STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Iberia Manor North	1803 Jane Street New Iberia, LA 70563

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on record reviews, observations, and interview, the facility failed to ensure the resident was treated with respect and dignity as evidenced by the facility failing to keep a resident's urine collection bag covered and private for 1 (Resident # 35) of 3 residents (# 35, # 52 and # 66) investigated for urinary catheter or urinary tract infection. Findings: Review of Resident # 35's electronic medical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses, in part: Urinary Tract Infection, Other Retention of Urine, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. Review of Resident # 35's current physician orders for May 2024 revealed, in part: 03/19/2024- Foley Catheter Care Q (every) Shift and PRN (as needed); Privacy bag or covering over urine collection bag for dignity every evening and night shift. Review of Resident # 35's care plan revealed the resident had an indwelling catheter with an intervention of privacy bag or covering over urine collection bag for dignity. On 05/13/2024 at 6:50 a.m., an observation was made of Resident # 35 from the hallway as his room door was open resting in bed and his urine collection bag was observed hanging on the right side, at the foot of his bed without a privacy bag or covering. The urine collection bag was visible from the hallway. On 05/14/2024 at 8:26 a.m., upon entering the resident's room, his door was opened and Resident # 35 was observed in bed. His urine collection bag was hanging on the right side, at the foot of his bed without a privacy bag or covering. The resident's door remained open and his urine collection bag was visible from the hallway. On 05/14/2024 at 8:35 a.m., an interview and observation was conducted with S10LPN (Licensed Practical Nurse). She entered Resident # 35's room and confirmed the resident's urinary collection bag did not have a privacy bag or covering. S10LPN further confirmed there should have been a privacy bag or covering present over the urine collection bag to ensure the resident's dignity.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319 Based on record review and interview, the facility failed to ensure the resident's Minimum Data Set (MDS) was completed accurately for 1 (#31) out of 35 sampled residents. Findings: Review of Resident #31's electronic clinical record revealed he was admitted to the facility on [DATE]. The resident's diagnoses included in part Hypertension, Angina Pectoris, Cerebral Infarction and Venous insufficiency (Chronic) (Peripheral). Review of the resident's quarterly MDS (Minimum Data Set) dated 02/14/2024 revealed under Section N-Medications, the resident was coded for the use of an anticoagulant (blood thinner). Review of the resident's active physician order as of 05/15/2024 revealed no order for an anticoagulant medication. On 05/15/2024 at 2:53 p.m., a review of Resident # 31's MDS dated [DATE] and current physician orders was conducted with S9RMDS (Regional MDS). S9RMDS stated that according to the physician orders, Resident #31 was not ordered any anticoagulant medications. She confirmed that the resident's MDS assessment conducted on 02/14/2024 was not accurate for the use of an anticoagulant.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental disorder to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 2 (Resident #37 and #57) of 2 (#37 and #57) residents investigated for PASARR in a final sample of 35 residents. Findings: Resident #37 A review of Resident 37#'s medical record revealed an admitted [DATE]. Further review revealed he was diagnosed with Unspecified Psychosis on 03/13/2024. Further review of Resident #37's medical record revealed a Level 1 PASARR (Preadmission Screening and Resident Review) dated 03/01/2024. No PASARR Level II was noted in Resident #37's record. On 05/15/2024 at 12:43 p.m., an interview was conducted with S11SSD (Social Service Director) and S1ADM (Administrator) regarding resubmission for a Level II PASARR after a diagnosis of Unspecified Psychosis. S1ADM stated she would look into the matter, and would update when available. On 05/15/2024 at 3:45 p.m., an interview was conducted with S11SSD, she stated they would get back with an update shortly. On 05/15/2024 at 6:45 p.m., at survey exit, the facility failed to provide any further information. 49784 Resident #57 A review of Resident #57's record revealed an admitted [DATE]. Further review revealed she was diagnosed with Unspecified Psychosis on 09/16/2023; Major Depressive Disorder on 07/28/2023; and Generalized Anxiety Disorder on 7/28/2023; Adjustment Disorder with Mixed Disturbance of Emotions and Conduct on 7/28/2024; Unspecified Mood (Affective Disorder) on 7/28/2023; and Anxiety Disorder on 7/28/2023. A record review of the Office of Behavioral Health- PASRR Level II Evaluation Summary and Determination Notice dated 07/10/2023 stated that a Level II decision is not required. There were no additional PASARR forms on or after the resident's diagnoses on 7/28/2023 in the resident's record. On 05/15/2024 at 3:30 p.m., an interview was conducted with S1ADM and S11SSD. Both confirmed that Resident #57 received a qualifying diagnosis after her admitted . Both confirmed the facility had not resubmitted for a Level II PASARR and should have.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on record reviews and interviews, the facility failed to ensure that a resident with a qualifying mental disorder, was not admitted to the facility before a preadmission screening by the State Office of Behavioral Health (OBH) was completed or obtained for 1 (#33) of 4 (#31, #33, #37, and #57) residents investigated for PASARR (Preadmission Screening and Resident Review) out of 34 sampled residents. Findings: Resident #33 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Major Depressive Disorder and Psychotic Disorder with Delusions Due to Known Physiological Condition. A review of the resident's quarterly MDS (Minimun Data Set) with an ARD (Assessment Reference Date) of 03/18/2024 revealed under section I: Primary Medical Condition, that the resident had diagnoses which included Depression and Psychotic Disorder. A review of the resident's current plan of care revealed: 1)The resident was physically aggressive. On 05/03/2023 the resident had a physical fight with another resident .Interventions included administering medications as ordered .intervene when resident becomes agitated . 