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	08/20/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to:1. Ensure hazardous chemicals were not accessible to residents (Resident #75's room, Hall c, Hall d, Room f); and, 2. Ensure a resident had sufficient supervision to prevent a fall (Resident #72). This deficient practice was identified for 5 (Resident #75's room, Hall c, Hall d, Room f) of 5 (Resident #75's room, Hall c, Hall d, Room f) locations observed containing unsecured chemicals during observations and for 1 (Resident #72) of 4 (Resident #5, Resident #47, Resident #72, Resident #105) sampled residents investigated for accidents. Findings:1. Observation on 08/18/2025 at 10:26AM revealed a spray bottle with an unknown purple chemical substance on the housekeeper’s cart located on Hall “c”. In an interview on 08/18/2025 at 10:28AM, S5Housekeeper indicated her housekeeper’s cart located on Hall “c” did contain a spray bottle which contained a purple floor cleaner. S5Housekeeper further indicated the floor cleaner was E31, a pH neutralizer cleaner. Observation on 08/18/2025 at 10:30AM revealed a bottle of plant food/fertilizer on a table in the Hall “c” dining room. In an interview on 08/18/2025 at 10:34AM, S6Licensed Practical Nurse (LPN) indicated the plant food/fertilizer should not have been accessible to residents in the Hall “c” dining room. Observation on 08/18/2025 at 10:48AM revealed Hall “d” cabinet next to Room “e” contained a spray bottle with an unknown green chemical substance. In an interview on 08/18/2025 at 10:50AM, S7Certified Nursing Assistant (CNA) indicated the spray bottle located in the Hall “d” cabinet contained a sanitizer. S7CNA further indicted the chemical should be secured and was not. Observation on 08/18/2025 at 11:09AM revealed, in part, the door to Room “f”, a general room for hair care, was propped open. Further observation of Room “f” revealed an cleaning chemicals contained in an unsecured cabinet, and an opened 64 ounce bottle of disinfectant used to clean salon/barbershop equipment/tools. In an interview on 08/18/2025 at 11:13AM, S3LPN indicated the door to Room “f” should always be locked while not in use to avoid resident access to sharps and chemicals. In an interview on 08/18/2025 at 11:30AM, S2Director of Nursing (DON) indicated all chemicals should (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be secured and not available to residents. Review of Resident #75’s care plan review dated 08/31/2025, revealed, in part, Resident #75 had sensory and perception alterations related to vision. Further review revealed an intervention for staff to remove possible environmental barriers to ensure safety. Further review revealed an intervention for the facility to perform safety risk evaluations as needed. In an interview on 08/18/2025 at 3:57PM, Resident #75 indicted she had two cans of aerosolized insecticide in the room. Observation on 08/18/2025 at 4:00PM revealed two cans of aerosolized insecticide the lower shelf of Resident #75’s room. Observation on 08/19/2025 at 2:44PM revealed S8Licensed Practical Nurse (LPN) picked up the two cans of aerosolized insecticide and placed them in the closet of Resident #75’s room. S8LPN further indicated she was unaware Resident #75 had two cans of aerosolized insecticide in Resident #75’s room. In an interview on 08/20/2025 at 12:30PM, S1Administrator indicated Resident #75 should not have had aerosolized insecticide in her room. 2. Review of the facility’s Accidents/Incidents Policy, last revised on 06/17/2002, revealed, in part the charge nurse and/or the nursing supervisor will initiate a plan of care change that was professionally warranted to ensure a resident’s welfare and safety prior to the end of the shift. Review of Resident #72’s Electronic Medical Record revealed, in part, Resident #72 was admitted to the facility on [DATE] with a history of falling. Review of Resident #72’s Incident and Accident Log, revealed, in part, Resident #72 had a witnessed fall with no injury on 08/17/2025. Review of Resident #72’s Activities of Daily Living (ADL) care plan initiated and revised on 08/19/2025 revealed, in part, Resident #72 required maximal assistance and required the assistance of two person to transfer. Review of Resident #72’s Incident and Accident Log dated 08/20/2025 revealed, in part, S14Certified Nursing Assistant (CNA) attempted to transfer Resident #72 from the bed to the wheelchair without assistance which resulted in a witnessed fall. In an interview on 08/20/2025 at 12:45PM, S2DON indicated Resident #72 was care planned to have two staff assist for transfers. S2DON further indicated Resident #72’s fall care plan was not implemented when S14CNA attempted to transfer Resident #72 without assistance.

