STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195570	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Community Care Center	6001 Airline Dr Metairie, LA 70003

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to ensure hand hygiene procedures were implemented by staff for 4 (Resident #19, Resident #22, Resident #58, Resident #82) of 9 sampled residents investigated for infection control.Findings:Review of the facility's Handwashing/Hand Hygiene Policy dated August 2015 revealed, in part, staff were to perform hand hygiene after contact with objects in the immediate vicinity of the resident. Observation on 12/01/2025 at 10:45AM revealed S5Certified Nursing Assistant was passing ice to the residents. Further observation revealed S5Certified Nursing Assistant did not perform hand hygiene between passing ice to Resident #58 and passing ice to Resident #22 in their shared room, Room a. Further observation revealed S5Certified Nursing Assistant did not perform hand hygiene after leaving Room a, before passing ice to the residents in Room b. Observation on 12/01/2025 at 10:50AM revealed S5Certified Nursing Assistant did not perform hand hygiene between passing ice to Resident #82 and passing ice to Resident #19 in their shared room, Room b. In an interview on 12/01/2025 at 10:52AM, S5Certified Nursing Assistant indicated she should have performed hand hygiene between passing ice to each resident, and she had not performed hand hygiene as required. In an interview on 12/02/2025 at 1:03PM, S4Infection Preventionist indicated Certified Nursing Assistants should perform hand hygiene between each resident contact. S4Infection Preventionist further indicated S5Certified Nursing Assistant should have performed hand hygiene between passing ice to each resident. In an interview on 12/03/2025 at 12:25PM, S2Assistant Director of Nursing indicated Certified Nursing Assistants should perform hand hygiene between each resident contact. S2Assistant Director of Nursing further indicated S5Certified Nursing Assistant should have performed hand hygiene between passing ice to each resident. In an interview on 12/03/2025 at 12:28PM, S1Administrator indicated S5Certified Nursing Assistant should have performed hand hygiene between passing ice to each resident.

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and record reviews, the facility failed to ensure a resident had a comprehensive care plan which addressed the need for staff assistance with showers/baths which included measurable objectives and timeframes for 1 (Resident #10) of 4 sampled residents reviewed for activities of daily living. Findings:Review of Resident #10's Comprehensive Minimum Data Set with an Assessment Reference Date of 09/16/2025 revealed, in part, Resident #10 required substantial/maximal assistance from staff with showers/baths. Review of Resident #10's care plan revealed, in part, Resident #10 had a self-care deficit related to weakness. Further review revealed Resident #10's care plan did not address Resident #10's frequency and/or need for substantial/maximal assistance from staff with showers/baths. On 12/03/2025 at 3:52PM, S2Assistant Director of Nursing was informed of the above findings, and the surveyor presented S2Assistant Director of Nursing with the opportunity to present any additional evidence to dispute the above mentioned deficient practice. In an interview on 12/03/2025 at 4:07PM, S9Clinical Coordinator indicated Resident #10's care plan did not address Resident #10's need for assistance with showers/baths, as required. In interview on 12/03/2025 at 4:09PM, S2Assistant Director of Nursing indicated Resident #10's care plan did not address Resident #10's need for assistance with showers/baths, as required.

