

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  05/29/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure call lights were within reach for 2 (Resident #24, Resident #101) of 3 (Resident #24, Resident #64, Resident #101) sampled residents investigated for accommodation of needs.</p> <p>Findings:</p> <p>Review of the facility's Answering the Call Light policy dated 04/01/2021 with revised date of 10/01/2024 revealed, in part, it is the policy of the facility to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p> <p>Resident #24</p> <p>Review of Resident #24's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/2025 revealed, in part, Resident #24 required substantial and/or maximal assistance for self-care from staff, partial/ moderate assistance for activities of daily living (ADL) from staff and was dependent on staff for transfers.</p> <p>Observation on 05/28/2025 at 11:55AM revealed Resident #24 was lying in bed. Further observation revealed Resident #24's call light was on the floor, at the head of the bed, and out of reach of Resident #24.</p> <p>In an interview on 05/28/2025 at 12:00PM, S17Licensed Practical Nurse (LPN) confirmed Resident #24's call light was lying on the floor at the head of Resident #24's bed and was out of reach for Resident #24. S17LPN indicated it is the policy of the facility to ensure the call light is within reach of the resident.</p> <p>Resident #101</p> <p>Review of Resident #101's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/14/2025 revealed, in part, Resident #101 was dependent on staff for ADLs, transfers and mobility.</p> <p>Observation on 05/28/2025 at 11:47AM revealed Resident #101 was lying in bed and Resident #101's call light was clipped to the curtain, out of reach of Resident #101.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/28/2025 at 11:50AM, S18Certified Nursing Assistant (CNA) confirmed Resident #101's call light was clipped to the curtain, not in reach and should have been within reach of Resident #101.</p> <p>In an interview on 05/29/2025 at 4:09PM, S1Administrator indicated it is the facility's policy for call lights to be within reach at all times for all residents.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>The facility's dining room was kept in a clean/sanitary manner; and,</li> <li>The facility's hallways were kept in a clean/sanitary manner and in good repair for 3 (Hallway a, Hallway b, Hallway c) of 3 (Hallway a, Hallway b, Hallway c) hallways observed for physical environment.</li> </ol> <p>Findings:</p> <p>Review of the facility's Maintenance Service policy and procedure, with a revision date of 05/2024 revealed, in part, the functions of the facility's maintenance personnel included maintaining the building in good repair.</p> <p>Review of the facility's Environmental Services policy and procedure, with a revision date of 05/2024 revealed, in part, floors shall be maintained in clean, safe and sanitary manner.</p> <ol style="list-style-type: none"> <li> <p>Observation of the dining room on 05/27/2025 at 11:30AM revealed the following:</p> <ul style="list-style-type: none"> <li>-</li> <li>16 windows had a total of 85 dead insects, between them, on the window sills;</li> <li>-</li> <li>five of the output air vents, on the ceiling above the area where the dining room tables were, had an unknown light gray substance surrounding them; and</li> <li>-</li> <li>2 areas of wallpaper on the right side of the dining room wall leading from the entrance way, were peeling from the top of the wall, down the seam.</li> </ul> <p>Observation of the dining room on 05/29/2025 at 8:35AM revealed the following:</p> <ul style="list-style-type: none"> <li>-</li> <li>an unknown black/brown/gray particle build-up around the entrance way door jams;</li> <li>-</li> <li>a build-up of settled black/brown particles along an approximately 1 inch (in) ledge, located on the wall to the right near the entrance door, inside the dining room;</li> </ul> <p>(continued on next page)</p> </li> </ol>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-</p> <p>1 dead insect and a severed tail, resembling the tail of a reptile, in 1 window sill located on the right wall leading from the entrance of the dining room;</p> <p>-</p> <p>five of the output air vents, on the ceiling above the area where the dining room tables were, had an unknown light gray substance surrounding them; and</p> <p>-</p> <p>2 areas of wallpaper on the right side dining room wall leading from the entrance way, were peeling from the top of the wall, down the seam.</p> <p>In an interview on 05/29/2025 9:00AM, S7Housekeeping Supervisor/Dietary Manager confirmed the above observations and further indicated there should not be any dead insects or severed reptile tails in the window sills of the dining room or particle build up on the ledge inside the dining room door or around the dining room door jams.