 8. Further review of Resident #100's MAR for assess for pain each shift revealed her pain was documented as a level 3 on 05/09/2026 and documented as a level 0 on all other shifts except 05/18/2026 listed above.Pregabalin 75 mg three times daily was documented as not administered on the following dates and times by the following nurses:05/17/2026 at 2:00 p.m. by S8LPN;05/17/2026 at 7:30 p.m. by S7LPN; and05/18/2026 at 7:30 a.m. by S19LPN.Voltaren External Gel 1% apply to bilateral knees topically two times daily for pain was documented as administered on the following dates and times with the following pain level documented: 05/15/2026 at 7:30 a.m. - pain level 8;05/15/2026 at 7:30 p.m. - pain level 7; and05/16/2026 at 7:30 a.m. - pain level 7.Further review of Resident #100's MAR revealed no documentation any other form of pain medication was administered. Tylenol was available for administration and not utilized. Review of Resident #100's Nurses Notes dated 05/18/2026 revealed the following:05/18/2026 at 9:05 a.m. by S19LPN: Resident complaining of pain to left hip. Resident had a fall on Friday, 05/15/2026. Resident seen by S10NP at bedside at 9:00 a.m. and received new order to send resident to emergency room for evaluation. Review of Resident #100's Physician Progress Note by S10NP dated 05/18/2026 revealed the following, in part:Resident seen today for fall.Assessment/Plan:Resident had a fall on Friday and was complaining of left hip pain. Left hip x-ray negative. Today, she continues to complain of pain and is unable to ambulate. Transferring to local hospital for advanced imaging. Review of Resident #100's Hospital Record dated 05/18/2026 revealed the following, in part:History of present illness: .resident presented to the emergency room after a mechanical fall on Friday at the nursing home after tripping on her right shoe. She landed on her left hip. She has since not able to bear weight. She was sent for further evaluation today.Orthopedic was consulted in emergency room. Plan surgical repair in the morning.Treatment given in emergency room: Morphine 2 mg and Orphenadrine 60 mg intravenously.Physical Exam:Musculoskeletal: tenderness, deformity, and signs of injury present; Comments: left hip with pain, left lower extremity externally rotated.CT lower extremity left without contrast:Impression:Mildly impacted left femoral neck fracture; andTraumatic Non-displaced fractures of the left superior and inferior pubic rami.Vital Signs:05/18/2026 at 10:25 a.m. Pain adult numerical scale level 9. Review of Resident #100's CNA & Nursing Assignments dated 05/15/2026 through 05/18/2026 revealed the following:05/15/2026:6:00 a.m. to 6:00 p.m.: S18LPN and S22CNA6:00 p.m. to 6:00 a.m.: S6LPN and S23CNA05/16/2026:6:00 a.m. to 6:00 p.m.: S20LPN and S24CNA6:00 p.m. to 6:00 a.m.: S7LPN and S23CNA05/17/2026:6:00 a.m. to 6:00 p.m.: S8LPN and S26CNA6:00 p.m. to 6:00 a.m.: S7LPN and S23CNA05/18/2026:6:00 a.m. to 6:00 p.m.: S19LPN and S25CNA An observation and interview was conducted of/with Resident #100 on 05/18/2026 at 9:02 a.m. She was lying in bed. She stated she had a fall on 05/15/2026 in the hallway. She stated her left hip had been hurting since her fall. She stated the nurses had given her something for pain, which was mildly effective but not completely effective. She explained she had been staying in the bed since the fall and was having to use a brief for urination and bowel movements due to her left hip pain. She stated she normally could bring herself to the bathroom but it hurt too bad to get up. On 05/18/2026, Resident #100 was transferred to a local hospital for advanced imaging of her Left Hip. Resident #100 remained in the hospital for the duration of the survey. An interview was conducted with S22CNA on 05/19/2026 at 3:27 p.m. She confirmed she was assigned to Resident #100 from 6:00 a.m. to 6:00 p.m. on 05/15/2026. She stated, after Resident #100's fall, Resident #100 did not get out of bed, required incontinence care, was in pain, and was unable to ambulate. She stated, during care for Resident #100 on 05/15/2026, Resident #100 was taking deep breaths and had facial grimaces when she would (continued on next page)

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	195508	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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 0697 Level of Harm - Actual harm Residents Affected - Few	move. She stated Resident #100 had to stop multiple times during care and take a breath because she was in pain. She stated she notified S18LPN at least twice during her shift of Resident #100's change in condition and pain. She stated Resident #100 was requesting pain medication. A telephone interview was conducted with S18LPN on 05/19/2026 at 4:00 p.m. She confirmed she was assigned to Resident #100 when she fell on [DATE]. She stated Resident #100 initially complained of pain to her left hip. She stated she administered two 325 mg Tylenol tablets to Resident #100 for pain. She stated an x-ray was performed and revealed no acute findings. She stated Resident #100 not getting out of the bed, urinating in an incontinence brief, and requiring staff assistance with incontinence care was a change in condition for Resident #100. She stated she was not notified of a change in condition for Resident #100. She stated if she had been notified of the change in condition, she would have performed an additional assessment, to identify the cause of the change, and notified the NP or on-call NP of the change in condition. She confirmed Resident #100 not getting out of bed could have been related to pain. A telephone interview was conducted with S23CNA on 05/20/2026 at 11:14 a.m. She confirmed she was assigned to Resident #100 on 05/15/2026, 05/16/2026, and 05/17/2026 from 6:00 p.m. to 6:00 a.m. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She stated Resident #100 did not ever complain of pain. She stated, prior to Resident #100's fall, she was up and out of bed nightly when she would arrive for her shifts. She stated, on 05/15/2026, 05/16/2026, and 05/17/2026, Resident #100 was in bed when she arrived for her shifts and was having incontinent episodes. She stated she was unsure why Resident #100 was in bed when she arrived for her shifts and having incontinent episodes. She stated Resident #100 did rub her left leg during care. A telephone interview was conducted with S7LPN on 05/20/2026 at 3:39 p.m. She stated she was assigned to Resident #100 on 05/16/2026 and 05/17/2026 from 6:00 p.m. to 6:00 a.m. She stated, on 05/16/2026 and 05/17/2026, Resident #100 was rubbing her leg and saying she had a fall. She stated Resident #100 was not getting out of bed as normal and was calling the CNAs to change her incontinence brief. She stated Resident #100 said she was not getting up because of her fall. She stated she did not assess Resident #100 for pain and did not ask Resident #100 if she was hurting. She stated she should have assessed and asked Resident #100 if she was in pain. She confirmed she did not administer any pain medication to Resident #100. She explained she assumed Resident #100 was not getting out of bed because of fear from falling. She confirmed Resident #100 did not receive Pregabalin on 05/17/2026 at 7:30 p.m. as ordered. She confirmed she did not notify the physician Pregabalin was not available for administration. An interview was conducted with S26CNA on 05/20/2026 at 7:55 a.m. She confirmed she was assigned to Resident #100 on 05/17/2026 from 6:00 a.m. to 6:00 p.m. She stated Resident #100 required incontinence care three times during her shift. She stated Resident #100 complained of pain to her left hip during movement. She stated Resident #100 guarded her hip and said, ow, ow, ow during care. She stated each time Resident #100 complained of pain, S12RCNA reported it to the nurse. She stated S12RCNA reported Resident #100's pain to S21RN. An interview was conducted with S12RCNA on 05/20/2026 at 8:38 a.m. She confirmed she provided care for Resident #100 on 05/17/2026 on the day shift. She stated, on 05/17/2026, Resident #100 did not get out of bed and was utilizing an incontinence brief for urinary and bowel elimination. She stated, during care on 05/17/2026, Resident #100 was yelling and saying she was in so much pain. She stated, prior to Resident #100's fall, she never complained of pain. She stated she summoned S21RN. She stated S21RN observed Resident #100's care and pain. A telephone interview was conducted with S21RN on 05/20/2026 at 10:27 a.m. She confirmed, on 05/17/2026, she was notified Resident #100 was complaining of pain. She stated she observed the staff changing Resident #100's incontinence brief, and Resident #100 reported she was unable to bear weight on her left leg. She stated the hall nurse was administering Resident #100's medications and reported Resident #100 had something ordered for pain. She stated she was not made aware Resident #100 was out of Pregabalin. She stated the NP/MD and/or on-call provider should have been notified of Resident #100's pain and Resident #100's (continued on next page)

