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	12/17/2025

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

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interviews and record reviews, the facility failed to ensure staff administered a resident's scheduled pain medication as ordered for 1 (Resident #2) of 1 sampled residents investigated for pain. Findings: Review of the facility's Administering Medications policy, revised April 2019, revealed in part, medications should be administered in accordance with the prescriber's orders, including any required time frame and needs and benefits of the resident. Further review of the policy revealed if the dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences the nurse should contact the prescriber. Review of Resident #2's record revealed, in part, Resident #2 was admitted to hospice services on 07/26/2023. Review of Resident #2's December 2025 physician's orders revealed, in part, Resident #2 had an order for Hydrocodone-Acetaminophen tablet 5-325 milligrams (mg) by mouth four times daily for unspecified pain with a start date of 07/01/2024. Review of Resident #2's Minimum Data Set with an Assessment Reference Date of 09/30/2025 revealed, in part, Resident #2 was on a scheduled pain management regimen. Review of Resident #2's Plan of Care revealed, in part, Resident #2 received hospice services and interventions which included, to provide comfort measures and administer pain medications as ordered. Observation on 12/16/2025 at 9:17AM revealed Resident #2 was yelling out for the nurse. Resident #2 indicated to surveyor his legs and his back were hurting. Review of Resident #2's December 2025 electronic Medication Administration Record (eMAR) revealed, in part, on 12/09/2025 and 12/15/2025, S12Licensed Practical Nurse (LPN) documented she did not administer Hydrocodone-Acetaminophen tablet 5-325 mg to Resident #2 at 8:00PM, because Resident #2 was asleep; and on 12/16/2025 S12LPN documented she did not administer Hydrocodone-Acetaminophen tablet 5-325 mg to Resident #2 at 6:00AM, because Resident #2 was asleep. In an interview on 12/17/2025 at 9:00AM, S15LPN nurse indicated scheduled pain medications ordered four times daily should be administered as ordered. S15LPN confirmed Resident #2's pain medication was scheduled and ordered to be administered four times daily. S15LPN further indicated if Resident #2 was asleep at the time his scheduled medication were due, she would wake up Resident #2 and administer the pain medication as ordered, unless there was another reason not to administer the medication. Review of Resident #2's nursing progress notes revealed, in part, there was no documentation of any other reason Resident #2's scheduled pain medication was not administered by S12LPN as ordered on 12/09/2025 and 12/15/2025 at 8:00PM, and on 12/16/2025 at 6:00AM. In an interview on 12/17/2025 at 9:17AM, S2Director of Nursing (DON) confirmed Resident #2's pain medication was scheduled to be administered four times daily at 6:00AM, 11:00AM, 5:00PM, and 8:00PM. S2DON indicated Resident #2's scheduled pain medication should have been administered as ordered four times daily regardless if he was asleep at the time the medication was scheduled. S2DON further indicated if Resident #2's medications were held due to over sedation or side effects the nurse should have documented the changes observed and contacted the physician.