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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 interviews and record reviews, the facility failed to ensure a dependent resident received assistance with showers/baths for 1 (Resident #10) of 4 sampled residents investigated for assistance with activities of daily living. Findings:Review of Resident #10's Comprehensive Minimum Data Set with an Assessment Reference Date of 09/16/2025 revealed, in part, Resident #10 had a Brief Interview of Mental Status score of 14 which indicated she was cognitively intact. Further review revealed Resident #10 required substantial/maximal assistance from staff with showers/baths. Review of Resident #10's care plan revealed, in part, Resident #10 had a self-care deficit related to weakness. In an interview on 12/01/2025 at 10:51AM, Resident #10 indicated her bath schedule was Monday, Wednesday, and Fridays. Resident #10 further indicated she did not received a shower on Friday, 11/28/2025 per her bath schedule. Resident #10 further indicated she did not receive a shower/bath until Monday, 12/01/2025. Review of Resident #10's Care Task log dated 11/04/2025 through 12/02/2025 revealed, in part, no documented evidence Resident #10 received a shower/bath on 11/28/2025. Review of Resident #10's Documentation Survey Report dated November 2025 revealed, in part, no documented evidence Resident #10 received a shower/bath of 11/28/2025. In an interview on 12/03/2025 at 11:03AM, S3Social Worker indicated she received a call from Resident #10's daughter on Monday, 12/01/2025 who reported Resident #10 did not receive a shower/bath on Friday, 11/28/2025. In an interview on 12/03/2025 at 11:25AM, S2Assistant Director of Nursing was informed of the above findings, and the surveyor presented S2Assistant Director of Nursing with the opportunity to present any additional evidence to dispute and/or confirm Resident #10 received a shower/bath on Friday, 11/28/2025. In an interview on 12/03/2025 at 12:17PM, S2Assistant Director of Nursing indicated the facility had no documented evidence Resident #10 had received a bath/shower on Friday, 11/28/2025. In an interview on 12/03/2025 at 1:16PM, Resident #10's daughter/responsible party indicated Resident #10 informed her that Resident #10 had not received a shower/bath on Friday, 11/28/2025. Resident #10's daughter/responsible party indicated she reported that Resident #10 did not receive a shower/bath to the social worker on Monday, 12/01/2025.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, and record reviews, the facility failed to administer pressure ulcer care as prescribed for 1 (Resident #5) of 3 sampled residents investigated for pressure ulcers. Findings:Review of Resident #5's Minimum Data Set with an Assessment Reference Date of 11/03/2025 revealed, in part, a diagnosis of pressure ulcer stage 3. Review of Resident #5's facility contracted wound care progress note dated 11/10/2025 revealed, in part, Resident #5 had one pressure ulcer located on the sacrum and one pressure ulcer located on the buttocks. Review of Resident #5's skin and wound evaluations for November and December 2025 revealed an evaluation of Resident #5's sacral pressure ulcer dated 11/24/25. Further review revealed no documented evidence of a skin and wound evaluation for Resident #5's buttock pressure ulcer. Review of Resident #5's November and December 2025 electronic treatment administration record revealed the only evidence of orders for pressure ulcer care was for Resident #5's sacral pressure ulcer. Review of Resident #5's December 2025 Physician Orders revealed, in part, an order dated 11/24/2025 for Resident #5's stage 3 (wound caused by pressure which extends into the fat tissue) sacral pressure ulcer to cleanse Resident #5's sacral ulcer with wound cleanser, pat dry, apply gentian violet 1% (topical medication used to treat and/or prevent infections) to the peri-wound (tissue surrounding the wound), apply triad cream (topical medication used treat wounds) to the outer peri-wound, and pack and cover the wound with hydro fiber silver dressing (absorbent dressing which prevents infections), and cover the wound with a foam dressing twice a week and as needed. Review of Resident #5's contracted wound care provider wound evaluation note dated 12/01/2025 revealed, in part, Resident #5's had the following wound care orders:Wound 1, Sacral wound apply silver alginate to the wound, apply triad cream to the peri-wound, then cover a bordered foam dressing; and,Wound 2, Right Middle buttock wound apply gentian violet to the peri-wound, triad cream, and cover with a bordered foam dressing. In an interview on 12/03/2025 at 12:39PM, the nurse practitioner for facility's contracted wound care provider confirmed Resident #5 had two separate pressure ulcers; one pressure ulcer located on Resident #5's sacrum, and the other pressure ulcer was located on his buttocks. The nurse practitioner for facility's contracted wound care provider further indicated she evaluated and changed Resident #5's pressure ulcer orders on 12/01/2025 due to Resident #5's sacral pressure ulcer was no longer macerated and did not require gentian violet treatment. Observation on 12/03/2025 at 2:23PM of Resident #5's pressure ulcers and/or pressure ulcer care revealed Resident #5 had a golf ball size open area to his sacrum and a penny size open area to his left buttocks. Further observation revealed S10Treatment Nurse applied gentian violet to the peri-wound of Resident #5's sacral and buttock pressure ulcers. In an interview on 12/03/2025 at 2:44PM, S10Treatment Nurse indicated she did not assess and/or document Resident #5 to have two separate pressure ulcers. S10Treatment Nurse indicated she was not aware the nurse practitioner for the facility's contracted wound care provider made changes to Resident #5's pressure ulcer treatment on 12/01/2025. S10Treatment Nurse further confirmed on 12/03/2025 when she completed Resident #5's pressure ulcer care she did not follow the treatment orders written by the nurse practitioner on 12/01/2025. In an interview 12/03/2025 at 3:05PM, S2Assistant Director of Nursing indicated S10Treatment Nurse should have clarified and/or implemented the above mentioned changes to Resident #5s pressure ulcer orders on 12/01/2025. S2Assistant Director of Nursing further indicated S10Treatment Nurse should have documented Resident #5 as having two separate pressure ulcers.

