| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195610 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St. Helena Parish Nursing Home | 32 North 2nd Street<br>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) |
|---|---|
| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>Based on record review and interview, the facility failed to electronically submit payroll based staffing information for direct care staff as required. The deficient practice had the potential to affect the 57 residents residing in the facility.Review of the facility's Payroll Based Journal (PBJ) Staffing Data Report for Fiscal Year Quarter 1 2026 (October 1, 2025 through December 31, 2025) revealed, in part, the facility failed to submit staffing data for the quarter. On 05/04/2026 at 10:00 a.m., an interview was conducted with S1ADM. A request was made for the provider's PBJ Final Validation report for Quarter 1 of fiscal year 2026 (10/01/2025 through 12/31/2025). On 05/05/2026 at 10:45 a.m., an interview was conducted with S1ADM. S1ADM stated he was responsible for entering the facility's PBJ data each quarter. S1ADM confirmed he did not have documentation the facility submitted PBJ data for Quarter 1 of fiscal year 2026 (October 1, 2025 through December 31, 2025) and should have. As of 05/05/2026 at 4:15 p.m., the provider failed to submit its PBJ Validation report for Quarter 1 of fiscal year 2026 (10/01/2025 through 12/31/2025) for review. |

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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195610 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St. Helena Parish Nursing Home | 32 North 2nd Street<br>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) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure services provided by the facility met professional standards by failing to ensure nursing staff did not borrow medications from one resident to administer to another resident for 1 (#11) of 17 residents reviewed in the final sample.Review of Resident #11's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Rash and Other Nonspecific Skin Eruption. Review of Resident #11's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/16/2026 revealed that the resident had a Brief Interview for Mental Status (BIMS) of 15, indicating the resident was cognitively intact. Review of Resident #11's current Physician Orders revealed the following, in part: Order date: 01/10/2025 - Vistaril Oral Capsule 25 mg (Hydroxyzine Pamoate) Give 25 mg by mouth four times a day related to Rash and Other Nonspecific Skin Eruption. Review of Resident #11's MAR dated May 2026 revealed Vistaril was administered daily as ordered at the scheduled times of 8:00 a.m., 1:00 p.m., 5:00 p.m., and 8:00 p.m. with the exception of the two following occasions:05/02/2026 at 8:00 p.m. - 9 was documented by S4LPN05/04/2026 at 8:00 a.m. - 9 was documented by S6LPNReview of the MAR Chart Codes Key revealed 9 = other/see progress notes.Further review revealed Vistaril was administered daily as ordered on 05/01/2026-05/03/2026 at the scheduled times of 8:00 a.m., 1:00 p.m., 5:00 p.m. by S3LPN and on 05/03/2026 at 8:00 p.m. by S4LPN. Review of the May 2026 Nurses Administration Notes revealed the following in part: 05/02/2026 at 8:57 p.m., Orders - Administration Note: Note Text: Vistaril Oral Capsule 25 MGGive 25 mg by mouth four times a day related to rash and other nonspecific skin eruption. Awaiting pharmacy. Signed by: S4LPN.05/04/2026 at 8:06 a.m., Orders - Administration Note: Note Text: Vistaril Oral Capsule 25 MGGive 25 mg by mouth four times a day related to rash and other nonspecific skin eruption.Out will order. Signed by: S6LPN. On 05/05/2026 at 11:45 a.m., an interview was conducted with Resident #11. He stated he takes Vistaril four times a day for itching. He stated, on Saturday 05/02/2026, his day shift nurse told him he was out of his Vistaril and that she was going to order it from pharmacy. He stated he was told by his night shift nurse on Saturday 05/02/2026 that he was out of his Vistaril, so he did not receive his 8:00 p.m. dose. He stated the nurses administered all four doses of Vistaril to him on Sunday, 05/03/2026, and they told him they borrowed the Vistaril from another resident's medication while they waited on his to be delivered. On 05/05/2026 at 12:23 p.m., an interview was conducted with S6LPN. She stated she was assigned to Resident #11 on day shift yesterday, 05/04/2026, and when she went to administer Resident #11's morning dose of medications, he was out of his Vistaril. She stated the night nurse she relieved on 05/04/2026 told her that Resident #11 was out of the Vistaril, they ordered it, and it hadn't come in. She stated Resident #11 told her he was given all his Vistaril doses on Sunday, 05/03/2026, and that his Sunday nurses told him they had borrowed Vistaril from another resident to administer to him. On 05/06/2026 at 10:30 a.m., an interview was conducted with S3LPN. She confirmed she was the nurse assigned to Resident #11 on 05/01/2026 through 05/03/2026 from 6:00 a.m. to 6:00 p.m. She stated Resident #11was ordered to receive Vistaril 25 mg one capsule four times a day at 8:00 a.m., 1:00 p.m., and 5:00 p.m. and on night shift at 8:00 p.m. She stated 3 of those 4 administrations were scheduled on her shift. She stated, on Saturday 05/02/2026, she administered Resident #11's 1:00 p.m. dose of Vistaril and realized there was one pill left. She stated there were no other Vistaril blister