STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195645	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luling Living Center	1125 Paul Maillard Rd Luling, LA 70070

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure licensed nursing staff provided basic life support, including cardiopulmonary resuscitation [(CPR) chest compressions and rescue breaths to maintain blood flow and oxygen to vital organs], in accordance with the resident's physician orders and American Heart Association for 1 (Resident #54) of 1 sampled residents reviewed who had expired in the facility in a total sample of 19 residents. This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 12:49PM when Resident #54 was found unresponsive, without a pulse and not breathing by S4Licensed Practical Nurse (LPN) and S5LPN The Immediate Jeopardy situation continued on [DATE] at 1:19PM when Resident #54 was pronounced deceased by his hospice nurse after no life-saving measures were being implemented upon Resident #54's hospice nurse's arrival, despite a physician order for full code status. The Immediate Jeopardy further continued on [DATE] at 1:20PM when licensed nursing staff continued to provide care to residents without being re-educated on verifying residents' code status, initiating and continuing CPR to a resident until advanced medical providers arrived, placing other residents at risk for the same failure to provide CPR in accordance with physician orders. S1Administrator was notified of the Immediate Jeopardy situation on [DATE] at 5:33PM. This systemic failure had the likelihood to cause more than minimal harm to all 51 residents residing in the facility on [DATE], placing them at risk for care not provided in accordance with their code status and advance directives. Findings:Review of the facility's undated CPR policy and procedure revealed, in part, staff should provide basic life support, including CPR, to a resident requiring emergency care, prior to the arrival of emergency personnel, according to the resident's Physician's Orders and/or advance directives. Review of the [DATE] American Heart Association Basic Life Support Algorithm: A Step-by-Step Guide revealed, in part, the most critical part of basic life support was high-quality CPR. Further review revealed CPR should continue until advanced medical providers arrived or the patient presents signs of life. Review of Resident #54's Louisiana Physician Orders for Scope of Treatment dated [DATE] revealed, in part, if Resident #54 was unresponsive, pulseless and was not breathing and CPR was to be performed. Further review revealed the form was signed and dated by Resident #54's responsible party on [DATE] and the physician on [DATE]. Review of Resident #54's February 2026 Physician's Orders revealed, in part, an order dated [DATE] for Resident #54 to have a full code status (a code status where chest compressions and rescue breaths were to be provided in the event the resident was unresponsive, pulseless, or not breathing). Review of Resident #54's Hospice Certification and Plan of Care dated [DATE] revealed, in part, Resident #54 had diagnoses which included, in part, hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease (a condition where high blood pressure affects the heart and the kidneys at the same time, leading to failure in both systems) and chronic obstructive pulmonary disease (a progressive lung disease that restricts airflow). Further review revealed Resident #54's advanced directive was to be a full code status. Review of Resident #54's comprehensive care plan dated [DATE] revealed, in part, Resident #54's advanced directive was to be a full code status. Review of Resident #54's health status note (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	dated [DATE] at 2:34PM and documented by S4LPN revealed, in part, S4LPN was summoned to Resident #54's room and found Resident #54 unresponsive and not breathing. Further review revealed S4LPN attempted CPR but was unsuccessful. Further review revealed Resident #54's time of death was pronounced at 1:19PM by Resident #54's hospice nurse. Review of the facility's surveillance footage from [DATE] revealed, in part, the incident began at 12:47PM, when S18Certified Nursing Assistant (CNA) was observed exiting Resident #54's room and quickly walking towards S10CNA Supervisor's location. Further review revealed S10CNA Supervisor and S18CNA quickly walked back to Resident #54's room. Further review revealed S10CNA Supervisor then exited Resident #54's room and gestured for other staff to come to Resident #54's room. Further review of the facility's surveillance footage revealed S4LPN and S5LPN entered Resident #54's room at 12:49PM. S5LPN was observed exiting, entering, and then exiting Resident #54's room for a final time at 12:50PM. S4LPN was observed exiting Resident #54's room at 12:51PM. Further review of the facility's surveillance footage revealed from 12:47PM through 1:15PM multiple staff were observed entering Resident #54's room and none of the facility staff were observed to have brought cardiopulmonary emergency equipment, such as a backboard, Ambu bag (manual resuscitation bag/ventilation device) or crash cart into Resident #54's room. Further review revealed Resident #54's hospice nurse entered Resident #54's room at 1:15PM. In a telephone interview on [DATE] at 10:41AM, Resident #54's hospice nurse indicated she was notified by the facility on [DATE] sometime after 1:00PM that Resident #54 had expired. Resident #54's hospice nurse further indicated upon arrival, Resident #54 was in bed with a sheet covering his head and no life-saving measures were being implemented by the facility's staff. Resident #54's hospice nurse further indicated Resident #54 had no vital signs (measurements of basic body functions that signify life) and pronounced