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	04/16/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record reviews, the facility failed to immediately notify the resident's representative of a resident's injury of unknown origin for 1 (Resident #1) of 2 (Resident #1, Resident #2) sampled residents investigated for injuries of unknown origin. Findings: In an interview on 04/16/2025 at 8:30AM, S5Licensed Practical Nurse (LPN) indicated on 04/02/2025 at 8:04AM she assessed Resident #1 with right arm immobility and pain, and administered a standing order of Tylenol. S5LPN indicated Resident #1 had complaints of pain later in the day, and an x-ray was ordered at 1:30PM by Resident #1's physician. S5LPN confirmed Resident #1's daughter who was Resident #1's Responsible Party (RP) was not notified of Resident #1's change in condition or of the new physician's orders. Review of Resident #1's record revealed no documented evidence, and the facility was unable to present any documented evidence Resident #1's RP was notified of Resident #1's change in condition or new physician's orders. In an interview on 04/15/2025 at 2:51PM, Resident #1's RP indicated she was informed of Resident #1's right arm fracture on 04/02/2025 at approximately 6:00PM. Resident#1's RP indicated she wondered why she was notified at 6:00PM when Resident #1's arm pain began at 8:00AM in the morning. In an interview on 04/16/2025 at 3:15PM, S3Director of Nursing (DON) indicated Resident #1's Representative was notified at 6:00PM, after the facility received the results of the x-ray and not when Resident #1 was assessed with right arm immobility and pain or when Resident #1's x-ray order was placed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record reviews, the facility failed to implement its policy for Abuse Prevention and Prohibition by not thoroughly investigating an injury of unknown origin for 1 (Resident #1) of 2 (Resident #1, Resident #3) sampled residents investigated for injuries of unknown origin. Findings: Review of the facility's Abuse Prevention and Prohibition Policy and Procedure dated 03/25/2023 revealed, in part, the facility's process following an injury of unknown origin was that the Administrator would complete a thorough investigation. In an interview on 04/14/2025 at 12:50PM, S1Administrator indicated she was made aware of the results of Resident#1's x-ray, which revealed a fractured right arm, at 5:20PM on 04/02/2025, and S1Administrator began an investigation due to Resident #1's identified injury of unknown origin. S1Administrator indicated her review of surveillance camera footage revealed on 04/02/2025 at 7:00AM Resident #1 was ambulating out of her room using a rollator with no apparent issues, assisted into shower room by S10Shower Aide at 7:00AM approximately. Further review revealed surveillance camera footage showed Resident #1 was assisted out of shower room at 7:45AM by S10Shower Aide and left seated on her rollator in hallway. In an interview on 04/16/2025 at 12:04PM, S1Administrator indicated she thought her investigation of the facility video surveillance footage was thorough because she used the facility's video surveillance footage to pinpoint a time when the resident showed a change in condition related to her right arm. S1Administrator further indicated during her investigation, she observed Resident #1 enter the shower room and exit the shower room. S1Administrator indicated she did not consider or had a reason to determine if Resident #1 could have been left alone in the shower room. S1Administrator indicated she only viewed Resident #1's condition upon entrance and exit of the shower room, but not when S10CNA entered and exited the shower room. S1Administrator indicated she viewed the surveillance camera video at 16 speed the normal video speed and may have missed if S10CNA left Resident #1 unattended in the shower room. S1Administrator indicated the video surveillance footage was no longer available, and S1Administrator was unable to determine if Resident #1 was left unattended in the shower room.