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 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. (continued on next page)

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	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. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 40405 Based on record reviews and interviews, the facility failed to administer a medication as ordered by the physician for 1 (Resident #116) of 4 (Resident #97, Resident #116, Resident #177, Resident #204) sampled residents reviewed for hospitalization . Findings: Review of the facility's policy and procedure on Medication Administration with an effective date of 10/04/2024, revealed, in part, nursing personnel shall ensure the safe and effective administration of medications. Further review revealed, prior to administration, the nursing staff member administering the medication shall ensure medications match the physician's orders and label, and that the proper dose was administered. Review of Resident #116's medical record revealed he had the following diagnoses, in part, of Congestive Heart Failure, Hypertensive Heart Disease with Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of Resident #116's physician orders dated 11/12/2024, revealed, in part, to increase Digoxin (medication used to treat congestive heart failure) to 250 micrograms (mcg) to three times a day and repeat Digoxin level (a blood test to determine the amount of digoxin in your body at a certain time) on 11/21/2024. Record review revealed on 11/20/2024, revealed Resident #116 was transferred to a local hospital per physician orders for an elevated Digoxin Level of 4.2 nanograms per milliliter (ng/ml). Further review revealed the normal range was 0.9-2.0 ng/ml. In an interview on 03/27/2025 at 11:22AM, S3Director of Nursing (DON) indicated Resident #116 did not receive the correct dose of Digoxin as ordered by the physician. S3DON also indicated on 11/12/2024 the physician wrote an order to increase Resident #116's Digoxin to 250mcg three times a day and the order for 125mcg three times a day should have been discontinued. S3DON indicated the order for Digoxin 125mcg three times a day was not discontinued, so Resident #116 received Digoxin 250mcg and Digoxin 125 mcg by mouth three times a day from 11/12/2024 at 8:00PM to 11/18/2024 at 2:00PM. In an interview on 03/27/2025 at 6:20PM, S24Licensed Practical Nurse (LPN) acknowledged Resident #116 did not get her Digoxin medication as ordered by the physician, and should have.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39158 Based on observations, interviews, and record review, the facility failed to maintain adequate dietary staffing levels to ensure the timely preparation and delivery of resident meals by failing to ensure: 1. breakfast was served in a timely manner; and 2. lunch was served at an appropriate palatable temperature. Findings: 1. Review of the facility's posted undated Meal Times form revealed the following, in part: Dining Room II: Breakfast 7:00AM, Lunch 12 noon, and Supper 5:00PM Dining Room I: Breakfast 7:00AM, Lunch 12 noon, and Supper 5:30PM West I : Breakfast 7:45AM, Lunch 12 noon, and Supper 5:45PM Observations in the kitchen on 3/24/25 at 8:40AM, revealed 2 staff preparing meals for hallway carts. In an interview on 03/24/2025 at 8:40AM, S7Assistant Dietary Manager indicated one staff member called in, the Dietary Manager was on her way back from an appointment, and the kitchen was already short staffed. Observations during dining facility task on 3/24/25 starting at 12:50PM, revealed some residents had not been served in both dining areas. Further observations revealed meal carts had arrived to the first and second floor hallways after 1:00PM. Observations on 03/24/2025 at 1:20PM, revealed 2 staff members started to pass trays on the second floor east hall. S9Certfied Nursing Assistant (CNA) indicated meals had just been passed on the second floor west hall. When asked about meal times, S9CNA answered that for the last month or two the breakfast carts have arrived on the floor around 9:00AM on most days, and the lunch carts have arrived around 12:45PM. Observations were continued until 1:54PM when the last tray remained and the surveyor requested the tray for further observation. In an interview on 3/24/25 at 1:40PM, Resident #164 indicated he eats in his room and breakfast and lunch are always late. Resident #164 indicated breakfast was after 930AM and lunch is after 1:45PM at least 3 days per week. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/24/25at 1:29PM, revealed, in part, food cart for 100 hall arrived and trays were passed out to Residents in their rooms by S25CNA. In an interview on 3/24/25 at 2:10PM, Resident #134 indicated breakfast and lunch were always late. Resident #134 stated he ate in the dining area so he could get his meals faster. Resident #134 indicated if he ate in his room, breakfast would not get to him until 9:30AM-9:45AM and it would be cold and the grits would be hard as a rock; and lunch would definitely be served closer to 2:00PM at least 2-3 days per week. Observation on 03/25/2025 at 8:20AM, revealed breakfast trays were placed on hall carts and sent out from the kitchen by kitchen staff. In an interview on 03/26/2025 at 7:25AM, S6Dietary Manager acknowledged that breakfast was not served in the dining areas by 7:45AM and on the halls by 8:30AM. S6Dietary Manager further indicated lunch was not served by 12:45PM on 03/24/2025. S6Dietary Manager also indicated the kitchen has had daily call-ins from staff, and the kitchen was already not sufficiently staffed. Observation on 03/26/25 at 8:20AM, revealed breakfast trays were placed on hall carts and sent out from the kitchen by kitchen staff. In an interview on 03/27/2025 at 3:45PM, S7Assistant Dietary Manager indicated the posted meal time form times were correct, and [NAME] 1 represented the hallways. S7Assistant Dietary Manager acknowledged that breakfast was not served at 7:00AM, and lunch was not served at 12:00PM, the times listed on the Meal Time form. S7Assistant Dietary Manager further indicated that breakfast has been served after 8:30AM and lunch has been served after 1:00PM for the past few weeks. In an interview on 03/27/2025 at 4:10PM, S2Assistant Administrator indicated the meal time form presented at entrance has not been changed or modified, so the breakfast times were 7:00AM for dining rooms, 7:45AM for [NAME] 1 and halls, and lunch was 12:00Pm everywhere. 2. Observation on 03/24/2025 at 1:42PM of last tray passed on hall b, delivered by S25CNA, for room a, revealed the food was not at a palatable temperature. Observation on 03/24/2025 at 1:45PM revealed in part, S6Dietary Manager performed temperature checks to the above mentioned tray. Further observation revealed the macaroni temperature was 90 degrees Fahrenheit and the okra temperature was 88 degrees Fahrenheit. In an interview on 03/24/2025 at 1:45PM, S6Dietary Manager indicated the macaroni and the okra temperatures were not palatable and the temperatures should be maintained between 160 degrees Fahrenheit - 165 degrees Fahrenheit until served. In an interview on 03/24/25 at 2:10PM, Resident #134 indicated if he ate in his room, breakfast would not get to him until 9:30AM-9:45AM and it would be cold and the grits would be hard as a rock. 49259