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	12/22/2025

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

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 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, interviews, and record reviews, the facility failed to maintain accurate records for 1 (Resident #3) of 3 sampled residents reviewed for accurate documentation. Findings:Review of the facility's undated Licensed Practical Nurse (LPN) job description revealed, in part, duties and responsibilities included maintaining accurate documentation of nursing care, including nurse's notes and electronic records. Review of the facility's undated Checking Gastric Residual Volume (GRV) policy and procedure, revealed, in part, the person performing this procedure should record the date and time the procedure was performed and the amount of gastric residual in the resident's medical record. Review of Resident #3's December 2025 physician's orders revealed, in part, an order dated 11/11/2025 for Isosource 1.5 (a type of liquid nutritional supplement that is typically given through a tube directly inserted into the stomach) at 58 milliliters (mL)/hour via percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the skin into the stomach to provide liquid nourishment) for 21 hours to be started at 12:00PM and stopped at 9:00AM. Review of Resident #3's Medication Admin Audit Report, dated 12/17/2025, revealed, in part, S6LPN documented Resident #3's Isosource 1.5 feedings were restarted at a rate of 58 mL/hour on 12/17/2025 at 11:08AM. Review of Resident #3's nurse's notes, dated 12/17/2025 at 12:17PM, written by S6LPN indicated, in part, 315 mL of residual, feeding held. Further review revealed no nurse's notes dated 12/17/2025 when Resident #3's enteral feeds were restarted and/or Resident #3's subsequent residual checks. Observation on 12/17/2025 at 1:00PM revealed Resident #3's feeding pump remained off and feed tubing was not connected to Resident #3's PEG tube port. In an interview on 12/17/2025 at 2:38PM, S6LPN indicated Resident #3's enteral feedings were held and not currently running due to a high residual. S6LPN further indicated she documented Resident #3's enteral feedings were restarted at 11:08AM and should not have been. Observation on 12/17/2025 at 2:45PM revealed Resident #3's feeding pump remained off and feed tubing was not connected to Resident #3's PEG tube port. Observation on 12/17/2025 at 2:51PM revealed S6LPN performed a PEG tube residual check on Resident #3's PEG tube. Further observation revealed 50 mL residual was removed. Observation on 12/17/2025 at 3:08PM revealed S6LPN restarted Resident #3's enteral feeds. Review of Resident #3's medical record revealed, in part, S6LPN did not document the feeding residual check on 12/17/2025 at 2:51PM. Further review revealed S6LPN did not document the actual time Resident #3's enteral feedings were restarted on 12/17/2025. In an interview on 12/22/2025 at 10:19AM, S3Director of Nursing (DON) confirmed S6LPN should have accurately documented Resident #3's enteral feeding times and Resident #3's enteral feeding residual checks including the date, time, and amount in Resident #3's medical record.