2)The resident uses antidepressant medication .administer antidepressant medications as ordered by physician. A review of the resident's medical records revealed a PASARR Level II dated 04/28/2020 with a response from the Office of Behavioral Health stating the resident did not meet federal criteria for serious mental illness. There was no documentation of a PASARR Level I in the record. On 05/14/2024 at 4:25 p.m., an interview was conducted with S10LPN (Licensed practical Nurse). She stated that she had been working at the facility for two years and that Resident #33 had been at the facility well before her. S10LPN stated the resident did not like to get up in his chair and would scream when he was encouraged to do so. On 05/15/2024 at 10:21 a.m., an interview was conducted with S11SSD (Social Services Director). She stated that the resident was transferred from another facility on 10/22/2020 and since his transfer he had not had a new diagnosis. A review of the resident's admission records from the previous facility with S11SSD revealed that the resident had diagnoses including Violent Behavior, Major Depressive Disorder, and Psychotic Disorder with Delusions due to known Physiological Condition. S11SSD stated that she did not have a PASARR Level I screening from the previous facility to see what diagnoses were submitted to OBH. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024 at 1:00 p.m., S1ADM (Administrator) and S11SSD presented a copy of the Level I PASARR that was faxed from the resident's previous facility. A review of the Level I PASARR revealed a date of 01/28/2020 and under section 111: Mental Illness, the resident was suspected as having no mental illness. S11SSD confirmed that the facility did not request a Level I PASARR screening from the previous facility until it was requested by the survey team.

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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** 49176 Based on observations, record reviews, and interviews, the facility failed to develop and implement a person-centered care plan for 2 (#37 and #66) out of 2 residents investigated for care plans out of a total sample of 35 residents by: 1. failing to follow physician's orders for completing wound care for Resident #37, 2. failing to request a urine C/S (culture and sensitivity) from the laboratory after order was received for Resident #66 Findings: 1. Resident #37 Review of Resident #37's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to: Cerebral Infarction, Hemiplegia and Hemiparesis, Nontraumatic Intracerebral Hemorrhage, Contracture of Left Hand, and History of Falling. Review of Resident #37's nurse's notes revealed the resident had a fall on 04/21/2024 that resulted in a skin tear above his right eyebrow. Review of Resident #37's April 2024 physician's orders revealed the following order dated 04/25/2024: Skin tear right eyebrow: Clean with normal saline, pat dry, apply TAO (Triple Antibiotic Ointment) q (every) day until healed. Review of Resident #37's April 2024 TAR (Treatment Administration Record) revealed the following order dated 04/25/2024: Skin tear right eyebrow: Clean with normal saline, pat dry, apply TAO qday until healed. Treatment for the resident's skin tear was started on 04/25/2024. On 05/15/2024 at 04:55 p.m., an interview and record review was conducted with S3DONIP (Director of Nursing/Infection Preventionist). She reviewed Resident #48's April 2024 physician orders and TAR and confirmed the resident's treatment for his right eyebrow skin tear was not started until 04/25/2024, and should have been started on 04/21/2024. 49784 2. Resident #66 Review of Resident #66's electronic record revealed an admitted [DATE] with diagnoses that included Major Depressive Disorde.r Review of S15NP's Progress Note dated 03/26/2024 revealed that Resident # 66 was assessed for a chief complaint of urinary frequency with slight burning. S15NP ordered a UA (Urinalysis), C/S (Culture and Sensitivity) that was to be completed on the morning of 03/27/2024. (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 a nurse's progress note created by S21LPN on 03/26/2024 read: UA with C&S (Culture and Sensitivity) in the a.m. Review of the lab request form dated 03/26/2024 revealed a check in the box for Urinalysis w/ (with) reflex to culture. On 05/14/2024 at 2:30 p.m., a phone interview was conducted with a phlebotomist at the outpatient lab used for the resident's UA. The phlebotomist reported that the lab request sent for Resident #66 on 03/26/2024 from the facility, indicated that a UA with reflex culture was ordered. She stated the request for a urine culture was not indicated on the lab request, so therefore a urine culture was not performed. On 05/15/2024 at 1:12 p.m., a second phone interview was conducted with a Medical Technician from at the outpatient lab used for the resident's UA. The Medical Technician verified that if a provider orders a UA, C/S, the lab request should have a check mark placed for Urinalysis no reflex as well as a check mark for Culture, Urine. She confirmed that a Culture and Sensitivity should be requested and collected for an order for U/A, C/S.