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	03/03/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, the facility failed to ensure a dependent resident received:1) assistance with incontinence care (Resident #106); and,2) assistance with dressing (Resident #142). This deficient practice was identified for 2 (Resident #106, Resident #142) of 3 sampled residents reviewed for activities of daily living. Findings:Resident #106Review of Resident #106's quarterly Minimum Data Set with and Assessment Reference Date of 02/04/2026 revealed, in part, Resident #106 had a Brief Interview of Mental Status score of 13, which indicated Resident #106's cognition was intact. Further review revealed Resident #106 had a diagnosis of hemiplegia following a cerebral infarction affecting the right dominant side (severe weakness and muscle stiffness caused by a brain injury), was always incontinent (having insufficient or no control over urination and/or bowel movements) of bowel and bladder, and required substantial/maximal assistance from staff with toileting. Review of Resident #106's care plan revealed, in part, Resident #106 required staff assistance with activities of daily living related to hemiplegia. Further review revealed Resident #106 was incontinent of bowel and bladder and staff were to provide incontinence care after each incontinent episode. Further review revealed staff were to provide prompt responses to all requests for assistance. Observation on 03/02/2026 at 10:50AM revealed Resident #106's call light was alarming. Observation on 03/02/2026 at 10:53AM revealed S8Licensed Practical Nurse entered Resident 106's room. Observation on 03/02/2026 at 10:57AM revealed a staff member used the overhead monitor to alert staff that Resident #106 needed assistance. Observation on 03/02/2026 at 11:10AM revealed Resident #106's call light was alarming. Observation on 03/02/2026 at 11:12AM revealed S7Certified Nursing Assistant entered Resident #106's room and asked Resident #106 what assistance he required. Further observation revealed Resident #106's call light stopped alarming. In an interview on 03/02/2026 at 11:18AM, Resident #106 indicated he had a bowel movement and had been waiting at least an hour for his adult brief to be changed. Resident #106 further indicated he had reported to multiple staff members that he needed his adult brief to be changed. Resident #106 further indicated the staff members entered his room and turned off his call light without providing incontinence care. In an interview on 03/02/2026 at 12:55PM, Resident #106 indicated he was still waiting for staff to provide incontinence care. In an interview on 03/02/2026 at 12:59PM, S8Licensed Practical Nurse confirmed she entered Resident #106's room when his call light was alarming and Resident #106 reported he needed his adult brief to be changed. S8Licensed Practical Nurse indicated she made an overhead page to alert staff Resident #106 required staff assistance. In an interview on 03/02/2026 at 1:03PM, S7Certified Nursing Assistant indicated she entered Resident #106's room when his call light was alarming and Resident #106 reported his adult brief needed to be changed. S7Certified Nursing Assistant indicated she turned off Resident #106's call light alarm and told S6Certified Nursing Assistant that Resident #106 required assistance with incontinence care.In an interview on 03/02/2026 at 2:15PM, S6Certified Nursing Assistant indicated sometime after 11:00AM she entered Resident #106's room and he reported he needed his adult brief to be changed. S6Certified Nursing Assistant indicated she did not change Resident #106's adult brief at that time because she was assisting other residents. S6Certified Nursing Assistant confirmed she changed Resident #106's adult brief at approximately 1:00PM and his adult brief was soiled. S6Certified (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant indicated Resident #106 should not have waited 2 hours to receive incontinence care.Resident #142Review of Resident #142's quarterly Minimum Data Set with an Assessment Reference date of 02/18/2026 revealed, in part, Resident #142 had a Brief Interview of Mental Status score of 3, which indicated Resident #142's cognition was severely impaired. Further review revealed Resident #142 required partial to moderate assistance with upper body dressing and substantial to maximal assistance with lower body dressing and transfers. Observation on 03/02/2026 at 10:31AM revealed Resident #142 was in bed wearing only an adult brief. In an interview on 03/02/2026 at 10:31AM, Resident #142 indicated she had been waiting for staff to assist her with dressing. Observation on 03/02/2026 at 10:49AM revealed Resident #142 was lying in bed wearing only an adult brief. Observation on 03/02/2026 at 11:18AM revealed Resident #142 was lying in bed wearing only an adult brief. Observation with S6Certified Nursing Assistant on 03/02/2026 at 11:33AM revealed Resident #142 was lying in bed wearing only an adult brief. In an interview on 03/02/2026 at 11:35AM, S6Certified Nursing Assistant confirmed Resident #142 was lying in bed wearing only an adult brief, and should not have been. In an interview on 03/02/2026 at 1:28PM S1Director of Nursing indicated the nursing staff should have provided Resident #106 with timely incontinence care and Resident #142 with timely dressing assistance.