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	05/20/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews, the facility failed to provide silverware at meal service.Findings:Observation on 05/19/2026 at 11:28AM revealed 15 unidentified residents ate lunch in the dining room. Further observation revealed the 15 residents were provided with disposable cutlery.On 05/19/2026 at 10:30AM a Resident Council meeting was held with Resident #11, Resident #27, Resident #55, Resident #89, and Resident #136.In an interview on 05/19/2026 at 10:57AM, Resident #11 indicated they were almost always provided disposable cutlery for meal service.In an interview on 05/19/2026 at 10:58AM, Resident #136 indicated they were almost always provided disposable cutlery for meal service.In an interview on 05/19/2026 at 10:58AM, Resident #11 indicated he did not like to use a disposable knife during meals. Resident #11 further indicated it was difficult to cut food with a disposable knife.In an interview on 05/19/2026 at 11:00AM, Resident #136 indicated she did not care to use disposable cutlery for meals. Resident #136 indicated there have been times when the disposable fork had cracked in half during her meal.In an interview on 05/20/2026 at 9:55AM, S12Dietary Supervisor indicated the residents were provided with disposable cutlery at least 1 to 2 days a week because the silverware was not returned to the kitchen in a timely manner. In an interview on 05/20/2026 at 10:10AM, S1Administrator indicated the facility had to use disposable cutlery at times because the silverware was either thrown away by residents and staff or the silverware was not returned to the kitchen. S1Administrator indicated the use of disposable cutlery was a dignity concern.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record reviews, the facility failed to maintain a system to accurately reconcile controlled substances for 4 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d) of 4 sampled medication carts reviewed for controlled substance documentation requirements. Findings:Review of the facility's Controlled Substances policy and procedure, dated 09/01/1994, and revised on 06/11/2025, revealed, in part, controlled medications were counted at the end of each shift. Further review revealed the nurse coming on duty and the nurse going off duty determined the count together. Review of the facility's May 2026 Medication Cart a Narcotic Nurse Sign 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:- 05/06/2026 for the 7:00PM to 7:00AM shift; - 05/10/2026 for the 7:00AM to 7:00PM shift; and,- 05/12/2026 for the 7:00AM to 7:00PM shift.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 05/15/2026 for the 7:00PM to 7:00AM shift.In an interview on 05/19/2026 at 8:40AM, S11Licensed Practical Nurse (LPN) indicated the Narcotic Nurse Sign Off Log should have been signed by the off going and oncoming nurse during shift change daily to indicate a correct and accurate count of all controlled substances.Review of the facility's May 2026 Medication Cart b Narcotic Nurse Sign 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:- 05/04/2026 for the 7:00PM to 7:00AM shift; - 05/08/2026 for the 7:00AM to 7:00PM shift;- 05/09/2026 for the 7:00AM to 7:00PM shift;- 05/09/2026 for the 7:00PM to 7:00AM shift;- 05/10/2026 for the 7:00AM to 7:00PM shift;- 05/12/2026 for the 7:00AM to 7:00PM shift;- 05/13/2026 for the 7:00AM to 7:00PM shift;- 05/13/2026 for the 7:00PM to 7:00AM shift;- 05/14/2026 for the 7:00AM to 7:00PM shift;- 05/18/2026 for the 7:00AM to 7:00PM shift; and,- 05/18/2026 for the 7:00PM to 7:00AM shift.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:- 05/08/2026 for the 7:00AM to 7:00PM shift;- 05/09/2026 for the 7:00AM to 7:00PM shift;- 05/10/2026 for the 7:00AM to 7:00PM shift;- 05/12/2026 for the 7:00AM to 7:00PM shift;- 05/13/2026 for the 7:00AM to 7:00PM shift;- 05/14/2026 for the 7:00AM to 7:00PM shift; and,- 05/18/2026 for the 7:00AM to 7:00PM shift.Review of the facility's May 2026 Medication Cart c Narcotic Nurse Sign Off Log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart c's controlled substances with the oncoming nurse on:- 05/05/2026 for the 7:00AM to 7:00PM shift.- 05/12/2026 for the 7:00PM to 7:00AM shift; - 05/14/2026 for the 7:00AM to 7:00PM shift; and,- 05/17/2026 for the 7:00AM to 7:00PM shift.Review of the facility's May 2026 Medication Cart d Narcotic Nurse Sign Off Log revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart d's controlled substances with the oncoming nurse on:- 05/04/2026 for the 7:00AM to 7:00PM shift;- 05/05/2026 for the 7:00AM to 7:00PM shift;- 05/12/2026 for the 7:00AM to 7:00PM shift;- 05/13/2026 for the 7:00AM to 7:00PM shift;- 05/14/2026 for the 7:00AM to 7:00PM shift;- 05/16/2026 for the 7:00AM to 7:00PM shift;- 05/17/2026 for the 7:00AM to 7:00PM shift;- 05/17/2026 for the 7:00PM to 7:00AM shift; and,- 05/18/2026 for the 7:00AM to 7:00PM shift.Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart d's controlled substances with the off going nurse on:- 05/06/2026 for the 7:00AM to 7:00PM shift;- 05/09/2026 for the 7:00AM to 7:00PM shift;- 05/13/2026 for the 7:00AM to 7:00PM shift; and,- 05/18/2026 for the 7:00AM to 7:00PM shift.In an interview on 05/20/2026 at 1:30PM, S2Director of Nursing (DON) confirmed off going and oncoming nurses were required to perform a count of the controlled substances at shift change together and sign the Narcotic Nurse Sign Off Log to indicate the medication cart's controlled substance count was conducted and there were no discrepancies.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to:1. Ensure insulin (a medication that lowers blood glucose) multi-dose flex pens were dated when opened and/or removed from refrigerated storage or discarded as required (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d); and,2. Ensure opened, unpackaged, and/or unlabeled medication was not stored inside a medication cart (Medication Cart a).This deficient practice was identified for 4 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d) of 4 sampled medication carts observed for medication storage requirements. Findings:1.Review of the facility's Administering Medications policy and procedure, dated [DATE] and revised on [DATE], revealed, in part, when opening a multi dose container, the date the medication was opened should be recorded on the container. Review of the facility's Insulin Pen Administration policy and procedure, dated [DATE] and revised on [DATE], revealed, in part, opened insulin pens could only be kept at room temperature for up to 28 days. Further review revealed the opening date should be marked on the insulin pen to track expiration. Observation of Medication Cart a on [DATE] at 8:30AM revealed the following:-Resident #71's open insulin Lispro (a fast-acting insulin medication) multi-dose flex pen did not have an open date documented; -Resident #71's open insulin Lantus (a long-acting insulin medication) multi-dose flex pen did not have an open date documented;-Resident #131's open insulin Lantus multi-dose flex pen did not have an open date documented; and,-Resident #131's open insulin Novolog (a fast-acting insulin medication) multi-dose flex pen did not have an open date documented. In an interview on [DATE] at 8:40AM, S11Licensed Practical Nurse (LPN) indicated the above-mentioned multi-dose flex pens of insulin were opened, stored at room temperature, and should have been labeled with an opened date. S11LPN further indicated she did not know when the above-mentioned multi-dose flex pens of insulin were opened; therefore, the above-mentioned multi-dose flex pens of insulin in Medication Cart a should have not been available for resident use. Observation of Medication Cart b on [DATE] at 9:15AM revealed the following:-Resident #22's open insulin Novolog multi-dose flex pen did not have an opened date documented; and,-Resident #72's open insulin Novolog multi-dose flex pen did not have an opened date documented. In an interview on [DATE] at 9:20AM, S9LPN indicated the above-mentioned multi-dose flex pens of insulin were opened, stored at room temperature, and should have been labeled with an opened date. S9LPN further indicated she did not know when the above-mentioned multi-dose flex pens of insulin were opened; therefore, the above-mentioned multi-dose flex pens of insulin in Medication Cart b should have not been available for resident use. Observation of Medication Cart c on [DATE] at 9:40AM revealed the following:-Resident #127's open insulin Lantus multi-dose flex pen had an open date of [DATE] documented; and,-Resident #134's open insulin Novolog multi-dose flex pen did not have an opened date documented. In an interview on [DATE] at 9:45AM, S7LPN indicated Resident #127's insulin medication was opened, stored at room temperature, expired, available for use, and should not have been. S7LPN further indicated Resident #134's opened and undated insulin should not have been available for use. Observation of Medication Cart d on [DATE] at 9:54AM revealed Resident #90's open insulin Lantus multi-dose flex pen did not have an open date documented. In an interview