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 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 observations, interviews, and record reviews, the facility failed to ensure:1. Enhanced Barrier Precaution (EBP) signage was posted in a conspicuous place to identify a resident on EBP (Resident #3); and,2. Staff wore proper protective equipment (PPE) for EBP during high contact patient care activities (Resident #3). This deficient practice was identified for 1 (Resident #3) of 3 sampled residents reviewed for resident quality of care. Findings: Review of the facility's undated CNA job description revealed, in part, duties and responsibilities included following infection control and safety procedures to prevent the spread of disease and ensure a safe environment. Review of the facility's undated Assistant Director of Nursing (ADON) job description revealed, in part, essential duties and responsibilities as the infection control preventionist included ensuring nursing staff followed safety procedures, including the use of PPE and proper infection control protocols. 1.Review of the facility's undated EBP policy and procedure revealed, in part, EBP was indicated for residents with indwelling medical devices including feeding tubes. Further review revealed EBP signs should be posted on the door or wall outside the resident's rooms to communicate PPE required. Review of Resident #3's physician's orders, dated 12/2025, revealed, in part, an order for EBP due to Resident #3 having a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the skin into the stomach to provide liquid nourishment). Review of Resident #3's careplan, initiated on 03/10/2025, revealed, in part, EBP signage would be visible to alert visitors as to the use of EBP. Observation on 12/17/2025 at 10:05AM revealed no EBP signage posted on or around Resident #3's door and/or bed. Observation on 12/17/2025 at 3:45PM revealed no EBP signage posted on or around Resident #3's door and/or bed. In an interview on 12/17/2025 at 3:50PM, S7Certified Nursing Assistant (CNA) indicated Resident #3 did not have any EBP signs posted. 2. Review of the facility's undated EBP policy and procedure revealed, in part, EBP apply when a resident has a wound or indwelling medical device including a feeding tube. Further review revealed high contact resident care activities requiring the use of gown and gloves for EBPs include transferring, providing bed mobility, and feeding tube device care. Review of Resident #3's careplan initiated on 03/10/2025 revealed, in part, EBP would be followed. Observation on 12/17/2025 at 2:51PM revealed S6Licensed Practical Nurse (LPN) entered Resident #3's room to perform PEG tube care without wearing a gown. Further observation revealed S6LPN completed PEG tube residual check and connected Resident #3's PEG feeding tubing to the PEG tube port without wearing a gown. In an interview on 12/17/2025 at 3:15PM S6LPN indicated she did not wear a gown when performing Resident #3's PEG tube care and should have. Observation on 12/18/2025 at 8:11AM revealed an EBP sign on Resident #3's room door indicating staff must wear personal protective equipment during high contact resident care activities. Observation on 12/18/2025 at 12:44PM revealed S7CNA and S8Restorative Aide (RA) entered Resident #3's room to obtain Resident #3's weight using a Hoyer Lift. Further observation revealed S7CNA and S8RA removed Resident #3's blankets, rolled Resident #3 onto a Hoyer lift pad, performed Hoyer lift weight, rolled Resident #3 to remove the Hoyer lift pad, and replaced Resident #3's blankets without wearing a gown. In an interview on 12/18/2025 at 12:45PM, S8RA indicated she did not wear a gown while transferring and repositioning Resident #3 and should have. S8RA further indicated she was unaware Resident #3 was on EBP. In an interview on 12/18/2025 at 12:52PM, S7CNA indicated he did not wear a gown while transferring and repositioning Resident #3 and should have. S7CNA further indicated he was unaware Resident #3 was on EBP. In an interview on 12/18/2025 at 1:15PM, S4Assistant Director of Nursing/Infection Preventionist confirmed Resident #3 was on EBP. S4ADON/IP further indicated staff performing PEG tube care including checking residuals, and transferring/repositioning residents should have worn a gown while providing direct resident care. In an interview on 12/22/2025 at 10:19AM, S3Director of Nursing (DON) confirmed residents on EBP should have EBP signage on their door. S3DON further confirmed a gown should have been worn during PEG tube care and during resident transfer and positioning for a resident on EBP.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observations and interviews, the facility failed to ensure residents in semiprivate rooms had a ceiling suspended curtain around the bed for 2 (Resident #3, Resident #R4) of 4 sampled residents observed for environmental requirements. Findings:Observation on 12/18/2025 at 9:45AM revealed Resident #R4 did not have a ceiling suspended privacy curtain suspended around Resident #R4's bed as required, to ensure privacy. Observation on 12/18/2025 at 1:45PM revealed Resident #3 did not have a ceiling suspended privacy curtain suspended around Resident #3's bed as required, to ensure privacy. In an interview on 12/18/2025 at 12:44PM, S7CNA indicated the above mentioned residents were in semi-private rooms and both currently had a roommate. Observation on 12/22/2025 at 9:30AM revealed Resident #3 did not have a ceiling suspended privacy curtain suspended around Resident #3's bed as required, to ensure privacy. Observation on 12/22/2025 at 1:42PM revealed Resident #R4 did not have a ceiling suspended privacy curtain suspended around Resident #R4's bed as required, to ensure privacy. In an interview on 12/22/2025 at 10:00AM, S3Director of Nursing confirmed a resident in a semiprivate room should have a ceiling suspended privacy curtain suspended around the resident's bed to ensure privacy.