

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER St. Margaret's Daughters Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure: 1. Expired medication was not available for use (Med Prep Area d, Med Storage Room e); 2. Multi-dose medication containers were labeled with an expiration date to ensure medication was removed from use when the expiration date was exceeded (Med Prep Area b, Med Cart a); 3. Medication containers contained the necessary resident identifying information (Med Prep Area c). This deficient practice was identified for 3 (Med Prep Area b, Med Prep Area c, Med Prep Area d) of 4 sampled med prep areas, 1 (Med Storage Room e) of 1 sampled medication storage rooms, and 1 (Med Cart a) of 2 sampled medication carts observed for medication storage requirements. Findings: Review of the facility's Insulin policy and procedure, with a revision date of [DATE], revealed, in part, open insulin must be dated the day it was opened and the date it would expire. Further review revealed the life span for insulin was only 28 days from the date the container was opened and must be discarded after 28 days. Review of the facility's undated Liberalized Medication policy and procedure, revealed, in part, the date a multi-dose medication container was opened was to be recorded on the medication container. 1. Review of Lispro's (medication used to treat high blood glucose levels) Manufacturer's Guidelines revealed, in part, after Lispro multi-dose flex pens were opened, the medication could be stored at room temperature up to 86 degrees Fahrenheit (F) (30 degrees Celsius [C]) for up to 28 days. Further review revealed staff were to throw away all opened vials after 28 days of use, even if there was medication left in the vial. Review of Toujeo's (medication used to treat high blood glucose levels) Manufacturer's Guidelines revealed, in part, after Toujeo multi-dose flex pens were opened, the medication could be stored at room temperature up to 86 F (30 C) for up to 28 days. Observation of Med Prep Area d with S6Registered Nurse (RN) on [DATE] at 4:30AM revealed the following opened and unrefrigerated medications were available for resident use:- Resident #R5's Lispro insulin multi-dose flex pen with an opened date of [DATE] (32 days from open date); and,- Resident #R6's Toujeo multi-dose flex pen with an opened date of [DATE] (40 days from open date). Observation of Med Storage Room e with S6RN on [DATE] at 4:35AM revealed Resident #R8's Tramadol (medication used to treat pain) 50 milligrams (mg) with 21 pills remaining, with an expiration date of [DATE] available for use. In an interview on [DATE] at 4:40AM, S6RN indicated the above mentioned insulin flex pens were opened, unrefrigerated, expired, and available for resident use, and should not have been available for use. S6RN further indicated Resident #R8's expired Tramadol should have been removed from Med Storage Room e, and should not have been available for resident use. In an interview on [DATE] at 9:45AM, S2Director of Nursing (DON) indicated multi-dose medication pens were required to be labeled with the date the medication pen was opened and then discarded 28 days (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	later. S2DON further indicated the floor nurses should have contacted S2DON when they had expired controlled substances for S2DON to remove. 2. Review of Novolog's (medication used to treat high blood glucose levels) Manufacturer's Guidelines for Storage before Use revealed, in part, Novolog multi-dose flex pens could be stored at room temperature for up to 28 days. Observation of Med Prep Area b on [DATE] at 4:10AM revealed, in part, Resident #R7's opened and unrefrigerated Novolog insulin multi-dose flex pen did not have an opened date documented. In an interview on [DATE] at 4:20AM, S9Licensed Practical Nurse (LPN) indicated Resident #R7's above-mentioned multi-dose flex pen of insulin was opened, stored at room temperature, and should have been labeled with an opened date. S9LPN further indicated she did not know when the above-mentioned multi-dose flex pen of insulin was opened; therefore, the expiration date was unknown, and Resident #R7's Novolog multi-dose flex pen in Med Prep Area b should not have been available for use. Observation of Med Cart a with S8LPN on [DATE] at 6:15AM revealed Resident #R10's opened and unrefrigerated multi-dose injection pen of Tymlos (medication used to treat osteoporosis) 80 micrograms (mcg) per dose did not have an opened date documented. Further observation revealed Resident #R10's Tymlos multi-dose injection pen contained directions for the multi-dose pen to be discarded after 30 days of opening. In an interview on [DATE] at 6:30AM, S8LPN indicated Resident #R10's above mentioned multi-dose