

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2026
NAME OF PROVIDER OR SUPPLIER  St Bernard Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  4021 Roneagle Way New Orleans, LA 70122	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure a residents responsible party was immediately notified of a fall for 1 (Resident #1) of 4 sampled residents reviewed for falls. Findings: Review of Resident #1's Incident Report dated 01/11/2026 revealed, in part, Resident #1 had an unwitnessed fall on 01/11/2026 which resulted in a hematoma (closed wound were blood collects) and bleeding to her forehead. Further review revealed S7Licensed Practical Nurse received orders to send Resident #1 to the emergency room for an evaluation, and S7Licensed Practical Nurse attempted to notify Resident #1's responsible party/daughter twice with no success. Review of Resident #1's Nurse Note dated 01/11/2026 revealed, in part, Resident #1 was found to have bleeding and a large hematoma to her forehead. Further review revealed S7Licensed Practical Nurse received orders to send Resident #1 to the emergency room for an evaluation, and S7Licensed Practical Nurse attempted to notify Resident #1's responsible party/daughter twice with no success. In a telephone interview on 03/11/2026 at 8:55AM, Resident #1's responsible party indicated the facility did not notify her on 01/11/2026 when Resident #1 fell and was sent to the emergency room for evaluation of a fall which resulted in a hematoma and bleeding to her forehead. Resident #1's responsible party further indicated she was made aware of Resident #1's fall and emergency room transfer on 01/11/2026 by the hospital staff. In an interview on 03/11/2026 at 2:53PM, 7Licensed Practical Nurse indicated she sent Resident #1 as ordered by the physician to the emergency room on [DATE] for evaluation for a fall which resulted in a hematoma and bleeding to her forehead. S7Licensed Practical Nurse further indicated that the documented date and time the responsible party was notified on Resident #1's incident report dated 01/11/2026 was the date and time she attempted to notify Resident #1's responsible party. S7Licensed Practical Nurse confirmed she attempted twice to notify Resident #1's responsible party of Resident #1's fall but was unsuccessful. In an interview on 03/12/2026 at 3:51PM, S1Director of Nursing confirmed S7License Practical Nurse should have notified Resident #1's responsible party of Resident #1's fall on 01/11/2026 and emergency room transfer.</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's care plan to prevent falls included an individualized resident-centered intervention for 2 (Resident #1, Resident #2) of 4 sampled residents reviewed for falls. Findings: Resident #1 Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 12/16/2025 revealed, in part, Resident #1 had a Brief Interview for Mental Status score of 5, which indicated Resident #1 had severe cognitive impairment. Further review revealed Resident #1 had a diagnosis dementia (memory loss) and reduced mobility. Review of Resident #1's unwitnessed fall report dated 12/24/2025 revealed Resident #1 had an unwitnessed fall and was found on the floor in the hallway. Further review revealed Resident #1 was confused and unable to explain how the fall occurred. Review of Resident #1's unwitnessed fall report dated 01/11/2026 revealed Resident #1 had an unwitnessed fall and was found on the floor in her room. Further review revealed Resident #1 was confused and unable to explain how the fall occurred. Review of Resident #1's care plan revealed, in part, Resident #1 was at risk for falls related to impaired functional mobility and dementia. Further review revealed fall interventions were implemented on 12/24/2025 to encourage Resident #1 to ask for assistance with transfers and ambulation; and, on 01/11/2026 to make sure Resident #1's call light was within reach. In an interview on 03/10/2026 at 5:23PM, Resident #1's physician indicated Resident #1 was not aware of her physical inabilities, had poor safety awareness, and was difficult for Resident #1 to follow commands. In an interview on 03/12/2026 at 3:30PM, S2Assistant Director of Nursing indicated educating Resident #1 was not an appropriate fall intervention due to her impaired cognition and poor safety awareness. S2Assistant Director of Nursing further indicated Resident #1 would not remember due to poor cognition to use the all light to ask for staff