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	195508	A. Building B. Wing	05/20/2026

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St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Pregabalin being unavailable. She stated the facility had a standing order for Tylenol that could have been utilized. Multiple attempts were made to contact S20LPN, S24CNA, and S8LPN throughout the survey, which were unsuccessful. S15ADON was notified during the survey of the attempted interviews and was also unsuccessful in reaching the aforementioned employees. An interview was conducted with S25CNA on 05/19/2026 at 3:39 p.m. She stated she provided care for Resident #100 on the morning of 05/18/2026. She stated, during incontinence care on 05/18/2026, Resident #100 complained of pain, was guarding her hip, and saying, ouch. She stated it was abnormal for Resident #100 to complain of pain. She stated S19LPN was aware and had notified S10NP. An interview was conducted with S19LPN on 05/19/2026 at 2:29 p.m. She confirmed she was assigned to Resident #100 on 05/18/2026 beginning at 6:00 a.m. She stated, on the morning of 05/18/2026, Resident #100 was complaining of pain to her left leg, was not getting out of bed, and was requiring an incontinence brief and staff to change her. She stated she notified S10NP, and S10NP assessed Resident #100. She stated S10NP ordered Resident #100 to go to a local emergency room. She confirmed Resident #100 did not receive her 7:30 a.m. of Pregabalin on 05/18/2026. An interview was conducted with S1DON on 05/19/2026 at 12:00 p.m. She confirmed Resident #100 had a fall on the morning of 05/15/2026. She stated x-rays were immediately ordered and obtained. She stated the x-ray results were negative. She stated Resident #100 was unable to bear weight on 05/18/2026 so the nurse contacted the NP and received orders to transfer the resident to the hospital. She stated the hospital performed a CT, which revealed a left hip fracture. An interview was conducted with S10NP on 05/19/2026 at 2:20 p.m. She confirmed she was notified of Resident #100's fall on 05/15/2026 at the time of her fall, and she ordered a left hip x-ray. She stated the x-ray was negative. She stated she assessed Resident #100 on the morning of 05/18/2026, and Resident #100 was in pain. She stated Resident #100 said her thigh was hurting. She explained Resident #100's thigh pain was referred pain from her hip. She stated Resident #100 would not allow S10NP to touch her leg. She stated she ordered Resident #100 be transferred to the hospital for a CT. She stated the hospital CT showed Resident #100 had a left hip fracture. She stated Resident #100 had left hip surgery this morning. She stated she would expect Resident #100 to be in pain with a hip fracture. She stated, prior to Resident #100's fall, she was independent with transfers, ambulation and toileting, and was continent of bladder and bowel. She confirmed the nurses did not contact the on-call NP this weekend related to continued pain for Resident #100. She stated if she had been notified or the on-call NP had been notified, they would have ordered Resident #100 be sent to the hospital for a CT at that time. An interview was conducted with S1DON on 05/20/2026 at 3:10 p.m. She was made aware of staff interviews revealing Resident #100 was not getting out of the bed as usual over the weekend, requiring an incontinence brief, requiring changing by the staff, and complaining of pain. She stated when Resident #100 complained of pain, the nurse should have administered the standing order for Tylenol and contacted the NP or on-call NP. She reviewed Resident #100's clinical record and confirmed the nurse documented Tylenol administration immediately following the fall. She confirmed there was no other documentation of pain medication administration from 05/15/2026 through 05/18/2026. She stated Resident #100's Pregabalin should have been available and administered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. The facility failed to ensure medications were administered as ordered for 3 (#10, #46, and #100) of 10 residents reviewed for medication administration. Review of the facility's policy titled, Administering Medications with a revision date of 12/2012, revealed the following, in part: Policy: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. Review of the facility's policy titled, Emergency Medications with a revision date of 04/2021, revealed the following, in part: Policy: The facility shall maintain a supply of medications typically used in emergencies. Policy Interpretation and Implementation: 2. The emergency medication kit will include medications and biologicals that are essential in providing emergency treatment. 4. The contents of emergency medication kit will be clearly listed. Resident #10 Review of Resident #10's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Critical Illness Myopathy, Chronic Kidney Disease, Stage 3B, and Spondylosis without Myelopathy or Radiculopathy, Lumbar Region. Review of Resident #10's Quarterly MDS with an ARD of 05/13/2026 revealed he had a BIMS of 15, which indicated he was cognitively intact. Review of Resident #10's Physician Orders dated May 2026 revealed the following, in part: Order date: 02/09/2026, Start date: 02/10/2026- Lidocaine External Patch Apply to back topically one time a day for pain. Order date: 02/09/2026, Start date: 02/10/2026 - Risperidone Oral Tablet 0.5 mg. Give 1 tablet by mouth one time a day for antipsychotic. Review of Resident #10's Medication Administration Record dated May 2026 revealed the following, in (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	part: Lidocaine External Patch documentation was blank on the following dates: 05/07/2026, 05/08/2026, 05/12/2026, 05/16/2026, 05/17/2026. Lidocaine External Patch was documented as 9 indicating other on the following dates: 05/09/2026, 05/10/2026, 05/11/2026, 05/15/2026, Risperidone Oral Tablet 0.5 mg was documented 9 indicating other on the following dates: 05/16/2026 and 05/18/2026. Risperidone Oral Tablet 0.5 mg was documented as administered on 05/17/2026. Review of Resident #10's Nurses Notes dated May 2026 revealed the following, in part: Review of Nurse's Notes revealed the following: 05/09/2026 at 4:53 a.m. Lidocaine External Patch-Apply to back topically one time a day for pain-Pending delivery - Signed by S31LPN 05/10/2026 at 5:15 a.m. Lidocaine External Patch-Apply to back topically one time a day for pain-Pending delivery - Signed by S31LPN 05/11/2026 at 5:13 a.m. Lidocaine External Patch-Apply to back topically one time a day for pain-Pending delivery -Signed by S31LPN 05/15/2026 at 5:05 a.m. Lidocaine External Patch-Apply to back topically one time a day for pain-Pending delivery/restock - Signed by S31LPN 05/16/2026 at 7:03 a.m. Risperidone Oral Tablet 0.5 mg-Give 1 tablet by mouth one time a day or antipsychotic – Pending delivery - Signed by S30LPN 05/18/2026 at 10:15 a.m. Risperidone Oral Tablet 0.5 MG-Give 1 tablet by mouth one time a day or antipsychotic – Pending delivery – Signed by S28LPN Further review revealed no documented evidence the pharmacy or provider were notified of the above doses of medications were not available for administration. An interview was conducted with the facility's Pharmacist on 05/19/2026 at 12:05 p.m. He verified he was a pharmacist for the facility. He reviewed Resident #10's record and stated the refill request for Resident #10's Risperidone 0.5 mg with a 30 day supply was received