STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195593	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lagniappe Healthcare	1408 Summerlin Lane Bastrop, LA 71220

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure it stored all drugs and biologicals in locked compartments by having medications stored in resident rooms for 2 (#26, #72) of 2 sampled residents observed for medication storage. Findings: Resident #26 Review of the February 2026 physician's orders revealed there was no current order for the miconazole powder. Review of the February 2026 medication administration record revealed there was no documentation Resident #26 was receiving miconazole powder. On 02/09/2026 at 10:45 a.m., observation of the Resident #26's room revealed there were 3 bottles of miconazole powder in the room. On 02/10/26 at 12:10 p.m., interview with S2DON revealed the miconazole powder had been discontinued. She also confirmed the medication should not have been stored in the resident's room. Resident #72 Review of the medical record for Resident #72 revealed an admission date of 01/14/2026 with diagnoses that included chronic obstructive pulmonary disease, Takotsubo syndrome, atherosclerotic heart disease, hypertension, hyperlipidemia, dorsalgia, depression, and gastroesophageal reflux disease. Review of the admission MDS dated [DATE] revealed a BIMS score of 12 which indicated Resident #72 had moderate cognitive impairment with daily decision making. Review of the Physician Orders revealed no order for: 1) ferrous sulfate 325 mg tablet, 2) Ofloxacin otic solution 0.3%, 3) Albuterol Sulfate inhalation aerosol, and 4) Ventolin HFA 90 mcg/actuation. On 02/09/2026 at 10:16 a.m., an observation of Resident #72's room with S7LPN confirmed a labeled bottle with tablets was present on the side table. S7LPN further confirmed the label read ferrous sulfate 325 mg tab. S7LPN confirmed that Resident #72 did not have orders for: 1) ferrous sulfate 325 mg tab 2) ferrous sulfate 325 mg tab at bedside. (continued on next page)

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/2026 at 8:16 a.m., an observation of Resident #72's room with S7LPN confirmed the following on Resident #72's side table: 1) Ofloxacin otic solution 0.3% bottle, 2) Albuterol sulfate inhalation aerosol bottle in actuator 3) Ventolin HFA 90 mcg/actuation bottle in actuator. S7LPN confirmed solution was present in the Ofloxacin otic 0.3% bottle, and doses were available for both inhalation medications. S7LPN further confirmed that Resident #72 did not have: 1) orders for these medications, 2) orders for these medications at bedside. On 02/10/2026 at 8:40 a.m., S2DON was informed the following medications were found on Resident #72's side table: 1) ferrous sulfate 325 mg tablet, 2) Ofloxacin otic solution 0.3%, 3) Albuterol Sulfate inhalation aerosol, and 4) Ventolin HFA 90 mcg/actuation, and Resident #72 did not have orders for these medications at bedside.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to address the resident right to be informed of his or her treatment in advance, by the physician or other practitioner or professional, of the risks and benefits of psychotropic medication treatment. The facility failed to ensure consent for psychotropic medication was obtained for 2 (#7, #60) of 5 residents reviewed for unnecessary medications.Findings:Resident #7Review of the medical record for Resident #7 revealed an admission date of 01/25/2024 with diagnoses that included acute and chronic respiratory failure, diabetes mellitus with chronic kidney disease, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, secondary malignant neoplasm of large intestine and rectum, peripheral vascular disease, ischemic cardiomyopathy, and hypertension.Review of the admission MDS dated [DATE] revealed a BIMS score of 11 which indicated Resident #7 had moderate cognitive impairment with daily decision making. Further review revealed Resident #7 received psychotropic medication.Review of the Physician Orders revealed the psychotropic medication Zoloft was initiated on 12/08/2025. Further review revealed the order specified Zoloft 25 mg tab daily per PEG tube for major depressive order.Review of the January 2026 MAR revealed Zoloft 25 mg tab was administered daily as ordered to Resident #7.On 02/11/2026 at 3:00 p.m., S8LPN confirmed there was no documentation to support consent was obtained for Resident #7 to receive Zoloft 25 mg tab.Resident #60Review of the medical record for Resident #60 revealed an admission date of 02/18/2025 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus without complications, atherosclerotic heart disease of native coronary artery without angina pectoris, bipolar disorder, hyperlipidemia, and anemia.Review of the annual MDS assessment dated [DATE] revealed a BIMS score of 6 which indicated Resident #60 had severe cognitive impairment with daily decision making. Further review revealed Resident #60 received psychotropic medication.Review of the Physician Orders revealed the psychotropic medication Abilify was initiated on 07/21/2025. Further review revealed the order specified Abilify 2.5 mg by mouth daily for bipolar disorder.Review of the January 2026 MAR revealed Abilify 2.5 mg by mouth was administered daily as ordered to Resident #60, except during hospitalization.On 02/11/2026 at 2:55 p.m., S9RN confirmed there was no documentation to support consent was obtained for Resident #60 to receive Abilify 2.5 mg by mouth.