on [DATE] at 10:00AM, S8LPN indicated Resident #90's multi-dose flex pen of insulin was opened, stored at room temperature, and should have been labeled with an opened date. S8LPN further indicated Resident #90's above-mentioned multi-dose flex pen of insulin should have not been available for resident use. In an interview on [DATE] at 1:30PM, S2Director of Nursing (DON) confirmed the above- mentioned insulin multi-dose vials should have been dated when opened and discarded 28 days after opening per the nursing standards of care. 2. Review of the facility's Storage of Medications policy and procedure, dated [DATE] and revised on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], revealed, in part, drugs and biologicals should be stored in the packaging, containers, or other dispensing systems which they were received. Further review revealed, drugs that had missing, incomplete, or incorrect labels were to be returned to the pharmacy for proper labeling before storing. Observation of Medication Cart a on [DATE] at 8:30AM revealed 1 large oval white tablet and 1 small round off white pill stored in a medicine cup in the top left drawer of Medication Cart a.In an interview on [DATE] at 8:40AM, S11LPN indicated she did not know what the 2 uncontained and unidentified pills found in Medication Cart a were. S11LPN further indicated the 2 unidentified pills should not have been uncontained and unlabeled in Medication Cart a.In an interview on [DATE] at 1:30PM, S2Director of Nursing (DON) confirmed opened, unlabeled, loose medication should not have been stored in Medication Cart a.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to:1. Ensure staff wore proper Personal Protective Equipment (PPE) while performing care for residents on Enhanced Barrier Precautions (EBP) (Resident #4, Resident #37); and,2. Ensure staff completed hand hygiene and wore proper PPE during the administration of an injection (Resident #131).This deficient practice was identified for 3 (Resident #4, Resident #37, Resident #131) of 6 sampled residents observed for infection control practices. Findings:Review of the facility's Enhanced Barrier Precautions policy and procedure, dated 04/01/2024 and revised on 05/05/2025, revealed, in part, EBP was utilized to prevent the spread of multi-drug resistant organisms to residents. Further review revealed EBPs employed targeted gown and glove use during high contact resident care activities when contact precautions did not otherwise apply. Further review revealed examples of high contact resident care activities which required the use of gown and gloves included changing linens, changing briefs or assisting with toileting, and device care such as a urinary catheter care. 1.Resident #4Review of Resident #4's May 2026 physician's orders revealed, in part, an order dated 03/09/2026 for EBP. Observation of Resident #4's room door on 05/18/2026 at 9:25AM revealed EBP signage which indicated gowns were required for high contact care activities such as incontinence care and changing linens. Observation on 05/18/2026 at 9:42AM revealed S18Certified Nursing Assistant (CNA) and S19CNA performed Resident #4's incontinence care and linen change without either S18CNA or S19CNA wearing a gown. In an interview on 05/18/2026 at 10:00AM, S18CNA indicated she did not wear a gown when she performed Resident #4's incontinence care and should have. In an interview on 05/20/2026 at 1:30PM, S2Director of Nursing (DON) indicated S18CNA and S19CNA should have worn a gown when incontinence care and the linen change was provided to Resident #4. Resident #37Review of Resident #37's record revealed, in part, Resident #37 was admitted to the facility on [DATE] with a diagnosis of dependence on respirator with a tracheostomy. Review of Resident #37's May 2026 physician's orders revealed, in part, an order dated 04/27/2026 for EBP. Observation of Resident #37's room door on 05/18/2026 at 9:39AM revealed EBP signage which indicated gowns were required for high contact care activities such as incontinence care and changing linens. Observation on 05/18/2026 at 9:39AM revealed S22CNA drained urine from Resident #37's urine collection bag without S22CNA wearing a gown. In an interview on 05/18/2026 at 9:40AM, S22CNA indicated the EBP sign on Resident #37's door was not for Resident #37, so there was no need to wear a gown. 2. Resident #131Review of the facility's Handwashing/Hand Hygiene policy and procedure, dated 09/01/1994 and revised on 05/11/2025, revealed, in part, single use disposable gloves were indicated before aseptic procedures