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 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. Based on observation, interviews and record reviews, the facility failed to ensure:1. Narcotic logs were accurately reconciled for a resident (Resident #2); and, 2. Medications were available to be administered as ordered for a resident (Resident #2). This deficient practice was identified for 1 (Resident #2) of 1 sampled residents reviewed for pharmacy services. Findings: 1.Review of the facility's undated Controlled Drug policy and procedure revealed, in part, the inventory of the controlled drugs must be recorded on narcotic records and signed for correctness of count. If a discrepancy is found, residents' orders are to be checked and chart should be reviewed to see if a narcotic has been administered and not recorded. If the cause of the discrepancy cannot be located, report the matter to the supervisor. Review of Resident #2's Narcotics and Controlled Drug records from 11/29/2025 at 9:30AM through 12/07/2025 at 9:00PM revealed, in part, S14Licensed Practical Nurse (LPN) documented she administered Hydrocodone-Acetaminophen 5-325 milligrams (mg) 1 tablet on 12/07/2025 at 9:00PM and there were 0 tablets remaining. Review of Resident #2's Narcotics and Controlled Drug records from 12/07/2025 at 6:00AM through 12/16/2025 at 9:00PM revealed, in part, S14LPN documented she administered Hydrocodone-Acetaminophen 5-325 mg 1 tablet on 12/07/2025 at 9:00PM and there were 26 tablets remaining. Review of the Narcotics and Controlled Drug records mentioned above could not be reconciled accurately due to the discrepancies in the documentation when S14LPN documented she administered the scheduled pain medication two times on 12/07/2025 at 9:00PM. In an interview on 12/17/2025 at 9:17AM, S2Director of Nursing (DON) indicated she could not explain the discrepancy with the narcotic sheet, and further indicated the narcotic sheet should have been reconciled accurately. 2. Observation on 12/16/2025 at 2:50PM of Resident #2's Hydrocodone-Acetaminophen tablet 5-325 mg medication card revealed 1 tablet remaining in the bubble pack on the card. Review of Resident #2's electronic Medication Administration Record (eMAR) revealed, in a part Resident #2 was scheduled to receive Hydrocodone-Acetaminophen tablet 5-325 mg on 12/16/2025 at 5:00PM and 8:00PM, and 12/17/2025 at 6:00AM. Review of Resident #2's Hydrocodone-Acetaminophen tablet 5-325 mg Narcotics and Controlled Drug record from 12/07/2025 at 6:00AM through 12/16/2025 at 9:00PM revealed, in part, Resident #2 had 0 remaining tablets. Review of Resident #2's nursing progress note dated 12/17/2025 at 5:46AM revealed, in part, S18LPN documented Resident #2's Hydrocodone-Acetaminophen tablet 5-325 mg was not available for administration, waiting on hospice pharmacy. In an interview on 12/17/2025 at 9:07AM, S15LPN confirmed Resident #2 had 1 tablet of Hydrocodone-Acetaminophen 5-325 mg available on 12/16/2025 at 3:00PM. S15LPN indicated Resident #2's Hydrocodone-Acetaminophen 5-325 mg was documented as not available for administration on 12/17/2025 at 6:00AM, and further indicated the medication was not available on 12/17/2025 at 9:07AM. Review of Resident #2's nursing progress notes dated 12/17/2025 at 10:35AM revealed, in part, S15LPN documented Resident #2 was out of Hydrocodone-Acetaminophen tablet 5-325 mg, the hospice nurse was notified to send over the medication at approximately 9:00AM, and S2DON was notified. In an interview on 12/17/2025 at 10:00AM, S2DON confirmed Resident #2's Hydrocodone-Acetaminophen tablet 5-325 mg was not available for administration, and it should have been. S2DON indicated it was the nurses' responsibility to notify hospice when the medications needed to be refilled.

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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 observation, interviews, and record review, the facility failed to ensure all opened food items contained an opened and/or discard date for 1 (Cooler #1) of 1 sampled coolers observed during kitchen observations.Findings:Review of the 2022 United States Food and Drug Administration's Food Code revealed, in part, commercially processed food which was prepared and packaged by a food processing plant shall be clearly marked, at the time the original container was opened and if the held food was held for more than 24 hours, indicate the date or day by which the food shall be consumed, sold, or discarded.Observation on 12/15/2025 at 9:05AM of Cooler #1 revealed the following items were opened without an opened and/or discard date documented, in part:-one large package of shredded lettuce which was greenish brown in color;-one large bag of white shredded substance; and,-a 2.5 pound bag of sliced ham.In an interview on 12/15/2025 at 8:50AM, S10Dietary Manager stated the above food packages should have had an opened and/or discard date written on the outside of the packages. In an interview on 12/16/2025 at 12:15PM, S1Administrator stated previously opened food packages or containers in Cooler #1 should be labeled with an opened and/or use by or discard date.