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on record review and interview, the facility failed to perform daily wound care as ordered by the physician and failed to provide weekly wound assessments for 1 (#48) of 3 (#17, #35 and #48) residents investigated for pressure ulcers. Findings: Review of Resident #48's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Cerebral Ischemia, End Stage Renal Disease, Arteriovenous Fistula, Atherosclertoic Heart Disease of Native Coronary Artery, Moderate Protein Malnutrition, and Muscle Wasting and Atrophy. Review of Resident #48's May 2024 physician's orders revealed the following: orders dated 04/13/2024: Right big top of toe, clean with normal saline, pat dry, apply betadine, leave open to air, every day until healed; Right foot inner heel, clean with normal saline, pat dry, apply betadine and cover with dressing, every day until healed. Further review revealed the following orders dated 05/01/2024: DTI (deep tissue injury) of Left great toe: Clean with normal saline, pat dry, apply betadine, cover with gauze wrap with kerlix q (every) day and PRN (as needed); Unstageable Pressure Injury to Right great toe: Clean with normal saline, pat dry, apply betadine, wrap with kerlix q day and PRN every day shift; and Unstageable Pressure Ulcer to Right Heel: Clean with normal saline, pat dry, apply betadine, cover with with kerlix q day and PRN. Review of Resident #48's May 2024 TAR (Treatment Administration Record) revealed the following orders dated 05/01/2024: DTI (deep tissue injury) to Left great toe: Clean with normal saline pat dry, apply betadine, cover with with kerlix q day and PRN; Unstageable Pressure Injury to Right great toe: Clean with normal saline, pat dry, apply betadine, wrap with kerlix q day and PRN every day shift; and Unstageable Pressure Ulcer to Right Heel: Clean with normal saline, pat dry, apply betadine, cover with with kerlix q day and PRN. There was no documentation that treatment was done for the resident's wounds on the date of 05/07/2024. Resident #48's April 2024 Weekly Wound Observation Tool failed to reveal an assessment of the resident's right great toe and right heel for the week of 04/30/2024. On 05/14/2024 at 3:13 p.m., an interview and record review was conducted with S3DONIP (Director of Nursing/ Infection Preventionist). She reviewed Resident #48's TAR and confirmed the resident's treatment to her left great toe, right great toe and right heel were not completed as ordered on 05/07/2024. S3DONIP then reviewed Resident #48's Weekly Wound Observation Tool and confirmed there was no right great toe or right heel wound assessment or measurements documented for the week of 04/30/2024.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39319 Based on observation, record review and interview the facility failed to ensure that a resident (#62) with limited range of motion received the appropriate treatment and services by failing to implement recommendation by the physical therapy department for the restorative nursing program for 1 (#62) of 1 resident investigated for position/mobility in a total sample of 35 residents. Findings: Review of the resident's electronic record revealed she was admitted to the facility on [DATE]. Her admitting diagnoses in part: Cerebral Vascular Accident, Unspecified Myoneural Disorder, Muscle wasting and atrophy, right and left thigh and lower leg, and Lack of coordination. On 05/13/2024 at 10:52 a.m., Resident #62 stated she received 3 to 4 days of therapy after she was admitted , but she was no longer receiving therapy because her insurance would not pay for the therapy. When asked if she was on a restorative program, she replied No. Review of the resident's quarterly MDS (Minimum Data Set) dated 04/11/2024 revealed a BIMS (Brief Interview of Mental Status) score of 15, indicating she was cognitively intact. She had functional limitation in range of motion to both lower extremities. She required substantial to maximal assistance with sitting to standing and chair/bed-to chair transfer. Toilet transfer and walking 10 feet or more was not attempted due to a medical condition or safety concerns. Further review under Section O-Special Treatments, Procedures and Programs revealed the resident was not receiving therapy or on the Restorative Nursing Program. On 05/14/2024 at 11:10 p.m., S17TD (Therapy Director) stated Resident #62 had started therapy but went to a different payer source and that payer source denied payment for her to continue receiving physical and occupational therapy. She stated they recommended that the resident be placed in the restorative nursing program. Review of the physical therapy discharge summary dated 11/03/2023 revealed the resident was seen for 4 days during the 10/26/2023 to 10/31/2023 progress period. Further review revealed that the resident was discharged due to a change in payer source. Discharge recommendations included in part, .Restorative program . Review of the Occupational Therapy discharge summary dated 11/07/2023 revealed the resident was seen for 4 days during the 10/26/2023 to 10/31/2023 progress period. Further review revealed that the resident was discharged because she reached her highest practical level. Discharge recommendation included in part, .Restorative Program . On 05/15/2024 at 9:35 a.m., S3DONIP (Director of Nursing/Infection Preventionist) stated that when therapy recommends a resident be placed on the restorative nursing program, a form is completed by the therapist and the Restorative aide. The form is then given to the Medical Records department and an order is generated for the resident to start receiving restorative care. The order is entered in the resident electronic record so that the restorative aides can document the restorative task. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 10:40 a.m., a review of the resident's Ambulation, Transfer and Range of Motion (ROM) Competency and Discharge Planning Form dated 11/13/2023 was reviewed with S3DONIP. She confirmed that this was the form completed by the therapist and the restorative aide when a resident is placed on the restorative nursing program. She confirmed that Resident #62's form had not been given to the Medical Records personnel; therefore, no order was obtained for the resident to be placed in the Restorative Nursing Program.