medication was not labeled with an opened date and should have been. In an interview on [DATE] at 9:45AM, S2Director of Nursing (DON) indicated multi-dose medication pens were required to be labeled with the opening date and then discarded after 28 days. 3. Observation of Med Prep Area c with S7RN on [DATE] at 4:54AM revealed Resident #R4's medication storage area contained a medication cup with 17 unlabeled small white pills. In an interview on [DATE] at 4:57AM, S7RN confirmed she was the nurse responsible for Resident #R4's medication storage area which contained a medication cup with 17 unlabeled small white pills. S7RN indicated she was unaware the above mentioned pills were in Resident #R4's medication storage area, when they were placed there, who placed them there, what the above 17 white pills were, or when the pills expired. S7RN further indicated the above mentioned 17 unlabeled unknown small white pills should not have been available for resident administration. In an interview on [DATE] at 9:45AM, S2Director of Nursing (DON) indicated Med Prep Area c should not have had 17 unlabeled small round pills in a medicine cup in Resident #R4's storage area available for administration.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and record reviews, the facility failed to ensure:1. A resident's grievance was formally documented on the facility's Grievance Log (Resident #R12); and,2. The facility's grievance policy included the required components. This deficient practice was identified for 1 (Resident #R12) of 4 sampled residents investigated for grievances. Findings: 1.Review of the facility's undated Complaints/Grievances policy and procedure revealed, in part, all grievances/complaints and the resolutions would be documented in the facility's grievance log. On 07/20/2026 at 9:30AM S1Administrator was presented with a written request for the facility's Grievance Log for the past 3 months. Review of S5Licensed Practical Nurse (LPN) Supervisor's written statement, dated 07/13/2026, revealed, in part, Resident #R12 complained about a night shift Certified Nursing Assistant (CNA) who told Resident #R12 to stop calling the front desk for the CNA. Further review revealed the CNA did not want to empty Resident #R12's urinal or get Resident #R12 up in the morning. Further review revealed the CNA told Resident #R12 the CNA had other things to do. Further review revealed S5LPNSupervisor informed Resident #R12 an investigation would be done, and S1Administrator was notified. Review of the facility's July 2026 Grievance Log revealed, in part, no documentation of Resident #R12's 07/13/2026 grievance against unprofessional CNA conduct. In an interview on 07/22/2026 at 3:15PM, S4Social Services (SS) indicated she was the facility's grievance official. S4SS further indicated the above mentioned July 2026 grievance report was complete. S4SS further indicated the facility's Grievance Log did not include Resident #R12's 07/13/2026 complaint. In an interview on 07/23/2026 at 3:30PM, S2Director Nursing (DON) indicated Resident #R12's complaint was not documented in the facility's Grievance Log because by the time S2DON interviewed Resident #R12, S11CNA had already been terminated for an unrelated issue. 2.On 07/23/2026 at 3:45PM, S1Administrator was presented with a request for the facility's updated and complete grievance policy. Review of the facility's undated Complaints/Grievances policy and procedure, revealed, in part, no documentation the facility's grievance policy included the following required components:- The facility would take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated;- The facility would ensure all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; and,- The facility would maintain evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. In an interview on 07/23/2026 at 4:00PM, S1Administrator indicated the above mentioned policy was the most up to date grievance policy the facility had.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to ensure an allegation of neglect was reported to the State Survey Agency for 1 (Resident #3) of 3 sampled residents investigated for neglect. Findings:Review of the facility's Abuse Prevention policy and procedure, revised on 06/17/2002, revealed, in part, neglect was defined as the failure to provide goods or services to avoid physical harm, mental anguish, or mental illness. Further review revealed neglect was interpreted as a failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, and treatment and care, including, but not limited to actives of daily living care. Further review revealed the absence of reasonable accommodations of individual needs or preferences may result in neglect. Further review revealed any person who witnesses or suspected abuse