STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195437	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Margaret's Daughters Home	3525 Bienville St New Orleans, LA 70119

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interviews and record reviews, the facility failed to develop an individualized behavioral health care plan to address a resident's behavioral health needs for 1 (Resident #1) of 3 sampled residents reviewed for Findings:Review of Resident #1's Psychiatric Consult Note dated 03/12/2026 revealed, in part, Resident #1 was noted with increased agitation and was verbally aggressive when his needs were not met right away. Further review revealed Resident #1 was defensive and irritable during conversation, and stated he talked loud because he wanted people to understand what he was saying. Further review revealed Resident #1 stated he was a slave in Honduras, and he did not like being disrespected or labeled as something he was not. Review of Resident #1's Nurses Notes dated 04/11/2026, 04/12/202604/18/2026, 04/19/2026, 04/25/2026, and 04/26/2026 was assessed as having behaviors present. Review of Resident #1's Nurses Notes dated 04/08/2026 revealed Resident #1 was observed in the hallway yelling at staff, stating I need a pillowcase. Further review revealed staff promptly provided Resident #1 with a pillowcase; however, Resident #1 continued to yell and display irate behavior. Review of Resident #1's Psychosocial Note dated 04/23/2026 revealed, in part, Resident #1 exhibited increased agitation when his needs or preferences were not met immediately. Review of Resident #1's care plan with a target date of 05/14/2026 revealed a plan of care was not developed to address Resident #1's behaviors, cultural background and preferences, and refusal of outside services. revealed no evidence of a care plan for Resident #1's cultural differences from being from Honduras, nor any evidence of a care plan for Resident #1's refusal for outside services. In an interview on 05/19/2026 at 10:48AM, S5Licensed Practical Nurse (LPN) indicated Resident #1 was a very agitated man and was not easy to calm down when he did not get his way. S5LPN further indicated Resident #1 was never physically aggressive, just verbally aggressive and moved his hands around while yelling. S5LPN further indicated although she was educated on how to de-escalate agitated/aggressive residents, she was never given Resident #1 specific interventions to address Resident #1's above-mentioned behaviors. In an interview on 05/19/2026 at 2:25PM, S3Social Services indicated Resident #1 was scary. S3Social Services further indicated Resident #1 felt as though he was superior to the staff, due to he had to work to become an American citizen. S3Social Services further indicated because of this he viewed situations differently, and was offended by the slightest inconvenience. In an interview on 05/19/2026 at 3:10PM, S3Social Services indicated Resident #1 had refused all therapeutic psychiatric services except the consulting psychiatric group at the facility. S3Social Services further indicated Resident #1 hated answering assessment questions, and he voiced that he felt the assessment questions were questioning his intelligence. In an interview on 05/20/2026 at 12:42PM, S4MDS Nurse indicated Resident #1 would have loud outbursts when things did not go the way he wanted. S4MDS Nurse further indicated the facility should have developed a care plan with interventions on how to handle Resident #1's behaviors and refusal of services. In an interview on 05/20/2026 at 12:55PM, S1Administrator indicated she did not realize this information should have been included on his care plan and confirmed he was having behaviors and refusing services, interventions should have been included on his care plan. In an interview on 05/20/2026 at 1:24PM, S2Director of Nursing (DON) indicated most of Resident #1's (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors were usually due to misunderstandings and his background growing up in Honduras. S2DON confirmed since he had a different background this information should have been care planned to assist staff in providing care to Resident #1. S2DON further confirmed the refusal of the recommended services should have been care planned, and was not.