

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  10/02/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081</b></p> <p>Based on record reviews and interviews, the facility failed to ensure adequate respiratory staff were available to provide respiratory care and services as ordered for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for respiratory care.</p> <p>Findings:</p> <p>Review of the facility's undated policy and procedure titled, Ventilator Assessment / Monitoring, revealed, in part, complete physical and mechanical assessments should be made on the first ventilator round of both the resident and the ventilator. Further review revealed ventilator rounding was every 4 hours.</p> <p>Review of the Facility assessment dated [DATE] revealed, in part, the facility's Technology Dependent Unit (TDU) staff needs required 2 respiratory therapists (RT) per shift. Further review revealed, minimum staffing requirements included 2 RTs twenty-four hours a day, every day.</p> <p>Review of Resident #1's Minimum Data Set with an Assessment Reference Date of 09/05/2024 revealed, in part, Resident #1 had diagnoses of cardiorespiratory conditions and chronic respiratory failure with hypoxia. Further review revealed Resident #1 received tracheostomy care and invasive mechanical ventilation.</p> <p>Review of Resident #1's 10/2024 physician's orders revealed, in part, an order with a start date of 11/20/2023 for Resident #1 to receive tracheostomy care twice per day at 09:00 a.m. and 09:00 p.m. Further review revealed an order with a start date of 11/20/2023, for ventilator checks every 4 hours at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.</p> <p>Review of the facility's time cards revealed, in part, on 08/31/2024, from 7:03 p.m. to 10:27 p.m., only S8RT was working in the facility. Further review revealed no documented evidence any other RT was working in the facility at the above mentioned time.</p> <p>Review of Resident #1's Ventilator Check Administration history dated 08/31/2024 revealed, in part, Resident #1's 8:00 p.m. ventilator check was performed at 6:06 p.m. by S9RT (the RT scheduled for the day shift).</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195214
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/30/2024 at 12:15 p.m., S3Respiratory Director (RD) indicated on 08/31/2024 from 7:03 p.m. to 10:27 p.m. there was only one RT at the facility and there should have been 2 as per the facility assessment requirement.</p> <p>In an interview on 10/02/2024 at 12:45 p.m., S8RT indicated on 08/31/2024 while working the 7:00 p.m. to 7:00 a.m. shift he had not entered Resident #1's room to perform a ventilator check prior to Resident #1's ventilator alarming at 9:53 p.m.</p> <p>In an interview on 10/02/2024 at 2:15 p.m., S1Administrator confirmed the facility should have 2 respiratory therapists on duty in the TDU at all times. S1Administrator further indicated there was a period of several hours in the evening on 08/31/2024 when there was only 1 respiratory therapist on duty and should not have been.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>47081</p> <p>Based on record reviews and interviews, the facility failed to ensure Nurse Staffing Agency (NSA) Certified Nursing Assistants (CNAs) were trained on tracheostomy (a surgical opening in the neck to allow air to enter the lungs) and ventilator (a machine that moves air in and out of a person's lungs) safety prior to being assigned to the facility's Technology Dependent Unit (TDU) (unit at the facility that houses the tracheostomy and ventilator residents) for 2 (S6CNA and S7CNA) of 2 (S6CNA and S7CNA) NSA CNAs sampled for tracheostomy and ventilator competency.</p> <p>Findings:</p> <p>Review of the facility's nursing staff in-service records dated 02/22/2024 through 09/17/2024 revealed, in part, no documented evidence, and the facility could not provide any documented evidence, S6CNA and/or S7CNA were in-serviced on tracheostomy and ventilator safety.</p> <p>Review of the facility's staff assignment log dated 08/31/2024 revealed, in part, S6CNA and S7CNA were assigned to the [NAME] unit (TDU) during the 7:00 p.m - 7:00 a.m. shift.</p> <p>Review of S6CNA's NSA record revealed, in part, no documented evidence, and the facility could not provide any documented evidence, S6CNA was trained on tracheostomy and ventilator safety prior to being assigned to the TDU.</p> <p>Review of S7CNA's NSA record revealed, in part, no documented evidence, and the facility could not provide any documented evidence, S7CNA was trained on tracheostomy and ventilator safety prior to being assigned to the TDU.</p> <p>In an interview on 09/30/2024 at 12:30 p.m., S5Certified Nursing Assistant Supervisor indicated NSA CNAs did not receive training on tracheostomy and ventilator safety prior to being assigned to the TDU.</p> <p>In an interview on 09/30/2024 at 2:05 p.m., S3Respiratory Director indicated NSA CNAs were not given training or orientation by respiratory staff prior to caring for tracheostomy and/or ventilator residents.</p> <p>In an interview on 10/02/2024 at 12:16 p.m., S2Director of Nursing (DON) confirmed NSA CNAs were not given training on tracheostomy and ventilator safety prior to being assigned to the TDU and should have.</p> <p>In an interview on 10/02/2024 at 2:30 p.m., S1Administrator indicated NSA CNAs assigned to the TDU should have been trained on tracheostomy and ventilator safety prior to caring for tracheostomy and ventilator residents.</p>		