

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER New Iberia Manor North		STREET ADDRESS, CITY, STATE, ZIP CODE 1803 Jane Street New Iberia, LA 70563	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540</p> <p>Based on record review and interviews, the facility failed to ensure residents were free from verbal abuse for 1 (Resident #1) out of 5 (Resident #1, Resident #2, Resident #3, Resident #R1, and Resident #R2) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>On 12/03/2024, a review of the facility's manual titled, Abuse Prohibition Policy with a last revision date of 05/17/2024, read in part: Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. The policy also indicated verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p> <p>Review of Resident #1's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Cerebral Infarction, Aphasia, and Dementia.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was incomplete indicating he was unable to participate in this portion of the MDS.</p> <p>Review of a witness statement dated: 11/11/2024 by S3SSD (Social Service Director) read, Resident #2 informed S3SSD that his roommate was mistreated. Resident #2 stated that Resident #1 was making a grunting noise and the male CNA (Certified Nursing Assistant) told Resident #1 to shut up twice. The third time that Resident #1 made the noise, the male CNA said shut up and Resident #2 heard a slapping noise twice. Resident #2 said that this happened on Friday or Saturday night. Resident #2 stated that he was laying down in bed so he did not see where the CNA slapped Resident #1 but he heard the slapping noise twice .</p> <p>Review of Resident #2's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 15 indicating his cognition was intact.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a witness statement dated: 11/12/2024 by S4CNA read, I, S4CNA, around last week (Thursday or Friday), Resident #1 was resistant to care. He is usually calm when he takes his medication but that day was fighting, hitting his hands and pushing his hands away. He stopped and waited until he calmed down. I did not notify the nurse because he calmed down eventually. On the allegation of telling him to shut up, I might have done that because it was out of reflex .</p> <p>On 12/02/2024 at 12:59 p.m., an interview was conducted with Resident #2. Resident #2 stated the night of the incident was either on 11/07/2024 or 11/08/2024, he did not remember exactly what night. He stated his roommate (Resident #1) was nonverbal and only made grunting noises which made him vulnerable. He stated a male CNA entered their room and walked to Resident #1's side of the room. Resident #2 stated he was not able to see what was going on due to the privacy curtain drawn in between them, but he was able to hear the male CNA and Resident #1. Resident #1 made a grunting noise then he heard the male CNA say shut up. He stated Resident #1 made another grunting noise then he heard the male CNA say shut up. He stated the resident made a grunting noise for a third time and he heard the male CNA say shut up again then heard a slapping noise at the same time. Resident #2 stated the male CNA said shut up with an attitude and it sounded like the CNA was expressing frustration towards Resident #1 due to the CNA's harsh tone of voice. He stated he notified S3SSD of the incident a few days later.</p> <p>On 12/02/2024 at 1:08 p.m., an observation was made of Resident #1. Resident #1 was awake and laying down in his bed. Attempted to interview Resident #1, but he was only able to respond by making grunting noises, and was therefore unable to be interviewed.</p> <p>On 12/02/2024 at 1:17 p.m., an interview was conducted with S3SSD. She stated during her morning rounds on the residents Resident #2 (Resident #1's roommate) notified her that he was worried about his roommate. He stated a male CNA that worked either on Thursday 11/07/2024 or Friday 11/08/2024 night came into their room while he was awake. He stated to her the male CNA walked over to Resident #1's side of the room, Resident #1 made a loud grunting sound, and the male CNA said shut up. Resident #1 grunted a few more times and the CNA told Resident #1 to shut up. Resident #1 grunted again and the CNA told him to shut up then heard slapping noises. Resident #2 reported that he was unable to see the incident due to a privacy curtain between the two residents. S3SSD stated she reported this to S2DON (Director of Nursing) and S1ADM (Administrator). She stated S1ADM was able to determine the male CNA that Resident #2 was speaking of was S4CNA.</p> <p>On 12/02/2024 at 2:45 p.m., an interview was conducted with S1ADM. She stated she was told by S3SSD that Resident #2 heard a male CNA tell Resident #1 to shut up and heard a slapping noise. She stated she was able to narrow it down to Friday 11/08/2024, and determined the male CNA was S4CNA. S1ADM interviewed S4CNA who stated he might have said shut up to Resident #1, but it was out of reflex. S1ADM confirmed saying shut up is against professionalism and company policy.</p> <p>On 12/03/2024 at 8:44 a.m., a phone interview was conducted with S4CNA who confirmed he was a previous employee at the facility. Questions were asked regarding these incidents. The phone line was abruptly disconnected.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/03/2024 at 11:10 a.m., an interview was conducted with S2DON. Resident #2 notified her of an incident while she was doing morning rounds. She interviewed Resident #2 with S3SSD present when he reported he overheard a male CNA giving care on the other side of the room telling Resident #1 to shut up, but could not see what was going on. She stated Resident #2 told her that the male CNA seemed short with Resident #1. She stated S4CNA saying shut up to the resident was inappropriate.</p>		