on 05/18/2026 and the facility would have received the medication that same day around 10 pm. An interview was conducted with S28LPN on 5/19/2026 at 3:12 p.m. She stated medications should be ordered when the medication gets low on the medication card indicated by a blue color. S28LPN stated medications were usually ordered when last white strip on the medication card was used up. S28LPN verified she worked on 05/18/2026 and was assigned to Resident #10. She reviewed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident#10's May 2026 MAR and confirmed she had documented 9 on the 05/18/2026 a.m. Risperidone 0.5 mg dose due to medication being unavailable. She stated 9 indicated other and there would be a progress note. She reviewed the progress note for the same day, and confirmed it stated pending delivery. She further reviewed and confirmed Resident #10 had not received his a.m. dose of Risperidone 0.5 mg tablet on 05/16/2026 and 05/18/2026 due to it being unavailable in the facility, and should have. S28LPN stated Resident #10 should not have run out of his medication. She stated she had not checked the facility's emergency kit for the medication, and had not notified the DON nor the NP regarding Resident #10's missed Risperidone 0.5 mg doses. An interview was conducted with S30LPN on 05/19/2026 at 4:53 p.m. S30LPN stated she would reorder medications when she finished the last white strip and begins the blue strip on the medication card. She stated if a resident was totally out of a medication she should notify the nurse practitioner and check the emergency kit. She stated if the medication was not in the emergency kit she would call the pharmacy and see why it had not been delivered. She verified she worked on 05/16/2026 and 05/17/2026 and was assigned to Resident #10. She stated a 9 on the MAR indicated other and to see progress note. She stated Resident #10 was out of his Risperidone 0.5mg a.m. dose on 05/16/2026 and 5/17/2026 and it was not administered. She stated she documented medication as administered on 05/17/2026 in error and she did not actually administer the medication as it was not available. S30LPN stated she did not notify the NP nor DON Resident #10 had missed doses of his prescribed Risperidone. She stated she was not sure if this medication was in the emergency kit and she did not check the emergency kit to see if medication was available. An interview was conducted on 05/20/2026 9:01 a.m. with S10NP. S10NP reviewed Resident #10's May 2026 MAR and confirmed the above listed missed Risperidone 0.5 mg doses. She stated Risperidone 0.25 mg was in the emergency kit and staff could have given 2 tablets to equal his prescribed dosage. S10NP stated she would have expected staff to check the emergency kit, notify her of the missed doses, and/or call the pharmacy to see check on the prescription delivery. S10NP stated Resident #10 should not have missed his Risperidone 0.5 mg doses since they were available in the emergency kit. An interview was conducted with S27LPN on 05/20/2026 at 1:05 p.m. She verified she worked on the following 6p.m.-6a.m. shifts: 05/07/2026, 05/11/2026, 05/12/2026, 05/15/2026, and 05/16/2026 and was assigned to Resident #10. She stated the DON was responsible for ordering OTC stock medications and staff should notify her when supply was low. She further verified Lidocaine External Patches were an OTC stock medication. She confirmed Resident #10's Lidocaine External Patch was not available for administration when she worked on the above listed dates, and therefore was not administered. She stated when she realized the stock supply of Lidocaine External Patches were empty she slid a note under the administrator's door to let him know. S27LPN stated she did not notify the DON or the NP of Resident #10's missed administration of his prescribed Lidocaine External Patch. An interview was conducted with S31LPN on 05/20/2026 at 1:16 p.m. She verified she worked on the following 6 p.m.-6 a.m. shifts: 05/09/2026, 05/10/2026, 05/11/2026, and 05/15/2026 and was assigned to Resident #10. She confirmed she did not administer these doses due to medication not being available. She stated if a resident was completely out of a medication she would notify the DON. She stated she had charted 9 on Resident #10's MAR on the above listed dates which indicated see progress notes. S31LPN stated she notified DON that resident was out of his Lidocaine patches, but did not notify the NP. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 Review of Resident #46's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Personal History Of Pulmonary Embolism, Long Term Current Use Of Anticoagulants, Personal History Of Other Venous Thrombosis And Embolism, Paraplegia, and Neuromuscular Dysfunction Of Bladder. Review of Resident #46's Quarterly MDS with an ARD of 03/18/2026 revealed he had a BIMS of 15, which indicated he was cognitively intact. Further review revealed he had an indwelling catheter and was taking Anticoagulants. Review of Resident #46's Physician Orders dated May 2026 revealed the following, in part: Order date: 10/28/2025, Start date: 10/28/2025- Eliquis oral tablet 5 mg give one tablet by mouth two times a day for history of Thromboembolism related to Personal History of Pulmonary Embolism; and Order date: 03/25/2026, Start date: 04/03/2026- Macrobid oral capsule 100 mg give one capsule by mouth one time a day for Urinary Tract Infection prophylaxis. Review of Resident #46's Medication Administration Record dated May 2026 revealed the following, in part: Eliquis was documented as not administered for the following doses: 05/11/2026 at 7:30 a.m., 05/13/2026 at 7:30 p.m., 05/14/2026 at 7:30 p.m., 05/15/2026 at 7:30 p.m., 05/16/2026 at 7:30 p.m., 05/17/2026 at 7:30 a.m., and 05/18/2026 at 7:30 p.m.; and Macrobid was documented as not administered for the following doses: 05/06/2026 at 7:30 a.m., 05/08/2026 at 7:30 a.m., 05/09/2026 at 7:30 a.m., and 05/11/2026 at 7:30 a.m. Review of Resident #46's Nurses Notes dated May 2026 revealed the following, in part: 05/06/2026 at 10:04 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S3LPN 05/08/2026 at 9:05 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S3LPN 05/09/2026 at 9:47 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S4LPN 05/11/2026 at 7:21 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. Reordered. Signed by S5LPN 05/11/2026 at 7:22 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Reordered. Signed by S5LPN 05/13/2026 at 6:40 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/14/2026 at 8:02 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. Awaiting delivery. Signed by S5LPN 05/14/2026 at 6:42 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN 05/15/2026 at 6:41 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN 05/16/2026 at 7:51 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. Pending delivery. Signed by S7LPN 05/17/2026 at 7:40 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. Not available. Signed by S8LPN 05/18/2026 at 7:59 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o Thromboembolism related to Personal History of Pulmonary Embolism. Awaiting Delivery. Signed by S6LPN Further review revealed no documented evidence the pharmacy or provider were notified of the above doses of medications were not available for administration. An interview was conducted with the facility's Pharmacist on 05/19/2026 at 12:05 p.m. He verified he was a pharmacist for the facility. He stated medications were delivered to the facility once a day in the evenings, Monday through Friday. He stated the facility's nursing staff should use the color change indicator on the blister cards to order refills of medications. He stated medications refills should be requested on Monday through Friday. He stated the pharmacy was closed on Saturday's and Sunday's. He stated the pharmacy contracted with an on call pharmacy for emergency medications needed on the weekends, not for medication refills. He reviewed Resident #46's record and stated Macrobid was last refilled on 03/31/2026 and 05/11/2026 with a 30 day supply. He stated Resident #46's Eliquis was last refilled on 04/17/2026 and 05/18/2026 with a 14 day supply. An observation was made of the facility's electronic emergency medication kit with