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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 reviews, the facility failed to maintain accurate documentation of the electronic medication administration record (eMAR) and the narcotic and controlled drug records for 1 (Resident #2) of 1 sampled residents reviewed for accurate documentation. Findings:Review of Resident #2's December 2025 eMAR revealed, in part, S13Licensed Practical Nurse (LPN) documented she administered Resident #2 Hydrocodone-Acetaminophen 5-325 milligrams (mg) 1 tablet on 12/10/2025 at 8:00PM, 12/13/2025 at 8:00PM, 12/14/2025 at 8:00PM, and 12/16/2025 at 5:00PM. Review of Resident #2's Hydrocodone-Acetaminophen 5-325 mg narcotic and controlled drugs record revealed, in part, no evidence of the 12/10/2025 at 8:00PM, 12/13/2025 at 8:00PM, 12/14/2025 at 8:00PM, and 12/16/2025 at 5:00PM doses had been documented on the narcotic and controlled drug record. In an interview on 12/17/2025 at 10:00AM, S2Director of Nursing (DON) indicated Resident #2's eMAR and Narcotic and Controlled Drug record did not match and the documentation was not accurate. In a telephone interview on 12/17/2025 at 11:10AM, S13LPN indicated on 12/16/2025 at 5:00PM she did not administer Resident #2 Hydrocodone-Acetaminophen 5-325 mg to Resident #2 and the documentation for 12/16/2025 on the eMAR was incorrect.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and record reviews, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) to a resident or his/her responsible party prior to the discontinuation of Medicare Part A services for 1 (Resident #46) of 3 residents reviewed for Beneficiary Notification. Findings:Review of Resident #46's NOMNC revealed, in part, the effective date of coverage for current skilled nursing facility services would end on 10/30/2025 and was signed by Resident #46 on 10/30/2025. Review of Resident #46's Physical Therapy Discharge Summary revealed, in part, a start date of 08/26/2026, a discharge date of 09/30/2025. Further review revealed the reason for Resident #46's therapy discharge was Resident #46's highest practical level was achieved. In an interview on 12/17/2025 at 1:25PM, S17Social Services indicated the NOMNC for Resident #46 should have a service end date of 09/30/2025, and should have been signed by Resident #36 no later than 09/28/2025, and was not. In an interview on 12/17/2025 at 1:50PM, S2Director of Nursing indicated the NOMNC for Resident #46 should have been signed prior to the end of services, and was not.

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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 and interviews, the facility failed to ensure a resident's tube feeding pump (a pump that delivers liquid nutrients directly into a person's stomach or small intestine) and the tube-feeding pump's pole were maintained in a sanitary manner for 1 (Resident #1) of 3 residents sampled for tube feedings. Findings: Observation on 12/15/2025 at 11:21AM revealed Resident #1's tube feeding pole and pump was observed to have a dried beige substance covering the tube-feeding pump and the bottom of the tube-feeding pole.Observation on 12/16/2025 at 12:00PM revealed Resident #1's tube feeding pole and pump was observed to have a dried beige substance covering the tube-feeding pump and the bottom of the tube-feeding pole.Observation on 12/17/2025 at 11:20AM revealed Resident #1's tube feeding pole and pump was observed to have a dried beige substance covering the tube-feeding pump and the bottom of the tube-feeding pole.In an interview on 12/17/2025 at 12:05PM, S3Licensed Practical Nurse indicated Resident #1's tube feeding pump and pole should have been cleaned and should not have a dried beige substance on it.In an interview on 12/17/2025 at 12:06PM, S2Director of Nursing confirmed Resident #1's tube feeding pump and pole should have been cleaned daily and should not have a dried beige substance on it.In an interview on 12/17/2025 at 12:15PM, S1Administrator indicated Resident #1's tube feeding pump and pole should not have a dried beige color substance on it, and should have been cleaned.