and when anticipating coming into contact with blood or bodily fluids. Further review revealed hand hygiene was required to be performed prior to medication administration. Observation on 05/19/2026 at 8:21AM revealed S11Licensed Practical Nurse (LPN) administered Resident #131's Novolog (an insulin medication injected into the body to lower blood sugar) Novolog flex pen injection without performing hand hygiene and/or wearing gloves. In an interview on 05/19/2026 at 8:25AM, S11LPN indicated she did not perform hand hygiene and/or wear gloves to administer Resident #131's Novolog flex pen injection. S11LPN further indicated she did not normally wear gloves to administer an insulin injection to residents.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents' tube feeding pumps were clean and sanitary for 3 (Resident #4, Resident #35, Resident #106) of 33 sampled residents reviewed for environmental concerns during the initial pool observations. Findings: Review of the facility's Homelike Environment policy and procedure, dated [DATE] and revised on [DATE], revealed, in part, residents were provided with a clean, comfortable, and homelike environment. Further review revealed the facility staff maximized to the extent possible, a clean, sanitary and orderly environment. Resident #4 Observation on [DATE] at 1:20PM revealed the base of Resident #4's tube feeding pole and the surrounding floor was covered with an unidentified dried tan substance. Further observation revealed an unidentified dried sticky tan substance was present on the side and top of Resident #4's tube feeding pump. Observation on [DATE] at 10:40AM revealed numerous spots, varying in size, of an unidentified dried sticky tan substance on the base of Resident #4's tube feeding pole. Further observation revealed an unidentified dried sticky tan substance was present on the side and top of Resident #4's tube feeding pump. Observation on [DATE] at 9:00AM revealed numerous spots, varying in size, of an unidentified dried sticky tan substance on the base of Resident #4's tube feeding pole. Further observation revealed an unidentified dried sticky tan substance was present on the side and top of Resident #4's tube feeding pump. Resident #35 Observation on [DATE] at 1:00PM revealed the base of Resident #35's tube feeding pole and surrounding floor was covered with an unidentified dried tan substance. Further observation revealed an unidentified dried sticky tan substance was present on the sides of Resident #35's tube feeding pump. Observation on [DATE] at 10:30AM revealed numerous spots, varying in size, of an unidentified dried sticky tan substance on the base of Resident #35's tube feeding pole. Further observation revealed an unidentified dried sticky tan substance was present on the sides of Resident #35's tube feeding pump. Observation on [DATE] at 8:45AM revealed numerous spots, varying in size, of an unidentified dried sticky tan substance to the base of Resident #35's tube feeding pole. Further observation revealed an unidentified dried sticky tan substance was present on the sides of Resident #35's tube feeding pump. In an interview on [DATE] at 1:30PM, S2Director of Nursing (DON) confirmed Resident #4's and Resident #35's tube feeding pole bases and pumps had a dried sticky substance on it and were not maintained in a sanitary manner as required. S2DON further indicated resident equipment should be maintained in a clean and sanitary manner at all times. (continued on next page)

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	195214	A. Building B. Wing	05/20/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #106 Observation on [DATE] at 9:11AM revealed an unidentified dried sticky tan substance was present on the side and top of Resident #106's tube feeding pump. Observation on [DATE] at 1:05PM revealed an unidentified dried sticky tan substance was present on the side and top of Resident #106's tube feeding pump. In an interview on [DATE] at 10:58AM, S4Registered Nurse (RN) indicated it was the responsibility of the nurse to ensure the resident's feeding pump was kept clean. S4RN confirmed Resident #106's tube feeding pump had a dried sticky tan substance on the side and top. S4RN indicated Resident #106's tube feeding pump needed to be tidied up.