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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** 49176 Based on record review and interview, the facility failed to ensure the resident was free from accidents for 1 (#37) of 2 (#37 and #61) residents investigated for accidents. Findings: Review of Resident #37's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Cerebral Infarction, Hemiplegia and Hemiparesis, Nontraumatic Intracerebral Hemorrhage, Contracture of Left Hand and History of Falling. Review of Resident #37's significant change MDS (Minimum Data Set) dated 04/11/2024, revealed he had a BIMS (Brief Interview for Mental Status) score of 8, indicating the resident had moderate cognitive impairment. A review of Resident #37's care plan revealed he was at risk for falls and for an actual fall. Further review of the plan of care revealed Resident #37 had actual falls on 03/02/2024, 03/05/2024, 03/09/2024 and 04/21/2024. Interventions included in part .staff assist back to bed when ready. A review of the facility's investigative report by S1ADM (Administrator) on 04/21/2024 at 2:40 p.m., revealed Resident #37 would slide down in his wheelchair whenever he became tired. S19LPN instructed S22CNA (Certified Nursing Assistant) to put Resident #37 in his bed after lunchtime. Resident #37 fell and sustained a small laceration to his forehead right above the brow line as a result of S22CNA failing to put the resident in bed as instructed. On 05/15/2024 at 03:05 p.m., an interview was conducted with S19LPN. She stated on 04/21/2024, she found Resident #37 on the floor soon after the resident returned from lunch. When the resident returned from lunch, he was seated at the nurses' station, and attempted to slide out of his wheelchair. S19LPN stated she asked S22CNA to assist the resident into his room and transfer the resident to his bed to rest. S19LPN stated S22CNA did not bring the resident to his room to put him in his bed as instructed. As a result, the resident and was left in his wheelchair in his room, unsupervised, and fell shortly after S22CNA left the room. On 05/15/24 at 04:55 p.m., an interview was conducted with S3DONIP (Director of Nursing/Infection Preventionist). S3DONIP stated through the investigation conducted by the facility, it was determined the incident could have been prevented had Resident #37 been placed in bed as delegated per S19LPN.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on observations, record reviews and interview, the facility failed to ensure a resident received necessary respiratory care and services as evidenced by: 1. Failing to ensure the resident was assessed for respiratory therapy and 2. Failing to obtain a physician's order for respiratory therapy. This deficient practice was evidenced for 1 (Resident # 35) of 3 residents (# 35, # 50 and # 71) investigated for respiratory care. Findings: On 05/14/2024 a review of the facility's Policy and procedure titled, Oxygen Administration, with a revision date of February 2023, revealed in part: The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order .Review the resident's care plan to assess for any special needs of the resident .Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: .4. Vital Signs . Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record 1.The date and time the procedure was performed .4.The frequency and duration of the treatment. 5. The reason for p.r.n. (as needed) administration. 6. All assessment data obtained before, during and after the procedure. Review of Resident # 35's electronic medical record revealed the resident was readmitted to the facility on [DATE] with the following diagnoses, in part: Dysphagia Following Cerebral Infarction, Acute Respiratory Failure with Hypoxia, Seizures and Tracheostomy Status. Further review of Resident # 35's electronic medical record failed to reveal an assessment for respiratory therapy. Review of Resident # 35's May 2024 physician's orders revealed: 03/06/2024 Tracheostomy suction prn (as needed) every 24 hours as needed related to Tracheostomy status. Further review of Resident # 35's May 2024 physician's orders failed to reveal an order for additional respiratory therapy of oxygen administration via tracheostomy tube. Review of nursing progress notes revealed an entry dated 05/07/2024 at 8:10 p.m. per S20LPN (Licensed Practical Nurse): Resident returned from hospital per stretcher per ambulance, alert, trach (tracheostomy) not capped at present, trach mask and oxygen applied, sat (saturation) 94% . On 05/13/2024 at 6:50 a.m., an observation was made of Resident # 35 resting in bed with oxygen in place at 5 Liters via his tracheostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 8:26 a.m., Resident # 35 was observed resting in bed with oxygen in place at 5 Liters via his tracheostomy. On 05/14/2024 at 8:35 a.m., an interview and observation was conducted with S10LPN in Resident # 35's room. S10LPN confirmed Resident # 35 was receiving oxygen at 5 Liters via his tracheostomy. On 05/15/2024 at 4:20 p.m., an interview was conducted with S3DONIP (Director of Nursing / Infection Preventionist) who confirmed the resident did not have a respiratory assessment nor an order to receive oxygen at 5 Liters via tracheostomy and should have.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on interview and record review, the facility failed to thoroughly investigate and adequately intervene when the resident reported his pain medication was not treating his pain effectively for 1 resident (#326) out of 1 sampled resident (#326) for pain. Findings: Review of Resident #326's electronic record revealed an admitted [DATE] with diagnoses that included Pain Unspecified, Other Chronic Pain, and Chronic Venous Hypertension (Idiopathic) with Ulcer of Bilateral Lower Extremity. Review of Resident #326's MAR (Medication Administration Record) for May 2024 revealed the resident was ordered and received: Acetaminophen Tablet 650 mg (Milligrams). Give one tablet by mouth three times a day related to Other Chronic Pain, started on 05/07/2024. Gabapentin Capsule 300 mg. Give 1 capsule by mouth three times a day related to Other Chronic Pain, started on 05/07/2024. Oxycodone-Acetaminophen Tablet 7.5-325mg. Give 1 tablet by mouth every four hours as needed for pain, started on 05/07/2024. Review of his MAR indicated the resident had been receiving Oxycodone-Acetaminophen as needed 4-5 times a day since his admission. An average pain rating of 8-10 (0 means no pain, and 10 means the worst possible pain) was recorded prior to Oxycodone-Acetaminophen administration. The resident received a dose on 05/14/24 at 07:41a.m., approximately two hours before being interviewed below. On 05/14/2024 at 09:37 a.m., an interview was conducted with Resident (#326). He stated that his pain was at a level of 10 on the pain scale and was located in his lower extremities. He stated and he had received a dose of pain medication after 7:00 a.m., this morning but he remained in a great amount of pain. He stated that he received minimal relief from his pain medications. He stated he informed the nurses of this when they asked him about the effectiveness of pain medications. On 05/15/2024 at 10:18 a.m., an interview was conducted with S16LPN (Licensed Practical Nurse). She stated that the resident asked for pain medications every hour and that his pain medications were not effective. She stated that she had informed S15NP (Nurse Practitioner) at least three times since Resident #326's admission. She stated S15NP reported to her that he could not change the pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/2024 at 12:20 p.m., an interview was conducted with S15NP and S3DONNIP. S15NP stated the nurse had reported to him in the past that the resident's pain regimen was ineffective. He stated that he definitely found the pain regimen to be ineffective but wanted to wait for a period of time to make changes to Resident #326's pain medication. S3DONNIP verified that there was no progress note from the NP or nursing documentation since admit mentioning the ineffectiveness of Resident #326's pain regimen.