S1DON on 05/19/2026 at 12:37 p.m. S1DON reviewed the list of medications contained in the emergency medication kit. She stated the emergency kit contained 10 tablets of Eliquis 2.5 mg and 30 capsules of Macrobid 100 mg. During the observation, S1DON contacted the facility's Pharmacist who reported the facility's emergency kit contained 8 available tablets of Eliquis 2.5 mg and 16 available capsules of Macrobid 100 mg. An interview was conducted with S7LPN on 05/19/2026 at 1:04 p.m. She stated when the medication card label changed color indicating a refill was needed, she ordered the medication electronically through the computer system. She verified she was assigned to Resident #46 on 05/16/2026 from 6:00 p.m. to 6:00 a.m. She stated Resident #46 was ordered Eliquis. She stated she cannot recall if Resident #46's Eliquis was not available for administration on 05/16/2026 during her shift. She stated if she documented a nurse's note indicating she was waiting on pharmacy, then the medication was not available and she did not administer it. She confirmed she did not check the facility's emergency (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195508	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kit to see if the Eliquis was available. She confirmed she did not contact the pharmacy or notify the Nurse Practitioner the medication was not available for administration. An interview was conducted with S3LPN on 05/19/2026 at 1:35 p.m. She verified she was assigned to Resident #46 on 05/06/2026 and 05/08/2026 from 6:00 a.m. to 6:00 p.m. She stated if she documented a nurses' note and the medication was not administered on the MAR, then she did not administer the medication. She stated she could not recall if she notified the facility staff, the pharmacy or the Nurse Practitioner, Resident #46's Macrobid was not available for administration. She stated she did not check the facility's emergency kit to see if the medication was available. An interview was conducted with S5LPN on 05/19/2026 at 1:45 p.m. She stated if she documented Resident #46's Eliquis and Macrobid were not administered, it was because they were not available. She stated if a medication was not available to administer she would call the pharmacy, see if the medication was ordered, and if not she would reorder it. She stated she had never used the facility's emergency kit and was not sure what medications were available in it. She stated she did not notify the pharmacy, the Nurse Practitioner, or any staff at the facility of Resident #46's medications were unavailable. An interview was conducted with Resident #46 on 05/19/2026 at 2:18 p.m. He stated in the last month, some of the nurses, unsure who, told him they did not have some of his medications. He stated he did not know which medications were missing or why they did not have them. He stated he took Eliquis for a history of blood clots. He stated he had a catheter and took Macrobid, to prevent urinary tract infections. An interview was conducted with S8LPN on 05/19/2026 at 3:02 p.m. She verified she was assigned to Resident #46 on 05/17/2026 from 6:00 a.m. to 6:00 p.m. She stated Resident #46's Eliquis was not available for administration. She stated she did not notify the pharmacy or the Nurse Practitioner the medication was not available for administration. She stated she did not check the facility's emergency kit to see if the Eliquis was available. An interview was conducted with S6LPN on 05/19/2026 at 3:41 p.m. She verified she was assigned to Resident #46 on 05/13/2026, 05/14/2026, 05/15/2026, and 05/18/2026 from 6:00 p.m. to 6:00 a.m. She stated Resident #46's Eliquis was not available for administration, and therefore not administered on the above dates. She stated the Eliquis was reordered electronically, but she was not sure who or when it was reordered. She stated she left report with the morning nurse each day Resident #46's Eliquis was not available to follow up with the pharmacy. She stated she did not notify the pharmacy or the Nurse Practitioner Resident #46's Eliquis was not available. She stated she did not check the facility's emergency kit to see if the medication was available. She stated medication refill requests were ordered electronically when the medication card label changed color indicating a refill was needed. An interview was conducted with S4LPN on 05/19/2026 at 4:03 p.m. She verified she was assigned to Resident #46 on 05/09/2026 from 6:00 a.m. to 6:00 p.m. She stated his ordered Macrobid was not available. She stated she electronically reordered Resident #46's Macrobid on 05/09/2026 and let the oncoming night nurse, unsure who, know the Macrobid was not available and had been reordered. She stated she did not notify the Nurse Practitioner, pharmacist, or facility staff, Resident #46's Macrobid was not available for administration. She stated she did not check the facility's emergency medication kit for the medication. (continued on next page)

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St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with S10NP on 05/19/2026 at 4:15 p.m. She stated Resident #46 was prescribed Eliquis for a history of Deep Vein Thrombosis and a Pulmonary Embolism. She stated Resident #46 had an indwelling catheter and was prescribed Macrobid prophylactically for Urinary Tract Infections. She reviewed Resident #46's clinical record and verified the above-mentioned dates the Eliquis and Macrobid were not administered. She stated she was not notified Resident #46 missed any doses of Eliquis or Macrobid. She stated had she been notified she would have told the nurses both medications were available in the facility's emergency kits and to contact the pharmacy to have the medications delivered the next day. She confirmed she expected Resident #46's Eliquis and Macrobid to be administered as ordered. Resident #100 Review of Resident #100's Clinical Record revealed an admission date of 01/25/2026 and diagnoses, which included Other Frontotemporal Neurocognitive Disorder and Polyneuropathy. Review of Resident #100's current Physician Orders revealed the following, in part: Pregabalin 75 mg by mouth three times daily for Ployneuropathy at 7:30 a.m., 2:00 p.m., and 7:30 p.m. Review of Resident #100's MAR dated May 2026 revealed the following, in part: Pregabalin 75 mg three times daily was documented as not administered, see progress notes, on the following dates and times by the following nurses: 05/17/2026 at 2:00 p.m. by S8LPN; 05/17/2026 at 7:30 p.m. by S7LPN; and 05/18/2026 at 7:30 a.m. by S19LPN. Review of Resident #100's Nurses Notes dated 05/15/2026 through 05/18/2026 revealed the following: 05/17/2026 at 3:42 p.m. by S8LPN: Pregabalin Oral Capsule 75 mg give 1 capsule by mouth three times a day was not administered – medication unavailable, unavailable in emergency kit, and unable to reach provider. 05/18/2026 at 3:52 a.m. by S7LPN: Pregabalin Oral Capsule 75 mg give 1 capsule by mouth three times a day was not administered – pending delivery. 05/18/2026 at 8:30 a.m. by S19LPN: Pregabalin Oral Capsule 75 mg give 1 capsule by mouth three times a day was not administered – medication unavailable. Review of Resident #100's current Care Plan revealed the following, in part: Problem: Resident has chronic pain related to lower back and bilateral knees. Interventions: Administer pain medication per order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with S7LPN on 05/19/2026 at 1:28 p.m. She confirmed Resident #100's Pregabalin was not administered on 05/17/2026 at 7:30 p.m. because it was not available for administration. She stated she did not contact the pharmacy regarding refill of the Pregabalin. She confirmed she did not contact the NP regarding the Pregabalin not being available for administration and should have. An interview was conducted with S19LPN on 05/19/2026 at 2:29 p.m. She confirmed Resident #100 missed her 7:30 a.m. dose of Pregabalin on 05/18/2026. She stated the medication was not available to be administered. She stated S10NP was in the facility on 05/18/2026 and she verbally notified her the medication was not available. Interviews attempted with S8LPN throughout the survey were unsuccessful. An interview was conducted with a pharmacist from the facility's contracted pharmacy on 05/20/2026 