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews and record reviews the facility failed to ensure certified nursing assistants (CNAs) were provided Quality Assurance and Performance Improvement (QAPI) training for 5 (S13CNA, S14CNA, S15CNA, S16CNA, S17CNA) of 5 sampled CNAs reviewed for QAPI training requirements.Findings:Review of facility's training policy and procedure, with a revision date of 05/05/2025, revealed, in part, upon hire and prior to performing any functions of their position, each new employee and volunteer will be trained and oriented in accordance with state and federal regulations, as well as company policy and procedure. Review of S13CNA's personnel file revealed, in part, S13CNA had a hire date of 01/12/2026. Further review revealed no documented evidence S13CNA had received QAPI training, as required. Review of S14CNA's personnel file revealed, in part, S14CNA had a hire date of 02/25/2026. Further review revealed no documented evidence S14CNA had received QAPI training, as required. Review of S15CNA's personnel file revealed, in part, S15CNA had a hire date of 09/30/2025. Further review revealed no documented evidence S15CNA had received QAPI training, as required. Review of S16CNA's personnel file revealed, in part, S16CNA had a hire date of 10/25/2016. Further review revealed no documented evidence S16CNA had received QAPI training, as required. Review of S17CNA's personnel file revealed, in part, S17CNA had a hire date of 04/25/2023. Further review revealed no documented evidence S17CNA had received QAPI training, as required. On 05/19/2026 at 3:00PM, the surveyor requested QAPI trainings for the above-mentioned CNAs from S2Director of Nursing. On 05/20/2026 at 9:00AM, the surveyor requested QAPI trainings for the above-mentioned CNAs from S2Director of Nursing. In an interview on 05/20/2026 at 11:40AM, S2Director of Nursing indicated the above-mentioned CNAs did not have any QAPI trainings provided, as required.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews, and record reviews, the facility failed to provide privacy for a resident during incontinence care for 2 (Resident #4, Resident #95) of 2 sampled residents observed during incontinence care. Findings:Review of the facility's undated Resident Rights policy and procedure revealed, in part, employees should treat all residents with respect and dignity. Further review revealed all residents had the right to privacy and confidentiality. Resident #4Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/2026 revealed, in part, Resident #4 did not have a Brief Interview for Mental Status (BIMS) score completed due to Resident #4 not being able to be understood or understand others. Further review revealed Resident #4 was dependent on staff assistance for toileting hygiene. Observation on 05/18/2026 at 9:42AM revealed S18Certified Nursing Assistant (CNA) and S19CNA entered Resident #4's room to perform incontinence care while Resident #4's roommate, Resident #95, remained in the room. Further observation revealed S18CNA and S19CNA did not close Resident #4's bedside privacy curtain and proceeded to remove Resident #4's pants, remove Resident #4's incontinence diaper and perform Resident #4's incontinence care. Further observation revealed Resident #4's genitalia remained uncovered and exposed to Resident #95 during the entire incontinence care process. Resident #95Review of Resident #95's MDS with an ARD of 04/23/2026 revealed, in part, Resident #95 had a BIMS score of 11, which indicated Resident #95 had moderate cognitive impairment. Further review revealed Resident #95 was dependent on staff assistance for toileting hygiene. Observation on 05/18/2026 at 9:37AM revealed S18CNA and S19CNA entered Resident #95's room to perform incontinence care while Resident #95's roommate, Resident #4, remained in the room. Further observation revealed S18CNA and S19CNA did not fully close Resident #95's bedside privacy curtain and proceeded to remove Resident #95's pants, remove Resident #95's incontinence diaper and perform Resident #95's incontinence care. Further observation revealed Resident #95's genitalia remained uncovered and exposed to Resident #4 during the entire incontinence care process. In a Resident Council meeting interview on 05/19/2026 at 10:57AM, Resident #11, Resident #22, Resident #27, Resident #31, and Resident #55 indicated they often saw residents receiving personal care with the doors open. In an interview on 05/20/2026 at 1:30PM, S2Director of Nursing indicated S18CNA and S19CNA should have ensured Resident #4's and Resident #95's privacy curtains were pulled while their respective incontinence care was performed.