Resident #54 deceased at 1:19PM. Resident #54's hospice nurse further indicated she had been informed the facility's nursing staff had provided CPR to Resident #54 and stopped. Resident #54's hospice nurse further indicated she did not instruct the facility's nursing staff to stop CPR and expected CPR to continue until emergency medical services staff or a physician directed otherwise. In an interview on [DATE] at 11:24AM, S5LPN indicated she assisted S4LPN at the time of Resident #54's death on [DATE]. S5LPN further indicated she and S4LPN were called to Resident #54's room by S10CNA Supervisor and Resident #54 was found in bed, unresponsive and not breathing. S5LPN further indicated when she assessed Resident #54 he was found to have no pulse, was still warm to the touch with no observable signs of prolonged death. S5LPN further indicated Resident #54's code status was not discussed and she assumed, because Resident #54 had hospice services, that Resident #54's code status was do not resuscitate [(DNR) a code status where chest compressions and rescue breaths where not provided to maintain blood flow and oxygen to vital organs). S5LPN further indicated on [DATE] she was not aware Resident #54's code status was full code and she had not observed anyone implementing CPR to Resident #54. In an interview on [DATE] at 11:55AM, Resident #54's responsible party indicated she had been reluctant to initiate hospice services; however, she had not requested or agreed to a change in Resident #54's code status. Resident #54's responsible party further indicated she expected Resident #54 to remain a full code and to receive all life-saving interventions, including CPR, in the event of an emergency. In an interview on [DATE] at 12:53PM, S2Director of Nursing (DON) indicated on [DATE] S4LPN came to her office and notified her that Resident #54 had expired. S2DON further indicated S4LPN then informed her that she (S4LPN) had thought Resident #54's code status was DNR, but Resident #54's code status was actually full code. S2DNR further indicated S4LPN then indicated to her that she had not yet implemented CPR. S2DON indicated she then instructed S4LPN to go back to Resident #54's room and initiate CPR on Resident #54. S2DON indicated S4LPN should have been aware of Resident #54's cull code status. The facility was unable to provide evidence S4LPN or any of the facility's licensed nursing staff immediately verified and/or implemented Resident 54's code status and/or ensured Resident #54 received continuous CPR from when Resident #54 was found not breathing and with no pulse on [DATE] at (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	12:49PM, until his official time of death on [DATE] at 1:19PM. In an interview on [DATE] at 1:17PM, S1Administrator indicated on [DATE] S4LPN should have provided continuous CPR to Resident #54 until emergency medical services arrived and took responsibility for Resident #54's resuscitation efforts. The Immediate Jeopardy situation was removed on [DATE] at 3:24PM, after it was verified through observations, interviews, and record reviews, the facility implemented an acceptable Plan of Removal, prior to the survey exit. A Plan of removal was accepted on [DATE] at 3:24PM which included the following actions to correct the deficient practice: 1. Resident #54 expired on [DATE]. S4LPN last day worked was on [DATE] and was terminated on [DATE] for excessive absences. S5LPN was in-serviced on [DATE] on checking Code Status in the Electronic Medication Administration Record (EMAR) and proper procedures for CPR. 2. All 51 Residents have the potential to be affected. All active Residents' EMAR's were reviewed to make sure code status was posted. 25 Residents have a DNR status. All nurses for each shift were in-serviced on [DATE] and prior to shift on [DATE] for checking code status in the EMAR and proper procedures for CPR. 3. On [DATE] the Facility implemented a policy to train all nurses on checking code status in the EMAR and proper procedures for CPR prior to working on the floor to ensure the likelihood for serious harm to any resident no longer exists. All new hire nurses will be trained on checking code status and proper procedures for CPR prior to working on the floor to ensure the likelihood for serious harm to any resident no longer exists. The code status binder and the red dot stickers have been removed and are no longer in use. A resident's code status must be checked in the EMAR. 4. Starting on [DATE] the DON will monitor weekly for proper training to all nurses and to make sure training is completed prior to working on the floor. DON will audit training documents prior to scheduling nurses to the floor on a weekly basis and before all new hires. The DON will not schedule any nurse who was not completed training. The facility asserted that as of [DATE] at 3:24PM the likelihood of serious harm to any resident no longer existed.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** I.Based on observations, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of each resident by failing to implement and maintain an adequate system to ensure administrative staff identified deficient practices, implemented corrective actions, and ensured licensed nursing staff were trained and competent in verifying residents' code status, initiating and continuing CPR until emergency medical services arrived.This deficient practice was identified for 1 (Resident #54) of 1 sampled residents reviewed who had expired in the facility in a total sample of 19 residents.This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 12:49PM when Resident #54 was found unresponsive, without a pulse, and not breathing, and licensed nursing staff failed to ensure CPR was initiated and continuously provided in accordance with the resident's physician's orders for full