at 11:46 a.m. She confirmed Resident #100 had a physician's order for Pregabalin 75 mg by mouth three times daily. She stated there was a highlighted section on each medication card that should be reordered prior to reaching the first pill in the highlighted section. She stated Pregabalin required a hard script from the NP/MD so they would have to communicate with the provider to obtain the hard script. She stated the Pregabalin hard script was sent to the pharmacy on the evening of 05/17/2026, and it was filled and delivered to the facility on [DATE]. She stated the medication should have been ordered sooner to ensure delivery to the facility prior to the resident running out. She confirmed the pharmacy had a 24 hour on call service and there was always a pharmacist available to fill emergency medications. An interview was conducted with S10NP on 05/19/2026 at 2:20 p.m. She stated the nurses notified her on Friday, 05/15/2026 that Resident #100 was running low on Pregabalin. She stated she thought she sent the hard script to the pharmacy that day but she realized on 05/17/2026 she had not. She stated at that time, she sent the Pregabalin hard script to the pharmacy and the medication was delivered to the facility on the evening of 05/18/2026. She stated the nurses should have let her know sooner Resident #100 was running low on Pregabalin. An interview was conducted on 05/20/2026 at 1:50 p.m. with S1DON. She stated the nurses were responsible for obtaining medication refills. She stated medications could be refilled electronically or by phone. She stated if a medication was not available, the expectation was for the nurse to reach out to pharmacy to see why the medication was not available, or the backup pharmacy if needed. She stated resident medications should be available for administration and doses should not be missed. She stated the Nurse Practitioner should be notified of any missed doses of medication. She stated she was responsible for ordering the OTC stock medications and she had not been made aware the facility was running low on Lidocaine patches or had completely run out of lidocaine patches. S1DON stated staff should notify her if stock medication supply is low and she would reorder. S1DON further confirmed Resident #10 should not have missed his Lidocaine External Patch administration. She was notified of the above mentioned missed doses of Resident #10's Risperidone, Resident #46's Eliquis and Macrobid, and Resident #100's Pregabalin. She stated she would have expected Resident #10's Risperidone, and Resident #46's Eliquis and Macrobid to be administered as ordered as these medications were available in the facility's emergency kit. She further stated the nurses should have contacted S10NP if a hard script was needed for a medication. She stated the medication should have been ordered prior to running out. She stated when the medication was out, the nurse should have contacted the pharmacy and the NP or on-call NP to obtain the ordered medication.

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St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure residents were free of significant medication errors for 1 (#46) of 10 residents reviewed for medication administration. The facility failed to ensure Resident #46 received Eliquis and Macrobid as ordered by the Physician. Findings: Review of the facility's policy titled, Administering Medications with a revision date of 12/2012, revealed the following, in part:Policy: Medications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation:3. Medications must be administered in accordance with the orders, including any required time frame. Review of the medication Black Box Warning for Eliquis revealed the following, in part: Warning: Premature discontinuation of Eliquis can increase the risk of thrombotic events. To reduce this risk, consider coverage with another anticoagulant if Eliquis is discontinued for a reason other than Pathological bleeding or completion of a course of therapy. Eliquis is indicated for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy. Review of Resident #46's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Personal History Of Pulmonary Embolism, Long Term Current Use Of Anticoagulants, Personal History Of Other Venous Thrombosis And Embolism, Paraplegia, and Neuromuscular Dysfunction Of Bladder, Unspecified. Review of Resident #46's Quarterly MDS with an ARD of 03/18/2026 revealed he had a BIMS of 15, which indicated he was cognitively intact. Further review revealed he had an indwelling catheter and was taking Anticoagulants. Review of Resident #46's Physician Orders dated May 2026 revealed the following, in part:Start date: 10/28/2025- Eliquis oral tablet 5 mg give one tablet by mouth two times a day for history of Thromboembolism related to Personal History of Pulmonary Embolism; and Start date: 04/03/2026- Macrobid oral capsule 100 mg give one capsule by mouth one time a day for Urinary Tract Infection prophylaxis. Review of Resident #46's Medication Administration Record dated May 2026 revealed the following, in part:Eliquis was documented as not administered for the following doses: 05/11/2026 at 7:30 a.m., 05/13/2026 at 7:30 p.m., 05/14/2026 at 7:30 p.m., 05/15/2026 at 7:30 p.m., 05/16/2026 at 7:30 p.m., 05/17/2026 at 7:30 a.m., and 05/18/2026 at 7:30 p.m.; and Macrobid was documented as not administered for the following doses: 05/06/2026 at 7:30 a.m., 05/08/2026 at 7:30 a.m., 05/09/2026 at 7:30 a.m., and 05/11/2026 at 7:30 a.m. Review of Resident #46's Nurses Notes dated May 2026 revealed the following, in part:05/06/2026 at 10:04 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S3LPN05/08/2026 at 9:05 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S3LPN05/09/2026 at 9:47 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Not available. Signed by S4LPN05/11/2026 at 7:21 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. Reordered. Signed by S5LPN05/11/2026 at 7:22 a.m. Macrobid oral capsule 100 mg give one capsule by mouth one time a day for UTI prophylaxis. Reordered. Signed by S5LPN05/13/2026 at 6:40 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN05/14/2026 at 8:02 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. Awaiting delivery. Signed by S5LPN05/14/2026 at 6:42 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN05/15/2026 at 6:41 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. On order. Signed by S6LPN05/16/2026 at 7:51 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. Pending delivery. (continued on next page)

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St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Signed by S7LPN05/17/2026 at 7:40 a.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. Not available. Signed by S8LPN05/18/2026 at 7:59 p.m. Eliquis oral tablet 5 mg give one tablet by mouth two times a day for h/o thromboembolism related to Personal History of Pulmonary Embolism. Awaiting Delivery. Signed by S6LPNFurther review revealed no documented evidence the pharmacy or provider were notified the above doses of medications were not available for administration. Review of the facility's Emergency Kit List revealed Eliquis and Macrobid were available for use in the emergency kit. An interview was conducted with the facility's Pharmacist on 05/19/2026 at 12:05 p.m. He reviewed Resident #46's record and stated Macrobid was requested on 05/09/2026 and filled on 05/11/2026 with a 30 day supply. He stated Resident #46's Eliquis was requested and filled on 05/18/2026 with a 14 day supply. He stated there was no documented evidence the pharmacy was notified the medications were not available for administration on the above-mentioned dates. He stated Macrobid 100 mg capsules and Eliquis 2.5 mg tablets were available for administration in the facility's emergency kit. An observation was made of the facility's electronic emergency medication kit with S1DON on 05/19/2026 at 12:37 p.m. S1DON reviewed the list of medications contained in the emergency medication kit. She stated the emergency kit contained 10 tablets of Eliquis 2.5 mg and 30 capsules of Macrobid 100 mg. An interview was conducted with S7LPN on 05/19/2026 at 1:04 p.m. She verified she was assigned to Resident #46 on 05/16/2026 from 6:00 p.m. to 6:00 a.m. She