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	195214	A. Building B. Wing	05/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure fall risk assessments were completed and new individualized fall prevention interventions were implemented to prevent future falls for 3 (Resident #108, Resident #112, Resident #142) of 3 sampled residents investigated for falls. Findings: Review of the facility's Resident Incident/Accident/Falls policy and procedure, dated 09/01/1994 and revised on 05/13/2025, revealed, in part, if falling occurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remained relevant. Further review revealed the nursing supervisor on duty at the time should compete an incident report for resident falls no later than 24 hours after the fall occurred. Further review revealed when a resident fell, a falls risk assessment and the appropriate interventions taken to prevent future falls would be recorded in the resident's medical record. Review of the facility's Fall Risk Assessment form, revised on 12/2003 revealed, in part, upon admission and quarterly, at a minimum, a resident's fall risk should be assessed. On 05/19/2026 at 3:00PM, S2Director of Nursing (DON) was provided with a request for all Fall Risk Assessments for Resident #108, Resident #112, and Resident #142. On 05/20/2026 at 11:00AM, S5Minimum Data Set (MDS) Nurse was provided with a request for all Fall Risk Assessments for Resident #108, Resident #112, and Resident #142. Resident #108Review of Resident #108's medical record revealed, in part, Resident #108 was admitted to the facility on [DATE] with diagnoses which included pain, stroke, and seizures. Review of Resident #108's nurses' notes, dated 05/15/2026 at 2:52AM, revealed, in part, S24Licensed Practical Nurse (LPN) documented Resident #108 sustained an unwitnessed fall. Review of Resident #108's record revealed, in part, no documented evidence a Fall Risk Assessment was performed upon admission, quarterly, and/or after Resident #108's above- mentioned fall. Review of the facility's 2026 Fall List, updated and provided by S1Administrator on 05/18/2026, revealed, in part, no documentation Resident #108 sustained a fall incident on 05/15/2026. Review of Resident #108's care plan, with a start date of 09/10/2024 and a goal date of 07/07/2026, revealed, in part, Resident #108 had a potential for falls related to physical and cognitive limitations. Further review revealed an intervention for the facility to complete a Fall Risk Assessment per facility protocol. Further review revealed Resident #108's care plan was not updated with new individualized interventions and/or had supervision increased to prevent future falls after Resident #108's fall on 05/15/2026. Resident #112Review of Resident #112's medical record revealed, in part, Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, pain, insomnia, and nightmare disorder. Review of the facility's 2026 Fall List, updated and provided by S1Administrator on 05/18/2026, revealed, in part, Resident #112 sustained unspecified falls on 01/26/2026, 01/27/2026, 01/28/2026, and 02/14/2026. Review of Resident #112's care plan, with a start date of 01/03/2025 and a goal date of 07/21/2026, revealed, in part, Resident #112 had a potential for falls related to physical and cognitive limitations. Further review revealed an intervention for the facility to complete a Fall Risk Assessment per facility protocol. Further review revealed Resident #112's care plan was not updated with new individualized interventions and/or had supervision increased to prevent future falls after the above-mentioned falls occurred. Review of Resident #112's records revealed, in part, no documented evidence a Fall Risk Assessment was performed after Resident #112's above-mentioned falls. Resident #142Review of Resident #142's medical record revealed, in part, Resident #142 was admitted to the facility on [DATE] with diagnoses of, in part, muscle weakness, dementia, unsteadiness on feet, lack of coordination, and cognitive communication deficit. Review of the facility's 2026 Fall List, updated and provided by S1Administrator on 05/18/2026, revealed, in part, Resident #142 sustained unspecified falls on 03/05/2026, 03/13/2026, 03/24/2026, and two falls on 04/05/2026. Review of Resident #142's care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, with a start date of 03/05/2026 and a goal date of 06/12/2026, revealed, in part, Resident #142 had a potential for falls related to unsteady gait, muscle weakness, and medications. Further review revealed an intervention for the facility to complete a Fall Risk Assessment per facility protocol. Further review revealed Resident #142's care plan was not updated with new individualized interventions and/or had supervision increased