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to:1. Store oxygen tubing and nebulizer mouthpiece per facility policy (Resident #1 Resident #126); 2. Label oxygen tubing and nebulizer mouthpiece per facility policy (Resident #1, Resident #126); and,3. Administer oxygen as per physician orders (Resident #126). This deficient practice was identified for 2 (Resident #1, Resident #126) of 3 sampled residents reviewed for respiratory care requirements. Findings: Review of the facility's Oxygen Concentrator Cleaning Policy and Procedure, dated 11/16/2014 revealed, in part, oxygen tubing, nasal cannula, and facemask should be stored in a plastic bag when not in use. Further review revealed oxygen tubing, nasal cannula and facemask should be changed weekly and as needed. Review of the facility's Nebulizer Machine Cleaning Policy and Procedure, dated 11/04/2014 revealed, in part, nebulizer tubing, mouthpiece, and mask should be stored in a plastic bag when not in use. Further review revealed the tubing, mouthpiece and facemask should be changed weekly and as needed. 1. Review of Resident #1's medical record revealed, in part, Resident #1 had a diagnosis of chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia. Review of Resident #1's March 2026 Physician orders revealed, in part, Ipratropium-Albuterol nebulizer solution (a medication primarily used to treat respiratory conditions) 0.5milligram (mg) per 2.5millitleter (ml) inhale orally via nebulizer every 6 hours via nebulizer related to COPD and oxygen at 2 liters per minute per nasal cannula. Review of Resident #1's March 2026 electronic Medication Administration Record revealed, in part, Resident #1 received Ipratropium-Albuterol nebulizer solution 0.5mg per 2.5ml as ordered every 6 hours. Observation on 03/01/2026 at 10:30AM revealed Resident #1's oxygen tubing was on Resident #1's bed and was not stored in a plastic bag. Further observation also revealed Resident #1's nebulizer facemask was observed stored on Resident #1's nightstand and was not stored in a plastic bag. Observation on 03/02/2026 at 8:45AM revealed Resident #1's nebulizer facemask was observed stored on Resident #1's nightstand and was not stored in a plastic bag. Observation on 03/02/2026 at 2:45PM revealed Resident #1's nebulizer facemask was observed stored hanging on Resident #1's bedrail and was not stored in a plastic bag. Further observation also revealed Resident #1's oxygen tubing was observed stored on Resident #1's oxygen concentrator and was not stored in a plastic bag. In an interview on 03/02/2026 at 2:45PM, S3Licensed Practical Nurse indicated oxygen tubing and nebulizer facemask should be stored in a plastic bag when not in use. S3Licensed Practical Nurse confirmed Resident #1's oxygen tubing and nebulizer facemask was not stored properly and indicated Resident #1's oxygen tubing and nebulizer facemask should have been stored in a plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #126' medical record revealed, in part, Resident #126 had a diagnosis of respiratory disorders of chronic obstructive pulmonary disease, and emphysema. Review of Resident #126's physician orders dated 3/02/2026 revealed, in part, Ipratropium-Albuterol Inhalation (breathing treatment medication per nebulizer facemask) solution 0.5-2.5 (3) mg3ml one vial inhale orally every 6 hours as needed for interstitial pulmonary edema, emphysema, and chronic respiratory failure with hypoxia. Review of Resident #126's quarterly Minimum Data Set with an Assessment Reference Date of 01/20/2026 revealed, in part, a brief interview mental status of 15 which indicated Resident #126 was cognitively intact. Further review of Resident #126's Minimum Data Set revealed Resident #126 required oxygen therapy. Observation on 03/01/2026 at 9:35AM revealed Resident #126's nebulizer facemask with tubing was uncontained. Observation on 03/02/2026 at 11:15AM revealed Resident #126's nebulizer facemask was not contained in a plastic bag on Resident #126's nightstand. In an interview on 03/02/2026 at 11:45AM, S5Licensed Licensed Practical Nurse indicated Resident #126's nebulizer facemask was not contained in a plastic bag as required. In an interview on 03/02/2026 at 1:18PM, S1Director of Nursing indicated Resident #126's nebulizer facemask should have been contained in a plastic bag. 2. Observation on 03/01/2026 at 10:30AM revealed Resident #1's oxygen tubing and nebulizer facemask was not dated. Observation on 03/02/2026 at 8:45AM revealed Resident #1's oxygen tubing was not dated. Observation on 03/02/2026 at 2:45PM revealed Resident #1's oxygen tubing was not dated. In an interview on 03/02/2026 at 2:45PM, S3Licensed Practical Nurse indicated oxygen tubing and nebulizer facemask should be changed and dated weekly. S3Licensed Practical Nurse confirmed Resident #1's oxygen tubing and nebulizer facemask was not dated as required. In an interview on 3/2/2026 at 3:13PM, S1Director of Nursing indicated oxygen tubing and nebulizer tubing should be stored in a plastic bag when not in use and should be change and dated weekly. Review of Resident #126's physician orders dated 3/02/2026 revealed, in part, change nasal cannula every week and as needed. Observation on 03/01/2026 at 9:35AM revealed Resident #126 was wearing undated nasal cannula tubing. In an interview on 03/02/2026 at 11:00AM, S4Licensed Practical Nurse indicated Resident #126's nasal cannula tubing was not dated as required. