

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER New Iberia Manor South		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269</p> <p>Based on record review and interviews, the facility failed to ensure pain management was provided to residents complaining of pain for 1 (Resident #3) out of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. This had the potential to affect the 82 residents that resided in the facility.</p> <p>Findings:</p> <p>On 03/25/2025 a review of the facility's policy titled, Pain Management Program Policy, with a revised and reviewed dated of 01/2025 read in part . The facility will ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan and the resident's choices, related to pain management. If pain is identified, the following steps are initiated:-Created a Pain Care Plan using standardized pain assessment tools, obtain orders for pharmaceutical and/or non pharmaceutical interventions. Nurses will assess residents' pain every shift using the appropriate pain evaluation tool and document the effectiveness of interventions.</p> <p>Review of Resident #3's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, atrial septal defect as current complication following acute myocardial infarction, encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft (CABG), spastic cerebral palsy, paraplegia, spastic hemiplegia, chronic systolic congestive heart failure and dysarthria following cerebrovascular disease.</p> <p>Review of Resident #3's March 2025 physician's orders revealed an order dated 03/11/2025 for Hydrocodone-Acetaminophen oral tablet 5-325 mg (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain.</p> <p>Review of Resident #3's current care plan revealed Resident #3 was at risk for Potential/actual pain r/t (related to) spasticity, Cerebral palsy, recent CABG, history of angina (chest pain) with interventions including, but not limited to: Hydrocodone-Actaminophen, Monitor/record/report to nurse if resident complaints of pain or requests for pain treatment, Monitor /record pain characteristics Q (every) shift and PRN as needed, Monitor/record/report to nurse any signs and symptoms of non-verbal pain and Notify physician if interventions are unsuccessful.</p> <p>Review of Resident #3's electronic clinical record revealed the following nursing progress notes:</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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dated 03/12/2025 at 11:30 AM per S3LPN (Licensed Practical Nurse) read: The resident's mother came to the nurse's station asking when the resident's pain meds will be in. S3LPN went through all the bins that the pharmacy sent and no pain meds were in the bin for the resident. S3LPN explained to the mother that a hard script from the NP (Nurse Practitioner) will be needed for the pharmacy to fill his med (medication).</p> <p>Dated 03/13/2025 at 1:00 AM per S3LPN read: Resident c/o (complains of) chest pain. Tylenol was offered d/t (due to) pain medication not in, the patient refused and stated he needed something stronger. S3LPN explained to the resident and his mother that need a physician's order to give pain meds. A note was left for S5NP (Nurse Practitioner) to review the resident's medications.</p> <p>Dated 03/13/2025 at 1:30 AM per S3LPN read: The resident's mother asked if S3LPN could give the resident someone else's pain med. S3LPN explained that nurses are not allowed to share medications.</p> <p>Dated 03/13/2025 at 14:30 (2:30 PM) per S4LPN read: therapist stated to S4LPN that resident would like to see a nurse, for pain relief. S4LPN went in to assess Resident #3 for pain, he stated that he is in pain. S4LPN stated that she could possibly give a standing order pain relief medication, expressing that, the hydrocodone pain medication is on order and has not been delivered at this time. Resident called mother and gave the phone to S4LPN. S4LPN spoke with Resident #3's mother and the mother stated that the doctor okayed pain medication administration to the resident there is no narcotic available to administer presently. S4LPN informed resident's mother of this and stated that she would have to clarify giving anything other than standing order medications with the NP or DON (Director of Nursing).</p> <p>Review of Resident #3's eMAR (electronic Medication Administration Record) for March 2025 revealed Hydrocodone-Acetaminophen 5-325 mg was not administered on 03/12/2025 or 03/13/2025. Further review of the resident's eMAR revealed that on 03/12/2025 the resident complained of pain of 5 on a pain scale of 0-10 with 5 being moderate pain on the night shift. There was no documentation the resident received anything for pain on 03/12/2025.</p> <p>On 03/24/2025 at 4:30 PM, a phone interview was attempted with Resident #3's representative but no answer was received.</p> <p>On 03/25/2025 at 8:00 AM, a second attempt was made to notify Resident #3's representative via phone but no answer was received.