STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195632	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafon Nursing Facility of the Holy Family	6900 Chef Menteur Hwy New Orleans, LA 70126

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interviews and record reviews, the facility failed to maintain the resident's right to confidentiality of their medical records for 80 (Resident #1, Resident #2, Resident #3, Resident #R4, Resident #R5, Resident #R7, Resident #R8, Resident #R9, Resident #R10, Resident #R11, Resident #R12, Resident #R13, Resident #R14, Resident #R15, Resident #R16, Resident #R17, Resident #R18, Resident #R19, Resident #R20, Resident #R21, Resident #R22, Resident #R23, Resident #R24, Resident #R25, Resident #R26, Resident #R27, Resident #R28, Resident #R29, Resident #R30, Resident #R31, Resident #R32, Resident #R33, Resident #R34, Resident #R35, Resident #R36, Resident #R37, Resident #R38, Resident #R39, Resident #R40, Resident #R41, Resident #R42, Resident #R43. Resident #R44, Resident #R45, Resident #R46, Resident #R47, Resident #R48, Resident #R49, Resident #R50, Resident #R51, Resident #R52, Resident #R53, Resident #R54, Resident #R55, Resident #R56, Resident #R57, Resident #R58, Resident #R59, Resident #R60, Resident #R61, Resident #R62, Resident #R63, Resident #R64, Resident #R65, Resident #R66, Resident #R67, Resident #R68, Resident #R69, Resident #R70, Resident #R71, Resident #R72, Resident #R73, Resident #R74, Resident #R75, Resident #R76, Resident #R77, Resident #R78, Resident #R79, Resident #R80, Resident #R81) of 80 residents whose medical information were released without their consents. Findings:Review of the facility's Resident Rights and Dignity policy, with a revision date of 03/07/2011, revealed, in part, the facility would safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information. Further review revealed release of resident information would be handled in a manner to protect resident rights. Review of S4Social Services electronic mail (e-mail) to a contracted outside provider dated 10/15/2025 revealed Resident #R7, Resident #R8, Resident #R9, Resident #R10, Resident #R11, Resident #R12, Resident #R13, and Resident #R14's face sheets were attached to the e-mail. Further review of Resident #R7, Resident #R8, Resident #R9, Resident #R10, Resident #R11, Resident #R12, Resident #R13, and Resident #R14's face sheets revealed the face sheet contained the following information, in part, the resident's name, the resident's date of birth , the resident's social security number, the resident's admit date , the resident's Medicare and/or Medicaid number, the resident's drug allergies, the resident's care providers, the resident's pharmacy name, the resident's emergency contacts, the resident's diagnoses, and the resident's advance directive. Review of S4Social Services e-mail to a contracted outside provider dated 03/20/2026 revealed the census for 03/16/2026 was emailed to the contracted outside provider. Further review of the attached facility census revealed information for Resident #1, Resident #2, Resident #3, Resident #R4, Resident #R5, and Resident #R7 through Resident #R81 were contained on the census. Further review of the census for the above mentioned residents revealed the following information was contained on the census, the resident's room number, the resident's name, the resident's date of birth , the resident status in the facility, the resident's primary payer source, and the resident's room rate designation. In an interview on 04/22/2026 at 2:41PM, S4Social Services indicated every month to every quarter, she sent a daily census to the contracted outside provider, so the contracted outside provider could go through the list of residents and identify any residents they were not providing services. S4Social Services further indicated the contracted outside provider would then come to the facility and talk with the residents (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to see if they wanted services. When the surveyor asked to see the evidence of the residents' consent to release medical records, S4Social Services was unable to produce consents for release of medical records to the contracted outside provider at the time of the request. In an interview on 04/23/2026 at 11:59AM, S1Chief Operating Officer (COO) indicated the facility did not have any evidence to present at this time that a consent was received prior to giving the contracted outside provider the residents' information. S1COO further indicated the facility should not have released any of the residents' medical information without the residents or the residents' responsible party consent prior to the release. In an interview on 04/23/2026 at 12:46PM, S4Social Services indicated she had sent medical information to the contracted outside provider on 10/15/2025 and 03/17/2026.