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	195328	A. Building B. Wing	05/15/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on record review and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility as evidenced by failing to change the physician's order to reflect dialysis treatment days for 1 (#48) out 1 (#48) resident investigated for dialysis. Findings: Review of Resident #48's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to: End Stage Renal Disease (ESRD), Arteriovenous Fistula, and Dependence on Renal Dialysis. Review of Resident #48's care plan read in part . The resident needs hemodialysis r/t (related to) ESRD with Pulmonary Edema/Congestion .new order noted: Resident to receive dialysis 3 days a week on M, W, F (Monday, Wednesday, Friday) at dialysis center. Review of the Resident #48's nurses notes dated 05/10/2024 at 2:35 p.m. revealed, pt (patient) will have a new day and time starting 5/13/2024. Chair time will be at 11:15 MWF notified van driver. Review of Resident #48's May 2024 physician's orders revealed the following order dated 01/22/2024: Resident to receive dialysis 3 days a week on T, R, S (Tuesday, Thursday, Saturday) at the dialysis center under the care of Dr.___ (nephrologist) On 05/14/2024 at 3:13 p.m., an interview and record review was conducted with S3DONIP (Director of Nursing/ Infection Preventionist). Resident #48's care plan, nurses notes, and May 2024 physician's orders were reviewed with S3DONIP. She confirmed Resident #48 attended dialysis on MWF and the current physician's order was not accurate and should have been revised.

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	195328	A. Building B. Wing	05/15/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record review, and interviews, the facility failed to ensure the Nurse Practitioner (NP): 1. Re-evaluated Resident # 66's urinary tract infection symptoms after lab (laboratory) results were received for 1(#66) of 3 residents (#66, #35, #52) investigated for UTI (Urinary Tract Infection); and 2. Responded to staff reporting a change in medical status for 2 (#66, #326) of 2 residents (#66, #326) investigated for UTI and Pain. This deficient practice had the potential to affect 73 residents that reside at the facility. Findings: 1. Resident #66 Review of Resident #66's electronic record revealed an admitted [DATE] with diagnoses that included Major Depressive Disorder. Review of Resident #66's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Review of a S15NP's Progress Note dated 03/26/2024 revealed that Resident #66 was assessed for a chief complaint of frequency with urination with slight burning. S15NP ordered a Urinalysis (UA) C/S (Culture and Sensitivity) to be collected on the morning of 03/27/2024. Review of nurse's note created by S21LPN on 03/26/2024 revealed new orders noted per S15NP UA with C/S in the A.M. Review of UA results collected on 03/26/2024 revealed Trace Blood, Positive Nitrites, and Moderate Bacteria. No Culture and Sensitivity was initiated. On 05/14/2024 at 3:00 p.m., an interview was conducted with Resident #66. The resident reported that she had been having burning with urination and frequency with urination for the last couple of days. She also stated months ago, she was having similar urinary symptoms. She stated she did not see the NP, but the nurse did collect her urine. She stated no one reported the results of her urine sample until she asked the nurse and who told her that she did not have an infection. Resident #66 stated no one, including the S15NP, asked her if her symptoms continued. She states she then treated the symptoms herself with a supply of AZO (medication for urinary pain relief) that she had in her purse. When she ran out of her AZO supply she reported her symptoms were better but returned again a couple of days ago. (continued on next page)

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	195328	A. Building B. Wing	05/15/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/15/2024 at 1:12 p.m., an interview was conducted with S15NP along with a review of his progress notes from 03/26/2024 to present date. He verified that he was aware of the UA results from 3/26/2024. He stated he could not recall relaying the results to her nor following up on her symptoms, but he should have. He also verified that there was no documentation from him regarding the UA results received on 03/26/2024 addressing her symptoms until 5/14/24. 