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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 follow a physician's order for oxygen administration. This deficient practice was identified for 1 (Resident #84) of 1 sampled residents reviewed for respiratory care.Findings:Review of the facility's undated Oxygen Administration policy and procedure revealed, in part, staff should verify that there is a physician's order prior to oxygen administration. Further review revealed the nurse was to review the physician's orders or facility protocol for oxygen administration.Review of Resident #84's December 2025 physician orders revealed, in part, an order dated 11/05/2025 For Resident #84 to be administered oxygen at 4 liters per minute per nasal cannula (oxygen administered per the nose) every shift. Resident #84 oxygen every shift at 4 liters per minute via nasal cannula.Observation on 12/01/2025 at 11:07AM revealed Resident #84 was receiving continuous oxygen at 2.5 liters per minute via oxygen concentrator.In an interview on 12/02/2025 at 2:15PM with S6Licensed Practical Nurse indicated Resident #84 had an order for oxygen to be administered at 4 liters per minute, and should not have been receiving oxygen at 2.5 liters per minute. In interview on 12/02/2025 at 3:55PM, S1Administrator was informed of the above findings and indicated Resident #84's Hospice Nurse was about to write an order to change Resident #84's oxygen setting to 2.5Liters/minute.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and record review, the facility failed to ensure a dietary employee (S8Dietary Manager) wore a beard restraint during the handling and preparation of food for 1 (S8Dietary Manager) of 4 dietary personnel observed during kitchen observations. Findings: Review of the Food and Drug Administration 2022 Food Code Chapter 22, revealed, in part, food employees should wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covered body hair, which are designed and worn to effectively keep hair from contacting exposed food. Observation on 12/02/25 at 12:25PM revealed S8Dietary Manager had facial hair on his lip and chin. Further observation revealed S8Dietary Manager was standing in a food preparation area in the kitchen while exposed food was present without a beard restraint. Observation on 12/03/2025 at 2:10PM revealed S8Dietary Manager had facial hair on his lip and chin. Further observation revealed S8Dietary Manager was standing in a food preparation area in the kitchen while exposed food was present without a beard restraint. In an interview on 12/03/2025 at 2:25PM, S1Administrator was informed of the above findings. S1Administrator indicated S8Dietary Manager's facial hair was not long, did not think S8DDietary Manager required a beard restraint, and offered no explanation or evidence to refute the above mentioned deficient practice.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the assigned State's Long-Term Care Ombudsman in writing of a resident's discharge for 1 (Resident #81) of 1 sampled residents reviewed for discharge requirements.Findings: Review of Resident #81's Discharge summary dated [DATE] revealed, in part, Resident #81 was discharged from the facility on 08/14/2025.Review of the facility's Emergency Transfer Log dated August 2025, revealed, in part, the facility's assigned Long-Term Care Ombudsman was not notified of Resident #81's discharge on [DATE]. Review of the facility's Emergency Transfer Log dated September 2025, revealed, in part, the facility's assigned Long-Term Care Ombudsman was not notified of Resident #81's discharge on [DATE]. In an interview on 12/20/2025 at 9:55AM, S3Social Worker indicated she did not notify the facility's assigned State's Long-Term Care Ombudsman in writing when Resident #81 was discharged on 08/14/2025, as required. In a phone interview on 12/02/2025 at 10:10AM, the facility's assigned Long-Term Care Ombudsmen indicated she had not received a written discharge notice when Resident #81 was discharged from the facility on 08/14/2025. In an interview on 12/02/2025 at 10:22AM, S1Administrator indicated she was not aware the facility's Long-Term Care Ombudsman had to be notified in writing when a resident was discharged from the facility. S1Administrator further offered no further explanation to refute the above mentioned deficient practice.