STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195374	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph of Harahan	405 Folse Drive Harahan, LA 70123

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44336 Based on interview and record reviews, the facility failed to ensure an allegation of abuse was reported to the State Survey Agency within the required two hour timeframe for 2 (Resident #105, Resident #115) of 4 (Resident #51, Resident #105, Resident #115, Resident #187) sampled residents investigated for abuse. Findings: Review of the facility's Abuse Prevention and Prohibition Policy and Procedure dated 03/25/2023 revealed, in part, the administrator shall immediately initiate a Statewide Incident Management System (SIMS) report to the Louisiana Department of Health, but not less than 2 hours after forming a suspicion of a crime if the alleged violation involves abuse (physical abuse) or results in serious bodily injury. Review of the Louisiana Department of Health (LDH) Health Standards Incident Report #272956 revealed, in part, an allegation of physical abuse involving Resident #115 and Resident #105: -Occurred on 03/05/2025 at 11:14 PM; -Was entered into the SIMS reporting system on 03/10/2025 at 4:40PM. In an interview on 03/25/2025 at 10:48AM, S1Administrator confirmed the facility did not report an allegation of physical abuse involving Resident #115 and Resident #105 to the State Survey Agency within two hours and should have.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34608 Based on observations, interviews, and record reviews, the facility failed to: 1. Ensure Resident #47's care planned fall interventions were implemented; and 2. Ensure Resident #115 a known wanderer, had a care plan developed for wandering. This deficient practice was identified 2 (Resident #47, Resident #115) of 5 (Resident #30, Resident #47, Resident #51, Resident #115, Resident #187) sampled residents reviewed for accidents. Findings: 1. Resident #47 Review of Resident #47's medical record revealed, in part, Resident #47 had an unwitnessed fall on 03/05/2025 while transferring from her bed to her wheelchair unassisted. Further review revealed Resident #47's fall on 03/05/2025 resulted in a left hip fracture. Review of Resident #47's Significant Change Minimum Data Set (MDS) and State Optional Assessment with an Assessment Reference Date (ARD) of 03/18/2025 revealed, in part, Resident #47 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated Resident #47 was cognitively intact, required extensive assistance with two person physical assistance for transfers, toileting, and had a hip fracture. Review of Resident #47's physician orders revealed, in part, an order for a fall mat every shift with a start date of 03/07/2025. Review of Resident #47's care plan revealed, in part, a plan of care was initiated 09/30/2024 for risk for falls related to deconditioning, and gait/balance problems. The plan of care was revised on 03/05/2025 due to an unwitnessed fall which included an intervention for bright colored tape to #47's wheelchair brakes. Observation on 03/25/2025 at 4:00PM revealed, in part, there was no fall mat in Resident #47's room. Observation on 03/26/2025 at 8:40AM revealed, in part, Resident #47 was sitting in wheelchair there was no fall mat in Resident #47's room, and there was no bright colored tape on the brakes of Resident #47's the wheelchair. Observation on 03/27/2025 at 10:00AM revealed, in part, Resident #47 was lying in bed. Further observations revealed no fall mat in Resident #47's room, and there was no bright colored tape on the brakes of Resident #47's wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/26/2025 at 8:45AM, S10Certified Nursing Assistant indicated she was not aware Resident #47 required a fall mat in her room or bright colored tape to her wheelchair to decrease the risk of falls. In an interview on 03/27/2025 at 10:00AM, Resident #47 indicated she never had a fall mat next to her bed, or bright colored tape to the brakes on her wheelchair to decrease the risk of falls with injury. In an interview on 03/27/2025 at 10:10AM, S8Licensed Practical Nurse (LPN) indicated he was not aware Resident #47 had orders for a fall mat, or required bright colored tape to the brakes on her wheelchair to decrease the risk of falls with injury. In an interview on 03/27/2025 at 10:20AM, S3Director of Nursing (DON), confirmed Resident #47 did not have a fall mat in her room, and did not have bright colored tape to the brakes of Resident #47's wheelchair. S3DON furthered indicated Resident #47 should have had a fall mat and bright colored tape to the brakes of her wheelchair as specified in the physician's orders and care plan. 2. Resident #115 Review of Resident #115's medical record revealed, in part, Resident #115 had an unwitnessed fall on 03/05/2025 while wandering in another resident's (Resident #105) room. Further review revealed Resident #115 had a fall in