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	01/07/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to document behaviors of a resident diagnosed with mental disorders, to ensure the resident attained the highest practicable mental and psychosocial well-being for 1 (Resident #1) out of 8 (#1- #8) sampled residents. Findings: Review of Resident #1's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, bipolar disorder, anxiety disorder, and dementia. Review of Resident #1's January 2026 Physician's Orders revealed the following in part: - busPIRone HCl (Hydrochloride) Oral Tablet 10 MG (milligrams) (Buspirone HCl)- Give 10 mg by mouth three times a day for anxiety. Ordered 12/09/2025 -OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth two times a day for dementia. Ordered 06/28/2025. -Venlafaxine HCl ER Tablet Extended Release 24 Hour 75 mg- Give 1 tablet by mouth one time a day for depression. Ordered 06/1/2024. - Behavior monitoring Anti-Psychotic Q Shift: 0.None 1.Afraid 2.Agitated 3.Angry 4.Anxious 5.Mood change 6.Noisy 7.Restless 8.Withdrawn/crying 9.Crying 10.Combative 11. See nurses notes -Behavior monitoring Anti-Anxiety Q Shift: 0.None 1.Afraid 2.Agitated 3.Angry 4.Anxious 5.Mood Change 6.Noisy 7.Restless 8.Withdrawn/depressed 9.Crying 10.Combative 11. See nurses notes-Behavior Monitoring Anti-Depression Q Shift: 0.None 1.Afraid 2.Agitated 3.Angry 4.Anxious 5.Mood change 6.Noisey 7.Restless 8.Withdrawn/depressed 9.Crying 10.Combative 11. See nurses notesReview of Resident #1's plan of care revealed the following in part: - The resident uses anti-anxiety medications r/t (related to) anxiety disorder. Interventions in part . monitor for side effects and effectiveness Q shift (every shift). - The resident uses antidepressant medication r/t depression. Interventions in part: Behavior Monitoring Anti-Depression Q Shift: 0.None 1.Afraid 2.Agitated 3.Angry 4.Anxious 5.Mood change 6.Noisey 7.Restless 8.Withdrawn/depressed 9.Crying 10.Combative 11.- The resident has a mood problem r/t dementia, depression, anxiety. Interventions in part: Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record/ report to MD (Medical Director) prn (as needed) patterns s/sx (signs and symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. Review of Resident #1's MAR (Medication Administration Record) from October 2025 to January 2026 revealed the following in part: -Behavior monitoring antianxiety q (every) shift- 6. Noisy was documented on night shift on 10/16/2025 and 12/09/2025, and on day and evening shift on 10/17/2025 and 12/10/2025. -Behavior monitoring anti-depression q shift & - Behavior monitoring Anti-psychotic q shift 6. Noisy was documented on the night shift on 12/09/2025, and on the day and evening shift on 12/10/2025. On 01/05/2026 at 11:10 a.m., an interview was conducted with S4LPN (Licensed Practical Nurse) who stated she had been the resident's day shift nurse for several months. S4LPN stated that the night shift nurses had reported that Resident #1 yells out at night and that was his normal behavior. She stated that it was reported to her by the night shift nurses that he yells to get the attention of staff (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

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	01/07/2026

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New Iberia Manor South	600 Bayard St New Iberia, LA 70560

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because he had bad dreams and did not want to be by himself. On 01/05/2026 at 11:28 a.m., an interview was conducted with S7CNA (Certified Nursing Assistant) who stated that Resident #1 yells out or hollers during the day and at night to get the attention of staff because he did not want to be alone. On 01/05/2026 at 11:57 a.m., a phone interview was conducted with S5LPN who stated that on 12/17/2025 at approximately 2:45 a.m., Resident #1 began yelling. She stated he did not like to be alone, which had been an ongoing problem for him. S5LPN stated she would go into Resident #1's room and asked him to stop yelling because other residents were trying to sleep, and he would stop for a little while and start again.On 01/05/2026 at 3:30 p.m., an interview was conducted with S1ADMIN (Administrator). She stated that neither the nurses nor CNAs told her that Resident #1 yelled out or hollered at night prior to 12/17/2025. She stated that if she or S2DON (Director of Nursing) had known, they would have tried to get to the root cause of the outbursts or contacted his psychiatric provider for a possible medication change. On 01/06/2026 at 1:50 p.m., a phone interview was conducted with S6LPN. She stated that she had worked night shift and had been Resident #1's nurse since he was admitted to the facility. She stated the resident always had outbursts and yelled at night since his admission. She stated the resident hollered and said different things. Sometimes he wanted to get up and get out of bed, then he would want to get right back in bed. S6LPN stated sometimes the resident didn't need anything and when he was told that other residents were sleeping, he would sometimes say he didn't care and continued to holler. She stated that she and the CNAs would try to get the resident what he asked for, but he continued to holler which was a known behavior he had often. S6LPN stated that she wrote a note in July 2025 about the resident's behavior because she was simply charting the behavior, however the nurses usually documented this behavior on their nurse report sheets which was a tool the nurses shared among themselves when reporting off for shift, and not a part of the resident's clinical record. On 01/06/2026 at 3:28 p.m., a joint interview was conducted with S1ADMIN, S2DON, and S3CORP (Corporate Nurse). S2DON stated she was unaware of Resident #1's outbursts at night prior to the documented behavior on July, 13 2025. S2DON stated that when a resident had a new behavior, their process was to contact psychiatric services. She stated she assumed Resident #1 was already on psychiatric rotations. Review of the resident's October 2025 to January 2026 MARs was conducted with S2DON and S3CORP, who both confirmed that the nurses were not documenting the resident's behaviors on the MARs. S2DON was asked if the nurses' report sheets were official documentation for the residents' record and she stated they were not. S3CORP stated the nurses should have been documenting the resident's behaviors on the MARs.On 01/07/2026 at 9:55 a.m., a review of monthly psychiatric services notes provided by S1ADMIN was conducted with S1ADMIN, S2DON, and S3CORP. The psychiatric provider reported that Resident #1's sleep was fair. S1DON was asked if the psychiatric provider spoke with or consulted the nurses to ask about the residents' behaviors. S3CORP stated the providers used the 24 hour nursing reports which were generated from the MARs and progress notes. They stated had the nurses documented Resident #1's behaviors at night, it would have been on the report, and the psychiatric provider would have known about the resident's behaviors and provided services to treat those behaviors.