2. Resident #66 Review of Section D of Resident #66's Quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed that the resident answered yes to feeling down, depressed or hopeless nearly every day. Section D also revealed that Resident #66 answered yes to trouble falling or staying asleep or sleeping too much. Review of the Resident's PHQ-9 (Patient Health Questionnaire) dated 04/16/2024 completed by S11SSD revealed the resident answered yes to feeling down, depressed or hopeless nearly every day. The PHQ-9 also revealed that resident answered yes to trouble falling or staying asleep or sleeping too much. Interview Details read: Resident stated that she has been depressed on nearly every day in the last two weeks because of things in the past with her family. Resident stated that on several days in the last two weeks she had trouble sleeping because she was worried about things going on with her funds. Further review of the resident's electronic medical record revealed S11SSD placed the resident on the S15NP's list to be seen for depression and difficulty sleeping. Review of S15NP's progress notes from 04/16/2024 to 05/15/2024 revealed no documentation regarding the resident's depression or trouble sleeping. On 05/14/2024 at 03:00 p.m. an interview was conducted with Resident #66. She verified that she had reported feelings of depression and that she was having trouble sleeping to S11SSD. She stated that no one, including the NP, had asked her about these issues since she reported them. She stated that the NP had not come to visit her for these issues, and continued to feel this way. On 05/14/2024 at 3:41 p.m., an interview was conducted with S11SSD. She stated she completed the PHQ-9 with the resident on 04/16/2024. She verified that the resident reported feeling down, depressed, or hopeless nearly every day and also had trouble with sleep. She stated that she placed the resident's name in the communication binder for the NP to address these problems, and she did specify on the communication form what symptoms the resident was experiencing. On 05/15/2024 at 1:12 p.m., an interview was conducted with S15NP who verified that his progress note for a visit on 04/16/2024 had no indication of the resident being assessed for depression or trouble sleeping. Resident #326 Review of Resident #326's electronic record revealed an admitted [DATE] with diagnoses that included Pain Unspecified, Other Chronic Pain, and Chronic Venous Hypertension (Idiopathic) with Ulcer of Bilateral Lower Extremity. Review of Resident #326's MAR (Medication Administration Record) for May 2024 revealed the resident was ordered and received: (continued on next page)

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	195328	A. Building B. Wing	05/15/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Acetaminophen Tablet 650 mg (Milligrams). Give one tablet by mouth three times a day related to Other Chronic Pain, started 05/07/2024. Gabapentin Capsule 300 mg. Give 1 capsule by mouth three times a day related to Other Chronic Pain, started 05/07/2024. Oxycodone-Acetaminophen Tablet 7.5-325mg. Give 1 tablet by mouth every four hours as needed for pain, started 05/07/2024. Review of his MAR indicated the resident had been receiving Oxycodone-Acetaminophen as needed 4-5 times a day since his admission. An average pain rating of 8-10 (0 mean no pain, and 10 means the worst possible pain) was recorded prior to Oxycodone-Acetaminophen administration. The resident received a dose on 05/14/2024 at 07:41a.m., approximately two hours before being interviewed below. On 05/14/2024 at 9:37 a.m., an interview was conducted with Resident (#326). He stated that his pain was at a level of 10 on the pain scale and was located in his lower extremities. He stated he had received a dose of pain medication after 7:00 a.m. this morning but he remained in a great amount of pain. He stated that received minimal relief from his pain medications. He stated he informed the nurses of this when they asked him about the effectiveness of pain medications. An interview was conducted with S16LPN on 05/15/2024 at 10:18 a.m. She stated that the resident asked for pain medications every hour and that his pain medications were not effective. She stated that she had informed S15NP at least three times since Resident #326's admission. She stated S15NP reported to her that he could not change the pain medication. On 05/14/2024 at 12:20 p.m., an interview was conducted with S15NP and S3DONNIP. S15NP stated the nurse had reported to him in the past that the resident's pain regimen was ineffective. He stated that he definitely found the pain regimen to be ineffective but wanted to wait for a period of time to make changes to Resident #326's pain medication. S3DONNIP verified that there was no progress note from the NP or nursing documentation since admit mentioning the ineffectiveness of Resident #326's pain regimen.

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	195328	A. Building B. Wing	05/15/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44269 Based on record review and interview, the facility failed to ensure a RN (Registered Nurse) was on duty for 8 consecutive hours per day for 7 days per week. Findings: Review of the facility's PBJ (Payroll Based Journal) Staffing Data Report for FY (Fiscal Year) Quarter 1, 2024 (October1 - December 31), revealed a One Star Staffing Rating. Review of Time Card Reports and RN (Registered Nurse) clock in hours for the months of October 2023 to December 2023 revealed an RN did not work a total of 8 hours for the following dates in October 2023: 10/13, 10/16, 10/17, 10/30, and 10/31. Further review revealed an RN did not work a total of 8 hours for the following dates in November 2023: 11/13, 11/14, 11/15, 11/20, and 11/22. On 05/14/2024 at 2:50 p.m., a phone interview was conducted with S1PBJ (Payroll Based Journal) who confirmed that the facility did not have an RN for 8 hours per day for the dates mentioned from October and November of 2023.

