STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195214	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ferncrest Manor Living Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on record reviews, interviews, facility document reviews, and facility policy reviews, it was determined that the facility failed to keep a resident free from staff physical and verbal abuse for 1 (Resident #1) of 3 sampled residents reviewed for abuse. This deficient practice resulted in an actual harm on 11/19/2024when Resident #1 was physically abused by S2Maintenance and sustained injuries to his right face and left hand, which resulted in pain. Findings included: Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised on 07/25/2023 revealed, in part, residents have the right to be free from verbal, mental, and physical abuse. Review of Resident #1's electronic medical record (EMR) revealed, in part, Resident #1 had diagnoses, which included, blindness to both eyes and a conduct disorder (a behavioral and emotional disorder that presented as repetitive, disruptive and violent behavior). Review of Resident #1's Minimum Data Set, dated dated dated [DATE] revealed, in part, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Further review revealed Resident #1 used a wheelchair for mobility. Review of the facility's Incident/Accident report dated 11/19/2024 revealed, in part, Resident #1 was involved in a verbal and physical altercation with an employee. Further review revealed Resident #1 indicated that he was pushed by the employee and fell out of his wheelchair. Further review revealed a body audit was completed and Resident #1 had a pinpoint open area of the skin to the right side of his face and on the top of his left hand. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigative report for physical abuse dated 11/21/2024 revealed, in part, on 11/19/2024 at 2:00 p.m., S1Administrator received a report of an altercation between S2Maintenance and Resident #1 which had occurred outside of the building in the smoking area. Further review revealed S2Maintenance stood up over Resident #1, who was sitting in a wheelchair, and started to point at him. Further review revealed S2Maintenance told Resident #1 to go dig up his dead mother and that Resident #1's girlfriend had a d*ck he had been sucking on. Further review revealed Resident #1 swung at S2Maintenance, and S2Maintenance attempted to block Resident #1's swings. Further review revealed Resident #1 flipped out of his wheelchair after he grabbed S2Maintenance's chains and both Resident #1 and S2Maintenance fell to the ground. Further review revealed the allegation of physical abuse was substantiated. Review of the facility's New Employee Request/Termination sheet dated 11/21/2024 revealed, in part, S2Maintenance was terminated on 11/20/2024 for a Code of Conduct violation, and was not eligible for re-hire. Review of the facility's Employee Disciplinary report dated 11/19/2024 revealed, in part, S2Maintenance failed to walk away from a situation that led to verbal abuse and physical abuse of a resident. Review of Resident #1's progress notes dated 11/19/2024 at 3:53PM revealed, in part, S5Director of Nursing (DON) was notified at approximately 2:00PM on 11/19/2024, an incident had occurred between Resident #1 and an employee. Further review revealed Resident #1 indicated he was pushed by the employee. Further review revealed a pinpoint open area was present to Resident #1's left hand and the right side of Resident #1's face. Review of Resident #1's progress notes dated 11/20/2024 at 3:54PM revealed, in part, on the morning of 11/20/2024, Resident #1's right eye was observed to be blood shot (eye redness from irritated or inflamed blood vessels on the surface of the white part of the eye) and slightly swollen. Further review revealed Resident #1 indicated his right eye was tender to the touch. Further review revealed Resident #1's left hand was observed to be swollen and Resident #1's left hand grip was not as strong as his right hand grip. Resident #1 further indicated his left hand hurt. Further review revealed the physician ordered a cool compress for five days to the right eye, twice a day for ten minutes, and the administration of one (1) drop of artificial tears to Resident #1 right eye, three times a day for seven days. In an interview on 11/22/2024 at 11:18AM, Resident #1 indicated he had a fight with S2Maintenance on 11/19/2024. Resident #1 further indicated S2Maintenance was speaking about his girlfriend and his mother in a derogatory manner. Resident #1 further indicated S2Maintenance hit him. Resident #1 further indicated he was having some swelling and tenderness to his left hand. In a telephone interview on 11/22/2024 at 11:48AM, S3Smoking Aide indicated on 11/19/2024, Resident #1 was outside in the smoking area and began to curse at S2Maintenance. S3Smoking Aide further indicated, as S2Maintenance was walking away from Resident #1, Resident #1 stated