code status. On [DATE] at 1:19PM when Resident #54 was pronounced deceased by Resident #54's hospice nurse after no life-saving measures were being implemented upon arrival, despite a physician's order for full code status. The Immediate Jeopardy continued as facility administration failed to identify the deficient practice, failed to implement immediate corrective actions, failed to ensure licensed nursing staff were re-educated and competent in verifying code status, and initiating and continuing CPR until emergency medical services arrived.S1Administrator was notified of the Immediate Jeopardy situation on [DATE] at 5:33PM. This systemic failure had the likelihood to cause more than minimal harm to all 51 residents residing in the facility on [DATE], placing them at risk for care not provided in accordance with their code status and advance directives.Findings:Cross Reference F678 In an interview on [DATE] at 12:53PM, S2Director of Nursing (DON) indicated she had not identified the above mentioned incident as deficient practice on [DATE] when S4LPN did not accurately determine Resident #54's code status, and did not continuously provide CPR to Resident #54 until emergency medical services arrived and took responsibility. S2DON further indicated she had not realized the magnitude of the above deficient practice until it was brought to her attention today. S2DON further indicated the facility did not provide additional education to the facility's nursing staff on verifying a resident's code status and/or continuing CPR once it was started until emergency medical services arrived and took responsibility of resuscitation efforts, and should have. In an interview on [DATE] at 1:17PM, S1Administrator indicated when S2DON discovered S4LPN did not properly determine Resident #54's code status and did not continuously provide CPR to Resident #54 until emergency medical services arrived, S2DON and/or facility's administrative staff should have completed a review of the above mentioned incident to determine the root cause of the deficient practice. S1Administrator further indicated S2DON and/or the facility's administrative staff should have provided re-education to the facility's nursing staff on the facility's CPR policy and procedure. A Plan of Removal was accepted on [DATE] at 3:24PM which included the following actions to correct the deficient practice: 1. Resident #54 expired on [DATE]. S4LPN last day worked was on [DATE] and was terminated on [DATE] for excessive absences. S5LPN was in-serviced on [DATE] on checking a residents Code Status in the Electronic Medication Administration Record (EMAR) and proper procedures for CPR. 2. All 51 Residents have the potential to be affected. All active Residents' EMAR were reviewed to make sure Code Status was posted. 25 Residents have a Do Not Resuscitate (DNR) status. All nurses (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	for each shift were in-serviced on [DATE] and prior to shift on [DATE] for checking Code Status in the EMAR and proper procedures for CPR. 3. On [DATE] the facility updated the policy and procedure for Review of Resident Deaths and the Death Review form was implemented for the DON and/or Quality Nurse to complete the Death Review form and immediately initiate any changes necessary to ensure the likelihood that serious harm to any resident no longer exits. All residents' deaths must be reviewed within 5 business days by the DON or designee. Deaths identified as unexpected or high-risk must be reviewed within 48 hours. The case must be presented to the Quality Assurance Performance Improvement (QAPI) Committee the next scheduled meeting. On [DATE] the Administrator consulted with the on the Policy and Procedure for Review of Resident Deaths, how to fill out the Death Review form and the actions to take place if there are any discrepancies noted on the Death Review form, on training the nurses to look up code status in the Electronic Medication Administration Record, and the proper procedure for CPR. 4. The QAPI Team will review that the DON is reviewing completed Death Review forms and that the DON is following through with any discrepancies. The Quality Assurance Performance Improvement Team will monitor weekly for 3 months and quarterly, thereafter. The Quality Assurance Performance Improvement team will review all Death Review forms weekly for the next 3 months and quarterly, thereafter. The facility asserted that as of [DATE] at 3:24PM the likelihood of serious harm to any resident no longer existed. II. Based on observations, record reviews, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to have an adequate system in place to ensure administrative staff made licensed nursing staff aware of their assigned responsibilities in the absence of a Treatment Nurse for 3 (Resident #7, Resident #16, Resident #44) of 3 sampled residents investigated for pressure ulcers. Findings: Cross Reference F686 Review of the undated DON's job description revealed, in part, the DON provided direction to the nursing staff and coordinated health services. Further review revealed the DON must organize and oversee all nursing operations in the facility. Review of the undated Registered Nurse (RN) Supervisor job description revealed, in part, the RN Supervisor would monitor elements of patient care. Further review revealed the RN Supervisor will report any concerns to the DON. Review of the undated Floor Nurse/LPN job description revealed, in part, the LPN would initiate the orders of physicians involved in the care of the resident and carry out any treatments and procedures outlined in the patient's plan. Review of the facility's Wound Care Protocol, dated 2026, revealed, in part, residents with wounds would have wound care provided to them as ordered by the physician. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #7 In an interview on [DATE] at 11:05AM, S3Treatment Nurse indicated the weekend nurse(s) should have performed Resident #7's wound care if a Treatment Nurse was not present. In a telephone interview on [DATE] at 8:55AM, S6LP indicated she was Resident #7's nurse on [DATE]. S6LPN indicated she did not provide Resident #7's sacral wound care as ordered by the physician. S6LPN indicated she was not aware she was responsible to complete wound care on her assigned residents. In a telephone interview on [DATE] at 9:01AM, S7LPN indicated she was Resident #7's nurse on [DATE]. S7LPN further indicated she did not provide wound care to Resident #7's Stage IV sacral pressure ulcer on [DATE], because she was not informed that she had to perform wound care on her assigned residents. In an interview on [DATE] at 11:18AM, S2DON indicated the facility did not have an assigned Treatment Nurse for [DATE] and [DATE]. S2DON indicated on [DATE] and [DATE] it was the responsibility of S9Registered Nurse (RN) Supervisor to remind the floor nurses to complete wound care in the absence of an assigned Treatment Nurse. S2DON also indicated she provided S9RN Supervisor with a list of responsibilities which included reminding the floor nurses to complete wound care due to not having a Treatment Nurse. S2DON indicated S9RN Supervisor was responsible to ensure wound care was provided as ordered. In a telephone interview on [DATE] at 11:53AM, S9RN Supervisor indicated S2DON had provided her with a list of responsibilities for the dates of [DATE] and [DATE]. S9RN Supervisor further indicated it was an understood responsibility that the floor nurses were responsible for wound care in the absence of a Treatment Nurse. Review of the communication sheet provided to S9RN Supervisor dated [DATE] revealed, in part, nurses need to remember to do wound care on weekends and sign the Treatment Administration Record off when we do not have a Treatment Nurse. Further review revealed the RN Supervisor was to remind them of this responsibility. In an interview on [DATE] at 2:10PM, S1Administrator indicated wound care treatments should have been provided as ordered by the physician. Resident #16 In a phone interview on [DATE] at 4:28PM, S14LPN indicated she was not aware she was responsible to provide wound care to Resident #16 on [DATE] and [DATE]. In an interview on [DATE] at 11:53AM, S9RN Supervisor indicated it was the responsibility of the residents' assigned nurse to provide wound care to the residents' wounds, as ordered by the physicians on [DATE] and [DATE]. Resident #44 In an interview on [DATE] at 4:40PM, S6LPNindicated she did not perform Resident #44's Stage III right heel pressure ulcer wound care as ordered by Resident #44's physician on [DATE] and [DATE], (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and should have. In an interview on [DATE] at 4:54PM, S7LPN indicated she was not aware that she was responsible for providing daily wound care treatment to Resident #44's Stage III right heel pressure ulcer. S7LPN further indicated she did not provide wound care to Resident #44's right heel pressure ulcer on [DATE] and [DATE] as ordered by the physician, and should have.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews and record review, the facility failed to ensure medications were administered as ordered by the physician for 1 (Resident #47) of 2 sampled residents reviewed, in accordance with professional standards of nursing practice. Findings:In accordance with the Louisiana Nurse Practice Act (La. R.S. 37:913), nursing practice includes executing medical regimens prescribed by a licensed physician or authorized prescriber; therefore, medications must be administered as ordered. Review of the facility's policy titled Physician Orders Policy and Procedure, revised 09/12/2025, revealed Licensed Practical Nurses are required to follow physician orders as prescribed. Review of Resident #47's physician orders dated January 2026 through March 2026 revealed, in part, the following:An order dated 01/19/2026 for Simethicone 80 mg tablet (used to relieve symptoms caused by excess gas in the digestive tract), administer 1 tablet by mouth twice daily at 8:00AM and 5:00PM for 14 days;An order dated 02/10/2026 for Pataday ophthalmic solution 0.2% (used to treat allergic conjunctivitis), instill one drop in both eyes daily at 9:00AM;An order dated 03/01/2026 for Gabapentin 300 mg capsule (used to treat nerve pain), administer 1 capsule by mouth daily at 9:00PM;An order dated 03/01/2026 for Meloxicam 15 mg tablet (used to relieve pain and inflammation), administer 1 tablet by mouth daily at 9:00AM; and,An order dated 04/25/2026 for Sertraline HCl 25 mg tablet (used to treat depression), administer 1 tablet by mouth daily at 9:00PM. Review of Resident #47's January 2026 Medication Administration Record (MAR) revealed:Simethicone 80 mg was not administered on 01/21/2026 at 8:00AM, 01/23/2026 at 8:00AM, and 01/24/2026 at 5:00PM and the MAR was blank with no documented reason;Gabapentin 300 mg was not administered on 01/21/2026 at 9:00PM and the MAR was blank with no documented reason;Meloxicam 15 mg was not administered on 01/21/2026 at 9:00AM and the MAR was blank with no documented reason;Sertraline HCl 25 mg was not administered on 01/21/2026 at 9:00PM and the MAR was blank with no documented reason. Review of Resident #47's March 2026 MAR revealed Pataday ophthalmic solution 0.2% was not administered on 03/10/2026 at 9:00AM and 03/12/2026 at 9:00AM and the MAR was blank with no documented reason. In an interview on 03/25/2026 at 10:32AM, S13Licensed Practical Nurse indicated she believed the Pataday ophthalmic solution was out of stock; however, she further indicated she did not verify the location of available medication and did not administer the medication as ordered. In an interview on 03/25/2026 at 3:00PM, S2Director of Nursing (DON) indicated Simethicone and Pataday ophthalmic solution were stocked with the facility's over-the-counter medications and available for use. In an interview on 03/25/2026 at 4:26PM, S16Registered Nurse indicated non-over-the-counter medications were delivered weekly from the pharmacy and verified the above-mentioned medications were available for administration. In an interview on 03/25/2026 at 4:30PM, S2DON indicated the above-mentioned medications were available for use, should have been administered as ordered, and were not.