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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. Based on observation and interviews, the facility failed to ensure a medication storage room was not accessible to residents and unauthorized staff for 1 (Medication Storage Room a) of 1 (Medication Storage Room a) medication storage rooms observed during general facility observations. Findings:Observation on 08/18/2025 at 11:03AM revealed the door to Medication Storage Room a was unlocked, and unattended. Further observation revealed medications stored in Medication Storage Room a were accessible to residents and unauthorized staff. In an interview on 08/18/2025 at 11:05AM, S3Licensed Practical Nurse (LPN) confirmed Medication Storage Room a was unlocked, and unattended. S3LPN further indicated she left Medication Storage Room a unlocked. In an interview on 08/18/2025 at 11:30AM, S2Director of Nursing indicated Medication Storage Room a should not have been left unlocked and unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to:1. Ensure the facility's ice machine was maintained in a sanitary manner;2. Ensure food stored in the facility's refrigerator and freezer were properly contained and labeled with an open date; and,3. Ensure dietary staff wore proper hair restraints during food handling and preparation (S10Dietary Aide, S11Dietary Manager).This deficient practice was identified for 2 (S10Dietary Aide, S11Dietary Manager) of 2 (S10Dietary Aide, S11Dietary Manager) dietary staff observed for hair restraints. Findings:1. Observation on 08/18/2025 at 9:19AM revealed pink colored residue located on the inside top corner of the facility's ice machine. Further observation revealed a black colored substance on the inside corner of the facility's ice machine. In an interview on 08/18/2025 at 9:19AM, S11Dietary Manager (DM) confirmed the facility's ice machine was not maintained in a sanitary manner and should have been. In an interview on 08/19/2025 at 12:12PM, S2Director of Nursing (DON) acknowledged the ice machine was not maintained in a sanitary manner and should have been. In an interview on 08/20/2025 at 10:30AM, S1Administrator acknowledged the ice machine was not maintained in a sanitary manner as required. 2. Review of the facility's undated policy titled Food Receiving and Storage revealed, in part: the facility's foods were to be stored in a manner that complied with safe handling of food practices. Further review revealed all foods stored in the facility's refrigerator or freezer were to be covered, labeled, and dated so the food would be used by their use-by date, frozen, or discarded. Observation on 08/18/2025 at 9:08AM revealed the following foods were in the facility's refrigerator opened, unlabeled, undated, and available for use: - 1 bag of partially brown shredded lettuce; and, - a fourth of a watermelon. Observation on 08/18/2025 at 9:11AM revealed an opened box of corn dogs in the facility's freezer that was undated, and available for use. Observation on 08/18/2025 at 9:14AM revealed the following foods were in the facility's refrigerator opened, unlabeled, undated, and available for use: - 1 bag of partially brown cilantro; - 1 bag of tortillas; - 1 package of swiss cheese; and, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a half of a red cut onion. Observation on 08/18/2025 at 9:15AM revealed the following cooked foods were in the facility's refrigerator opened, unlabeled, undated, and available for use: - 1 container of a soup like liquid; - 1 container of pureed sweet potatoes; - 1 container of gravy; - 1 container of pureed ham; - 1 container of canned vegetables; - 1 container of pork sausage; and, - 1 container of baked chicken. Observation on 08/18/2025 at 9:16AM revealed the following foods were in the facility's refrigerator opened, unlabeled, undated, and available for use: - 1 package of sliced ham; and, - 1 package of diced ham. In an interview on 08/18/2025 at 9:17AM, S11DM indicated all of the above mentioned items should have been labeled and dated once opened. In an interview on 08/19/2025 at 12:12PM, S2DON Indicated all of the above mentioned items should have been labeled and dated once opened. In an interview on 08/20/2025 at 10:30AM, S1Administrator indicated all of the above mentioned items should have been labeled and dated once opened. 