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	195328	A. Building B. Wing	05/15/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observations, interviews, and record reviews, the facility failed to ensure that their medication error rate was less than five percent, by failing to administer medications at the right time for 4 of 4 (#16, #41, #53, and #67) residents observed during morning medication pass. This deficient practice had the potential to affect a census of 74 residents. Findings: On 05/15/2024, a review of the facility's policy titled Administering Medications with a revision date of 04/05/2024, read in part: Policy heading: Medications are administered in a safe and timely manner, and as prescribed .3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . A review of the facility's medication pass schedule revealed Med Pass Times: Culture Times .BID (twice a day): 6 a.m. (before noon) - 11 a.m., 7 p.m. (after noon) - 10 p.m. TID (three time a day): 6 a.m. - 11 a.m., 12 p.m. - 1 p.m., 7 p.m. - 10 p.m . On 05/13/2024 beginning at 11:07 a.m., an observation was made of S18LPN (Licensed Practical Nurse) during morning medication pass on Hall W. As she was preparing the resident's medications, the EMARs (Electronic Medical records) revealed the following residents' names highlighted in red which indicated the medications were being administered late: Resident #16: Resident #16 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Cardiomyopathy, Chronic Diastolic Heart Failure and Essential Primary Hypertension. A review of current physician's orders revealed an order for Carvedilol tablet 3.125mg (milligrams) two times a day related to Essential Primary Hypertension. A review of the medication audit report revealed on 05/13/2024, Carvedilol tablet 3.125 mg was scheduled to be given at 7:00 a.m., but was administered by S18LPN at 12:18 p.m. Resident #41 Resident #41 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Unspecified Atrial Fibrillation, Unspecified Diastolic Congestive Heart Failure, and Anxiety Disorder. A review of current physician's orders revealed an order for Xanax Tablet 0.5 mg. Give 1 tablet by mouth two times a day for anxiety related to Anxiety Disorder. Further review revealed an order for Buspirone HCL (Hydrochloride) tablet 10 mg. Give 1 tablet by mouth two times a day related to Anxiety Disorder. (continued on next page)

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	195328	A. Building B. Wing	05/15/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medication audit report revealed that on 05/13/2024, Xanax Tablet 0.5 mg, and Buspirone HCL Tablet 10mg were scheduled to be given at 7:00 a.m., but were administered by S18LPN at 11:34 a.m. Resident #53 Resident #53 was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, Central Cord Syndrome at C2 Level of Cervical Spinal Cord, Central Cord Syndrome at C4 Level of cervical Spinal Cord, Neuralgia and Neuritis, Pain, and Legal Blindness. A review of current physician's orders revealed orders for Gabapentin capsule 100 mg Give 1 capsule by mouth three times a day for nerve pain related to Neuralgia and Neuritis, Timolol Maleate Ophthalmic Solution 0.5% (percent) Instill 1 drop in left eye two times a day for Intraocular pressure, and Docusate sodium capsule 100 mg. Give 1 capsule by mouth two times a day related to constipation. A review of the medication audit report revealed that on 05/13/2024, Gabapentin capsule 100 mg, Timolol Ophthalmic solution 0.5% and Docusate Sodium capsule 100mg were to be given between 6 a.m. to 11 a.m. , and were administered by S18LPN at 12:56 p.m. Resident #67 Resident #67 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to Hypertensive Heart Disease with Heart Failure, Type 2 Diabetes Mellitus without Complications, Atherosclerosis of Coronary Artery Bypass Graft (s) without Angina Pectoris, Vitamin Deficiency, and Critical Illness Myopathy. A review of current physician's orders revealed orders for Apixaban Oral Tablet 5 mg. Give 1 tablet by mouth two times a day related to Atherosclerosis of Coronary Artery Bypass Graft without Angina Pectoris, Jardiance Oral Tablet. Give 1 tablet by mouth one time a day related to Type 2 Diabetes Mellitus with Unspecified Complications, Magnesium Oxide Tablet 400 mg. Give 1 tablet by mouth two times a day related to Vitamin Deficiency, and Metformin HCL Oral Tablet 500 mg. Give 2 tablets by mouth two times a day related to Type 2 Diabetes Mellitus. A review of the medication audit report revealed that on 05/13/2024, Apixaban Oral Tablet 5 mg, Magnesium Oxide Tablet 400 mg, Jardiance Oral Tablet 25 mg, and Metformin HCL oral Tablet 500 mg were scheduled to be given at 7:00 a.m., but were administered by S18LPN at 11:47 a.m. On 05/13/2024 at 12:13 p.m., an interview was conducted with S18LPN. She stated that morning medication pass was between 6:00 a.m. and 11:00 a.m., but she was late for work this morning and reported it to the S3DONIP (Director of Nursing/Infection Control) and S4ADON (Assistant Director of Nursing). S18LPN confirmed all the medications listed above were administered late. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/2024 at 7:59 a.m., an interview was conducted with S3DONIP and S4ADON. S4ADON stated she worked the night shift on 05/12/2024 and was also on call. She confirmed that S18LPN called to inform her that she was running late for work. S4ADON stated that when she was leaving on 05/13/2024 at 9:30 a.m., S18LPN was just doing her narcotic count. S3DONIP stated that she became aware on 05/13/2024 at 7:18 a. m. that S18LPN was running late for work. She further stated that she was informed by S18LPN on 05/13/2024 at 3:00 p.m. that the medications were late. S3DONIP stated S18LPN should have informed her that residents' medications were going to be late, but she did not.

