STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195564	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acadia St. Landry Nursing & Rehabilitation Center	830 S. Broadway St. Church Point, LA 70525

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 - Minimal harm or potential for 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 interviews and record review, the facility failed to immediately inform the resident's physician of a major injury for 1 resident (#1) of 3 sampled residents. Findings: Review of the facility's policy titled Change in a Resident's Condition or Status, with a last revised date of May 2017, read in part: Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's physical/mental condition and/or status.1. The nurse will notify the resident's Attending Physician or physician call when there has been a (an): d. significant change in the resident's physical/emotional/mental condition.2. A significant change of condition is a major decline or improvement in the resident's status that: c. Requires interdisciplinary review and/or revision to the care plan.Review of Resident #1's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] and had diagnoses including, but not limited to, displaced fracture of left tibial tuberosity , subsequent encounter for closed fracture with routine healing, anxiety disorder, unspecified dementia, and unspecified sequelae of cerebral infarction. Review of Resident #1's nursing progress notes from 05/22/2026 to 05/26/2026 revealed the following in part : -05/22/2026 3:00 a.m. S3LPN wrote: 3 a.m. called to resident room by husband(roommate). resident noted sitting on floormat with back against bed, legs extended out.head to toe assessment done. no apparent injuries noted.3:39 a.m. send secured message to S4NP to make her aware of fall. -05/22/2026 4:45 p.m. S2ADON wrote: Alerted to Resident #1's room per CNA (Certified Nursing Assistant) who stated that the residents Lt. (left) leg was swollen and painful at the knee .I assessed the resident and noted that the lateral lower area beneath the knee was swollen and painful to touch and movement. Instructed the attending LPN (Licensed Practical Nurse) S3LPN to notify the attending provider and the family of the change in status. New orders were noted.-05/22/2026 5:04 p.m. S3LPN wrote: 4 p.m. made aware by Adon (Assistant Director of Nursing) that resident was c/o (complaining of) leg pain. upon assessment resident edema noted to left leg and raised area noted below knee on left leg. resident c/o bil (bilateral) leg pain to touch. 4 p.m. phoned S4NP and made her aware of resident c/o bil leg pain. new order noted to send resident to [hospital] ER for eval (evaluation) and tx (treatment). Phoned S5AN (Administrative Nurse) and made her aware of resident condition .4:20 p.m. resident left with nh staff via stretcher-05/24/2026 8:39 a.m. S6MDS wrote: On 5/22/26, resident was transferred to [hospital ER] d/t (due to) c/o increased pain to left lower leg. Resident assessed per ADON d/t left leg swollen & painful at the knee. On 5/23/26, resident returned with CT left knee w/o (without) contrast impression: mildly displaced avulsion fx. of the tibial tuberosity. Joint effusion present. Tricompartmental degenerative changes of the knee. Left knee x-rays, 2 views d/t pain, impression: lucency of the anterior tibial tuberosity, correlate for avulsion fx (fracture). Recommend follow-up CT.-05/26/2026 3:20 p.m. S6MDS wrote: S4NP. made rounds. N. O. (New Order) increase Seroquel to 50mg (milligrams) po (by mouth) at hs (hours of sleep). Start Seroquel 25mg po q (every) a.m. dx (diagnosis) Psychosis/Mood D/O (disorder). Schedule Ortho (Orthopedic) consult with [physician] for mildly displaced avulsion fx (fracture) of the left tibial tuberosity with joint effusion & tricompartmental degenerative changes (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	(status post fall). Resident is non-ambulatory. Hydrocodone/APAP 5/325mg 1 po q 4 hours prn (as needed) moderate to severe pain. Dispense #42 tabs, 7-day supply. Do paperwork for pain mgmt (management) for [physician] for next Tuesday. Review of Resident #1's written physician's orders revealed the following orders dated 05/26/2026: -Schedule Ortho consult with [physician] for mildly displaced avulsion fx (fracture) of the left tibial tuberosity with joint effusion & tricompartmental degenerative changes (status post fall)- Hydrocodone/APAP 5/325mg 1 po q 4 hours prn (as needed) moderate to severe pain. Dispense 42 tabs, 7-day supply- Do paperwork for pain mgmt (management) for [physician] for next Tuesday. Further review of Resident #1's physician's orders revealed the following order dated 05/28/2026: Knee immobilizer to left knee at all times , remove for bathing only, monitor q (every) shift. Review of Resident #1's plan of care and physician's orders for May 2026 reveled there were no interventions ordered for the resident's left knee fracture until 05/26/2026. Review of Resident #1's EHR failed to reveal evidence that the nurse practitioner or physician was immediately notified of the resident's fracture discovered on 05/22/2026. On 06/08/2026 at 12:45 p.m., an interview was conducted with S4NP. S4NP stated that she was not notified that Resident #1 had a left knee fracture until she made rounds at the facility on 05/26/2026. S4NP confirmed that she was the provider on call on the weekend of 05/22/2026 to 05/24/2026. She stated that the hospital did not send the resident back with any follow up orders or a knee immobilizer, so she ordered an orthopedic consult on 05/26/2026 because she felt like the resident needed that. She also ordered pain medications for the resident on 05/26/2026. S4NP stated that the facility would have needed to call her for an order for stronger pain medications. S4NP was asked if the facility should have notified her of the resident's imaging results when it was discovered that she had a fracture on 05/22/2026. S4NP stated, You would think.On 06/08/2026 at 3:26 p.m., a phone interview was conducted with S3LPN. S3LPN stated that she was the resident's nurse when she fell out of bed on 05/22/2026. When she returned for her shift later that evening, the CNA reported to S2ADON that the resident's left leg was swollen and bruised. S2ADON assessed her, and she [S3LPN] notified S4NP and received an order to send the resident out for evaluation. She stated that the ER nurse called her and told her that the resident's knee was fractured, and she notified the administrative nurse on call that night of the fracture, but she did not remember who it was. S3LPN stated she did not recall notifying S4NP of the fracture. On 06/09/2026 at 1:49 p.m., an interview was conducted with S1DON. She stated that S3LPN notified her via text message on 05/22/2026 that she had sent the resident out for evaluation of her leg and that the resident had a left knee fracture. S1DON stated that she did not notify S4NP of the knee fracture, and that was something that the resident's nurse would typically do. She stated that S3LPN should have notified the nurse practitioner that the resident fractured her knee at the time of discovery because it was a change in condition.On 06/09/2026 at 2:51 p.m., a second interview was conducted with S1DON. S1DON confirmed that S3LPN knew that Resident #1 had a fracture on 05/22/2026 and also worked with the resident again when she returned from the hospital on [DATE] and 05/24/2026. S1DON stated that when S3LPN noticed that the resident had no interventions in place, such as pain medication, a knee immobilizer, or any further instructions, S3LPN should have notified the nurse practitioner, physician, or herself that the resident had no interventions in place with a diagnosis of a left knee fracture.