STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195326	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Iberia Manor South	600 Bayard St New Iberia, LA 70560

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on interviews and record review the facility failed to notify the Physician and Responsible Party, immediately after an accident involving the resident for 1(#1) of 3 (#1, #2, #3) sampled residents. This deficient practice had the potential to affect any of the 82 residents residing at the facility. Findings: On 03/26/2024 at 1:30 p.m., a review of the facility's policy titled Policy for Resident Incident and Visitor Accident Report with a review date of 01/2023, revealed in part: Policy. The facility will conduct an investigation of all incidents involving residents of the facility .B. Resident Incidents/Accidents: 1. If you witness an incident/accident, you must .2. Licensed nurse must .e. notify the physician, family, legal representative. Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Acute Embolism and Thrombosis of Left Femoral Vein, Generalized Muscle Weakness, and Repeated Falls. On 03/21/2024, a review of a health standards intake form of a complaint filed by Resident #1's family member, revealed that on 02/17/2024, Resident #1 reported to family members that staff members at the facility dropped her while moving her from her chair to bed. Further review revealed that a family member called and spoke to S1ADM (Administrator), asking if an incident had been made. S1ADM stated she would check on it but had not followed up with the family. On 03/23/2024 at 11:00 a.m., an interview was conducted with the resident's family member who filed the complaint. She stated that Resident #1 told the family on 02/18/2024 that staff members dropped her on the floor while transferring her from her chair to her bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/2024 at 3:45 p.m., a review was conducted of an incident report prepared by S3LPN (Licensed Practical Nurse) with a date of 02/17/2024 at 7:40 p.m. It revealed in part: While S6CNA (Certified nursing Assistant) was assisting Resident #1 to transfer from wheelchair to bed, the resident stated her legs were weak. S6CNA called for assistance and S3LPN went in to assist. S3LPN and S6CNA were unable to hold resident up, as she was dead weight. The resident fell to the floor and suffered a skin tear to her left shin and stated her legs were weak and felt tired. The resident was lifted from the floor with assistance of other nursing staff and S6CNA. Further review of the incident report revealed the resident's physician was not notified until 02/19/2024 at 10:00 a.m., and the family member was notified on 02/19/2024 at 3:00 p.m. On 03/26/2024 at 11:04 a.m., an interview was conducted with S1ADM. She confirmed that Resident #1 fell on [DATE]. She further confirmed that the resident's physician and responsible party were not notified immediately after the incident occurred and should have been notified.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observations, interviews and record reviews, the facility failed to implement a person centered care plan for 2(#1, #2) of 3(#1, #2, #3) sampled residents, by failing to ensure the residents received nutritional supplement as ordered by the physician. This deficient practice had the potential to affect the 27 residents who were ordered nutritional supplements. Findings: Resident #1 Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Acute Embolism and Thrombosis of Left Femoral Vein, Unspecified Severe Protein-Calorie Malnutrition, Generalized Muscle Weakness, and Repeated Falls. A review of Resident #1's physician's orders revealed an order written on 02/22/2024 at 12:06 p.m. for Ensure Plus before meals for Anorexia/Malnutrition. On 03/26/2024 at 9:17 a.m., an interview and observation of the rehab unit refrigerator was conducted with S2LPN (Licensed Practical Nurse). She stated that supplements were kept in the refrigerator. An observation was made of the refrigerator revealing that Ensure Plus was not in the refrigerator. S2LPN stated that there was also a milk refrigerator. An observation of the milk refrigerator revealed that the ordered supplement was not stocked. On 03/26/2024 at 10:15 a.m., an interview was conducted with S1ADM (Administrator) who stated that S4LPNMR (Licensed Practical Nurse, Medical Records) was responsible for ordering all nutritional supplements. On 03/26/2024 at 10:20 a.m., an interview and review of the facility's online supplement orders was conducted with S4LPNMR. She confirmed that she was responsible for ordering all supplements for the facility. S4LPNMR could not provide evidence that she had ordered Ensure Plus for Resident #1. She stated that it had been a long time since she had placed an order for that supplement and could not remember the date. S4LPNMR further stated that she had not ordered Ensure Plus in 2024 and was not notified that she needed to fill an order for the supplement. 