pill packs available for Resident #11. She stated once she realized this, she faxed over a request to the pharmacy to have a refill for Resident #11's Vistaril to be delivered on Saturday 05/02/2026. She was able to provide surveyor with documented evidence of the fax sent to the pharmacy on 05/02/2026 at 4:30 p.m., requesting Resident #11's Vistaril refill. She stated she returned to work on Sunday, 05/03/2026, and realized the Vistaril had not been delivered for Resident #11. She stated she did not call the pharmacy or on call pharmacist to follow up on the medication. She stated, instead of<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195610 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St. Helena Parish Nursing Home | 32 North 2nd Street<br>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) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #11 missing his doses for the day, she borrowed 3 Vistaril pills from Resident #36. She confirmed she borrowed 3 doses of Vistaril from Resident #36, on 05/03/2026 at 8:00 a.m., 1:00 p.m., and 5:00 p.m., and administered it to Resident #11, and should not have. She confirmed it was not the facility's process to borrow medications from one resident and administer it to another. On 05/06/2026 at 2:31 p.m., a telephone interview was conducted with S4LPN. She stated she was the nurse assigned to Resident #11 on 05/02/2026 and 05/03/2026 from 6:00 p.m. to 6:00 a.m. She stated Resident #11 was ordered to receive Vistaril four times a day, which was once on her shift at 8:00 p.m. She stated on Saturday 05/02/2026 she was told by the day shift nurse that Resident #11 was out of his Vistaril but that she had ordered it from the pharmacy. She stated Resident #11's Vistaril was not available on 05/02/2026 at 8:00 p.m. so she did not administer it and charted it as awaiting pharmacy. She stated, on 05/03/2026, she was told by the same day shift nurse that Resident #11's Vistaril had not been delivered but that she had borrowed Vistaril from Resident #36 to administer to Resident #11. She stated she did not contact the pharmacy or on call pharmacist to try to obtain or follow up on the status of Resident #11's Vistaril. She confirmed, on 05/03/2026, Resident #11 was out of Vistaril and she borrowed Vistaril from another resident to administer to Resident #11. She confirmed medications should not have been borrowed from one resident to give to another resident. On 05/06/2025 at 1:45 p.m., an interview was conducted with S2DON. She stated the process for refilling medications was for the nurse to send a fax or call the pharmacy to request a refill from the pharmacy prior to the medication running out. She stated if the resident was out of medication, and it was outside of regular pharmacy hours of operation, the nurse should have called the on call pharmacist and notified them of the medication needed. She stated the on call pharmacist would deliver the medication to the facility. She stated she was made aware on 05/04/2026 by the day shift nurse of Resident #11's Vistaril being out and another resident's medication was used for Resident #11. She stated nurses should not have borrowed medications from one resident to give to another resident. She confirmed it was not the facility's process nor was it acceptable for nurses to borrow medications from one resident to administer to another resident. She stated she expected nurses to follow the facility's protocol to obtain medication refills. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195610 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St. Helena Parish Nursing Home | 32 North 2nd Street<br>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) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure all medical records regarding the resident's code status contained accurate documentation for 1 (#18) of 24 residents reviewed for advanced directives in the initial screening process.Findings:Review of Resident #18's clinical record revealed she was admitted to the facility on [DATE].Review of Resident #18's Physician's Orders in the Electronic Health Record revealed the following:Order date: [DATE] - Code Status: DNR.Review of Resident #18's Physical Chart revealed a LaPost, dated [DATE], with CPR checked and signed by Resident #18, which indicated she did want to be resuscitated if found with no pulse or respirations.On [DATE] at 3:15 p.m., an interview was conducted with S5LPN. She stated all residents had a LaPost which determined their end of life wishes. S5LPN stated physical copies of all residents' LaPost forms were kept in a red binder and also in their individual physical charts. Upon review of the red binder with S5LPN, she confirmed there was an updated LaPost form dated [DATE] which indicated Resident #18 was a DNR and matched the [DATE] Physician's Order. S5LPN further confirmed the LaPost on Resident #18's physical chart indicated she wished to be resuscitated if found with no pulse or respirations was dated [DATE], and did not contain the updated LaPost form dated [DATE]. She confirmed all of Resident #18's medical records should contain accurate documentation and Resident #18's physical chart did not.On [DATE] at 3:34 p.m., an interview was conducted with S2DON. She stated residents' most current LaPost was kept on their physical charts and in a red binder, which should match the current Code Status order in the Electronic Health Record. She stated all medical records should contain accurate and updated documentation. |