or neglect would immediately inform the house supervisor who would notify the Administrator, and a report would be uploaded or entered to the Statewide Incident Management System (SIMS) portal. Review of the facility's July 2026 SIMS incident log revealed, in part, no SIMS reports were entered for July 2026. Review of S5Licensed Practical Nurse Supervisor's written statement, dated 07/13/2026, revealed in part, Resident #3 felt someone was trying to kill him and that Resident #3 did not feel safe. Further review revealed Resident #3 indicated he was struggling to breathe after the Certified Nursing Assistant (CNA) closed Resident #3's room door and left Resident #3 alone. Further review revealed S1Administrartor and S2Director of Nursing were notified of the situation. In an interview on 07/22/2026 at 2:15PM, S4Social Services indicated Resident #3's amyotrophic lateral sclerosis (ALS) social worker informed her on 07/14/2026 that Resident #3's allegation that occurred on 07/13/2026 would need to be reported to state officials. In a telephone interview on 07/23/2026 at 10:11AM, S14Respiratory Therapist (RT) indicated she was the RT who provided care to Resident #3 from 10:45PM on 07/12/2026 through 7:15AM on 07/13/2026. S14RT further indicated Resident #3 had pressed his call bell as well as he texted S14RT several times from 2:30AM to 4:00AM on 07/13/2026 requesting care from S11Certified Nursing Assistant (CNA). S14RT further indicated after receiving the texts from Resident #3 she was not able to locate S11CNA until approximately 5:00AM. S14RT further indicated when S11CNA left Resident #3's room, S11CNA closed Resident #3's door against Resident #3's wishes. S14RT further indicated the facility did not interview her and/or request a written statement from her regarding the above mentioned incident. In a telephone interview on 07/23/2026 at 10:54AM, Resident #3's hospice administrator indicated she notified S1Administrator on 07/13/2026 at 6:30PM that Resident #3 made allegations he had not received adequate care from a CNA and Resident #3 felt unsafe. Resident #3's hospice administrator further indicated she informed S1Administrator the facility should investigate Resident #3's concerns. In an interview on 07/23/2026 at 3:20PM, S1Administrator indicated she was made aware of Resident #3's allegations on 07/13/2026 at 6:31PM. S1Administrartor further confirmed a SIMS report was not submitted to the State Survey Agency as required.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, the facility failed to ensure:1. An alleged incident of neglect was thoroughly investigated (Resident #3); and,2. Residents were protected from further potential neglect while an investigation was in progress.This deficient practice was identified for 1 (Resident #3) of 3 sampled residents investigated for neglect. Findings:In an interview on 07/22/2026 at 2:15PM, S4Social Services indicated she was informed by the amyotrophic lateral sclerosis (ALS) social worker that the incident on 07/13/2026 with Resident #3 would need to be reported to state officials, due to she was a mandated reporter for abuse and neglect. In a telephone interview on 07/23/2026 at 10:54AM, Resident #1's hospice administrator indicated she notified S1Administrator on 07/13/2026 at 6:30PM that Resident #3 made allegations he had not received adequate care from a CNA, Resident #3 felt unsafe, and the facility should investigate. Review of a written statement, dated 07/13/2026, by S5Licensed Practical Nurse Supervisor, revealed in part, Resident #3 felt someone was trying to kill him and that he did not feel safe. Further review revealed Resident #3 indicated he was struggling to breathe after the Certified Nursing Assistant (CNA) closed his room door and left him alone. Further review revealed S1Administartor and S2Director of Nursing were notified of the situation. 1.Review of the facility's Abuse Prevention policy and procedure, revised on 06/17/2002, revealed in part, a full investigation of neglect would include an interview with the resident, other residents who were in the area, any other witnesses who were in the area, and the complainant. Further review revealed written and signed statements would be solicited. Review of the facility's undated Resident Abuse policy and procedure revealed, in part, upon receipt of a report of an allegation or violation of the resident rights law, the administration shall thoroughly investigate the situation and a written report will be prepared. On 07/22/2026 at 1:50PM, S1Administrator was presented with a request for all documentation related to the facility's investigation of the 07/13/2026 alleged incident involving Resident #3. Review of the facility's investigation evidence of the 07/13/2026 incident involving