39319 Resident 2 Review of Resident #2's Admission Record revealed his initial admitted was 02/16/2024 and he was readmitted on [DATE]. His diagnoses include in part, Cerebral infraction, Hemiplegia and hemiparesis following Cerebral infraction affecting left non-dominant side, Dysphagia, Muscle Wasting and atrophy, multiple sites, Vitamin D and other vitamin deficiency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MDS (Minimum Data Sheet) dated 02/20/2024 revealed BIMS (Brief Interview for Mental Status) score of 14, cognitively intact. Review of the resident's comprehensive care plan read as follow, Focus: Dietary concern: Dysphagia following cerebral infarction, Unspecified protein-calorie malnutrition, HTN (Hypertension), Vitamin deficiency, GERD (Gastro-esophageal reflux disease), Hypomagnesemia, HLD (hyperlipidemia-high cholesterol), Iron deficiency, AFIB (Atrial Fibrillation): Date initiated: 03/01/2024 .Interventions: Ensure Clear . Review of the resident's Order Summary Report with active orders as of 03/26/2024 revealed an order for under dietary-supplements for Ensure Clear in the afternoon related to Unspecified Protein-calorie malnutrition. Order date: 03/15/2024. Review of the resident's MAR (Medication Administration Record) for 03/01/2024 to 03/31/2024 revealed on order for Ensure Clear in the afternoon. On 03/01/2024, the number nine was documented indicating that the resident refused his supplement. On 03/15/2024 to 03/25/2024, the number zero was documented indicating that the resident did not consume any of the supplement. On 03/25/2024 at 2:00 p.m., an interview was conducted with Resident #2. The resident stated he was not drinking the Ensure provided because he cannot drink milk products and the ones they were giving him were the milk-based Ensure, not the Ensure Clear. He stated that he was not provided the Ensure Clear since he was admitted . He stated he was told that they did not have the Ensure Clear. On 03/26/2024 at 10:00 a.m., an interviewed was conducted with S4LPNMR (Licensed Practical Nurse/Medical Records). She confirmed that she was responsible for ordering supplements for all the residents in the facility. She stated that she ordered the supplements online. A review of an online order page was reviewed. It showed the last order for Ensure Clear was placed on 2/20/24. S4LPNMR stated she ordered Ensure Clear berry and apple flavor but it was reported to her that the residents did not like them, so she started ordering the regular Ensure chocolate favor instead.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319 Based on record review, observation and interviews the facility failed to provide accurate documentation that the resident's nutritional supplement was offered for 1 (#3) out of 3 (#1, #2 and #3) sampled residents. This deficient practice has the potential to affect the 82 residents that resided in the nursing home. Findings: Review of Resident #3's admission record revealed she was admitted on [DATE]. Her diagnoses included in part, Cerebral ischemia, Dementia, Muscle Wasting and Atrophy, right upper arm, right and left shoulder, Pressure ulcer of sacral region-Stage 3, Pressure-induced deep tissue damage of left heel and Vitamin D deficiency. Review of the resident's order summary report of active orders as of 03/01/2024 revealed an order with an order date 02/14/2024 for staff to encourage intake of supplements brought by family in resident's room every shift. On 03/26/2024 at 9:50 a.m., an observation and interview was conducted with S5LPN (Licensed Practical Nurse). S5LPN was asked if she was aware that resident's family members were leaving supplements for the resident in her room. She stated that she was unaware that the resident had nutritional supplements in her room. An observation was conducted in the resident's room with S5LPN. She searched in the resident's two dressers and was unable to find any supplements in the resident's room. She confirmed again that she was unaware of the resident's family providing supplements for the resident. On 03/26/23024 at 11:15 a.m., a second interview and record review was conducted with S5LPN. The resident's MAR (Medication Administration Record) for 03/01/2024 to 03/31/2024 was reviewed with S5LPN. The MAR revealed an order dated 02/14/2024 for staff to encourage intake of supplements brought by family in resident's room every shift. The order was signed on 03/25/2024 and 03/26/204 for Day S (day shift) by S5LPN. S5LPN confirmed she did sign the order on those days and confirmed that she should not have because she had not offered the resident her supplement. On 03/26/2024 at 2:00 p.m., an interview was conducted with S1ADM (Administrator) and S7CN (Corporate Nurse). They both agreed that if the resident did not have the supplement available, S5LPN should not have initialed the MAR. S5LPN should have indicated that the supplement was not available or offered the resident a supplement from the facility that was an equal substitute.