</p> <p>Observation of the dining room on 05/29/2025 at 12:10 PM revealed the following:</p> <p>-</p> <p>1 dead insect and a severed tail, resembling the tail of a reptile, in 1 window sill located on the right wall leading from the entrance of the dining room;</p> <p>-</p> <p>five of the output air vents, on the ceiling above the area where the dining room tables were, had an unknown light gray substance surrounding them; and</p> <p>-</p> <p>2 areas of wallpaper on the right side dining room wall leading from the entrance way, were peeling from the top of the wall, down the seam.</p> <p>In an interview on 05/29/2025 12:12 PM, S8Plant Operations Manager confirmed the above observations of the dining room. S8Plant Operations Manager further indicated the above findings did not present a clean homelike environment.</p> <p>2.</p> <p>Observation of Hallway b on 05/27/2025 at 9:45AM revealed the following:</p> <p>-</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>an accumulation of unknown black/brown/gray particles that began at Hallway b's front entry door jambs, continued along Hallway b's baseboards where they met the floor, surrounded the door jambs of the resident's rooms on Hallway b, and covered the lower portion of multiple resident's room doors on Hallway b; and</p> <p>-</p> <p>multiple areas of an unknown dried brown substance in a splatter and drip pattern on the walls of Hallway b; and</p> <p>-</p> <p>multiple areas of missing or damaged sheet rock on the walls throughout Hallway b.</p> <p>Observation of Hallway a on 05/28/2025 at 12:35PM revealed the following:</p> <p>-</p> <p>an accumulation of unknown black/brown/gray particles that began at Hallway a's front entry door jambs, continued along Hallway a's baseboards where they met the floor, surrounded the door jambs of the resident's rooms on Hallway a, and covered the lower one-sixth portion of multiple resident's room doors on Hallway a. Further observation revealed the above accumulation of black/brown/gray particles affected more than 50 percent (%) of the baseboards and 50% of the 36 resident's doors and door jambs located on Hallway a.</p> <p>-</p> <p>5 areas of an unknown dried brown substance in a splatter and drip pattern on the walls of Hallway a; and</p> <p>-</p> <p>more than 50 areas of missing or damaged sheet rock on the walls throughout Hallway a.</p> <p>Observation of Hallway c on 05/28/25 at 4:30PM revealed the following:</p> <p>-</p> <p>an accumulation of unknown black/brown/gray particles that began at Hallway c's front entry door jambs, continued along Hallway c's baseboards where they met the floor, surrounded the door jambs of the resident's rooms on Hallway c, and covered the lower one-sixth portion of multiple resident's room doors on Hallway c. Further observation revealed the above accumulation of black/brown/gray particles affected more than 50% of the baseboards and 50% of the 35 resident's doors and door jambs located on Hallway c.</p> <p>-</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>an unknown dried brown substance in a splatter and drip pattern on the 9 areas of the walls of Hallway c; and</p> <p>-</p> <p>more than 50 areas of missing or damaged sheet rock on the walls throughout Hallway c.</p> <p>Observation of Hallway b on 05/28/2025 at 4:36PM revealed the following:</p> <p>-</p> <p>an accumulation of unknown black/brown/gray particles that began at Hallway b's front entry door jambs, continued along Hallway b's baseboards where they met the floor, surrounded the door jambs of the resident's rooms on Hallway b, and covered the lower one-sixth portion of multiple resident's room doors on Hallway b. Further observation revealed the above accumulation of black/brown/gray particles affected more than 50% of the baseboards and 50% of the 29 resident's doors and door jambs located on Hallway b.</p> <p>-</p> <p>an unknown dried brown substance in a splatter and drip pattern on the 7 areas of the walls of Hallway b; and</p> <p>-</p> <p>50 areas of missing or damaged sheet rock on the walls throughout Hallway b.</p> <p>Observation on 05/29/2025 at 9:00AM revealed the bottom of the metal exit door near the facility's dining room was rusted and cracked and had a scattered pattern of rust spots on the bottom one-half of the door.</p> <p>In an interview on 05/29/2025 at 9:00AM, S7Housekeeping Supervisor/Dietary Manager confirmed the above observations of Hallway a, Hallway b and Hallway c's walls, baseboards, door jambs, and resident's doors. S7Housekeeping Supervisor/Dietary Manager further acknowledged the above mentioned areas were not maintained as required. S7Housekeeping Supervisor/Dietary Manager further confirmed it was the facility's housekeeping department's responsibility to clean floors, door jambs, baseboards and walls, and the facility's maintenance department's responsibility to repair sheet rock, walls, and handrails.</p> <p>In an interview on 05/29/2025 at 9:10AM, S8Plant Operations Manager confirmed above observations of Hallway a, Hallway b and Hallway c's walls, baseboards, door jambs, and resident's doors and exit door near dining room. S8Plant Operations Manager acknowledged the door jambs, baseboards/floor junctions, resident's doors and hallway's walls should be clean and the sheetrock to Hallway a, Hallway b and Hallway c should have been repaired and was not. S8Plant Operations Manager acknowledged the above mentioned observations did not present a clean/homelike environment at present. S8Plant Operations Manager further acknowledged the building had a lot of needed maintenance repairs.