Resident #3, revealed, in part, no evidence witness interviews were performed and/or witness statements were obtained from any of the direct care staff that were present during the 07/13/2026 alleged incident involving Resident #3. In an interview on 07/22/2026 at 3:00PM, S2Director of Nursing (DON) indicated the only documentation the facility could present related to the facility's investigation of the 07/13/2026 alleged incident involving Resident #3 was a progress note, and 4 written statements by supervisory staff who were not present during the time of the alleged incident. In an interview on 07/22/2026 at 1:55PM, S13Respiratory Therapist (RT) indicated she was the RT assigned to Resident #3 on 07/13/2026 during the 6:45AM to 7:15PM shift. S13RT further indicated Resident #3 required a breathing treatment and suctioning on 07/13/2026 at 7:00AM, which was abnormal for Resident #3. S13RT further indicated the facility did not interview her and/or request a written statement from her regarding the above mentioned incident. In a telephone interview on 07/23/2026 at 10:11AM, S14RT indicated she was the RT who provided care to Resident #3 from 10:45PM on 07/12/2026 through 7:15AM on 07/13/2026. S14RT further indicated Resident #3 had pressed his call bell as well as he texted S14RT several times from 2:30AM to 4:00AM on 07/13/2026 requesting care from S11Certified Nursing Assistant (CNA). S14RT further indicated after receiving the texts from Resident #3 she was not able to locate S11CNA until approximately 5:00AM. S14RT further indicated when S11CNA left Resident #3's room, S11CNA closed Resident #3's door against Resident #3's wishes. S14RT further indicated the facility did not interview her and/or request a written statement from her regarding the above mentioned incident. In an interview on 07/23/2026 at 3:30PM, S1Administrator indicated she did not identify through the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation that Resident #3's alleged incident actually occurred on the overnight shift of 6:45PM on 07/12/2026 through 7:15AM on 07/13/2026 shift. S1Administrator further indicated she did not discover through the investigation the actual time the event took place. S1Administrartor further indicated the facility did not have statements from any staff working the overnight shift from 07/12/2026-07/13/2026. 2.Review of the facility's Abuse Prevention policy and procedure, revised on 06/17/2002, revealed in part, residents will be kept free and protected from any form of abuse or neglect. Further review revealed any current employee who had been identified in a report of alleged abuse or neglect will be immediately suspended from work without pay during the investigation of the report. Review of the facility's undated Resident Abuse policy and procedure, revealed, in part, any employee suspected of abuse or neglect will be removed from direct care of residents while the investigation was in progress. In an interview on 07/22/2026 at 3:10PM, S2DON indicated she was informed of Resident #3's allegations 07/13/2026 prior to 7:00PM. In an interview on 07/22/2026 at 3:30PM, S3Human Resources Coordinator (HRC) indicated S11CNA was not suspended and worked her normal 6:45PM to 7:15AM night shift on 07/13/2026. S3HRC further indicated it wasn't until 07/14/2026 that S11CNA was terminated for unprofessional conduct. In a telephone interview on 07/23/2026 at 11:52AM, S5LPN Supervisor indicated S11CNA was the only CNA assigned to Resident #3 on 07/12/2026 during the 6:45PM to 7:15AM night shift when the alleged incident occurred. Review of S11CNA's time records, dated 07/13/2026 through 07/14/2026, revealed in part, S11CNA was clocked in from 07/13/2026 at 7:25PM to 07/14/2026 at 7:28AM. Review of the facility's 07/13/2026 staffing schedule revealed, in part, S11CNA was assigned and worked on the unit Resident #3 resided on during the 6:45PM to 7:15AM night shift. In an interview on 07/23/2026 at 3:30PM, S1Administrator indicated S11CNA was allowed to work on 07/13/2026 during the 6:45PM to 7:15AM night shift. S1Administrator further indicated S11CNA should not have been allowed to work the night shift of 07/13/2026-07/14/2026 to allow the facility's residents to be protected from S11CNA's potential neglect during the investigation.