Resident #105's room on 03/05/2025 that resulted in a right hip fracture. Review of Resident #115's medical record revealed, in part, Resident #115 was admitted to the facility on [DATE] with a diagnoses of dementia, and cognitive communication deficit. Review of Resident #115's Minimum Data Set with an Assessment Reference Date of 02/26/2025 revealed, in part, Resident #115's Brief Interview for Mental Status should not be conducted and Resident #115 is rarely or never understood. Review of Resident #115's Long Term Care Evaluation dated 01/23/2025 revealed, in part, Resident #115 wanders at night. Review of Resident #115's care plan revealed no documented evidence and the facility did not present any documented evidence Resident #115 had a care plan developed to address the risks and interventions for wandering. In an interview on 03/26/2025 at 11:27AM, S3DON indicated Resident #115 was a known wanderer and was not care planned for wandering but should have been. In an interview on 03/27/2025 at 3:01 PM, S18Minimum Data Set (MDS) Nurse indicated Resident #115 was not care planned for wandering and should have been. 44336

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336 Based on interviews, and record reviews, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 (Resident #115) of 2 (Resident #115, Resident #165) sampled residents reviewed for wandering behaviors. This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 03/05/2025 at 8:46PM, when Resident #115, identified as a wanderer with dementia and cognitive communication deficits requiring supervision with walking, was unsupervised when she wandered into Resident #105's room and sustained a fall. Resident #115's fall resulted in an acute right femur fracture that required surgical intervention and rehabilitation. As a result of the fall, Resident #115 was required to use a wheelchair and experienced decreased mobility and independence. S1Administrator was notified of the Immediate Jeopardy on 03/26/2025 at 3:05PM. The Immediate Jeopardy was removed on 03/27/2025 at 10:35AM, after it was verified through observations, interviews, and record reviews, that the facility implemented an acceptable Plan of Removal prior to the exit of the survey. This deficient practice had the likelihood to cause more than minimal harm to the 12 residents who resided in the facility and were identified as wanderers. Findings: Review of Resident #115's hospital record dated 03/06/2025 revealed, in part, Resident #115 was diagnosed with a displaced fracture of right femoral neck. Further review revealed Resident #115 had a right hip hemiarthroplasty (partial hip replacement surgery) to repair fracture. Review of Resident #115's Electronic Medical Record (EMR) revealed, in part, Resident #115 was admitted to the facility on [DATE] with a diagnoses of dementia, and cognitive communication deficit. Review of Resident #115's Minimum Data Set with an Assessment Reference Date of 02/26/2025 revealed, in part, Resident #115's Brief Interview for Mental Status should not be conducted and Resident #115 is rarely or never understood. Further review revealed Resident #115 required staff supervision or touching assistance with walking 10 feet, 50 feet, and 150 feet. Review of Resident #115's care plan with a revision date of 01/09/2025 revealed, in part, Resident #115 was at risk for falls r/t confusion and poor communication/comprehension. Review of Resident #115's Long Term Care Evaluation dated 01/23/2025 revealed, in part, Resident #115 wanders at night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #115's progress note dated 03/05/2025, revealed, in part, on 03/05/2025 at 8:46PM, revealed Resident #115 wandered into another residents (Resident #105) room and when he (Resident #105) was trying to get her (Resident #115) out of his room she (Resident #115) fell on the ground. Review of the facility's incident report submitted on 03/10/2025 revealed, in part, Resident #115 had a fall on 03/05/2025 and returned to the facility with a fracture to the right hip. Further review revealed, in part, S1Administrator wrote: Resident #115 was found on the floor in Resident #105's room. S11CNA reported that Resident #105 pushed Resident #115 to the floor, but S11CNA did not see this happen. Resident #115 does have behavior of wandering throughout the day. Further review revealed after the fall, Resident #115 was noted to have pain to the right leg and back upon initial assessment and was sent to the Emergency Department. Resident #115 was not able to state what occurred. S11CNA stated that she observed Resident #115 walking in and out of resident's rooms about 30 minutes prior to incident. S11CNA said she saw Resident #105 walking toward Resident #115 with his hands up, when he was close enough he put his hands on her shoulder. The amount of force, if any, that Resident #105 used when he touched Resident #115's shoulder cannot be determined. Review of S11CNA's written