stated Resident #46 was ordered Eliquis. She stated she cannot recall if Resident #46's Eliquis was not available for administration on 05/16/2026 during her shift. She stated if she documented a nurse's note indicating she was waiting on pharmacy, then the medication was not available and she did not administer it. She confirmed she did not check the facility's emergency kit to see if the Eliquis was available. She confirmed she did not contact the pharmacy or notify the Nurse Practitioner the medication was not available for administration. An interview was conducted with S3LPN on 05/19/2026 at 1:35 p.m. She verified she was assigned to Resident #46 on 05/06/2026 and 05/08/2026 from 6:00 a.m. to 6:00 p.m. She stated she could not recall if Resident #46 was ordered Macrobid. She stated if she documented a nurses' note and the medication was not administered on the MAR, then she did not administer the medication. She stated she could not recall if she notified the facility staff, the pharmacy or the Nurse Practitioner, Resident #46's Macrobid was not available for administration. She stated she did not check the facility's emergency kit to see if the medication was available. An interview was conducted with S5LPN on 05/19/2026 at 1:45 p.m. She stated she did not recall when she worked at the facility the month of May, but had worked on Resident #46's hall. She stated if she documented Resident #46's Eliquis and Macrobid were not administered, it was because they were not available. She stated she had never used the facility's emergency kit and was not sure what medications were available in it. She stated she did not recall notifying the pharmacy, the Nurse Practitioner, or any staff at the facility of Resident #46's medications were unavailable. An interview was conducted with Resident #46 on 05/19/2026 at 2:18 p.m. He stated in the last month, some of the nurses, unsure who, told him they did not have some of his medications. He stated he did not know which medications were missing or why they did not have them. He stated he took Eliquis for a history of blood clots. He stated he had a catheter and took Macrobid to prevent urinary tract infections. An interview was conducted with S8LPN on 05/19/2026 at 3:02 p.m. She verified she was assigned to Resident #46 on 05/17/2026 from 6:00 a.m. to 6:00 p.m. She stated Resident #46's Eliquis was not available for administration. She stated she did not notify the pharmacy or the Nurse Practitioner the medication was not available for administration. She stated she did not check the facility's emergency kit to see if Eliquis was available. An interview was conducted with S6LPN on 05/19/2026 at 3:41 p.m. She verified she was assigned to Resident #46 on 05/13/2026, 05/14/2026, 05/15/2026, and 05/18/2026 from 6:00 p.m. to 6:00 a.m. She stated Resident #46's Eliquis was not available for administration. She stated the Eliquis was reordered, but she was not sure who reordered it. She stated she did not notify the pharmacy or the Nurse Practitioner Resident #46's (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Eliquis was not available. She stated she did not check the facility's emergency kit to see if the medication was available. An interview was conducted with S4LPN on 05/19/2026 at 4:03 p.m. She verified she was assigned to Resident #46 on 05/09/2026 from 6:00 a.m. to 6:00 p.m. She stated his ordered Macrobid was not available. She stated she electronically reordered Resident #46's Macrobid. She stated she did not notify the Nurse Practitioner, pharmacist, or facility staff Resident #46's Macrobid was not available for administration. She stated she did not check the facility's emergency medication kit for the medication. An interview was conducted with S10NP on 05/19/2026 at 4:15 p.m. She stated Resident #46 was prescribed Eliquis for a history of Deep Vein Thrombosis and a Pulmonary Embolism. She stated Resident #46 had an indwelling catheter and was prescribed Macrobid prophylactically for Urinary Tract Infections. She reviewed Resident #46's clinical record and verified Eliquis and Macrobid were not administered on the above mentioned dates. She stated Resident #46 not receiving Eliquis as ordered put him at potential risk for blood clot development. She stated the potential risk of Resident #46 not receiving Macrobid as ordered was potential overgrowth of bacteria. She stated she was not notified Resident #46 missed any doses of Eliquis or Macrobid. She stated had she been notified she would have told the nurses both medications were available in the facility's emergency kits and to contact the pharmacy to have the medications delivered the next day. She confirmed she expected Resident #46's Eliquis and Macrobid to be administered as ordered. An interview was conducted with S1DON on 05/20/2026 at 8:15 a.m. She stated the nurses were responsible for obtaining medication refills. She stated if a medication was not available, the expectation was for the nurse to reach out to pharmacy to see why the medication was not available. She stated resident medications should be available for administration and doses should not be missed. She stated the Nurse Practitioner should be notified of any missed doses of medication. She was notified of the above mentioned missed doses of Resident #46's Eliquis and Macrobid. She reviewed Resident #46's clinical record and stated he had a history of blood clots and was prescribed Eliquis. She stated Resident #46 was prescribed Macrobid prophylactically for an upcoming suprapubic catheter procedure. She stated the possible risk of Resident #46 not receiving Eliquis as ordered was a blood clot and not receiving Macrobid as ordered was a Urinary Tract Infection. She confirmed she did not receive notification from any nurse about Resident #46's Eliquis or Macrobid not being delivered by pharmacy or administered to Resident #46. She stated she would have expected Resident #46's Eliquis and Macrobid to be administered as ordered, as both medications were available in the facility's emergency kit.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each resident received a therapeutic diet as ordered by the physician for 4 (#5, #31, #50 and #87) of 11 residents reviewed for dining.Resident #5Review of Resident #5's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Dementia and Abnormal Weight loss.Review of Resident #5's Current Physician Orders revealed a dietary order for double portions with a start date of 01/22/2026.Resident #31Review of Resident #31's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction and Alzheimer's disease.Review of Resident #31's Current Physician Orders revealed a dietary order for double portions with a start date of 06/03/2024.Resident #50Review of Resident #50's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Dementia and Abnormal Weight loss.Review of Resident #50's Current Physician Orders revealed a dietary order for double portions with a start date of 10/29/2025.Resident #87Review of Resident #87's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction and Acquired Absence of Other Specified Parts of the Digestive Tract.Review of Resident #87's Current Physician Orders revealed a dietary order for double portions with a start date of 04/02/2026.On 05/20/2026 at 11:44 a.m., an observation was made of Resident #5, #31, #50, and #87 eating lunch in the Restorative dining room. Each resident was observed receiving one plate of food.On 05/20/2026 at 12:25 p.m., an interview was conducted with S12RCNA. She reviewed Resident #5, #31, #50 and #87's meal tickets and confirmed they were supposed to receive double portions and did not.On 05/20/2026 at 12:29 p.m., an interview conducted with S16DM. She stated residents with orders for double portions are expected to receive two plates of food. She stated she expected her kitchen staff to review each meal ticket for special diet instructions, including double portions to ensure they supply each resident the correct type and amount of food. She confirmed Resident #5, #31, #50, and #87 had active orders for double portions and should have received two plates of food.On 05/20/2026 at 2:50 p.m., an interview was conducted with S2ADMIN. He confirmed all residents with an order for double portions should receive double portions for all meals.