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure a resident received the correct enteral feeding (liquid nutrition that was administered through a tube directly into the stomach) for 1 (Resident #3) of 1 sampled residents investigated for enteral feedings.Findings:Review of Resident #3's April 2026 physician's orders revealed, in part, an order to administer Glucerna 1.2 (a type of enteral feeding) at 50 milliliters (ml) per hour for 12 hours a day, and if tolerated, to increase the rate to 60 ml per hour for 21 hours a day.Observation on 04/21/2026 at 1:20PM revealed Isosource (a type of enteral feeding) was being administered to Resident #3 at a rate of 60cml per hour.In an interview and observation on 04/21/2026 at 1:31PM, S8Licensed Practical Nurse (LPN) confirmed Isosource was currently being administered to Resident #3 at 60 ml per hour. S8LPN further indicated the Isosource was the wrong enteral feeding type, and confirmed Resident #3's physician's order was to administer Glucerna 1.2 at 60 ml per hour.In an interview on 04/21/2026 at 2:13PM, S3Director of Nursing indicated S8LPN should have verified Resident #3's physician's order for his enteral feeding before administering the enteral feeding to Resident #3.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interviews, and record reviews, the facility failed to ensure the medication error rate was not greater than 5 percent by having a medication error rate of 29 percent for 1 (Resident #R4) of 8 sampled residents observed during medication administration. Findings:Review of the facility's undated Administering Medications policy revealed, in part, medications were to be administered within one hour of their prescribed time, unless otherwise specified. Review of Resident #R4's April 2026 Physician Orders and April 2026 electronic Medical Administration Record (eMAR) revealed the following medications were scheduled to be administered at 9:00AM: Aspirin (medication used to prevent blood clots) Enteric Coated (EC) 81 milligrams (mg) one tablet by mouth once a day; Calcium Carbonate (medication used as supplement) 600mg one tablet by mouth twice a day; Ascorbic Acid (Vitamin C supplement, medication used to replace vitamin C in the body) 500mg one tablet by mouth once a day; Carvediolol (medication used to treat heart conditions) 25mg one tablet by mouth twice a day; Furosemide (diuretic, medication used remove excessive fluid from the body) 20mg one tablet by mouth once a day; Potassium Chloride (medication used as supplement to replace potassium) Extended Release (ER) 20 milliequivalent (meq) one tablet by mouth; Thiamin Hydrochloride (medication used to replace vitamin B-1 in the body) (Hcl) 100mg one tablet by mouth once a day; Timolol Maleate Ophthalmic (medication used to treat glaucoma) solution 0.5% one drop to both eyes once a day; and,Docusate Sodium (medication used to treat constipation) 100mg one tablet by mouth once a day. Observation on 04/20/2026 at 11:24AM revealed the following medications were administered by S7Licensed Practical Nurse (LPN) to Resident #R4: Aspirin 81 mg one tablet by mouth;Calcium Supplement 600 (600mg) one tablet by mouth;Vitamin C 500mg one tablet by mouth; Carvediolol 25mg one tablet by mouth; Furosemide 20mg one tablet by mouth; Potassium Chloride 20meq one tablet by mouth; Thiamin Vitamin B-1 100mg one tablet by mouth; Timolol Maleate Ophthalmic solution 0.5% one drop to both eyes; and,Docusate Sodium 100mg one tablet by mouth. There were 31 opportunities for error with 9 errors for a medication error rate of 29%. In an interview on 04/21/2026 at 12:31PM, S7LPN indicated the above medications were scheduled to be administered at 9:00AM, and should have been administered between 8:00AM and 10:00AM. In an interview on 04/23/2026 at 11:14AM, S3Director of Nursing (DON) indicated medications were to be administered within one hour before to one hour after the medications prescribed time, and therefore S7LPN should not have administered the above mentioned medications without having a physician order to change the medication order time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews and record reviews, the facility failed to ensure a resident received medications as ordered by the physician for 1 (Resident #2) of 3 sampled residents records reviewed for pharmaceutical services. Findings:Review of Resident #2's medical records revealed, in part, Resident #2 was re-admitted to the facility after a hospital stay on 03/09/2026. Review of Resident #2's handwritten physician's order sheet revealed in part, on 03/09/2026, Resident #2's physician gave orders for Resident #2 to be administered:-2 tablets of Acetaminophen (a medication used to treat mild pain and/or headaches) 500 milligrams (mg) every 6 hours as needed;-1 tablet of Eliquis (a blood thinning medication) 2.5 mg two times a day;-1 tablet of Buspirone (a medication for anxiety) 5 mg three times a day;-2 tablets of Losartan (a medication used to treat high blood pressure) 25 mg every day;-1 tablet of Mirtazapine (a medication used to treat depression) 7.5 mg every night;-2 tablets of Quetiapine (a medication used to treat mental health issues) 25 mg every night;-1 tablet of Senna Oral (a medication used to relieve occasional constipation) 8.6 mg two times a day; and,-1 tablet of Vistaril (a medication used to treat anxiety) every 8 hours as needed. Review of Resident #2's March 2026 electronic Medical Administration Record (eMAR) revealed, in part, no evidence Resident #2's above mentioned ordered medications were administered to Resident #2 between 03/09/2026 and 03/19/2026.In an interview on 04/23/2026 at 2:52PM, S3Director of Nursing indicated the facility's nurses were responsible for clarifying orders with a resident's physician when a resident came back from the hospital.In an interview on 04/23/2026 at 3:24PM, S5Clinical Support Licensed Practical Nurse indicated Resident #2's medications should have been restarted and administered as per the written physician's orders on 03/09/2026 and were not.