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record reviews, the facility failed to provide pressure ulcer treatments as ordered by the physician for 3 (Resident #7, Resident #16, Resident #44) of 3 sampled residents investigated for pressure ulcers. Findings:Review of the facility's Wound Care Protocol, dated 2026, revealed, in part, residents with wounds will have wound care provided to them as ordered by the physician. Resident #7 Review of Resident #7's March 2026 Physician's Orders revealed, in part, cleanse sacral pressure ulcer with wound cleanser, pat dry, loosely fill cavity with gauze soaked in Dakin's solution (an antiseptic used to clean infected skin and tissues, treat wounds, and manage odors), apply Santyl ointment (a prescription medicine used to remove dead tissue from chronic skin ulcers to promote healing), followed by calcium alginate (a highly absorptive fiber commonly used in specialized wound dressings), cover with silicone foam border or equivalent dressing, change dressing daily and as needed. Review of Resident #7's Care Plan Report revised on 03/11/2026 revealed, in part, Resident #7 had a Stage IV sacral pressure ulcer. Further review revealed a documented intervention to administer wound care treatments as ordered. On 03/23/2026 at 11:05AM, S3Treatment Nurse and the surveyor observed Resident #7's sacral dressing. Further observation revealed the date written on Resident #7's sacral wound dressing was 03/20/2026. In an interview on 03/23/2026 at 11:05AM, S3Treatment Nurse indicated Resident #7 had a physician's order for daily wound care for her sacral pressure ulcer. S3Treatment Nurse indicated Resident #7's dressing dated 03/20/2026 was the dressing she had applied on 03/20/2026. S3Treatment Nurse further indicated Resident #7 should have received wound care as ordered by the physician on 03/21/2026 and 03/22/2026, and did not. S3Treatment Nurse indicated the weekend staff nurse assigned to Resident #7, should have performed wound care on Resident #7 as ordered. Review of Resident #7's March 2026 Treatment Administration Record revealed, in part, no documented evidence Resident #7's Stage IV sacral pressure ulcer wound care was provided on 03/21/2026 and 03/22/2026. In a telephone interview on 03/24/2026 at 8:55AM, S6Licensed Practical Nurse indicated she was Resident #7's assigned nurse on 03/21/2026. S6Licensed Practical Nurse indicated she did not provide Resident #7's sacral wound care as ordered by Resident #7's physician. In a telephone interview on 03/24/2026 at 9:01AM, S7Licensed Practical Nurse indicated she was Resident #7's assigned nurse on 03/22/2026. S7Licensed Practical Nurse indicated she did not provide Resident #7's sacral wound care as ordered by Resident #7's physician. In an interview on 03/23/2026 at 11:18AM, S2Director of Nursing indicated Resident #7's sacral pressure ulcer wound care should have been completed daily as ordered by Resident #7's physician. Resident #16 (continued on next page)

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	195645	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luling Living Center	1125 Paul Maillard Rd Luling, LA 70070

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's electronic medical record revealed, in part, Resident #16 had a diagnosis of a Stage II sacral pressure ulcer. Review of Resident #16's Physician's Orders dated 02/18/2026 revealed, in part, cleanse sacral pressure ulcer with wound cleaner, pat dry, apply Santyl ointment to wound bed, followed by calcium alginate, apply Collagenase ointment (ointment to remove dead tissue from skin ulcers) to sacral wound every day shift, cover with silicone foam border or equivalent dressing, and to change dressing daily and as needed if soiled or dislodged. Review of Resident #16's Care Plan Report revealed, in part, Resident #16 had a Stage II sacral pressure ulcer. Further review revealed a documented intervention to administer daily wound care treatment to Resident #16's Stage II sacral pressure ulcer as ordered. Review of Resident #16's Treatment Administration Record for March 2026 revealed, in part, daily wound care to Stage II sacral pressure ulcer was not completed on 03/21/2026 and 03/22/2026. On 03/23/2026 at 11:34AM, S3Treatment Nurse and the surveyor observed Resident #16's sacral dressing. Further observation revealed the date written on Resident #16's sacral wound dressing was 03/20/2026. In an interview on 03/23/2026 at 11:35AM, S3Treatment Nurse indicated Resident #16 should have received daily wound care as ordered by the physician. In an interview on 03/24/2026 at 3:00PM, S2Director of Nursing indicated Resident #16's daily Stage II sacral pressure ulcer wound care should have received daily wound care as ordered by the physician. In a phone interview on 03/24/2026 at 4:28PM, S14Licensed Practical Nurse indicated she did not provide wound care on 03/21/2026 and 03/22/2026 to Resident #16's sacral pressure ulcer as ordered by the physician, and should have. In an interview on 03/25/2026 at 10:00AM, S11Contracted Wound Care Nurse Practitioner indicated Resident #16's sacral pressure ulcer wound care should have been performed daily as ordered by Resident #16's physician. In an interview