to S2Maintenance, I dare you to come closer. S3Smoking Aide further indicated that S2Maintenance should have walked away from Resident #1 when Resident #1 dared him to come closer. S3Smoking Aide further indicated S2Maintenance instead turned around and went back towards Resident #1. S3Smoking Aide also indicated both Resident #1 and S2Maintenance were talking about each other's family members in a derogatory manner, were using profanity, and were yelling at each other. S3Smoking Aide further indicated she told them Resident #1 and S3Maintenance to calm down and also left to go and get assistance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/22/2024 at 12:02PM, S4Social Worker indicated while in her office, she looked out of her window and saw Resident #1 and S2Maintenace arguing with each other. S4Social Worker further indicated she heard S2Maintenance tell Resident #1 he could go dig his own mother out of the grave. S4Social Worker further indicated S2Maintenance told Resident #1 that his girlfriend was a man. S4Social Worker further indicated that both Resident #1 and S2Maintenance were calling each other a b*tch and telling each other f*ck you. S4Social Worker further indicated when she got closer to the smoking area, she saw S2Maintenance was standing over Resident #1 and pointing his finger in Resident #1's face. S4Social Worker further indicated Resident #1 swung and hit S2Maintenance's hat. S4Social Worker further indicated S2Maintenance then looked at her and told her that he (S2Maintenance) would be wrong if he hit Resident #1, while S2Maintenance made a punching arm gesture. S4Social Worker indicated she was unsure if S2Maintenance hit Resident #1. S4Social Worker further indicated Resident #1's right eye was redder than normal after the incident and Resident #1's left hand was swollen the next day. In an interview on 11/22/2024 on 12:45PM, S5DON indicated she was notified an incident had occurred on 11/19/2024 around 2:00 p.m. between Resident #1 and S2Maintenance. S5DON further indicated when interviewing Resident #1 after the above mentioned incident, Resident #1 indicated S2Mainteance had hit him and pushed him out of his wheelchair. S5DON further indicated Resident #1 also indicated that S2Maintence had told him his girlfriend was a man and had spoken about his mother. S5DON further indicated, during the post incident assessment, she noted a pinpoint open area of skin to the top of Resident #1's left hand and the right side of Resident #1's face. S5DON further indicated on 11/20/2024, she checked on Resident #1 and noted that his conjunctival sac (the small fluid filled space between the eyelid and the white part of the eye) to his right eye was swollen and his left hand was swollen. S5DON further indicated she asked Resident #1 if he was hit in the right eye, and Resident #1 indicated that he was hit in the right eye. S5DON further indicated Resident #1 indicated that he was so upset yesterday (11/19/2024) that he did not tell her anything about it. S5DON further confirmed what S2Maintenance said to Resident #1 in the above documented incident was verbal abuse. Review of the provider's surveillance footage from 11/19/2024 revealed, in part: -At 1:54:37PM, S2Maintenance walked up toward Resident #1, made a pointing hand gesture towards Resident #1's head, and continued to walk past Resident #1. Further observation revealed S3Smoking Aide was also present. -At 1:54:48PM, S2Maintenance stopped walking and turned around and started to speak to Resident #1. Further observation revealed Resident #1 then appeared to become agitated. -At 1:54:59PM, S2Maintenance walked briskly towards Resident #1 and then started to hover over Resident #1, who was sitting in a wheelchair, while speaking to Resident #1. -At 1:55:09PM, S2Maintenance pointed his finger very close to Resident #1's face. Further observation revealed Resident #1 and S2Maintenance appeared to be speaking in a loud manner to one another. - At 1:55:17PM, S2Maintenance closed the distance between himself and Resident #1 and S2Maintenance's head was hovering over Resident #1's shoulder. Further observation revealed, Resident #1 then swung his arm and hit S2Maintenance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-At 1:55:19PM, S2Maintenance continued to hover over Resident #1, appeared to be shouting at Resident #1, and pointed his finger in Resident #1's face. -At 1:55:33PM, Resident #1 again swung at S2Maintenance, but did not hit S2Maintenance -At 1:55:37PM, S2Maintenance began to walk away from Resident #1, but turned towards Resident #1 and appeared to be shouting. Further observation revealed S2Maintenace continued to hover over Resident #1, appeared to be shouting at Resident #1, and pointed his finger in Resident #1's face. -At 1:55:42PM, Resident #1 swung at S2Maintenace as S2Maintenance was turning around to walk away, but did not hit S2Maintenance. -At 1:55:45PM, S2Maintenance turned back towards Resident #1. Further