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to implement a person-centered care plan for each resident to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (#23, #60) of 5 residents reviewed for falls. The facility failed to ensure:1. Proper functioning of Resident #23's motion sensor, and2. A wheelchair brake extender was on Resident #60's wheelchair as stated in the care plan. Findings:Resident #23 Review of the medical record for Resident #23 revealed an admission date of 10/12/2023. Resident #23 had diagnoses that included dementia, heart disease, muscle weakness, Alzheimer's disease, peripheral vascular disease, aortic valve disorders, and lack of coordination. Review of the quarterly MDS assessment dated [DATE] revealed Resident #23 had a BIMS score of 9 which indicated moderate cognitive impairment for daily decision making. Further review revealed Resident #23 used a manual wheelchair for mobility and required assistance with ADLs. Review of the fall risk assessment dated [DATE] revealed Resident #23 was at high risk for falls. Review of the current care plan revealed Resident #23 required assistance with mobility and was at high risk for injury related to weakness and a history of falls. Further review of the care plan revealed an approach, after a fall, dated 01/15/2026 revealed Resident #23 would be screened by therapy, and a stand alone motion sensor would be placed in the bathroom to notify staff when Resident #23 entered the bathroom. Upon arrival to Resident #23's room on 02/10/2026 at 11:30 a.m., the resident was observed seated in wheelchair. Further observation revealed the motion sensor located in the bathroom was lying on the floor. When the surveyor walked in front of the sensor, it did not alarm. On 02/10/2026 at 11:40 a.m. observation of Resident #23's room with S4LPN revealed the stand alone motion sensor was not turned. On 02/10/2026 at 11:45 a.m. interview with S4LPN confirmed the motion sensor should have been turned on to alert the staff that someone was in the bathroom. On 02/10/2026 at 12:00 p.m. S2DON was informed that the stand alone motion sensor located in Resident #23's bathroom was not turned on while the resident was in the room on 02/10/2026 at 11:30 a.m. Resident #60 Review of the medical record for Resident #60 revealed an admission date of 02/18/2025 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus without complications, atherosclerotic heart disease of native coronary artery without angina pectoris, bipolar disorder, hyperlipidemia, and anemia. Review of the annual MDS assessment dated [DATE] revealed a BIMS score of 6 which indicated Resident #60 had severe cognitive impairment with daily decision making. Further review revealed Resident #60 used a manual wheelchair for mobility.Review of the fall risk assessments dated 12/12/2025 and 02/06/2026 revealed Resident #60 was at high risk for falls. Review of the current plan of care revealed Resident #60 was at risk for injurious falls related to weakness, history of falls, cognitive impairment, polypharmacy, use of psychotropic medications, lack of safety awareness, and loss of mobility with hemiplegia. Further review revealed an approach after a fall dated 08/18/2025 for wheelchair brake extenders to be placed on wheelchair. On 02/10/2026 at 10:40 a.m., Resident #60 was observed seated upright in wheelchair in the main dining area. No wheelchair brake extenders were observed. On 02/10/2026 at 10:45 a.m., S6LPN observed Resident #60 in the main dining area, seated upright in wheelchair, and confirmed that wheelchair brake extenders were not in place.On 02/10/2026 at 11:18 a.m., S2DON observed Resident #60 in the main dining area, seated in wheelchair, and confirmed that wheelchair brake extenders were not in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Facility staff failed to utilize gown and gloves during high contact resident care activities for 2 (#7, #15) of 2 residents observed.Findings: Review of the Enhanced Barrier Precautions policy (undated) read in part; Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms to residents. Examples of high-contact resident care activities requiring the use of gown and gloves for enhanced barrier precautions include: device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) Resident #7 Review of the medical record for Resident #7 revealed an admission date of 01/25/2024 with diagnoses that included acute and chronic respiratory failure, diabetes mellitus with chronic kidney disease, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, secondary malignant neoplasm of large intestine and rectum, peripheral vascular disease, ischemic cardiomyopathy, and hypertension. Review of the Physician Orders revealed an order dated 01/23/2026: Place under EBP due to PEG. Review of the admission MDS dated [DATE] revealed a BIMS score of 11 which indicated Resident #7 had moderate cognitive impairment with daily decision making. Further review revealed a nutritional approach of feeding tube. Review of the current plan of care revealed a focus of EBP with an intervention that specified the use of EBP for high contact activities. Further review revealed high contact activities included, in part, care or use of feeding tubes. On 02/11/2026 at 11:27 a.m., S5LPN was observed at Resident #7's bedside during bolus administration per PEG tube. S5LPN did not have on a gown during the bolus administration. Following bolus administration, S5LPN confirmed Resident #7 had an order for EBP precautions due to PEG. On 02/11/2026 at 11:35 a.m., S2DON was informed that EBP precautions were not implemented during bolus administration through PEG. Resident #15 Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses which included urinary tract infections and hemiplegia. Review of the February 2026 physician orders revealed Resident #15 had an indwelling Foley catheter and an order to provide catheter care each shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2026 at 10:18 a.m., S3LPN was observed as she performed catheter care. S3LPN wore gloves but did not don a gown prior to performing catheter care. On 02/11/2026 at 10:40 a.m., interview with S2DON confirmed S3LPN should have donned a gown prior to performing catheter care.