on 03/25/2026 at 11:53AM, S9Registered Nurse Supervisor indicated the assigned nurse should have provided wound care to the residents as ordered by their physicians. Resident #44 Review of Resident #44's March 2026 Physician's orders revealed, in part, cleanse right heel pressure injury/ulcer with wound cleanser, pat dry, apply Santyl ointment to wound bed, cover with silicone foam border or equivalent dressing, change dressing daily and as needed, Collagenase ointment to right heel every day shift for pressure injury/ulcer. Review of Resident #44's Care Plan Report revised on 02/23/2026 revealed, in part, Resident #44 had a Stage III right heel pressure ulcer with an intervention to administer treatment as ordered. Review of Resident #44's March 2026 Treatment Administration Record revealed, in part, wound care (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to Resident #44's right heel was not completed on 03/21/2026 and 03/22/2026. Observation on 03/23/2026 at 9:42AM revealed Resident #44's dressing to right heel was dated 03/20/2026. In an interview on 03/23/2026 at 11:18AM, S2Director of Nursing indicated Resident #44's wound care to the Stage III right heel pressure ulcer wound should have been completed daily as ordered by Resident #44's physician. In an interview on 03/23/2026 at 1:01PM, S3Treatment Nurse confirmed Resident #44's dressing on his right heel had a date of 03/20/2026. S3Treatment Nurse confirmed Resident #44 did not receive wound care to the right heel wound care as ordered by Resident #44's physician. In an interview on 03/24/2026 at 4:40PM, S6Licensed Practical Nurse indicated she did not perform Resident #44's Stage III right heel pressure ulcer wound care as ordered by Resident #44's physician on 03/21/2026 and 03/22/2026, and should have. In an interview on 03/24/2026 at 4:54PM, S7Licensed Practical Nurse indicated she did not perform Resident #44's Stage III right heel pressure ulcer wound care as ordered by Resident #44's physician on 03/21/2026 and 03/22/2026, and should have. In an interview on 03/25/2026 at 11:10AM, S11Contracted Wound Care Nurse Practitioner indicated Resident #44's should have had wound care performed daily to the Stage III right heel pressure ulcer as ordered by Resident #44's physician.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. Based on interviews and record reviews, the facility failed to ensure a resident received dental services as required for 1 (Resident #47) of 1 sampled residents investigated for dental services. Findings:Review of the facility's Dental Services policy and procedure, last revised 08/2006, revealed, in part, social services personnel will be responsible for assisting the resident in making dental appointments and transportation arrangements as necessary. Review of Resident #47's physician's progress noted dated 01/29/2026 revealed, in part, Resident #47 was seen by the facility's contracted dental company with a chief complaint of a lower left broken tooth. Further review revealed the contracted dental company's plan to address Resident #47's broken tooth was a #18 Distolingual (DL) Silver Modified Atraumatic Restorative Technique (SMART) filling (a minimally invasive filling technique that was to be used to completed a filling to the back and tongue area of Resident #47's permanent lower left second molar). Review of Resident #47's medical records revealed Resident #47's dentist sent an email correspondence dated 02/17/2026 at 2:20PM to S15Social Services Director requesting the completion of a triage form for Resident #47 to be seen by the dentist. In an interview on 03/23/2026 at 10:26AM, Resident #47 indicated she had a broken tooth that occurred during a contracted dental cleaning procedure in the facility. Resident #47 further indicated the facility's contracted dental hygienist indicated to her (Resident #47) the tooth would have to be filled on a follow-up appointment. Resident #47 indicated she never had a follow-up appointment with the facility's contracted dental company to have the broken tooth addressed. In an interview on 03/25/2026 at 10:19AM, S15Social Services Director indicated Resident #47 had complained of dental pain on 02/13/2026. S15Social Services emailed the contracted dentist on 02/13/2026 and on 02/17/2026 the contracted dentist requested that S15Social Services Director complete a triage form. S15Social Services indicated she did not complete Resident #47's dental triage form until 03/23/2026, which resulted in Resident #47 not to be seen by the contracted dentist during the 02/23/2026 dental visit. In an interview on 03/25/2026 at 4:30PM, S2Director of Nursing indicated the triage form should have been sent to the contracted dental company by S15Social Services Director prior to 03/23/2026.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record review, the facility failed to maintain complete and accurate medical records for 6 residents (Residents #2, #7, #16, #27, #44, #47) of 6 sampled residents reviewed for accurate documentation. Findings:Review of the facility's Medical Records policy and procedure, last revised 09/02/2025, revealed, in part, the facility should maintain medical records on each resident that are complete and accurately documented. Review of the facility's Charting and Documentation policy and procedure revealed, in part, all observations, medications administered, and services performed must be documented in the resident's clinical record. Resident #2 Review of Resident #2's March 2026 physician orders revealed, in part: Mirtazapine 15 milligrams (medication used to treat major depressive disorder); Seroquel 25 milligrams (medication used to treat insomnia); Artificial Tears ophthalmic solution (used to treat dry eyes); and, Systane ophthalmic solution (used to treat dry eyes) were ordered to be administered