observation revealed S2Maintenance appeared to be shouting at Resident #1 and was hovering over Resident #1. -At 1:55:53PM, S2Maintenance appeared to walk away from Resident #1, but then immediately turned around and started to speak to Resident #1. Further observation revealed S2Maintenance was hovering over Resident #1 and made pointing hand gestures towards Resident #1's shoulder and then face. -At 1:55:56PM, Resident #1 swung his left arm near S2Maintenance's head and then swung his left arm at S2Maintenance's right shoulder. Further observation revealed S2Maintenance appeared to hit Resident #1's arm away to prevent Resident #1 from striking him, and then grabbed Resident #1's left hand. -At 1:55:59PM, Resident #1 pulled his left hand out of S2Mainteance's grip and swung at S2Maintenance with his left hand. Further observation revealed S2Maintenance's then grabbed Resident #1's left hand and they appeared to struggle with each other, which resulted in Resident #1's left arm being extended back over his wheelchair and slightly behind his body. -At 1:56:05PM, Resident #1 appeared to place his cigarette in his mouth with his right hand, and then grabbed S2Maintenance with his right hand, which caused S2Maintenance to let go of Resident #1's left hand. Further observation revealed S2Maintenance immediately grabbed Resident #1's left hand as Resident #1 and S2Maintenance continued to struggle with each other. -At 1:56:18PM, an unknown object fell to the ground and S2Maintenance released Resident #1's hand and stepped back from Resident #1. Further observation revealed S2Maintenance continued to speak to Resident #1 and then stepped towards Resident #1. -At 1:56:25PM, S2Maintenance pointed his finger at the side of Resident #1's face and it appeared that S2Maintenance's finger made contact with Resident #1 face, as his head appeared to jerk back. Further observation revealed Resident #1 swung his left arm at S2Maintenance. Further observation revealed Resident #1 and S2Maintenance continued to argue with S2Maintenance walking away and coming back to hover over Resident #1 multiple times. -At 1:56:39PM, S2Maintenance pointed his finger at the side of Resident #1's face and it appeared that S2Maintenance's finger made contact with Resident #, as his head appeared to jerk back. Further observation revealed Resident #1 swung his left arm at S2Maintenance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-At 1:56:43PM, S2Maintenance put his hands out, with palms up, and motioned his fingers towards his own body as Resident #1 and S2Maintenance continued to appear to argue. Further observation revealed S2Maintenance continued to transition from walking away from Resident #1 to returning to hover over Resident #1. -At 1:57:08PM, Resident #1 appeared say something to S2Maintenance and S2Maintenance moved his face closer to Resident #1's face. Further observation revealed S2Maintenance then banged on his own chest with his hands and then pointed toward the ground. Further observation revealed S2Maintenance and Resident #1 appeared to continue to argue with S2Maintenance continuing to hover over Resident #1. -At 1:57:56PM, S4Social Worker walked into frame, and S2Maintenance then started to walk away from Resident #1, but returned and pointed his finger in Resident #1's face. -At 1:58:07PM, Resident #1 swung at S2Maintenance and appeared to hit him on the rim of his baseball cap. Further observation revealed S2Maintenace then turned towards S4Social Worker, and made a gesture with his closed fist towards Resident #1. Further observation revealed S2Maintenance then appeared to push his fist onto the side of Resident #1's face as evidenced by Resident #1's head pushing back. Further observation revealed Resident #1 and S2Maintenance continued to appear to be shouting at each other. -At 1:58:16PM, S2Maintenance pointed his finger into Resident #1's face and Resident #1 swung at S2Maintenance and grabbed S2Maintenance with his left hand. Further observation revealed S2Maintenance then tried to use his right arm to remove Resident #1's left hand from his person, and in the process, Resident #1 swung and hit S2Mainteance's right arm, causing S2Maintenance's right arm to knock back into Resident #1. Further observation revealed at this point, Resident #1 toppled over backwards in his wheelchair and hit the ground. In an interview on 11/22/2024 at 1:41PM, S1Administrator indicated he substantiated physical and verbal abuse had occurred for the above mentioned incident. S1Administrator further indicated Resident #1 was harmed by the above mentioned incident because Resident #1 had a scratch under his eye and was complaining of tenderness to the area of the scratch. In an interview on 11/25/2024 at 1:50PM, S4Social Worker indicated she called her supervisor to contact S5DON when she saw the above mentioned altercation between Resident #1 and S2Maintenance. S4Social Worker further indicated she was scared of getting hit if she got in the middle of Resident #1 and S2Maintenace because both were large men, and Resident #1 was swinging his arms, but could not see what he would have been hitting. In an interview on 11/25/2024 at 2:29PM, S5DON confirmed S2Maintenance made physical contact with Resident #1's head at 1:58:07PM on 11/19/2024 per the facility's surveillance video. S5DON further indicated Resident #1 was both physically and verbally harmed by the above mentioned incident.