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/29/2025 at 10:36AM, S1Administrator acknowledged Hallway a, Hallway b and Hallway c's walls, baseboards, door jambs, and resident's doors should have been clean and the sheetrock to Hallway a, Hallway b and Hallway c should have been repaired and was not. S1Administrator further acknowledged the above mentioned observations did not present a clean/homelike environment at present.</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>Based on interview and record review, the facility failed to ensure the annual Minimum Data Set (MDS) Assessment was transmitted within the required timeframe after completion for 1 (Resident #69) of 1 (Resident #69) sampled resident reviewed for assessment transmission.</p> <p>Findings:</p> <p>Review of Resident #69's annual MDS Assessment Section Z - Assessment Administration revealed, in part, Resident #69's annual MDS Assessment was completed and electronically signed by the Registered Nurse (RN) Assessment Coordinator on 04/17/2025.</p> <p>Review of the Final Validation Report dated 05/29/2025 revealed, in part, Resident #69's annual MDS Assessment was not submitted to the Centers for Medicare &amp; Medicaid Services (CMS) database until 05/29/2025.</p> <p>In an interview on 05/29/2025 at 8:24AM, S11Registered Nurse (RN) indicated Resident #69's annual MDS Assessment was completed on 04/17/2025 but was not transmitted until 05/29/2025. S11RN further indicated that the assessment should have been transmitted within 7 days of the completion date but was not as required.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on interview and record reviews the facility failed to ensure a resident's Minimum Data Set (MDS) assessment reflected the resident's accurate discharge status for 1 (Resident #111 ) of 3 (Resident #109, Resident #110, Resident #111 ) sampled residents investigated for closed records.</p> <p>Findings:</p> <p>Review of Resident #111's Discharge MDS with an Assessment Reference Date (ARD) of 03/12/2025 revealed, in part, Resident #111 was discharged to a short term general hospital.</p> <p>Review of Resident #111 progress note dated 3/12/2025 revealed Resident #111 had a planned discharge to home.</p> <p>In an interview on 05/29/2025 at 11:26AM, S11Registered Nurse (RN), MDS Coordinator confirmed Resident #111's discharge MDS with ARD of 03/12/2025 indicated Resident #11 was discharged to a short term general hospital and was incorrect. S11RN, MDS Coordinator indicated Resident #111 was discharged to home.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to administer a medication per a physician's orders for 1 (Resident #91) of 5 (Resident #2, Resident #29, Resident #91, Resident #101, Resident #162) residents reviewed for unnecessary medication review.</p> <p>Findings:</p> <p>Review of the scope of Practice of Practical Nursing defined in Section 961 of Chapter 11, Louisiana Revised Statutes revealed the licensed practical nurse must practice under the direction of, in part, a licensed physician.</p> <p>Review of Resident #91's Electronic Medical Record (EMR) revealed, in part, Resident #91 was admitted on [DATE] with diagnoses, which included, cerebrovascular vasospasm and vasoconstriction; diabetes mellitus; essential (primary) hypertension; malignant melanoma of skin of breast; anxiety disorder, unspecified; morbid (severe) obesity due to excess calories; and major depressive disorder.</p> <p>Review of Resident #91's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/2025 revealed, in part, Resident #91 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #91 was cognitively intact.</p> <p>Review of Resident #91's May 2025 physician's orders revealed, in part, an order to administer Resident #91 one alprazolam (a medication used to treat anxiety disorder) 0.5 milligrams (mg) tablet orally at bedtime.</p> <p>Review of Resident #91's May 2025 eMAR (electronic Medication Administration Record) revealed Resident #91's alprazolam was not administered on 05/19/2025 and 05/20/2025.</p> <p>Review of Resident #91's alprazolam 0.5 mg Individual Narcotic Record, revealed, in part, no documented evidence Resident #91 was administered alprazolam 0.5 mg on 05/19/2025, and an undated line of an administration of Resident #91's alprazolam 0.5 mg between 05/22/2025 and 05/25/2025.</p> <p>In an interview on 05/29/2025 at 10:10AM, S3Director of Nursing (DON) confirmed Resident #91 was not administered alprazolam as ordered on 2 days between 05/19/2025 and 05/24/2025. S3DON further indicated the facility could not provide documented evidence that Resident #91's alprazolam 0.5mg was administered daily to Resident #91 as ordered. S3DON further indicated Resident #91's alprazolam 0.5 mg Individual Narcotic Record revealed Resident #91 was only administered 14 tablets of alprazolam 0.5 mg in the 16 day period from 05/13/2025 to 05/28/2025.