on 03/19/2026 at 9:00PM. Review Resident #2's March 2026 Medication Administration Record revealed the above mentioned medications were not documented as administered on 03/19/2026 at 9:00PM. In an interview conducted on 03/24/2026 at 10:15AM, S2Director of Nursing indicated the above mentioned medications should have been documented as administered as ordered; therefore, the facility was unable to verify the above mentioned medications were administered as ordered. Resident #7 Review of Resident #7's March 2026 physician orders revealed wound care to a sacral pressure ulcer (treatment used to promote healing and prevent infection), use of a low air loss mattress (device used to reduce pressure and prevent skin breakdown), and pain assessments prior to wound care (assessment used to evaluate pain and ensure appropriate treatment) were ordered daily. Review of Resident #7's March 2026 Treatment Administration Record (TAR) revealed wound care was not documented as provided on 03/07/2026, 03/08/2026, and 03/14/2026. The low air loss mattress and pain assessments were not documented as provided on 03/07/2026, 03/08/2026, 03/14/2026, 03/21/2026, and 03/22/2026. Review of Resident #7's Care Plan revised on 06/05/2025 revealed, in part, Resident #7 had an Activities of Daily Living self-care performance deficit and required assistance for bed mobility, toileting, and transfers. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Activities of Daily Living documentation for 03/12/2026 through 03/23/2026 revealed bed mobility, toileting, and transfers were not documented as provided on 03/15/2026, 03/16/2026, 03/19/2026, and 03/22/2026. In an interview conducted on 03/24/2026 at 11:05AM, S11Contracted Wound Care Nurse indicated the above mentioned treatments and pain assessments should have been documented as provided as ordered; therefore, the facility was unable to verify treatments and services were provided as ordered. Resident #16 Review of Resident #16's Activities of Daily Living documentation for March 2026 revealed, in part, Resident #16 had an Activities of Daily Living self-care performance deficit and required total assistance from staff for bed mobility. Review of Resident #16's Activities of Daily Living documentation for 03/11/2026 to 03/23/2026 revealed, in part assistance with bed mobility was not documented as provided on all shifts for 03/12/2026, 03/13/2026, 03/15/2026, 03/16/2026, 03/17/2026, 03/18/2026, on the morning on 03/20/2026, day and evening of 03/21/2026, day and evening of 03/22/2026, and day shift of 03/23/2026. In an interview on 03/24/2026 at 3:03PM, S10Certified Nursing Assistant Supervisor indicated the above documented dates did not include documentation for bed mobility, and should have. In an interview on 03/24/20265 at 3:00PM, S2Director of Nursing indicated Certified Nursing Assistant staff should have documented Resident #16's bed mobility, transfers, and toileting. Resident #27 Review of Resident #27's physician orders revealed: Atorvastatin calcium 40 milligrams (medication used to lower cholesterol); Hydrocortisone acetate 25 milligrams rectal suppository (medication used to treat rectal inflammation/irritation); Melatonin 10 milligrams (medication used to treat insomnia); Trazodone HCl 150 milligrams (medication used to treat depression); Xarelto 20 milligrams (medication used to prevent blood clots); and, Buspirone HCl 15 milligrams (medication used to treat anxiety) were ordered to be administered on 03/03/2026 and 03/19/2026 at 9:00PM. Review of Resident #27's March 2026 Medication Administration Record revealed the above mentioned medications were not documented as administered on those dates and times. In interview conducted on 03/25/2026 at 10:10AM, S2Director of Nursing indicated the above (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mentioned medications should have been documented as administered as ordered; therefore, the facility was unable to verify Resident #27's medications were administered as ordered. Resident #44 Review of Resident #44's March 2026 physician orders revealed a wound care treatment order for a pressure ulcer to the right heel (treatment used to promote wound healing and prevent infection); the use of a low air loss mattress (device used to reduce pressure and prevent further skin breakdown); pain assessments prior to wound care (assessment used to evaluate pain and guide treatment); and, staff assistance with Activities of Daily Living, including bed mobility, toileting, and transfers (services used to maintain safety and functional status). Review of Resident #44's Care Plan revised on 02/23/2026 revealed, in part, Resident #44 had an Activities of Daily Living Self-care performance deficit and required assistance for bathing/showering, dressing, eating, personal hygiene. Review of Resident #44's March 2026 Treatment Administration Record and Activities of Daily Living documentation revealed the treatments and services were not documented as provided on 03/01/2026, 03/07/2026, 03/08/2026, 03/14/2026, 03/21/2026, and 03/22/2026. Review of Resident #44's March 2026 Activities of Daily Living documentation revealed Resident #44's Activities of Daily Living were not documented as completed on 03/01/2026, 03/05/2026, 03/102026, 03/11/2026, 03/14/2026, 03/16/2026, 03/19/2026, 03/22/2026, and 03/23/2026. In an interview on 03/24/26 at 1:40PM, S10Certiifed Nursing Assistant Supervisor indicated the above documented dates did not include documentation Resident #44 received assistance with bed mobility, transferring, and toileting, and should have. S10Certified Nursing Assistant Supervisor further indicated S2Director of Nursing was responsible to complete audits of the Activities of Daily of Living charting. In an interview on 03/24/2026 at 1:46PM, S2Director of Nursing indicated the