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St. Francisville Nursing and Rehab, LLC	15243 LA Hwy 10 Saint Francisville, LA 70775

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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, interviews, and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure:1. Meat products were stored separate from or below dairy products in the facility's refrigerator; and2. The dishwasher reached 120 ˆ consistently during the rinse cycle while washing dishes.This deficient practice had the potential to affect 103 residents who consume food from the facility's kitchen.Review of the facility's policy dated 2001 and titled, Food Receiving and Storage, revealed, the following, in part:Policy Statement: Food shall be received and stored in a manner that complies with safe food handling practices.Refrigerated/Frozen Storage:8. Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods to prevent meat juices from dripping onto these foods. Review of the facility's policy dated 2001 and titled, Sanitization, revealed the following, in part:Policy statement: The food service area is maintained in a clean and sanitary manner.Policy interpretation and implementation:5. Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: b. Low-Temperature Dishwasher (Chemical Sanitization):1. Wash temperature (120 ˆ)On 05/18/2026 at 8:03 a.m., a tour of the kitchen was conducted with S11CH. An observation was made of 2 boxes of diced chicken, 2 boxes of sausage, and a container including 2 rolls of ground meat stored directly above eggs and dairy products in the facility's refrigerator.On 05/18/2026 at 8:10 a.m., an interview was conducted with S11CH. She confirmed meat products should not have been stored above dairy products. She stated dietary staff was trained to store meat products in a separate refrigerator from dairy products. On 05/18/2026 11:57 a.m., an observation was made of the facility's dishwashing process with S11CH. The dishwashing process was observed for 5 sets of dishes, during which the rinse cycle did not reach 120 ˆ for 4 out of 5 sets of dishes washed.On 05/18/2026 at 12:10 p.m., an interview was conducted with S11CH. She confirmed the dishwasher did not reach 120 ˆ during the rinse cycle until the 5th set of dishes were washed. She further confirmed the dishwasher should reach 120 ˆ during each rinse cycle to ensure proper sanitization.On 05/18/2026 at 1:05 p.m., an interview was conducted with S2ADMIN. He confirmed meat products should not be stored above dairy products in the facility's refrigerator. He further confirmed the dishwasher should reach 120 ˆ during the rinse cycle each time it is utilized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure staff performed proper glove usage and utilized proper Personal Protective Equipment (PPE) while providing care for 3 (#1, #89, and #98) of 4 sampled residents who were on Enhanced Barrier Precautions (EBP). Findings: Review of the facility's policy, revised December 2024, titled, Enhanced Barrier Precautions revealed the following, in part: Policy Statement: Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organism (MDROs) to residents. 2. Enhanced barrier precautions apply when: b. A resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gown and gloves are applied prior to performing the high contact resident care activity. 8. Exampled of high-contact resident care activities requiring the use of gown and gloves for EBPs include: c. providing hygiene or grooming; d. changing brief or assisting with toileting; f. providing bed mobility; i. device care or use; and j. wound care. Resident #1 Review of Resident #1's Clinical Record revealed an admission date of 09/24/2025 and diagnoses, which included Other Complications of Gastrostomy, and Left Gluteal Pressure Ulcer. Review of Resident #1's current Physician Order revealed the resident had daily treatment orders for a Left gluteal Pressure Ulcer and PEG site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's current Care Plan revealed the following, in part: Date Initiated: 09/29/2025 Problem: Risk for infection related to history of infection to PEG site. Intervention: (03/24/2026) Resident is on Enhanced Barrier Precautions. On 05/19/2026 at 8:49 a.m., an observation was made of the EBP sign above Resident #1's head of bed. The sign indicated the following: STOP - Enhanced Barrier Precautions Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: Hygiene; Device care; and Wound care. On 05/19/2026 at 10:25 a.m., an observation was made of S35LPN performing wound care for Resident #1 with S36CNA assisting. S35LPN performed wound care to Resident #1's Left Glute Pressure Ulcer and PEG tube site. S36CNA assisted with turning Resident #1 from side to side in bed. S35LPN and S36CNA did not don a gown for any portion of the treatment. On 05/19/2026 at 10:38 a.m., an interview was conducted with S35LPN. She stated enhanced barrier precautions should have been followed when the resident had a catheter, PEG tube, or a wound. She stated Resident #1 was on EBP due to her Pressure Ulcer and PEG tube. She confirmed she should have worn a gown while providing wound care and PEG site care, and she did not. On 05/19/2026 at 11:12 a.m., an interview was conducted with S36CNA. She stated EBP was when you wear a gown and gloves for providing care to residents with indwelling medical devices and wounds. She confirmed Resident #1 had a PEG tube and a Pressure Ulcer. She confirmed she did not don a gown when assisting with providing care for Resident #1 and should have. On 05/19/2026 at 4:20 p.m., an interview was conducted with S1DON. She confirmed Resident #1 was on EBP for her PEG tube and Pressure Ulcer. She stated the expectation was for staff to don a gown and gloves when performing wound care and PEG site care. Resident #89 Review of Resident #89's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #89's current Physician's Orders revealed the resident had orders for enteral feeding. On 05/19/2026 at 8:40 a.m., an observation was made of the EBP sign above Resident #89's head of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. The sign indicated the following: STOP - Enhanced Barrier Precautions Everyone must: Clean their hands, including before entering and when the leaving the room Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: Providing hygiene and changing briefs. On 05/19/2026 at 10:02 a.m. an observation was made of S17CNA performing peri-care for Resident #89. S17CNA performed hand hygiene and donned gloves. S17CNA removed Resident #89's soiled brief and cleaned resident with peri spray and wipes. Without removing the soiled gloves, performing hand hygiene, or donning clean gloves, S17CNA applied a clean brief and straightened residents clothing and bed linens. S17CNA did not don a gown while performing high contact care to Resident #89. On 05/19/2026 at 10:12 a.m. an interview was conducted with S17CNA. She stated she was not aware she should have worn PPE while changing Resident #89's brief. S17CNA confirmed she had not removed soiled gloves and performed hand hygiene before going from dirty to clean when performing peri care and should have. On 05/20/2026 at 10:00 a.m., an interview was conducted with S1DON. She stated staff should don a gown and gloves when providing high contact care for any residents on Enhanced Barrier Precautions. Resident #98 Review of Resident #98's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Gastrostomy Status. Review of Resident #98's current Physician's Orders revealed the resident had orders for PEG tube care and feeding. Review of Resident #98's current Care Plan revealed the following, in part: Date Initiated: 02/14/2026 Problem: Risk for infection related to Dysphagia, PEG tube status. Intervention: (03/24/2026) Resident is on Enhanced Barrier Precautions. On 05/20/2026 at 8:40 a.m., an observation was made of the EBP sign above Resident #98's head of bed. The sign indicated the following: STOP - Enhanced Barrier Precautions Everyone must: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clean their hands, including before entering and when the leaving the room Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: Device care or use: Feeding tube . On 05/20/2026 at 9:17 a.m., an observation was made of S9LPN administering tube feeding and water flushes for Resident #98. S9LPN pulled up Resident #98's gown, picked up the PEG tube and administered the tube feeding and water flush. S9LPN did not don a gown while performing high contact care to Resident #98. On 05/20/2026 at 9:30 a.m., an interview was conducted with S9LPN. She confirmed she did not don a gown prior to administering Resident #98's tube feeding. On 05/20/2026 at 10:00 a.m., an interview was conducted with S1DON. She stated Resident #98 had a PEG tube and was on Enhanced Barrier Precautions. She stated staff should don a gown and gloves when providing high contact care for Resident #98 and for any residents on Enhanced Barrier Precautions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record review, the facility failed to ensure resident equipment was maintained in a sanitary manner by failing to ensure wheel chairs were clean for 1 (#99) of 6 residents reviewed in the final sample.Findings: On 05/18/2026 and on 05/19/2026, observations were made of Resident #99 sitting in her wheelchair in the hallway. Resident #99's wheelchair frame appeared to be covered in approximately 1/2 inch thick, gray, dust-like substance. The frame of the wheelchair near the wheels had approximately 1/2 inch thick amount of hair and dust wrapped around it. On 05/19/2026 at 1:30 p.m., an interview was conducted with S32CNA. S32CNA observed Resident #99's wheelchair base to be covered in thick dust and hair. S32CNA confirmed Resident #99's wheelchair needed to be cleaned. She stated the night shift CNAs are expected to clean the wheelchairs. On 05/19/2026 at 1:34 p.m., an interview was conducted with S34CNA. S34CNA observed Resident #99's wheelchair base to be covered in thick dust and hair. S34CNA confirmed Resident #99's wheelchair needed to be cleaned. On 05/19/2026 at 1:38 p.m., an interview was conducted with S15ADON. S15ADON observed the above findings. S15ADON stated the night shift CNAs have a schedule to clean odd room wheelchairs every Monday, Wednesday, and Friday. S15ADON stated night shift CNAs clean even room wheelchairs every Tuesday, Thursday, and Saturday. S15ADON stated CNAs are expected to clean the entire wheelchair. S15ADON confirmed Resident #99's wheelchair needed to be cleaned. On 05/19/2026 at 2:02 p.m., an interview was conducted with S1DON. S1DON stated she expected CNA staff to follow the process on cleaning wheelchairs. S1DON stated wheelchairs should not be dirty. S1DON stated she expected CNA staff to be cleaning wheelchairs per the cleaning schedule.

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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. Based on observations, interviews, and record review, the facility failed to implement a resident's comprehensive care plan by failing to ensure PEG tube free water flushes was administered as ordered by the physician for 1 (#1) of 3 residents reviewed for tube feeding.Findings: Review of Resident #1's Clinical Record revealed an admission date of 09/24/2025 and diagnoses, which included Cerebral Palsy, Moderate Protein-Calorie Malnutrition, and Other Complications of Gastrostomy. Review of Resident #1's current Physician Orders revealed the following, in part:Enteral Feed: Two Cal continuous feed at 40mL/hour and free water flushes at 54 mL/hr. Review of Resident #1's current Care Plan revealed the following, in part:Problem: Risk for altered fluid balance related to modified diet (NPO) with PEGInterventions: Fluids via PEG as ordered. An observation was made of Resident #1 on 05/19/2026 at 8:50 a.m. She had tube feeding and water flushes infusing via pump. The pump did not immediately display the water flush rate. An observation was made of Resident #1's tube feeding and pump with S19LPN on 05/19/2026 at 9:06 a.m. S19LPN toggled through the pump selections and observed Resident #1's water flush rate on Resident #1's tube feeding pump. S19LPN confirmed the water flush rate was set at 300 mL water flush every four hours. An interview was conducted with S19LPN on 05/19/2026 at 9:10 a.m. S19LPN reviewed Resident #1's clinical record and confirmed Resident #1 was ordered water flushes via PEG tube at 54 mL/hr. S19LPN confirmed Resident #1's water flush via PEG tube was not infusing at the ordered rate and should have been. S19LPN stated all nurses were responsible for checking tube feeding and water flush rates each shift. An interview was conducted with S1DON on 05/19/2026 at 4:20 p.m. She confirmed Resident #1's water flushes via PEG tube were not infusing at the physician ordered rate and should have been. She confirmed she observed the pump, and the free water was infusing at 300 mL every 4 hours and should have been at 54 mL/hr.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to maintain records in accordance with accepted professional standards and practices for 1 (#5) of 11 residents reviewed for dining. The facility failed to ensure Resident #5's eating ability and performance was documented daily and accurately.Review of the facility's policy dated 2001 and titled, Charting and Documentation, revealed the following, in part:Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation3. Documentation in the medical record will be objective, complete, and accurate.Review of Resident #5's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Dementia, Dysphagia, and Right Dominant Side Hemiplegia and Hemiparesis.Review of Resident #5's Current Care Plan revealed the following, in part:Focus: Restorative Nursing Programs needed due to assist in safely eating and drinking.Interventions: Please give a verbal and tactile cue to swallow. Check his mouth to make sure that it is clear. Continue until the meal is completed. Please check the resident's mouth to make sure it is clear when the meal is completed.Review of Resident #5's CNA Documentation Report for GG-Eating: The ability to use suitable utensil to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident, revealed missing documentation on the following dates: 04/03/2026, 04/08/2026, 04/09/2026, 04/11/2026, 04/13/2026, 04/14/2026, 04/18/2026, 04/19/2026, 04/21/2026, 04/23/2026, 04/27/2026, and 04/28/2026. Further review revealed the following documentation completed by S13CNA on 04/29/2026:7:30 a.m. and 12:30 p.m.: 06-Independent; and17:30 p.m.: 04-Supervision or Touching Assistance.On 05/20/2026 at 11:51 a.m., an observation was made of Resident #5 during his lunch meal. S12RCNA was observed providing Resident #5 1-on-1 feeding assistance during the entire meal. She was observed providing verbal and tactile cues for Resident #5 to swallow multiple times per bite of pureed solids. She was also observed feeding Resident #5 liquids and solids in an alternating pattern and checking his mouth throughout the meal to ensure it was clear before proceeding.On 05/20/2026 at 11:56 a.m., an interview was conducted with S12RCNA. She stated Resident #5 required 1-on-1 feeding assistance during meals due to impulsivity and high risk for aspiration and choking. She further stated all CNAs were required to accurately complete daily documentation regarding each resident's eating ability and performance.On 05/20/2026 at 1:40 p.m., an interview was conducted with S15ADON. She stated Resident #5 was not independent with eating in April of 2026. She stated he had always required at least close supervision due to cognitive safety concerns and ongoing swallowing issues. She reviewed the CNA documentation report for GG-Eating in April of 2026 and confirmed it was incomplete on the aforementioned dates. Upon further review, she confirmed Independent did not accurately reflect Resident #5's eating abilities. She stated she expected all CNAs to complete documentation daily and accurately in order to reflect each resident's eating ability and performance.On 05/20/2026 at 4:23 p.m., a phone interview was conducted with S13CNA. She stated she was familiar with Resident #5 and cared for him on 04/29/2026. She stated he always required at least close supervision during his meals due to his ongoing swallowing difficulties. She confirmed CNAs were required to accurately complete documentation daily to reflect each resident's eating ability and performance. She stated if an entry box was blank on the CNA Documentation Report, it was not completed and should have been. She further stated if she scored Resident #5's eating ability as Independent on 04/29/2026, it was inaccurate.