STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195278	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metairie Health Care Center	6401 Riverside Drive Metairie, LA 70003

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interviews, and record review the facility failed to maintain privacy and confidentiality of medical records observed during a medication pass for 1 (Resident R4) of 1 (Resident R4) random resident observed. Findings: Review of the facility's policy titled Resident Rights, dated 02/2017, revealed, in part, federal and state laws guarantee the right to privacy and confidentiality to all resident of the facility. Observation on 07/21/2025 at 9:25AM revealed S6Licensed Practical Nurse (LPN) stepped away from her computer in the hallway to administer Resident R4's medication in Resident R4's room. Further observation revealed the unattended computer screen visibly displayed and allowed access to Resident R4's private medical information.In an interview on 07/22/2025 at 9:28AM, S6LPN confirmed she should not have allowed Resident R4's private medical information to be visible and accessible when she left her computer unattended in the hallway. S6LPN indicated her action was a Health Insurance Portability and Accountability Act (HIPAA) violation.In an interview on 07/22/2025 at 1:33PM, S2Director of Nursing (DON) confirmed that the staff computer screen should have been locked to prevent the resident's private information is being accessed. S2DON further indicated that S6LPN's action of leaving her computer screen unattended with resident's information available for access was a violation of HIPAA.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record reviews, the facility failed to provide a Baseline Care Plan summary to a resident and the resident representative for 2 (Resident #1, Resident #3) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for care plans.Findings: Resident #1Review of Resident #1's medical record revealed, in part, an admit date of 05/21/2025. Review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/28/2025 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 7, which indicated Resident #1 had severe cognitive impairment. Review of Resident #1's Baseline Care Plan revealed, in part, the Baseline Care Plan was completed on 05/21/2025. Further review revealed the resident and resident's representative signature and date box was not signed or dated.There was no documented evidence, and the facility could not present any documented evidence, the facility had provided Resident #1 and Resident #1's representative a summary of Resident #1's Baseline Care Plan.In a telephone interview on 07/16/2025 at 4:55PM, Resident #1's representative indicated the facility had not provided them with a summary of Resident #1's Baseline Care Plan. Resident #3Review of Resident #3's medical record revealed, in part, an admit date of 05/30/2025. Review of Resident #3's admission MDS with an ARD of 05/28/2025 revealed, in part, Resident #3 had a BIMS score of 15, which indicated Resident #3 was cognitively intact. Review of Resident #3's Baseline Care Plan revealed, in part, the Baseline Care Plan was completed on 05/30/2025. Further review revealed the resident and resident's representative signature and date box was not signed or dated.There was no documented evidence, and the facility could not present any documented evidence, the facility had provided Resident #3 and Resident #3's representative a summary of Resident #3's Baseline Care Plan.In an interview on 07/22/2025 at 7:51AM, Resident #3 indicated the facility had not provided her with a summary of her Baseline Care Plan since she had been admitted into the facility. In an interview on 07/22/2025 at 12:25PM, S2Director of Nursing (DON) indicated she could not provide any documentation that revealed Resident #1, Resident #1's representative, Resident #3, or Resident #3's representative were provided a summary of their Baseline Care Plan.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, the facility failed to ensure residents' comprehensive care plan was prepared by an interdisciplinary team (IDT) with all required members for 2 (Resident #1, Resident #3) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for care plans.Findings:Resident #1Review of Resident #1's medical records revealed, in part, an admit date of 05/21/2025. Review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/28/2025 revealed, in part, Resident #1 Brief Interview of Mental Status (BIMS) score of 7, which indicated Resident #1 had severe cognitive impairment.Review of Resident #1's progress note dated 05/29/2025 revealed, in part, a comprehensive care plan meeting was held to discuss Resident #1's progress in therapy. Further review revealed the only members of the IDT in attendance were S3Social Worker, S4MDS Coordinator, and S7Rehab Director. Further review revealed no documented evidence, and the facility was unable to present any documented evidence, Resident #1 and/or Resident #1's representative and the additional required IDT members were included in the preparation of Resident #1's comprehensive care plan. There was no documented evidence, and the facility did not present any documented evidence, Resident #1 and/or Resident #1's representative were invited by the facility to prepare Resident #1's comprehensive care plan.In a telephone interview on 07/16/2025 at 4:55PM, Resident #1's representative indicated the facility had not given him the opportunity to attend and participate in the preparation of Resident #1's comprehensive care plan. Resident #3Review of Resident #3's medical records revealed, in part, an admit date of 05/30/2025. Review of Resident #3's admission MDS with an ARD of 05/28/2025 revealed, in part, Resident #3 had a BIMS score of 15, which indicated Resident #3 was cognitively intact.Review of Resident #3's Care Plan Signature Sheet dated 06/10/2025 revealed, in part, a comprehensive care plan meeting was held to discuss Resident #3's care. Further review revealed the only members of the IDT in attendance were S3Social Worker, S4MDS Coordinator, and Resident #3's representative. Further review revealed no documented evidence, and the facility was unable to present any documented evidence, Resident #3 and the additional required IDT members were included in the preparation of Resident #3's comprehensive care plan.There was no documented evidence, and the facility did not present any documented evidence, Resident #3 was invited by the facility to prepare Resident #3's comprehensive care plan.In an interview on 07/22/2025 at 7:52AM, Resident #3 indicated she had not been given the opportunity by the facility to participate in in the preparation of a resident's comprehensive care plan.In an interview on 07/22/2025 at 11:25AM, S3Social Worker indicated a resident's comprehensive care plan was prepared by only the social worker and the MDS coordinator nurse. S3Social Worker further indicated a resident's attending physician did not participate in the preparation of a resident's comprehensive care plan.In an interview on 07/22/2025 at 12:25PM, S2Director of Nursing (DON) indicated none of the attending physicians or other designated providers participated in the preparation of the resident's individual comprehensive care plans. In an interview on 07/22/2025 at 3:15PM, S4MDS Coordinator indicated none of the attending physicians or other designated providers participated in the preparation of the resident's individual comprehensive care plans.In an interview on 07/22/2025 at 12:40PM, S1Administrator indicated the attending physicians did not participate in the preparation of the resident's comprehensive care plans. S1Administrator also indicated there was no documented evidence and he could not provide documented evidence, the above mentioned residents, the above mentioned resident representative, physicians or designated provider's participated in the preparation of the residents' individual comprehensive care plan.