3. Observation on 08/18/2025 at 12:20PM revealed S10Dietary Aide assembled food in Hall g kitchen with her hair not restrained. Observation on 08/20/2025 at 12:38PM revealed S11DM assembled food in the Hall d, her hair not restrained, as required. In an interview on 08/20/2025 at 12:39PM, S11DM indicated she should have restrained her hair while she assembled food in Hall d's kitchen. In an interview on 08/20/2025 at 12:46PM, S1Administrator indicated S10Dietary Aide should have restrained their hair while assembling the residents' food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure medical documents containing resident health information was stored in a confidential manner for 6 (Resident #2, Resident #13, Resident #65, Resident #92, Resident #97, Resident #106) of 6 (Resident #2, Resident #13, Resident #65, Resident #92, Resident #97, Resident #106) residents identified as not having their health information confidentially maintained. Findings:Observation with S3Licensed Practical Nurse (LPN) on 08/19/2025 at 10:35AM revealed a cardboard box filled with resident records was located under a countertop in the common area, near the kitchen on Hall b. In an interview on 08/19/2025 at 10:36AM, S3LPN indicated after reviewing the documents in the cardboard box, the box contained original copies of the facility's High Risk Meeting sheets, 24-hour Reports, Resident Controlled Drug Record Forms, and Pharmacy Receipts. S3LPN confirmed the documents contained resident health information that should be kept confidential. Observation with S4Assistant Director of Nursing (ADON) on 08/19/2025 at 10:45AM revealed S4ADON reviewed the contents of the above mentioned cardboard box. In an interview on 08/19/2025 at 10:46AM, S4ADON confirmed the above mentioned cardboard box contained facility records with resident specific medical information. S4ADON further indicated these records should not have been placed in a common area and accessible to unauthorized personnel and residents. S4ADON confirmed the contents of the box included original copies of the facility High Risk Meeting Sheets, 24-hour Reports, Resident Controlled Drug Record Forms, and Pharmacy Receipts. In an interview on 08/19/2025 at 10:52AM, S2Director of Nursing (DON) confirmed the box of facility records containing resident specific medical information should not have been placed in a common area which was accessible to the public. In an interview on 08/19/2025 at 10:58AM, S1Administrator confirmed the box which contained facility records containing resident specific medical information should not have been place in a common area which was accessible to unauthorized personnel and residents. Observation of the contents of the above mentioned cardboard box on 08/19/2025 at 11:10AM revealed, in part, multiple documents containing resident specific information. Further review revealed the following documents were contained in the cardboard box: -Resident #65's Controlled Drug Receipt/Record/Disposition Forms for Hydrocodone (narcotic medication used to control pain) and Lorazepam (medication used to treat anxiety) with the date dispensed, drug strength, amount of medication administered and unused medication amount; -The facility's contracted pharmacy's Shipping Manifest dated 06/22/2023 which documented delivery or disposition of Resident #97's Hydralazine (medication used to treat high blood pressure and/or anxiety) and Resident #13's Citalopram (medication used to treat depression);-An untitled document dated 12/30/2024 with a listing of Resident #2, Resident #92, and Resident #97's prescribed antibiotic; and,-A 24-Hour Report for a Resident with a first initial and last name (identified as Resident #106) which revealed documentation of Resident #106's medication received, physician, activities of daily living capabilities, and oxygen orders. In an interview on 08/19/2025 at 11:12AM, S4ADON indicated the resident with the first initial and last name was confirmed as Resident #106

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record reviews, the facility failed to ensure the facility was free of pests. Findings:Observation on 08/18/2025 at 8:56AM revealed 4 black flying insects were present in the kitchen's dry storage room. In an interview on 08/18/2025 at 8:56AM, S11Dietary Manager (DM) confirmed the presence of the black flying insects in the facility's dry storage room and in the facility's kitchen. In an interview on 08/19/2025 at 11:13AM, S11DM confirmed that the facility's kitchen had an increased amount of black flying insects. Observation on 08/19/2025 at 11:20AM revealed 3 black flying insects were present in the kitchen's dry storage room. Observation on 08/19/2025 at 11:23AM revealed 3 black flying insects flying around the kitchen's shelving unit. Observation on 08/19/2025 at 11:24AM revealed a gallon bottle of distilled vinegar with the