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview and record reviews, the provider failed to ensure a Registered Nurse (RN) worked at least 8 hours for 1 (04/19/2025) of 22 (04/19/2025, 04/20/2025, 04/26/2025, 04/27/2025, 05/03/2025, 05/04/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/15/2025, 05/16/2025, 05/17/2025, 05/18/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/24/2025, 05/25/2025) days reviewed for staffing requirements.</p> <p>Findings:</p> <p>Review of the facility's weekend Nursing/Ancillary Personnel Staffing Pattern Reporting Form, dated 04/19/2025 through 05/25/2025, signed as complete and accurate by S1Administrator on 05/27/2025 revealed, in part, one RN worked on 04/19/2025.</p> <p>Review of the facility's time sheets dated 04/19/2025 revealed, in part, S2Director of Nursing (DON) was the only RN with a time clock entry for 04/19/2025. Further review revealed, S2DON clocked in at 9:01AM and clocked out on 11:13AM.</p> <p>In an interview on 05/29/2025 at 10:45AM, S2DON confirmed she was the only RN that worked on 04/19/2025. S2DON further indicated she was unable to provide any documented evidence she worked at least 8 hours on 04/19/2025.</p> <p>There was no documented evidence, and the provider was unable to present any documented evidence, an RN worked at least 8 hours as required on 04/19/2025.</p> <p>In an interview on 05/29/2025 at 11:00AM, S1Administrator was presented with the above mentioned findings and could offer no explanation as to why an RN did not work at least 8 hours as required on 04/19/2025.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interviews and record reviews, the facility failed to maintain a system to accurately reconcile controlled substances for 6 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d, Medication Cart e, Medication Cart f) of 6 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d, Medication Cart e, Medication Cart f) medication carts reviewed for the reconciliation documentation of controlled substances.</p> <p>Findings:</p> <p>Review of the facility's May 2025 Medication Cart a Narcotic Nurse Sign on/off log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart a's controlled substances with the oncoming nurse on:</p> <ul style="list-style-type: none"> <li>- 05/01/2025 for the 7:00PM to 7:00AM shift; and,</li> <li>- 05/22/2025 for the 7:00AM to 7:00PM shift.</li> </ul> <p>Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart a's controlled substances with the off going nurse on 05/01/2025 for the 7:00PM to 7:00AM shift. Further review on 05/29/2025 at 1:57PM revealed S13Licensed Practical Nurse's (LPN) signature that indicated Medication Cart a's controlled medications had been reconciled by the off going nurse on 05/29/2025 for the 7:00PM to 7:00AM shift</p> <p>There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart a for the above mentioned dates and/or times.</p> <p>Review of the facility's May 2025 Medication Cart b Narcotic Nurse Sign on/off log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart b's controlled substances with the oncoming nurse on:</p> <ul style="list-style-type: none"> <li>- 05/13/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/14/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/18/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/27/2025 for the 7:00AM to 7:00PM shift; and,</li> <li>- 05/29/2025 for the 7:00PM to 7:00AM shift.</li> </ul> <p>Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart b's controlled substances with the off going nurse on:</p> <ul style="list-style-type: none"> <li>- 05/15/2025 for the 7:00PM to 7:00AM shift;</li> </ul> <p>(continued on next page)</p>		

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  05/29/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 05/27/2025 for the 7:00AM to 7:00PM shift; and,</p> <p>- 05/28/2025 for the 7:00PM to 7:00AM shift.</p> <p>There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart b for the above mentioned dates and/or times.</p> <p>Review of the facility's May 2025 Medication Cart c Narcotic Nurse Sign on/off log revealed, in part, there was not a signature of both the off going nurse and on oncoming nurse indicating the off going and oncoming nurses had reconciled Medication Cart c's controlled substances together on:</p> <p>- 05/01/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/01/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/02/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/02/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/03/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/03/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/04/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/04/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/05/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/05/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/06/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/06/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/07/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/07/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/08/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/08/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/09/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/09/2025 for the 7:00PM to 7:00AM shift;</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- 