

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2025
NAME OF PROVIDER OR SUPPLIER  St. Helena Parish Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  32 North 2nd Street Greensburg, LA 70441	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews, the facility failed to send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (#4) of 4 (#1, #3, #4, #5) residents reviewed for admission, transfer and discharge requirements. Review of Resident #4's Medical record revealed he was admitted to the facility on [DATE] and was transferred from the facility to a local hospital emergency room on [DATE]. Further review revealed Resident #4 returned to the facility on [DATE]. Review of the facility's Ombudsman Emergency Transfer Log for August 2025 revealed no documentation of Resident #4's transfer to a hospital emergency room on [DATE]. Review of the facility's Census Change Sheet for August 2025 revealed no documentation of Resident #4's transfer to the hospital emergency room on [DATE]. On 10/01/2025 at 7:48 a.m., an interview was conducted with S1ADM. He stated S3BOM was responsible for updating the Emergency Transfer Log that provides written notice to the Ombudsman for all resident transfers. On 10/01/2025 at 8:18 a.m., an interview was conducted with S3BOM. She stated she was responsible for updating the Ombudsman Emergency Transfer log and to document any resident transfers to the hospital and/or emergency room. She stated she was notified daily of all resident transfers through the Census Change Sheet. She reviewed the facility's Census Change Sheet for August 2025 and confirmed Resident #4's transfer to the hospital emergency room on [DATE] was not documented. On 10/01/2025 at 8:43 a.m., an interview was conducted with S1ADM. He stated the resident's assigned nurse was responsible for updating the Census Change Sheet at time of the transfer. He reviewed the facility's Census Change Sheet and the facility's Ombudsman Emergency Transfer Log for August 2025. He confirmed Resident #4's transfer to the hospital emergency room on [DATE] was not documented and should have been. On 10/01/2025 at 12:05 p.m., an interview was conducted with S4LPN. She confirmed she did not fill out the Census Change Sheet when Resident #4 was transferred to the hospital emergency room on [DATE]. She stated she did not know she was required to complete the Census Change Sheet with each resident transfer to the hospital and/or emergency room. On 10/01/2025 at 1:22 p.m., an interview was conducted with S2DON. She stated she expected all resident transfers to be documented on the Census Change Sheet by their assigned nurse to allow for the Ombudsman Transfer Log to be accurate.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  195610	Facility ID:  195610  If continuation sheet Page 1 of 2

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure a resident's discharge assessment was completed and transmitted for 1 (#3) of 5 (#1, #2, #3, #4, and #5) residents reviewed for Resident Assessment. Review of Resident #3's Clinical Record revealed he admitted to the facility on [DATE] and was discharged to a local hospital on [DATE]. Review of Resident #3's Minimum Data Set (MDS) Assessments revealed no discharge MDS was opened and/or completed. On 10/01/2025 at 1:52 p.m., an interview was conducted with S5MDS. She stated she was one of the facility's MDS nurses. She confirmed Resident #3 had discharged from the facility on 08/11/2025 and a discharge MDS had not been opened, completed, nor transmitted, and should have been. On 10/01/2025 at 1:56 p.m., an interview was conducted with S6ADON. She stated an MDS assessment should be completed upon a resident's discharge from the facility. She confirmed Resident #3 discharged from the facility on 08/11/2025 and there was no discharge assessment opened, completed, or transmitted, and there should have been.</p>		