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	195328	A. Building B. Wing	05/15/2024

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on observation and interview, the facility failed to ensure the menu was followed for 2 (#27, #37) residents out of 3 (#27, #30, #37) residents who received pureed diets. Findings: Resident #27 was admitted to the facility on [DATE] with diagnoses including, but not limited to: Unspecified Dementia and Gastro-Esophageal Reflux Disease. Review of Resident #27's physician's orders revealed a diet order dated 08/04/2022 that read in part: Regular diet, pureed texture, thin consistency. Resident #37 was admitted to the facility on [DATE] with diagnoses including, but not limited to: Other Sequelae of Cerebral Infarction, Type 2 Diabetes Mellitus, and Gastro-Esophageal Reflux Disease. Review of Resident #37's physician's orders revealed an order dated 04/03/2024 that read in part: Reduced Concentrated Sweets diet, pureed texture, nectar thickened consistency. Review of the facility's menu for 05/13/2024 revealed breakfast consisted of the following food items: Cereal Cream of Wheat, Scrambled Egg, Bacon Strip or Sausage Link, Biscuit. On 05/13/2024 at 8:14 a.m., an observation was made in the facility's kitchen as nursing staff returned to the kitchen, stating Resident #37 did not have enough food on his plate and complained that his portions were small. The kitchen staff made a second plate for the resident, but did not put any pureed biscuit on the resident's plate. On 05/13/2024 at 8:25 a.m., S14Dietary was asked where the pureed biscuit was on the food serving line. She proceeded to remove the lid from a steam pan that held the container of pureed biscuit. It was covered with saran wrap that had not been opened or removed. S14Dietary confirmed that Resident #27 and #37 did not receive their pureed biscuit on their breakfast tray as listed on the menu and ordered by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Iberia Manor North	1803 Jane Street New Iberia, LA 70563

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44269 Based on record review, observation, and interview, the facility failed to ensure the resident received a mechanically soft chopped meats diet as ordered for 1 (# 61) of 3 (# 61, # 66, and # 71) residents investigated for food concerns in a final sample of 34 residents. Findings: Review of Resident # 61's record revealed he was admitted to the facility on [DATE] with diagnoses, in part . Sequelae Cerebral Infarction, Potential for Malnutrition, Other Speech and Language Deficits Following Cerebral Infarction. Review of the resident's physician orders for May 2024 revealed an order dated 02/01/2024, Mechanical soft texture, thin consistency, chop meats, no grapefruit products Review of the resident's care plan revealed Focus: Dietary Concern Speech Deficits, Protein Calorie Malnutrition Interventions included: Mechanical soft texture, thin consistency, chop meats, no grapefruit products. On 05/13/2024 at 8:55 a.m., an observation was made of Resident # 61 sitting up on the side of his bed feeding himself breakfast. The resident's meal tray was observed with a whole slice of bacon and a biscuit. Review of the resident's meal ticket on his breakfast tray revealed Regular Diet, mechsoft (mechanical soft) with chopped meat and entree included bacon crumbles. On 05/13/2024 at 9:00 a.m., an interview and observation was conducted with S10LPN (Licensed Practical Nurse) who confirmed the resident's breakfast meal was not his ordered diet. S10LPN further confirmed that the resident was supposed to have bacon crumbles instead of the whole slice of bacon that was present.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on observation and interview the facility failed to store food in accordance with professional standards for food service and ensure sanitary conditions were maintained in the kitchen by failing to: 1. Ensure cooked food items were not stored on the same shelf as raw food items; 2. Remove expired food items from the kitchen's walk in cooler. Findings: A review of the facility's policy titled, Food Receiving and Storage with a last reviewed date of [DATE] read in part: 12. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetable and other ready-to-eat foods. On [DATE] at 6:30 a.m., an observation was made of the kitchen's walk in cooler with S5DM (Dietary Manager). Observation of the cooler revealed a bottom shelf to the right of the cooler. There were 2 rolls of uncooked ground beef defrosting in a pan on the bottom shelf, and uncooked sausage and raw chicken defrosting in a second pan. In between the two pans, was a large pan covered in foil labeled with a date of , d+[DATE] and pinto beans. S5DM stated the beans had been cooked and confirmed cooked food items should not be on the same shelf as the raw meat. Further observation of the cooler revealed 2 containers of cottage cheese with expiration dates of [DATE]. S5DM confirmed they were expired and should have been removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195328	A. Building B. Wing	05/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46149 Based on observation, record review and interview, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections as evidenced by failing to ensure clean laundry and linen was not stored on the contaminated side of the laundry department. Findings: A review of the facility's environmental services policy with a last revised date of 10/2023, read in part: Laundry Flow .After washing, clean linens should be transported from the washing area to the drying area . Linen Storage .Clean linen must always be kept separate from contaminated linen through the use of separate rooms, closets, or other designated spaces with a closing door as the most secure methods for reducing the risk of accidental contamination. On 05/13/2024 at 10:29 a.m., an observation was made of the laundry department. S12Laundry was observed on the contaminated side of the laundry department placing soiled linen into the washing machines. She stated that clean laundry could not be stored on the contaminated side and no soiled laundry could be on the clean side. Further observation of the contaminated side of the laundry department revealed a basket of dried mop heads, mop pads, and towels in a rolling basket. S12Laundry was asked if the mop heads, mop pads, and towels were dirty. She then stated they were clean, but that was where they kept them until the end of each day. On 05/13/2024 at 10:31 a.m., an observation of the laundry department and interview was conducted with S13HSKSup (Housekeeping Supervisor). S13HSK confirmed the basket of mop heads, mop pads, and towels were clean and they always kept them on the contaminated side until they were distributed to the facility's housekeeping staff. Further observation was made of the contaminated side of the laundry department which revealed a covered cart with blankets and comforters. S13HSK stated the blankets and comforters were clean, and that was where they were stored. A gray bin was then observed against the wall next to the soiled laundry barrels. There were white folded blankets in the bin. S13HSKSup stated that they were clean blankets, and that was where the blankets were always stored. On 05/13/2024 at 10:37 a.m., an interview was conducted with S3DONIP (Director of Nursing/Infection Preventionist). S3DONIP confirmed that clean laundry and linen should not be stored on the contaminated side of the laundry department.