05/10/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/10/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/11/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/11/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/12/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/12/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/13/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/14/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/14/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/15/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/15/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/16/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/16/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/17/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/17/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/18/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/18/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/19/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/19/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/20/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/20/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/21/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/21/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/22/2025 for the 7:00AM to 7:00PM shift;</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 05/22/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/23/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/23/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/24/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/24/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/25/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/25/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/26/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/26/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/27/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/28/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/28/2025 for the 7:00PM to 7:00AM shift; and,</p> <p>- 05/29/2025 for the 7:00AM to 7:00PM shift.</p> <p>Further review revealed there was no signature that indicated Medication Cart c's controlled medications had been reconciled on:</p> <p>- 05/13/2025 for the 7:00AM to 7:00PM shift; and,</p> <p>- 05/27/2025 for the 7:00PM to 7:00AM shift.</p> <p>Further review on 05/29/2025 at 1:45PM revealed a nurse's signature that indicated Medication Cart c's controlled medications had been reconciled on 05/29/2025 for the 7:00PM to 7:00AM shift.</p> <p>There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart c for the above mentioned dates and/or times.</p> <p>Review of the facility's May 2025 Medication Cart d Narcotic Nurse Sign on/off log revealed, in part, there was not a signature of both the off going nurse and on oncoming nurse indicating the off going and oncoming nurses had reconciled Medication Cart d's controlled substances together on:</p> <p>- 05/01/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/01/2025 for the 7:00PM to 7:00AM shift;</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- 05/02/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/02/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/03/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/03/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/04/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/04/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/05/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/06/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/07/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/07/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/08/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/09/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/09/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/10/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/10/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/11/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/11/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/12/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/12/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/13/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/13/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/14/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/14/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/15/2025 for the 7:00AM to 7:00PM shift;</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- 05/15/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/16/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/16/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/17/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/17/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/18/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/18/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/19/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/19/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/20/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/20/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/21/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/22/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/23/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/23/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/24/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/24/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/25/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/25/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/26/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/26/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/27/2025 