assistance. Resident #2 Review of Resident #2's Quarterly Minimum Data Set with an Assessment Reference Date of 01/13/2026 revealed, in part, Resident #2 had a Brief Interview of Mental Status score of 5, which indicated Resident #2 had severe cognitive impairment. Further review revealed Resident #2 was dependent on staff for transfers and had a diagnosis of dementia. Review of Resident #2's care plan revealed, in part, Resident #2 had a self-care deficit and required staff assistance with activities of daily living. Further review revealed Resident #2 was at risk for falls related to dementia and confusion and staff were to encourage the resident to use call light for staff assistance. Review of Resident #2's witnessed fall report dated 09/24/2025 revealed, in part, Resident #2 had a fall in his room witnessed by his wife. Further review revealed Resident #2's wife indicated she told Resident #2 to wait for help but he did not follow her command and attempted to get into the bed own his own, and fell to the floor. Review of Resident #2's Nursing Post Fall Risk Evaluation dated 09/24/2025 revealed, in part, Resident #2 was confused and/or disoriented. Further review revealed the immediate action taken by staff to prevent Resident #2 from further falls was to educate Resident #1 on the importance of calling for staff assistance. In an interview on 03/10/2026 at 12:09PM, S6Licensed Practical Nurse indicated Resident #2 would not understand to use a call light for staff assistance. In an interview on 03/10/2026 at 2:44PM, S5Director of Social Services and Recreation indicated educating Resident #2 to use his call light for staff assistance was not an appropriate fall intervention because Resident #2 could not be able to recall a command after he was told. In an interview on 03/10/2026 at 5:30PM, Resident #2's physician indicated Resident #2's dementia had progressed, had poor cognition, and Resident #2 would not remember to use a call light for staff assistance. In an interview on 03/12/2026 at 12:35PM, Resident #2 was asked and he was unable to understand what a call light was used for. In an interview on 03/12/2026 at 12:37PM, S4Certified Nursing Assistant indicated Resident #2 would not remember to use a call light if staff assistance was needed. In an interview on 03/12/2026 at 12:42PM, S4Licensed Practical Nurse indicated Resident #2 would not remember to use a call light if staff assistance was needed. In an interview on 03/12/2026 at 3:30PM, S2Assistant (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Director of Nursing indicated educating Resident #2 was not an appropriate fall intervention because Resident #2 would not remember to use a call light if staff assistance was needed</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interviews and record review, the facility failed to document a resident's newly identified wound in the resident's clinical record for 1 (Resident #6) of 3 sampled residents reviewed for pressure ulcers Findings:Review of the facility's undated Skin and Wound Management Guidelines revealed, revealed all pressure related injuries and/or moisture associated skin damage would be documented in the Skin and Wound Module. Further review revealed alterations in skin integrity which are not monitored in the Skin and Wound Module as mentioned above would require a detailed description in the resident's progress notes. Review of Resident #6's care plan revealed, in part, Resident #6 had a potential for impaired skin integrity related to decreased mobility and bladder/bowel incontinence. In a telephone interview on 03/12/2026 at 2:20PM, S8Licensed Practical Nurse indicated on 03/08/2026 when she was preparing to transfer Resident #6 to the hospital for an evaluation, she identified a new reddened area on Resident #6's buttocks. S8Licensed Practical Nurse further indicated she did not document the assessment of Resident #6's change in skin condition in Resident #6's clinical record. In an interview on 03/12/2026 at 3:23PM, S2Assistant Director of Nursing indicated when S8Licensed Practical Nurse identified a new reddened area to Resident #6's buttocks she should have documented the new reddened area in Resident #6's clinical record. In an interview on 03/12/2026 at 3:43PM, S1Director of Nursing further indicated when S8Licensed Practical Nurse identified a new reddened area to Resident #6's buttocks she should have documented the new reddened area in Resident #6's clinical record.</p>		