bottle's cap ajar. Further observation revealed at 4 black insects were floating in the liquid contained in the gallon bottle of distilled vinegar. In an interview on 08/19/2025 at 11:25AM, S11DM confirmed that there were insects floating in the gallon bottle of distilled vinegar. In an interview on 08/19/2025 at 12:12 PM, S2Director of Nursing (DON) was informed of findings in kitchen, including multiple black flying and dead insects. S2DON acknowledged insects should not have been present in the facility's kitchen. In an interview on 08/19/2025 at 12:15PM, S2DON confirmed she was aware that the black flying insects were in the facility, but that she was not aware the insects were in the facility's kitchen. In an interview on 08/20/2025 at 10:33AM, S1Administrator indicated that the black flying insects were periodically present in the facility. S1Administrator further indicated S11DM had not notified S1Administrator that the black flying insects had returned to the facility's kitchen. S1Administrator further indicated that it was part of S11DM's job to be aware of the state of the facility's kitchen. S1Administrator further indicated that S11DM should have notified pest control and facility administration as soon as the black flying insects had returned to the facility's kitchen. S1Administrator confirmed that the black insects should not have been present in the facility.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record reviews, the facility failed to ensure a resident was assessed to ensure the resident could safely self-administer a medication prior to the resident self-administering medications for 1 (Resident #47) of 4 (Resident #5, Resident #47, Resident #72, Resident #105) sampled residents investigated for accidents. Findings: Review of Resident #47's Minimum Data Set with an Assessment Reference Date of 07/02/2025 revealed, in part, a Brief Interview for Mental status score of 11, which indicated Resident #47 had moderate cognitive impairment. Review of Resident #47's Physician Orders as of 08/20/2025 revealed, in part, no orders for Resident #47 to self-administer his medications, and no order for Voltaren gel (a gel medication used for arthritis pain). Review of Resident #47's Care Plan with a target date of 10/09/2025 revealed, in part, Resident #47 was not care planned to self-administer medications or have medications at his bedside. Review of Resident #47's Electronic Medication Administration Record from 08/01/20225 to 08/31/2025 revealed, in part, documentation that Resident #47's medications were administered by facility staff.Observation on 08/18/2025 at 11:10AM revealed a tube of gel labeled as Voltaren gel was present on Resident #47's bedside table. Observation on 08/19/2025 at 12:19PM revealed a tube of gel labeled as Voltaren gel was present on Resident #47's bedside table. In an interview on 08/19/2025 at 12:22PM, S8Licensed Practical Nurse indicated Resident #47 should not have access to the medication Voltaren. In an interview on 08/19/2025 at 12:31PM, S8LPN indicated Resident #47 was not assessed and/or care planned to self-administer medications. In an interview on 08/20/2025 at 8:47AM, S2Director of Nursing indicated Resident #47 should not have had the medication Voltaren at his bedside because he wasn't assessed and care planned to self-administer medications .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and record reviews, the facility failed to notify the state's Long Term Care (LTC) Ombudsman in writing of a discharge for 1 (Resident #104) of 1 (Resident #104) sampled residents reviewed discharge. Findings: Review of Resident #104's electronic medical record (EMR) revealed, in part, Resident #104 was discharged from the facility on 07/18/2025. Review of Resident #104's nurse's note dated 07/18/2025 at 12:43PM revealed, in part, Resident #104 was discharged from the facility on 07/18/2025 at 10:00AM. Review of the facility's Emergency Transfer Log for June 2025 and July 2025 revealed, in part, the facility only notified the state's LTC Ombudsman of transfers. Further review revealed no evidence Resident #104's discharge was communicated by the facility to the state's LTC Ombudsman. In an interview on 08/19/2025 at 9:34AM, S9Social Services indicated she was unaware the state's LTC Ombudsman had to be notified in writing when any resident was discharged or transferred from the facility; therefore, she had not notified the state's LTC Ombudsman when Resident #104 had discharged on 07/12/2025. In a phone interview on 08/19/2025 at 10:05AM, the facility's assigned state's LTC Ombudsman indicated she had not received a written discharge notice when Resident #104 was discharged . In an interview on 08/20/2025 at 9:55AM, S1Administrator indicated she was unaware the state's LTC Ombudsman had to be notified in writing when any resident was transferred or discharged from the facility. S1Administrator further confirmed the state's LTC Ombudsman was not notified of Resident #104's discharge as required.