to prevent future falls until after the two falls on 04/05/2026 occurred. Review of Resident #142's records revealed, in part, no documented evidence a Fall Risk Assessment was performed upon admission, quarterly, and/or after Resident #142's above-mentioned falls. In an interview on 05/18/2026 at 2:30PM, S18Certified Nursing Assistant (CNA) indicated she was assigned to care for Resident #142. S18CNA further indicated she was not aware if he was a fall risk. In an interview on 05/20/2026 at 11:07AM, S3Assistant Director of Nursing (ADON) indicated fall assessments should be completed upon admission by the MDS nurse. In an interview on 05/20/2026 at 11:21AM, S5MDS Nurse indicated Fall Risk Assessments were not completed on the above-mentioned residents and should have been. S5MDS Nurse further indicated she was unaware a Fall Risk Assessment should have been completed after each fall and that new individualized care plan interventions were required after each fall. In an interview on 05/20/2026 at 1:30PM, S2DON confirmed the above-mentioned residents did not have Fall Risk Assessments completed as required. S2DON further indicated the above-mentioned residents should have had new individualized care plan interventions and/or had supervision increased to prevent future falls.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents who received psychotropic medications were monitored for potential adverse consequences associated with the use of psychotropic medications for 3 (Resident #10, Resident #115, Resident #149) of 5 sampled residents investigated for unnecessary medications. Findings: Review of the facility's Psychotropic Medication Use policy and procedure, dated 09/01/1994 and revised on 05/13/2025, revealed, in part, psychotropic medications were any medication that affected brain activity associated with mental processes and behavior. Further review revealed the following medications were considered psychotropic medications and were subject to monitoring: antipsychotics, antidepressants and antianxiety medications. Further review revealed psychotropic medication management involved the adequate monitoring for efficacy and adverse consequences. Further review revealed residents receiving psychotropic medications were monitored for side effects and the response to treatment was documented daily. Resident #10 Review of Resident #10's record revealed, in part, Resident #10 was admitted to the facility on [DATE] with diagnoses of, in part, anxiety, unspecified dementia without behavior disturbances, psychotic disturbances, mood disturbances, and bipolar disorder. Review of Resident #10's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/12/2026 revealed, in part, Resident #10 was on an antipsychotic medication which was assessed as a high risk medication.Review of Resident #10's care plan with a goal date of 08/21/2026 revealed, in part, Resident #10 received psychotropic drugs. Further review revealed an intervention for the facility to monitor Resident #10 for negative side effects related to Resident #10's psychotropic medication use.Review of Resident #10's May 2026 physician's Orders from 05/01/2026 to 05/20/2026 revealed, in part, an order for Resident #10 to be administered risperidone (a medication used to treat bipolar disorder) 1 milligram (mg) by mouth daily, with a start date of 05/06/2025. Further review revealed an order to monitor for side effects of antipsychotic medication, with a start date of 05/06/2025.Review of Resident #10's Medication Administration Record (MAR) dated 05/01/2026 to 05/20/262026 revealed, in part, risperidone 1mg was administered to Resident #10 daily from 05/01/2026 to 05/20/2026 as ordered. Further review revealed Resident #10 was not monitored for negative side effects related to risperidone use.In an interview on 05/20/2026 at 9:35AM, S2Director of Nursing (DON) indicated the documentation of psychotropic monitoring should be completed on the resident's MAR. S2DON further indicated there was no side effect monitoring completed for Resident #10's risperidone. Resident #115 Review of Resident #115's record revealed, in part, Resident #115 was admitted to the facility on [DATE] with diagnoses, in part, of schizophrenia, insomnia, and depression.Review of Resident #115's MDS with an ARD date of 05/05/2026 revealed, in part, Resident #115 was on antipsychotic and antidepressant medications, which were assessed as high risk medications.Review of Resident #115's care plan with a goal date of 08/04/2026 revealed, in part, Resident #115 received psychotropic drugs. Further review