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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. Based on observations, interview, and record reviews, the facility failed to ensure nurses documented the administration of enteral feeding (liquid nutrition that was administered through a tube directly into the stomach) for 1 (Resident #3) of 1 sampled residents investigated for enteral feedings.Findings:Review of Resident #3's April 2026 physician's orders revealed, in part, an order to administer Glucerna 1.2 (a type of enteral feeding) at 50 milliliters (ml) per hour for 12 hours a day, and if tolerated, to increase the rate to 60 ml per hour for 21 hours a day.Review of Resident #3's April 2026 eMAR revealed, in part, no documentation staff administered Resident #3's Glucerna 1.2 at 60 ml per hour for 21 hours on 04/21/2026 and 04/22/2026.Observation on 04/21/2026 at 9:40AM revealed, Resident #3 was being administered Glucerna 1.2 at 60 ml per hour.Observation on 04/22/2026 at 2:41PM revealed, Resident #3 was being administered Glucerna 1.2 at 60 ml per hour.In an interview on 04/23/2026 at 11:04AM, S3Director of Nursing indicated when the nurses administered Resident #3's Glucerna 1.2, they should have documented the administration in the resident's medication administration record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the S6Treatment Nurse completed appropriate hand hygiene when performing wound care for 1 (Resident #1) of 1 sampled residents observed for infection control practices during wound care. Findings:Review of the facility's Using Gloves policy and procedure, with a revised date of 03/10/2011, revealed, in part, employees were to wash hands after removing gloves. Further review revealed gloves did not replace handwashing. Review of Resident #1's April 2026 physician's orders revealed, in part, cleanse Resident #1's diabetic wound to the left second toe with normal saline or wound cleanser, pat dry, apply silver alginate (dressing with silver to prevent infections) to the wound bed, and cover with a clean dry dressing three times a week and as needed. Observation on 04/21/2026 at 10:43AM revealed S6Treatment Nurse removed the dressing to Resident #1's left second toe, removed her gloves, did not perform hand hygiene, and applied new gloves. Further observation revealed S6Treatment Nurse then cleaned Resident #1's left second toe wound, removed her gloves, did not perform hand hygiene, and applied new gloves.S6Treatment Nurse then applied the calcium alginate dressing and dry dressing to Resident #1's left second toe wound. In an interview on 04/21/2026 at 10:45AM, S6Treatment Nurse indicated she completed hand hygiene before and after wound care; however she had not completed hand hygiene between each glove change because there was no hand sanitizer in the room, and did not wash her hands as an alternative to hand sanitizer. In an interview on 04/21/2026 at 12:03PM, S3Director of Nursing (DON) indicated S6Treatment Nurse should have performed hand hygiene between every glove change.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record reviews, the facility failed to ensure the facility's Certified Nursing Assistants (CNAs) received no less than 12 hour of in-services per year for 1 (S12CNA) of 4 sampled CNA's personnel records reviewed for training requirements.Findings:Review of S12CNA's personnel file revealed, in part, S12CNA was hired on 03/23/2025. Further review revealed S12CNA had not completed 12 hours of in-service training annually. In an interview on 04/23/2026 at 4:23PM, S1Chief Operations Officer indicated the facility had no documented evidence S12CNA had completed 12 hours of in-service training annually.