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) screening was completed for a resident admitted with a mental health disorder for 1 (Resident #46) of 1 (Resident #46) sampled residents investigated for PASRR. Findings:Review of the Louisiana Department of Health's Instructions for Completing the PASRR Level 1 Screen revised on 06/01/2018 revealed, in part, a resident with a mental illness would not require a Level II screening if the resident did not have a suspected mental illness or intellectual disability. Review of Resident #46's Electronic Medical Record (EMR) revealed Resident #46 was admitted to the facility on [DATE] with diagnoses of, in part, Major Depressive Disorder and Bipolar Disorder. Further review revealed Resident #46 did not have a diagnosis of either dementia and/or Alzheimer's disease. Review of Resident #46's Level 1 PASRR dated 11/12/2024 revealed Resident #46 was identified with a mental disorder of Major Depressive Disorder. Further review revealed the physician documented Resident #46 would need care indefinitely. Review of Resident #46's EMR and physical chart revealed no evidence a Level II PASRR was completed for Resident #46.In an interview on 08/19/2025 at 2:57PM, S9Social Service Designee (SSD) indicated the facility had not submitted a request and ensured a PASRR level II screen was completed prior to or after Resident #46's admit. In an interview on 08/20/2025 at 12:59PM, S2Director of Nursing (DON) indicated Resident #46 did not have a completed PASRR Level II screening, and she was not aware a Level II PASRR was needed for Resident #46.

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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 - Few	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** Based on observations, interviews, and record reviews, the facility failed to:1. Ensure a resident's care plan was revised after a witnessed fall (Resident #72); and,2. Ensure a residents fall care plan interventions were implemented after a witnessed fall (Resident #72). This deficient practice was identified for 1 (Resident #72) of 4 (Resident #5, Resident #47, Resident #72, Resident #105) sampled residents investigated for accidents. Findings:1.Review of the facility's Accidents/Incidents Policy, last revised on 06/17/2002, revealed, in part the charge nurse and/or the nursing supervisor will initiate a plan of care change that was professionally warranted to ensure a resident's welfare and safety prior to the end of the shift. Review of Resident #72's Electronic Medical Record revealed, in part, Resident #72 was admitted to the facility on [DATE] with a history of falling. Review of Resident #72's Incident and Accident Log, revealed, in part, Resident #72 had a witnessed fall with no injury on 08/17/2025. Review of Resident #72's care plan with a next review date of 11/10/2025 and last revision date of 05/19/2025 revealed, in part, Resident #72's care plan was not updated with new goals and/or interventions following Resident #72's fall on 08/17/2025. In an interview on 08/19/2025 at 1:30PM, S2Director of Nursing (DON) indicated Resident #72's care plan was not updated with fall interventions after a witnessed fall on 08/17/2025, and should have been. In an interview on 08/19/2025 at 2:30PM, S13Minimum Data Set (MDS) Nurse indicated the nurse supervisor/charge nurse on duty did not update Resident #72's care plan after Resident #72's fall prior to the end of the shift on 08/17/2025, and should have. 2. Review of Resident #72's Activities of Daily Living (ADL) care plan initiated and revised on 08/19/2025 revealed, in part, Resident #72 required maximal assistance and required the assistance of two person to transfer. Review of Resident #72's Incident and Accident Log dated 08/20/2025 revealed, in part, S14Certified Nursing Assistant (CNA) attempted to transfer Resident #72 from the bed to the wheelchair without assistance which resulted in a witnessed fall. In an interview on 08/20/2025 at 12:45PM, S2DON indicated Resident #72 was care planned to have two staff assist for transfers. S2DON further indicated Resident #72's fall care plan was not implemented when S14CNA attempted to transfer Resident #72 without assistance.