STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195336	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marrero Healthcare Center	5301 August Avenue Marrero, LA 70072

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to maintained infection control practices while disturbing drinks in the dining room for 2 (S6Certified Nursing Assistant, S7Certified Nursing Assistant[CNA]) of 2 staff observed serving drinks in the dining room. Findings:Review of the facility's undated Handwashing/Hand Hygiene policy revealed, in part, hand hygiene should be performed after touching residents' environment or belongings.Observation on 03/22/2026 at 12:15PM revealed S7CNA was refilling drinking cups from the hydration cart during lunch in the dining room. Further observation revealed the hydration cart contained 2 large carafes on the top shelf and a clear container with ice and an ice scooper on the second shelf. Further observation revealed S7CNA picked up Resident #8's personal drinking cup, opened the lid, picked up the ice scoop from the ice container, and refilled Resident #8's personal drinking cup with ice. Further observation revealed S7CNA placed the ice scoop into the ice container, with the handle of the ice scoop touching the ice. Further observation revealed S7CNA then picked up Resident #4's personal drinking cup, removed the lid, picked up the ice scoop from the ice container, and refilled Resident #4's personal drinking cup with ice. Further observation revealed S7CNA placed the ice scoop into the ice container, with the handle of the ice scoop touching the ice. Observation revealed S7CNA did not perform hand hygiene between picking up Resident #8's personal drinking cup and Resident #4's personal drinking cup. Observation on 03/22/2026 at 12:20PM revealed S6CNA picked up Resident #37's used drinking cup and brought it to S7CNA , who refilled Resident #37's cup with a beverage and ice. Further observation revealed S7CNA handed Resident #37's cup back to S6CNA, who returned the glass back to Resident #37. Further observation revealed S7CNA replaced the ice scoop back into the ice container, with the handle of the ice scoop touching the ice. Further observation revealed S7CNA and S6CNA did not perform hand hygiene during this observation. In an interview on 03/22/2026 at 12:25PM, S7CNA indicated she did not perform hand hygiene between picking up, opening and filling Resident #8's and Resident #4's cups with ice. S7CNA further stated she should sanitize her hands between assisting residents. S7CNA further indicated the ice scoop handle should not come into contact with the ice in the container. In an interview on 03/22/2026 at 12:35PM, S6CNA stated she did not perform hand hygiene before or after handling Resident #37's drinking cup and she should have. In an interview on 03/22/2026 at 12:45PM, S2Corporate Nurse indicated S7CNA and S6CNA should have performed hand hygiene in between handling residents' drinking cups. S2Corporate Nurse further indicated the ice scooper's handle should not come in contact with the ice in the container.

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
	195336	A. Building B. Wing	03/24/2026

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interviews and record review, the facility failed to ensure provider ordered laboratory services were completed as ordered for 1 (Resident #84) of 2 resident records reviewed for wound care. Findings:Review of Resident #84's Wound Care provider's progress note dated 02/25/2026 revealed orders for the nursing home to obtain a Complete Blood Count (CBC) (a blood test that measures the amount of white blood cells, red blood cells, and platelets), a Complete Metabolic Panel (CMP) (a blood test that measures several body functions and processes, such as kidney and liver functioning), an Erythrocyte Sedimentation Rate (ESR) (a blood test that is used to determine inflammation in the body), a C-Reactive Protein (CRP) (measures a protein made by the liver that increases when there is inflammation), a Prealbumin level (a blood test that measures the amount of protein in the dietary intake), and a Hemoglobin A1c (a blood test that measures the percentage of hemoglobin in red blood cells that has glucose attached, reflects the average blood sugar levels over the past 2-3 months) first week of the month, every 3 months. Review of Resident #84's record revealed no documented evidence that Resident #84's CBC, CMP, ESR, CRP, Prealbumin, and Hemoglobin A1c laboratory tests were competed as ordered by the Nurse Practitioner on 02/25/2026. On 03/23/2026 at 12:07PM, S2Treatment Nurse was presented with a request for Resident #84's above mentioned laboratory results. In an interview on 03/23/2026 at 12:07PM, S2Treatment Nurse indicated the facility was unable to present any documented evidence Resident #84's CBC, CMP, ESR, CRP, Prealbumin, and Hemoglobin A1c laboratory tests were competed as ordered by the provider. S2Treatment Nurse confirmed the above mentioned laboratory tests were not obtained as ordered and should have been. In an interview on 03/23/2026 at 12:23PM, S2Corporate Nurse confirmed Resident #84 did not have the above mentioned laboratory tests completed as ordered by the provider and should have.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record reviews, the facility failed to ensure staff donned necessary Personal Protective Equipment (PPE) during care to a resident on Enhanced Barrier Precautions (EBP) for 1 (Resident #61) of 1 sampled resident observed for catheter care. Findings:Review of the facility's policy for Catheter Care, Urinary, reviewed 03/03/2026, revealed, in part, staff are to maintain infection control by the use of EBP when handling or manipulating a resident's catheter drainage system. Review of the facility's policy for Enhanced Barrier Precautions, dated 04/01/2024 and reviewed 03/03/2026, revealed, in part, EBP were used in conjunction with standard precautions and expanded the use of PPE to donning of a gown and gloves during high-contact resident care activities that provided opportunities for the transfer of Multi-resistant organisms (MDROs) to staff's hands and clothing. Further review revealed, EBP was indicated for indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO. Further review revealed, an example of an indwelling medical device was a urinary catheter. Review of the facility's policy for Infection Prevention and Control Program, reviewed 03/03/2026, revealed, in part, to prevent infection, staff were educated to ensure they adhered to proper techniques and procedures. Further review revealed staff would implement appropriate isolation precautions when necessary and follow established general and disease-specific guidelines, such as those of the Centers for Disease Control. Review of Resident #61's care plan, initiated on 02/20/2026, revealed, in part, Resident #61 required EBP related to a urinary catheter. Review of Resident #61's physician's orders, dated 02/24/2026, revealed, in part, an order for Resident #61 to have an indwelling Foley catheter. Observation on 03/24/2026 at 9:10AM revealed S5Licensed Practical Nurse (LPN) performed Resident #61's catheter care without wearing a gown. In an interview on 03/24/2026 at 9:19AM, S5LPN indicated she should have donned PPE to provide Resident #61's catheter care due to Resident #61's EBP. In an interview on 03/24/2026 at 9:53AM, S4Infection Preventionist indicated S5LPN should have applied EBP PPE prior to performing Resident #61's catheter care. In an interview on 03/24/2026 at 10:09AM, S2Corporate Nurse indicated S5LPN should have applied Enhanced Barrier Precaution PPE prior to performing Resident #61's catheter care.