revealed an intervention for the facility to monitor Resident #115 for negative side effects related to Resident #115's psychotropic medication use.Review of Resident #115's May 2026 physician orders revealed, in part, an order for Resident #115 to be administered olanzapine (a medication used to treat schizophrenia) 2.5mg by gastric tube once in the evening, with a start date of 04/28/2026. Further review revealed an order or Resident #115 to be administered trazadone (a medication used to treat insomnia) 50mg daily at bedtime, with a start date of 04/28/2026.Review of Resident #115's MAR from 04/28/2026 to 05/20/2206 revealed, in part, olanzapine 2.5mg and trazadone 50mg were administered to Resident #115 from 04/28/2026 to 05/19/2026 as ordered. Further review revealed Resident #115 was not monitored for negative side effects related to olanzapine and trazadone use.In an interview on 05/20/2026 at 2:28PM, S2DON indicated there was no monitoring for negative side effects related to Resident #115's olanzapine and trazadone use. Resident #149Review of Resident (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#149's record revealed, in part, Resident #149 was admitted to the facility on [DATE] with diagnoses, in part, post-traumatic stress disorder and anxiety.Review of Resident #149's MDS with an ARD date of 05/15/2026 revealed, in part, Resident #149 received antipsychotic and antianxiety medications, which were assessed as high risk medications.Review of Resident #149's care plan with a goal date of 08/14/2026 revealed, in part, Resident #149 received psychotropic drugs. Further review revealed an intervention for the facility to monitor Resident #149 for negative side effects related to Resident #149's psychotropic medication use.Review of Resident #149's May 2026 physician orders revealed, in part, quetiapine (atypical antipsychotic used to relieve symptoms to treat mental disorders) 50mg by mouth at bedtime, with a start date of 05/14/2026. Further review revealed an order for Resident #149 to be administered lorazepam 0.5mg by mouth twice a day, with a start date of 05/07/2026. Further review revealed an order to monitor Resident #149 for the side effects associated with antipsychotics and antidepressants, with a start date of 05/07/2026.Review of Resident #149's MAR from 05/01/2026 to 05/19/2026 revealed, in part, lorazepam 0.5mg and quetiapine 50mg were administered to Resident #149 from 05/08/2026 to 05/19/2026 as ordered. Further review revealed Resident #149 was not monitored for the negative side effects associated with the administration of lorazepam or quetiapine.In an interview on 05/19/2026 at 3:34PM, S2DON indicated there was no monitoring for negative side effects related to Resident #149's lorazepam and quetiapine use.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews, and record reviews, the facility failed to maintain a resident's wheelchair in a safe working condition for 1 (Resident #91) of 5 residents reviewed for environment.Findings:Review of Resident #91's records revealed, in part, an admit date of 05/19/2025. Review of Resident #91's diagnoses revealed, in part, Resident #91 was diagnosed with lack of coordination, morbid (severe) obesity, right heart failure, and shortness of breath. Review of Resident #91's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/23/2026 revealed, in part, Resident #91 required the use of a manual wheelchair. In an interview on 05/18/2026 at 9:00AM, Resident #91 indicated his wheelchair tires were extremely damaged with the rubber peeling off of the wheels. Resident #91 further indicated due to the damaged wheels on his wheelchair, the wheels on the wheelchair did not properly lock.Observation on 05/19/2026 at 12:00PM revealed Resident #91's wheelchair had multiple areas of rubber missing off the wheelchair's wheels. In an interview on 05/19/2026 at 12:02PM, Resident #91 indicated his wheelchair was not safe because it did not lock properly.In an interview on 05/19/2026 at 12:21PM, S8License Practical Nurse (LPN) indicated Resident #91 was missing rubber off of his wheelchair's wheels.In an interview on 05/19/2026 at 12:25PM, S2Director of Nursing (DON) confirmed Resident #91's wheelchair was not safe as a result of the damaged wheels that caused the wheelchair's left wheel to not lock properly. Observation on 05/20/2026 at 9:59AM revealed Resident #91's damaged wheelchair was present in Resident #91's room, available for Resident #91's use.In an interview on 05/20/2026 at 10:00AM, Resident #91 indicated his wheelchair's wheels were still damaged.