</p> <p>On 03/25/2025 at 12:35 PM, an interview was conducted with S7LPN. S7LPN verified medications were ordered through an out of town pharmacy. S7LPN stated there was confusion with Resident #3's Hydrocodone-Acetaminophen 5-325 mg prescription and S5NP ended up having to write a second prescription on 03/13/2025.</p> <p>On 03/25/2025 at 12:45 PM, a third attempt was made to notify Resident #3's representative via phone but no answer was received.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/25/2025 at 2:38 PM, a phone interview was conducted with S3LPN. S3LPN stated Resident #3 had complained of pain and she went to look for his medication but it had not yet been delivered. S3LPN stated she had notified S5NP via text message about Resident #3's pain medication not being delivered, but did not get a response. S3LPN denied notifying administrative staff about not having the resident's ordered pain medication in the facility upon the resident's admit to the facility on [DATE].</p> <p>On 03/25/2025 at 3:50 PM, an interview was conducted with S4LPN. S4LPN stated Resident #3 was newly admitted to the facility on [DATE] and when the resident's mother inquired about the resident's Hydrocodone-Acetaminophen 5-325 mg prescription, S4LPN attempted to give Tylenol but the resident had refused. S4LPN was unable to recall if S5NP was aware of the delivery delay of the Hydrocodone-Acetaminophen 5-325 mg. S4LPN explained the facility had a white binder where the receipt of prescriptions faxed and delivered from the out of town pharmacy were kept.</p> <p>On 03/25/2025 at 4:02 PM, an interview was conducted with S2ADON (Assistant Director of Nursing) who confirmed she reviewed Resident #3's admit orders on 03/11/2025. She explained at times the discharging hospital will electronically file the prescriptions. S2ADON review the electronic health record system and the white binder. She was unable to find confirmation that the resident's prescription for Hydrocodone-Acetaminophen 5-325 mg-Give 1 tablet by mouth every 6 hours as needed for pain was sent to the pharmacy.</p> <p>On 03/25/2025 at 4:33 PM, a phone interview was conducted with S5NP. S5NP confirmed he was made aware that Resident #3's prescription for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 6 hours as needed for pain was delayed since admit. S5NP was unable to recall exactly when he was notified of the delay. S5NP denied implementing an alternative order until the medication was delivered.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269</p> <p>Based on record review and interviews, the facility failed to ensure pain medication was available for 1 (Resident #3) out of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. This had the potential to affect the 82 residents that resided in the facility.</p> <p>Findings:</p> <p>Review of Resident #3's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to: atrial septal defect as current complication following acute myocardial infarction, encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft (CABG), spastic cerebral palsy, paraplegia, spastic hemiplegia, chronic systolic congestive heart failure and dysarthria following cerebrovascular disease.</p> <p>Review of Resident #3's March 2025 physician's orders revealed an order dated 03/11/2025 for Hydrocodone-Acetaminophen oral tablet 5-325 mg (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain.</p> <p>Review of Resident #3's electronic clinical record revealed the following nursing progress notes:</p> <p>Dated 03/12/2025 at 11:30 AM per S3LPN (Licensed Practical Nurse) read: The resident's mother came to the nurses station asking when the resident's pain meds will be in. S3LPN went through all the bins that the pharmacy sent and no pain meds were in the bin for the resident. S3LPN explained to the mother that a hard script from the NP (Nurse Practitioner) will be needed for the pharmacy to fill his med.</p> <p>Dated 03/13/2025 at 1:00 AM per S3LPN revealed: Resident c/o (complains of) chest pain. Tylenol was offered d/t (due to) pain medication not in. S3LPN explained to the resident and his mother that need a Physician's order to give pain meds. A note was left for S5NP (Nurse Practitioner) to review the resident's medications.</p> <p>Dated 03/13/2025 at 14:30 (2:30 PM) per S4LPN revealed: The hydrocodone pain medication is on order and had not been delivered at this time. Resident called mother and gave the phone to S4LPN. S4LPN spoke with Resident #3's mother and the mother states that the doctor okayed pain medication administration to the resident there is no narcotic available to administer presently.</p> <p>Review of Resident #3's eMAR (electronic Medication Administration Record) for March 2025 revealed Hydrocodone-Acetaminophen 5-325 mg was not administered on 03/12/2025 after the resident complained of pain due to medication not being available.</p> <p>On 03/25/2025 at 2:33 PM, a phone interview was conducted with S6Pharm (Certified Pharmacy Technician) who verified the only pain medication prescription the pharmacy received for Resident #3 was on 03/13/2025 for Hydrocodone-acetaminophen 7.5-325 mg per S5NP.</p> <p>(continued on next page)</p>		

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