and signed fall investigation questionnaire revealed, in part: -What was Resident #115 doing? Resident #115 was walking in and out of rooms. Review of S15Licensed Practical Nurse (LPN) written and signed fall investigation questionnaire revealed, in part: -What time did you last see Resident #115 before the fall? The last time I saw Resident #115 before she fell , Resident #115 was walking down towards the end of the hall. -What was Resident #115 doing? Resident #115 was walking into different resident rooms. In an interview on 03/24/2025 at 10:28AM, S22Rehab Director indicated Resident #115 had a right hip fracture after a fall. S22Rehab Director further indicated since the fall rehab staff have been working on Resident #115's gait (refers to the manner or style of a person's walking or movement), balance, transfers and bed mobility. In a telephone interview on 03/25/25 at 3:33PM, S11CNA indicated that she tried to redirect Resident #115 several times but she did not stop wandering in other residents rooms. S11CNA further indicated while doing rounds she heard Resident #105 telling Resident #115 to get out of his room. S11CNA indicated when she arrived to Resident #105's room, she observed Resident #105's hands extended in front of him out towards Resident #115 while she was falling to the floor. S11CNA indicated she did not witness Resident #105 push Resident #115 to the floor. S11CNA indicated Resident #115 wandered into other resident's rooms most times she has worked with her. In a telephone interview on 03/25/25 at 10:06AM, S15LPN indicated on 03/05/2025 prior to Resident #115's fall, Resident #115 was re-directed a few times from walking into other resident's room. S15LPN indicated later in the shift S11CNA informed her that Resident #115 fell inside Resident #105's room. S15LPN indicated Resident #115 was guarding and grimacing after the fall and had to be sent to the hospital. S15LPN indicated it was hard to supervise Resident #115 because she wandered a lot. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview on 03/25/2025 at 1:39PM, S1Administrator stated staff was redirecting and providing activities to Resident #115 to keep her from wandering, but Resident #115 continued to walk the halls and go into other resident's rooms. S1Administrator further indicated they did everything they possibly could short of 1:1 supervision to keep the resident safe. In interview on 03/26/25 at 11:27AM, S3DON stated that the fall occurred after supper and staff were rounding and getting residents ready for bed. S3DON also indicated Resident #115 can be redirected and put in her bed, but would still wander. S3DON further indicated the next level of supervision would be 1:1 supervision but we don't provide 1:1 supervision at the facility, and there were a lot of residents that wander. A Plan of Removal was accepted on 03/27/2025 at 10:35AM, which included the following actions to correct the deficient practice: The facility identified those who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: -12 Residents have been identified as wanderers, identified as Residents 1-12. One of these residents is currently in the hospital. Date completed 03/26/2025. Actions that the facility will take: -Photos taken of all residents and made available at nurses' stations and the reception desk to identify residents 1-12 who are at risk for wandering. Date completed 03/26/2025. -Additional staff, hall monitor, added to stay on the 2nd floor hall and visually observe and document observation of residents 1-12 every 30 minutes to prevent the likelihood of serious injury, serious harm, serious impairment, or death from falls. During meal times, the monitoring of residents 1-12 will be handed off to CNA's and LPNs assigned to monitor the dining room and the hall monitor will remain on the hall to continue monitoring any of residents 1-12 that remain in their room for meals. Date begun 03/26/2026 and ongoing. Education/Training Plan: -Staff will be in-serviced on who the 12 residents are that are at risk for wandering, the need to visually observe residents 1-12 to prevent the likelihood of serious injury, serious harm, serious impairment, or death from falls, and methods for cueing, redirection, offering activities/snacks, and for what to do if a resident cannot be redirected. Date begun 03/26/2025 and ongoing until all staff are in-serviced. -Hall monitor will be trained on residents 1-12 at risk for wandering. How to monitor residents 1-12 every 30 minutes to prevent the likelihood of serious injury, serious harm, serious impairment, or death from falls. How to cue, redirect or offer activities/snacks, how to document on monitoring form, and how to handle meal time. Also trained on what to do if a resident cannot be redirected. Date begun 03/26/2025 and ongoing with each new hall monitor assigned. The facility asserts that the likelihood of serious harm to residents no longer exist as of 03/26/2025 at 6:00PM.