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/02/2026 at 3:13PM, S1Director of Nursing indicated Resident #126's nasal cannula oxygen tubing should have been dated. 3. Review of Resident #126's physician orders dated 3/02/2026 revealed, in part, oxygen at 3 liters per minute per nasal cannula (NC) continuous. Review of Resident #126's quarterly Minimum Data Set with an Assessment Reference Date of 01/20/2026 revealed, in part, a brief interview mental status of 15 which indicated Resident #126 was cognitively intact. Further review of Resident #126's Minimum Data Set revealed Resident #126 required oxygen therapy. Review of Resident #126's care plan initiated on 09/27/2024 revealed, in part, oxygen settings per nasal cannula as ordered. Observation on 03/02/2026 at 11:04AM revealed Resident #126 had oxygen in progress with a flow rate of 4 liters per minute per nasal cannula. In an interview on 03/02/2026 at 11:48AM, S5Licensed Practical Nurse indicated Resident #126's oxygen flow rate was set at 4 liters per minute and should have been set at 3 liters per minute per physician's orders. In an interview on 03/02/2026 at 1:18PM, S1Director of Nursing indicated Resident #126's physician order was for 3 liters per minute per nasal cannula, and not 4 liters per minute per nasal cannula.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to ensure a functional call light was available for 2 (Resident #142, #156) of 6 sampled residents investigated for call lights. Findings:Review of the facility's Resident Call Light System Policy and Procedure dated 09/14/2022 revealed, in part, the purpose was to provide a communication system that was in proper working order to allow residents to call for staff assistance from their bedside. Further review revealed when staff were providing care they were to position the call light conveniently within reach for the resident to use. Resident #142Review of Resident #142's care plan revealed, in part, Resident #142 had limited physical mobility and staff were to ensure Resident #142's call light was in reach. Observation on 03/02/2026 at 10:31AM revealed Resident #142 was lying in bed and Resident #142's call light was observed on the floor. In an interview on 03/02/2026 at 10:31AM, Resident #142 indicated she did not know where her call light was. Observation on 03/02/2026 at 10:49AM revealed Resident #142 was lying in bed and Resident #142's call light was observed on the floor. Observation on 03/02/2026 at 11:18AM revealed Resident #142 was lying in bed and Resident #142's call light was observed on the floor. Observation on 03/02/2026 at 11:33AM with S6Certified Nursing Assistant present, revealed Resident #142 was lying in bed and Resident #142's call light was observed on the floor. In an interview on 03/02/2026 at 11:35AM, S6Certified Nursing Assistant confirmed Resident #142 was lying in bed and Resident #142's call light was observed on the floor, and should not have been. In an interview on 03/02/2026 at 11:35AM, S9Licensed Practical Nurse indicated Resident #142's call light should have been within reach to allow her to call for staff assistance. In an interview on 03/02/2026 at 1:28PM, S1Director of Nursing confirmed Resident #142's call light should have been within reach to allow her to call for staff assistance. Resident #156Review of Resident #156's quarterly Minimum Data Set with an Assessment Reference Date of 02/11/2026 revealed, in part, Resident #156 had a Brief Interview for Mental Status score of 10, which indicates moderate cognitive impairment. Further review revealed Resident #156 required substantial/maximal assistance with transfers, toileting, and dressing. Review of Resident #156's care plan revealed Resident #156 required staff assistance with activities of daily living. Further review revealed staff were to ensure Resident #156's call light was within reach and provide prompt response to all requests. Observation on 03/01/2026 at 9:08AM revealed Resident #156's was lying in bed, and his call light cord was on the floor under his bed. Further observation revealed Resident #156's call light cord was severed and had no button attached. In an interview on 03/01/2026 at 9:08AM, Resident #156 indicated he did not have a call light for a few days and indicated he had to holler out when he needed assistance. Observation on 03/02/2026 at 10:29AM revealed Resident #156 was lying in bed, and his call light cord was on the floor under his bed. Further observation revealed Resident #156's call light cord was severed and had no button attached. In an interview on 03/02/2026 at 10:29AM, Resident #156 indicated he still did not have access to a call light to ask for assistance. Observation on 3/02/2026 at 3:53PM with S1Director of Nursing present, revealed Resident #156 was lying in bed and his call light cord was on the floor under his bed. Further observation revealed Resident #156's call light cord was severed and had no button attached. In an interview on 03/02/2026 at 3:53PM, S1Director of Nursing indicated Resident #156's call light should have been functional and available for use to call staff for assistance. In an interview on 03/03/2026 at 1:25PM, S2Corporate Nurse indicated Resident #156's call light should have been functional and available for use to call staff for assistance.