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's medication administration was accurately documented for 1 (Resident #R11) of 4 sampled residents investigated for accurate medication administration documentation. Findings:Review of the facility's undated Liberalized Medication Policy policy and procedure, revealed, in part, the individual that administered medication shall document under the resident's Electronic Medical Administration Record (eMAR) after giving each medication. Review of the facility's undated Licensed Practical Nurse (LPN) job description revealed, in part, a key responsibility of the LPN was to maintain accurate and timely documentation in accordance with state and federal regulations and facility policies. On 07/21/2026 at 11:00AM, S1Administrator was presented with a request for all July 2026 medication administration records for Resident #R11. Review of Resident #R11's medical record revealed, in part, Resident #R11 was admitted to the facility on [DATE] with diagnoses which included unspecified pain, chronic obstructive pulmonary disease (COPD), and rheumatoid arthritis. Review of Resident #R11's July 2026 physician's orders revealed, in part, an order for oxycodone hydrochloride (HCl) (a Schedule II controlled medication used to treat pain) oral tablet 5 milligrams (mg) one tablet by mouth every 6 hours as needed for pain. Review of Resident #R11's July 2026 Controlled Drug Receive/Record/Disposition Form revealed, in part, Resident #R11's oxycodone 5 mg was documented as having been administered on 07/17/2026 at 5:56PM with a count of 29 tablets remaining. Further review revealed the next administration was on 07/17/2026 at 3:30AM with 28 tablets remaining. Further review revealed Resident #R11's oxycodone 5 mg was documented as having been administered the following additional times:- 07/18/2026 at 2:30PM;- 07/18/2026 with an illegible PM time;- 07/19/2026 at 6:30AM;- 07/19/2026 at 12:23PM;- 07/20/2026 at 6:02AM;- 07/20/2026 at 8:36AM; and,- 07/21/2026 at 4:30AM. Review of Resident #R11's July 2026 eMAR revealed, in part, Resident #R11's oxycodone 5 mg was documented as having been administered the following times:- 07/17/2026 at 5:56PM;- 07/18/2026 at 2:29PM;- 07/20/2026 at 8:33AM; and- 07/20/2026 at 3:41PM. In an interview on 07/21/2026 at 6:30AM, S8LPN indicated Resident #R11's second dose of oxycodone 5 mg administered on 07/17/2026 at 3:30AM should not have been documented with an earlier time than the first dose documented as administered on 07/17/2026 at 5:56PM on Resident #R11's Controlled Drug Receive/Record/Disposition Form. S8LPN further indicated the number of doses of oxycodone 5 mg administered to Resident #R11 should have been the same on Resident #R11's eMAR and Controlled Drug Receive/Record/Disposition Form. In an interview on 07/21/2026 at 9:45AM, S5LPN Supervisor indicated S5LPN Supervisor did not document S5LPN Supervisor administered Resident #R11 a dose of oxycodone 5 mg on 07/20/2026 at 3:41PM on Resident #R11's Controlled Drug Receive/Record/Disposition Form and should have. In an interview on 07/21/2026 at 10:15AM, S2Director of Nursing confirmed Resident #R11's July 2026 eMAR and Controlled Drug Receive/Record/Disposition Form were not accurate and complete, and should have been.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interviews and record reviews, the facility failed to provide the required behavioral health training for 4 (S9Licensed Practical Nurse [LPN], S11Certified Nursing Assistant [CNA], S15CNA, S16CNA) of 5 sampled direct care staff's personnel files reviewed for training requirements. Findings:Review of S9LPN's personnel file revealed a hire date of 04/27/2026. Further review of S9LPN's personnel file revealed no evidence S9LPN had received behavioral health training, as required. Review of S11CNA's personnel file revealed a hire date of 05/19/2026. Further review of S11CNA's personnel file revealed no evidence S11CNA had received behavioral health training, as required. Review of S15CNA's personnel file revealed a hire date of 03/19/2026. Further review of S15CNA's personnel file revealed no evidence S15CNA had received behavioral health training, as required. Review of S16CNA's personnel file revealed a hire date of 11/16/2023. Further review of S16CNA's personnel file revealed no evidence S16CNA had received behavioral health training, as required. On 07/20/2026 at 3:55PM, S3Human Resources (HR) Coordinator was presented with a request for the above mentioned staff's behavioral health training. On 07/22/2026 at 9:38AM, S3HR Coordinator was presented with a request for the above mentioned staff's behavioral health training. In an interview on 07/22/2026 at 9:39AM, S3HR Coordinator indicated she was responsible for all staff members' training and was to ensure staff received the correct training, as required. In an interview on 07/22/2026 at 10:00AM, S3HR Coordinator indicated the facility could not provide any evidence the above mentioned staff had received behavioral health training, as required. In an interview on 07/23/2026 at 3:30PM, S1Administrator was presented with the above mentioned findings. S1Administrator could not present any documented evidence to dispute the above mentioned deficient practice.		