for the 7:00AM to 7:00PM shift;</li> <li>- 05/27/2025 for the 7:00PM to 7:00AM shift;</li> <li>- 05/28/2025 for the 7:00AM to 7:00PM shift;</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 Haynes Blvd. New Orleans, LA 70128	

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 05/28/2025 for the 7:00PM to 7:00AM shift; and,</p> <p>- 05/29/2025 for the 7:00AM to 7:00PM shift.</p> <p>Further review revealed there was no signature that indicated Medication Cart d's controlled medications had been reconciled on:</p> <p>- 05/05/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/06/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/08/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/21/2025 for the 7:00AM to 7:00PM shift; and,</p> <p>- 05/22/2025 for the 7:00AM to 7:00PM shift.</p> <p>There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart d for the above mentioned dates and/or times.</p> <p>Review of the facility's May 2025 Medication Cart e Narcotic Nurse Sign on/off log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart e's controlled substances with the oncoming nurse on:</p> <p>- 05/13/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/16/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/19/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/22/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/24/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/26/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/27/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/28/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/28/2025 for the 7:00AM to 7:00PM shift; and,</p> <p>- 05/29/2025 for the 7:00PM to 7:00AM shift.</p> <p>Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart e's controlled substances with the off going nurse on:</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 05/01/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/13/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/18/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/23/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/27/2025 for the 7:00PM to 7:00AM shift; and,</p> <p>- 05/28/2025 for the 7:00PM to 7:00AM shift.</p> <p>There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart e for the above mentioned dates and/or times.</p> <p>Review of the facility's May 2025 Medication Cart f Narcotic Nurse Sign on/off log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart f's controlled substances with the oncoming nurse on:</p> <p>- 05/12/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/12/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/13/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/13/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/14/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/21/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/22/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/24/2025 for the 7:00AM to 7:00PM shift;</p> <p>- 05/25/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/25/2025 for the 7:00AM to 7:00PM shift; and,</p> <p>- 05/27/2025 for the 7:00PM to 7:00AM shift.</p> <p>Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart f's controlled substances with the off going nurse on:</p> <p>- 05/12/2025 for the 7:00PM to 7:00AM shift;</p> <p>- 05/13/2025 for the 7:00PM to 7:00AM shift;</p> <p>(continued on next page)</p>		

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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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation and interview, the facility failed to ensure a nurse secured medications when unattended for 1 (Medication Cart b) of 6 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d, Medication Cart e, Medication Cart f) medication carts reviewed for medication storage.</p> <p>Findings:</p> <p>Observation on 05/27/2025 at 12:22PM, revealed Medication Cart b was left unlocked and unattended. Further observation revealed the following medications were present on the top of Medication Cart b and unsecured: 55 tablets of metoprolol tartrate (a medication used to treat high blood pressure and chest pain) 25 milligrams (mg) and two vials of Zosyn (a medication used to treat infections) 4.5 grams. Further observation revealed S16Licensed Practical Nurse (LPN) (the nurse responsible for Medication Cart b) was sitting at the nursing desk with her back turned to Medication Cart b. Further observation revealed Medication Cart b was left unattended by S16 LPN for 10 minutes.</p> <p>In an interview on 05/27/2025 at 12:33PM, S16LPN acknowledged she should not have the above mentioned medications and Medication Cart b unattended with the medications unsecured without proper supervision.</p> <p>In an interview on 05/29/25 at 8:35AM, S3Director of Nursing (DON) indicated the above mentioned medications should not have been left on top of Medication Cart b and unattended by the nurse. S3DON further indicated Medication Cart b should have been locked when not supervised.</p>		

