

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14500 Haynes Blvd. New Orleans, LA 70128	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46361</p> <p>Based on record reviews and interviews, the facility failed to:</p> <p>1. Ensure a residents gastrostomy tube (a tube inserted directly into the abdomen to provide nutrition) site was cleaned as ordered by the physician for 2 (Resident #1 and R5) of 4 (Resident #1, Resident #2, Resident #3, and R5) residents reviewed for gastrostomy site care.</p> <p>Findings:</p> <p>Resident #1</p> <p>Review of Resident #1's Quarterly Minimum Data Set with an Assessment Reference Date of 03/28/2024 revealed, in part, Resident #1 had a gastrostomy tube.</p> <p>Review of Resident #1's April 2024 physician's orders, in part, revealed an order with a start date of 03/10/2024 for cleanse gastrostomy site with wound cleanser, pat dry and cover with drain sponge every day and as needed.</p> <p>Review of Resident #1's Electronic Medication Administration Record (EMAR) revealed, in part, Resident #1 did not receive gastrostomy site care on 03/11/2024, 03/13/2024, 03/15/2024, 03/17/2024, 03/19/2024, 03/21/2024, 03/23/2024, 03/25/2024, 03/27/2024, 03/29/2024, 03/31/2024, 04/02/2024, 04/04/2024, 04/06/2024, 04/08/2024, 04/10/2024, 04/12/2024, and 04/16/2024.</p> <p>In an interview on 05/09/2024 at 12:10 p.m., S2Director of Nursing indicated Resident #1's gastrostomy tube site care order was entered incorrectly and Resident #1 did not receive gastrostomy tube site care daily as per physician orders.</p> <p>Resident #2.</p> <p>Record review revealed R5 was admitted to the facility on [DATE] with a gastrostomy tube.</p> <p>Review of R5's April 2024 Electronic Medication Administration Record, conducted on 05/09/2024 at 1:13pm, revealed no documented evidence, and the facility did not present any documented evidence, R5 had an order for and/or received gastrostomy tube site care since admit on 05/06/2024.</p> <p>(continued on next page)</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
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/09/2024 at 12:10 p.m., S2DON indicated R5 admitted to the facility on [DATE] with a gastrostomy tube. S2DON confirmed a standing order to receive gastrostomy site care was not implemented for R5 on admission and should have been.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46361</p> <p>Based on record reviews, observations, and interviews, the facility failed to maintain an environment that was free from pests as evidence by:</p> <ol style="list-style-type: none"> 1. Maggots were identified in a residents gastrostomy tube (a tube that is inserted into a person's stomach to provide nutrition) site; 2. A fly was observed on the gastrostomy tube of 1 (Resident #3) of 2 (Resident #2 and Resident #3) residents observed for gastrostomy tube site care; 3. A fly was observed in the facility's kitchen; 4. Flies were observed in the facility's dining room; and, 5. Flies were observed on a residents bed linens for 1 (R4) of 3 (Resident #2, Resident #3, and R4) resident rooms observed for pests. <p>Findings:</p> <p>Review of the facility's Root Cause Analysis Template dated 04/24/2024 revealed, in part, the description of event was a resident's gastrostomy tube site was found to have maggots. Further review revealed there were flies in the building.</p> <ol style="list-style-type: none"> 1. <p>Review of Resident #1's nurse note dated 04/19/2024 at 9:36 p.m. revealed, in part, S3Licensed Practical Nurse (LPN) initiated gastrostomy site care for Resident #1 and found Resident #1's gastrostomy site had a moderate amount of drainage and multiple maggots moved in and around the gastrostomy tube site. Further review Resident #1 was sent to the emergency roianom on [DATE] for evaluation.</p> <p>In an interview on 05/08/2024 at 8:08 a.m., S3LPN indicated she cared for Resident #1 on 4/19/2024 and when she attempted clean Resident #1's gastrostomy tube site she discovered live maggots on Resident #1's tissue where the gastrostomy tube entered the abdomen and around the gastrostomy tube site. S3LPN indicated the facility had flies in the building and it was an ongoing problem.</p> <p>Observation on 05/07/2024 at 10:30 a.m. revealed the facility's exit door located on Hall Z did not close properly. Further observation revealed there was an approximate 1/2 inch opening on the left side of the door which extended from the door handle to the bottom of the door. Further observation revealed daylight and the pavement on the outside of the exit door could be seen through the opening which was large enough for pests to enter the building.</p> <ol style="list-style-type: none"> 2. <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 05/08/2024 at 10:50 a.m. revealed S4Registered Nurse cleaned Resident #3's gastromoty tube site. During observation a fly landed on Resident #3's gastrostomy tube near the gastrostomy tube insertion site.</p> <p>In an interview on 05/08/2024 at 10:50 a.m., S4Registered Nurse confirmed a fly landed on Resident #3's gastrostomy tube near the gastrostomy tube insertion site.</p> <p>3.</p> <p>Observation on 05/08/2024 at 11:55 a.m. revealed a live fly on a saute pot on a shelf in the kitchen.</p> <p>In an interview on 05/08/2024 at 11:55 a.m., S5Dietary manager acknowledged the live fly on a clean saute pot on the shelf in the kitchen.</p> <p>4.</p> <p>Observation of the facility's dining room on 05/08/2024 at 12:23 p.m. revealed 10 dead flies and 2 live flies on the dining room windowsills.</p> <p>5.</p> <p>Observation on 05/08/2024 at 12:26 p.m. of R4's room revealed flies on R4's bed linen and pillow.</p> <p>In an interview on 05/08/2024 at 12:26 p.m., S2DON confirmed there were flies on R4's bed linen and pillow.</p> <p>In an interview on 05/08/2024 at 2:29 p.m., the facility's pest control provider stated he was not contacted by the facility to provide any extra services in the last month.</p> <p>In an interview on 05/09/2024 at 12:35 p.m., S2Director of Nursing (DON) indicated the facility had an ongoing problem with flies. S2DON further stated the flies in the facility increased the risk for residents to get parasites (an organism that lives in or on another species).</p> <p>In an interview on 05/08/2024 at 2:34 p.m., S1Administrator indicated he noticed the opening in the exit door on hall Z before but he did not realize it was a concern until this morning. S1Administrator acknowledged the opening in the exit door on hall Z could have allowed insects/flies to enter the facility. S1Administrator indicated the facility did not contact the pest control provider to request extra pest control treatments.</p>		