above documented dates did not include documentation Resident #44 received assistance with the above mentioned Activities of Daily Living and should have. S2Director of Nursing further indicated S10Certified Nursing Assistant Supervisor was responsible to complete audits of the Activities of Daily Living charting. S2Director of Nursing indicated Resident #44's March 2026 Treatment Administration Record did not have documentation treatments were documented as being completed, and should have. In an interview on 03/24/26 at 2:10PM, S1Administrator indicated S10Certified Nursing Assistant Supervisor should have performed audits on the Activities of Daily Living documentation. Resident #47 Review of Resident #47's March 2026 physician orders revealed, in part: Gabapentin 300 milligrams (medication used to treat nerve pain); Latanoprost ophthalmic solution 0.005% (medication used to treat glaucoma); Melatonin 3 milligrams (medication used to treat insomnia); (continued on next page)

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Luling Living Center	1125 Paul Maillard Rd Luling, LA 70070

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCl 25 milligrams (medication used to treat depression); and Amoxicillin-clavulanate 875-125 milligrams (medication used to treat infection) were ordered to be administered on 03/19/2026 at 9:00PM. Review of Resident #47's March 2026 Medication Administration Record revealed the above mentioned medications were not documented as administered on that date and time. In an interview conducted on 03/25/2026 at 11:35AM, S2Director of Nursing indicated the above mentioned medications should have been documented as administered as ordered; therefore, the facility was unable to verify the medications were administered as ordered.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record review the provider failed to ensure staff administered a resident's hydration through an enteral tube (a tube inserted directly into the stomach) per a Physician's Order for 1 (Resident #4) of 1 sampled residents investigated for enteral tube hydration. Findings:Review of Resident #4's 03/17/2026 Physician's Order revealed, in part, to administer Resident #4 Diabetisource (a type of enteral feeding [a liquid nutritional supplement delivered directly into the stomach through an enteral tube]) at a rate of 45 milliliters an hour with a flush of 200 milliliters (ml) of water every hour. Observation on 03/23/2026 at 9:15AM revealed Resident #4's enteral feeding pump was set to administer Resident #4 Diabetisource at 45 ml an hour continuously with a water flush at 150 ml every 4 hours. Observation on 03/24/2026 at 10:24AM revealed Resident #4's enteral feeding pump was set to administer Resident #4 Diabetisource at 45 ml an hour continuously with a water flush at 150 ml every 4 hours. In an interview on 03/24/2026 at 5:35PM, S8Licensed Practical Nurse (LPN) confirmed Resident #4's enteral feeding pump was programed to administer Resident #4 a flush of 150 ml of water every 4 hours. S8LPN further confirmed Resident #4's active Physician's Order was to administer Resident #4 a flush of 200 ml of water an hour with her continues enteral feeding. In an interview on 03/24/2026 at 5:43PM, S2Director of Nursing (DON) indicated Resident #4's enteral feeding pump was not programmed to administer a water flush at a rate of 200 ml an hour, as ordered by the physician; and it should have been administered as ordered.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interviews and record reviews, the facility failed to coordinate hospice care and obtain required information from the resident's hospice agency.This deficient practice was identified for 1 (Resident #23) of 1 sampled residents investigated for hospice services. Findings:Review of Resident #23's electronic medical record revealed Resident #23 had an initial admission date of 08/18/2025, and was admitted for hospice services on 02/24/2026. Review of the facility's Hospice Program policy and procedure revised, August 2006 revealed, in part, when a resident participated in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will be developed and would include directives for managing pain and other uncomfortable symptoms. Further review revealed on the day of admission, the facility's nurse must obtain admission orders and a binder from the hospice nurse. On 03/23/2026 at 8:55AM this surveyor requested Resident #23's hospice binder from S1Director of Nurse. On 03/24/2026 at 9:00AM this surveyor requested Resident #23's hospice binder from S17Licensed Practical Nurse. In an interview on 03/24/2026 at 9:00AM, S17Licensed Practical Nurse indicated the facility did not have a hospice binder for Resident #23, and should have. In an interview on 03/24/2026 at 9:17AM, the Resident #23's hospice agency's medical records representative indicated it is the hospice agency policy and procedure to create a hospice binder which contained the required documentation needed to coordinate hospice care for the resident. Resident #23's hospice agency's medical records representative further indicated Resident #23's hospice binder should be brought to the facility by the resident's hospice nurse. In an interview on 03/24/2026 at 9:55AM, S2Director of Nursing indicated Resident #23 did not have a hospice binder which contained the required documentation needed to coordinate hospice care for Resident #23 In a phone interview on 03/24/2026 at 10:21AM, Resident #23's hospice agency case manager indicated the facility did not have a hospice binder which contained the required documentation needed to coordinate hospice care for Resident #23. In an interview on 03/24/2026 at 11:20AM, S1Administrator indicated the facility did not have Resident #23's hospice binder, and should have had a hospice binder available at the facility.