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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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review the facility failed to:</p> <ol style="list-style-type: none"> <li>ensure food stored in the facility's walk in cooler was properly dated and labeled,</li> <li>ensure the dishwasher temperature and sanitizer log was properly maintained.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy for Food Receiving and Storage, with a revision date of 05/2024 revealed, in part, refrigerated foods are covered, labeled, and dated.</li> </ol> <p>An initial kitchen observation on 05/27/2025 at 8:25AM revealed the following:</p> <ul style="list-style-type: none"> <li>- 1 container of cooked carrots in a container covered with saran wrap not dated,</li> <li>- 1 container of barbeque sauce covered with saran wrap not dated and,</li> <li>- 14 styrofoam containers of chicken noodle soup were not dated</li> </ul> <p>In an interview on 05/27/2025 at 8:28AM, S7Dietary Manager confirmed the above mentioned containers of food should have been labeled and dated but were not.</p> <ol style="list-style-type: none"> <li>Review of the facility's policy titled Dishwashing Machine Use, with a revision date of 10/01/2024 revealed, in part, a supervisor will check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [ppm]) after filling the dishwashing machine. Concentrations will be recorded in an approved facility log. Further policy review revealed the operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log.</li> </ol> <p>An observation on 05/29/25 at 8:13AM, revealed the facility's dishwashing water temperature/sanitizer record was last documented on 05/20/2025 under the column listed for lunch. Further review revealed there was no documentation that the water temperature or sanitizer was checked prior to dishwashing after dinner was served on 05/20/2025.</p> <p>In an interview on 05/29/2025 at 8:26AM, S7Dietary Manager indicated the dishwashing temperature/sanitizer record should be documented on prior to dishwashing after breakfast, lunch, and dinner daily. S7Dietary Manager also confirmed the facility's dishwashing water temperature/sanitizer record was not documented from 05/20/2025 at lunch until 05/29/2025 at breakfast and it should have been.</p> <p>In an interview on 05/29/2025 at 8:40AM, S1Administrator indicated, the dishwasher water temperature/sanitizer record should have been completed on 05/20/2025 prior to dishwashing after dinner through 05/29/2025 but was not.</p>		

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NAME OF PROVIDER OR SUPPLIER  Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 Haynes Blvd. New Orleans, LA 70128	

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and record review, the facility failed to ensure the facility assessment included specific nursing staffing needs for day, night, and weekend shifts.</p> <p>Findings:</p> <p>Review of the facility's facility assessment, last updated on 05/07/2025 revealed, in part, there was no documented evidence the facility assessment included specific staffing needs of its resident population for Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA) for day, night, and weekend shifts.</p> <p>In an interview on 05/29/2025 at 11:00AM, S1Administrator was presented with the above mentioned findings and could offer no explanation as to why the facility assessment did not include specific LPN and CNA staffing needs for day, night, and weekend shifts.</p>

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NAME OF PROVIDER OR SUPPLIER  Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 Haynes Blvd. New Orleans, LA 70128	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure the Quality Assurance and Assessment (QAA) committee met at least quarterly; and</li> <li>2. Ensure the designated Infection Preventionist participated in the quarterly QAA meeting.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's QAA meeting sign-in sheet revealed the most recent QAA committee meeting was held on 04/09/2025. Further review revealed the prior QAA committee meeting was held on 10/09/2024.</li> </ol> <p>There was no documentation of a QAA meeting being conducted during the 1st quarter of 2025 (January-March) and the facility did not present any documented evidence a QAA meeting was held for the period of Jan-[DATE].</p> <ol style="list-style-type: none"> <li>2. Review of the Quarterly QAA meeting minutes dated 04/09/2025 revealed the Infection Preventionist (IP) was not documented on the sign-in sheet as being in attendance at the meeting.</li> </ol> <p>In an interview on 05/28/2025 at 3:01PM, S3Director of Nursing (DON) indicated the Infection Preventionist did not attend the 04/09/2025 QAA meeting. S3DON further indicated the committee failed to meet during the 1st quarter of 2025 and should have as required.</p>		

