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

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 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 .

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: 195437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
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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 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.

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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 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.

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NAME OF PROVIDER OR SUPPLIER St. Margaret's Daughters Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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 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.