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47487 Based on interviews, facility document reviews, and facility policy review, it was determined that the facility failed to ensure an allegation of physical abuse was reported to the Louisiana Department of Health no later than 2 hours after the allegation was made for 1 (Resident #1) of 3 residents investigated for abuse. Findings Included: Review of the facility's policy titled, Reporting, Abuse, Neglect, Misappropriation of Property, last revised on 07/25/2023 revealed, in part, the Director of Nursing, the Assistant Administrator, and/or the Administrator shall immediately notify the designated representatives through the State Incident Management System (SIMS) within 2 hours if an allegation involved physical abuse or resulted in bodily harm or injury. Review of the provider's investigative report for physical abuse dated 11/21/2024 revealed, in part, S1Administrator received a report an altercation between S2Maintenance and Resident #1 had occurred outside in the smoking area. Further review revealed S2Maintenance stood up over Resident #1, who was sitting in a wheelchair, and started to point at him. Further review revealed S2Maintenance told Resident #1 to go dig up his dead mother and Resident #1's girlfriend had a d*ck he had been sucking on. Further review revealed Resident #1 swung at S2Maintenance, and S2Maintenance attempted to block Resident #1's swings. Further review revealed Resident #1 flipped out of his wheelchair after he grabbed S2Maintenance's chains (jewelry) and both fell to the ground. Further review revealed the allegation of physical abuse was substantiated. Further review revealed the incident occurred on 11/19/2024 at 2:00PM and was reported to the Louisiana Department of Health on 11/20/2024 at 9:35AM. Review of Resident #1's progress notes dated 11/19/2024 at 3:53PM revealed, in part, S5Director of Nursing (DON) was notified at approximately 2:00PM an incident had occurred between Resident #1 and an employee. Further review revealed Resident #1 indicated he was pushed by the employee. Further review revealed a pinpoint open area was present to Resident #1's left hand and the right side of Resident #1's face. In an interview on 11/22/2024 on 12:45PM., S5DON indicated she was notified an incident had occurred on 11/19/2024 around 2:00PM between Resident #1 and S2Maintenance. S5DON further indicated when interviewing Resident #1 after the above mentioned incident, Resident #1 indicated S2Mainteance had hit him and pushed him out of his wheelchair. S5DON further indicated Resident #1 also indicated that S2Maintence had told him his girlfriend was a man and had spoken about his mother. S5DON further indicated, during the post incident assessment, she noted a pinpoint open area of skin to the top of Resident #1's left hand and the right side of Resident #1's face. In an interview on 11/22/2024 at 1:41PM, S1Administrator indicated that he did not report the above mentioned allegation of abuse until 11/20/2024 at 9:35AM and could offer no further explanation to dispute the deficient practice.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on interview and facility document review, it was determined that the facility failed to ensure staff members received behavioral health training for 5 (S2Maintenance, S3Smoking Aide, S4Social Worker, S6Certified Nursing Assistant [CNA], and S7CNA) of 5 personnel records reviewed for required trainings. Findings Included: Review of the Facility's assessment dated [DATE] revealed, in part, the facility had 58 residents with Psychiatric Diagnoses and 14 residents required behavior management. Review of S2Maintenance's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S2Maintenance received behavioral health training. Review of S3Smoking Aide's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S3Smoking Aide received behavioral health training. Review of S4Social Worker's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S4Social Worker received behavioral health training. Review of S6CNA's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S6CNA received behavioral health training. Review of S7CNA's personnel record revealed, in part, no documented evidence, and the facility did not present any documented evidence, S7CNA received behavioral health training. In an interview on 11/25/2024 at 2:22PM, S5Director of Nursing indicated she did not have any documented evidence the above mentioned staff received behavioral health training.