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NAME OF PROVIDER OR SUPPLIER  Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 Haynes Blvd. New Orleans, LA 70128	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, and records reviews, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Store clean mop heads in the clean linen area of the facility's laundry room;</li> <li>2. Store clean linen in a sanitary manner; and,</li> <li>3. Ensure residents' suction canisters were changed on the scheduled change date for 2 (Resident #62, Resident #82) of 2 (Resident #62, Resident #82) sampled residents reviewed for infection control.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. <ul style="list-style-type: none"> <li>Observation on 05/27/2025 at 10:00AM revealed, the facility's clean mop heads were stored in an open container next to an open container of dirty mop heads, and adjacent to containers of dirty laundry in the facility's contaminated laundry area.</li> <li>In an interview on 05/27/2025 at 10:01AM, S9Housekeeper indicated the mop heads stored in the above mentioned open container in the facility's contaminated laundry area were clean and ready to be used.</li> <li>In an interview on 05/27/2025 at 10:03AM, S10Housekeeper indicated the clean mop heads were normally stored in the above mentioned open container next to the dirty mop heads in the facility's contaminated laundry area.</li> <li>In an interview on 05/27/2025 at 10:04AM, S7Housekeeping Supervisor/Dietary Manager (HS/DM) confirmed the clean mop heads were stored in an open container next to the dirty mop heads in the facility's contaminated laundry area and should not have been.</li> <li>Observation on 05/28/2025 at 9:30AM revealed, the facility's clean mop heads were stored in an open container next to an open container of dirty mop heads, and adjacent to containers of dirty laundry in the facility's contaminated laundry area.</li> <li>In an interview on 05/29/2025 at 11:20AM, S1Administrator was presented with the above mentioned findings and could offer no explanation as to why the clean mop heads were stored in the facility's contaminated laundry area.</li> </ul> </li> <li>2. <ul style="list-style-type: none"> <li>Review of the facility's Infection Control policy and procedure, dated 11/22/2022, revealed, in part, linens should be properly handled, stored, processed, and transported to prevent the spread of infection.</li> <li>Observation of the facility's Hallway b on 05/28/2025 at 9:37AM revealed a storage container of soiled linen covered with a resident gown next to an open cart of clean linen and supplies.</li> </ul> </li> </ol> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 Haynes Blvd. New Orleans, LA 70128	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/28/2025 at 9:40AM, S15Certified Nursing Assistant (CNA) confirmed the storage container on Hallway b covered with a resident gown contained contaminated dirty linen and was next to an open cart of clean linen.</p> <p>Observation of the facility's Hallway c on 05/28/2025 at 9:54AM revealed a storage container of contaminated linen covered with a sheet next to an open cart of clean linen and supplies.</p> <p>Observation of the facility's Hallway a on 05/28/2025 at 9:55AM revealed a storage container of contaminated linen covered with a sheet next to and touching an open cart of clean linen and supplies.</p> <p>In an interview on 05/28/2025 at 9:56AM, S12Licensed Practical Nurse (LPN) indicated it was common practice for the facility's CNAs to place clean linen and contaminated linen next to each other while changing the residents' linen. S12LPN further indicated the contaminated linen should be covered with a lid and not stored next to the clean linen.</p> <p>In an interview on 05/28/2025 at 10:00AM, S7HS/DM confirmed clean linen should be covered with a lid at all times. S7HS/DM further confirmed clean linen should not be kept next to contaminated linen.</p> <p>In an interview on 05/29/2025 at 11:20AM, S1Administrator was presented with the above mentioned findings and could offer no explanation as to why clean linen was stored in an open cart next to contaminated linen in the hallways of the facility.</p> <p>3.</p> <p>Review of the facility's undated suction canister change schedule revealed, in part, suction canisters are be changed on Tuesdays, Thursdays, and Saturdays.</p> <p>Observation on 05/27/2025 at 10:24AM revealed Resident #62's suction canister was dated 05/22/2025. Further observation revealed Resident #62's suction canister contained a white and yellow liquid.</p> <p>Observation on 05/28/2025 at 1:20PM revealed Resident #82's suction canister was dated 05/22/2025. Further observation revealed Resident #82's suction canister contained a white and yellow liquid.</p> <p>In an interview on 05/28/2025 at 1:25PM S4Respiratory Director (RD) indicated suction canisters should be changed on Tuesdays, Thursdays and Saturdays. S4RD further indicated that a suction canister dated 05/22/2025 should have been changed on 05/24/2025 and again on 05/26/2025 but was not.</p>		