STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195578	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangeline Oaks Guest House	240 Arceneaux Road Carencro, LA 70520

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 distribute, store, and serve food in accordance with professional standards for food service safety by failing to ensure staff: 1 Labeled food items in the freezer with an open date;2. wore a beard restraint while preparing food items; 3. used hygienic practices while checking food temperatures on the serving line; and4. maintained a daily temperature log for the cooler and freezer. This deficient practice had the potential to affect the 72 residents who consumed food from the kitchen. Findings: On 06/02/2026, a review of the facility's policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices with no review date, read in part Policy Statement - Food services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation: 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food. On 06/02/2026, a review of the facility's policy titled, Food Receiving and Storage, with no review date, read in part .Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation.7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date.).11. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food service manager or designee and documented according to state specific requirements. 1. On 06/01/2026 at 8:30 a.m., an initial tour of the kitchen was conducted with S3DM. Upon entering the freezer, one opened clear plastic bag was observed that contained garlic cheddar biscuits with a small hole in the bottom of the bag. The package was not labeled with a date that it was opened. On 06/01/2026 at 8:31 a.m., an observation and interview was conducted with S3DM, who confirmed the bag was opened and not labeled and stated it should have been labeled and dated. 2. On 06/01/2026 at 8:35 a.m., further observation of the kitchen was conducted with S3DM. S4CH was preparing the dessert and placing the fruit crisp into small bowls. S4CH had a beard and was not wearing a beard restraint. On 06/01/2026 at 8:36 a.m., an interview was conducted with S3DM who confirmed S4CH should have been wearing a beard restraint while in the kitchen. 3. On 06/01/2026 at 9:04 a.m., a review of the kitchen's cooler and freezer temperature logs was conducted with S3DM. The temperature logs for the freezer and the cooler were not completed on the following dates in 2026: -March: 14th ,15th, 22nd, 23rd, 28th, and 29th. -April: 4th, 5th, 11th ,12th, 18th, 19th, 25th, 26th, and 31st. May 2nd, 3rd, 9th, 10th, 16th, and 17th. On 06/01/2026 at 9:05 a.m., an interview was conducted with S3DM who confirmed staff should have been documenting the temperatures for the cooler and freezer daily. 4. On 06/01/2026 at 9:40 a.m., S5C was observed putting the temperature monitor inside her pants pocket. The temperature gauge had a red string attached to it. S5C was then observed removing the temperature gauge from her pants pocket, removing the protective cover from the temperature gauge and placing it in the rice pan. The red string and the temperature gauge were observed resting on the rice. S5C was then observed replacing the protective covering on the tip of the temperature gauge and placing it inside of her pants pocket. On 06/01/2026 at 9:41 a.m., an interview was conducted with S5C who confirmed the string from the thermometer had been resting on the rice and stated she should not have placed the temperature gauge inside of her pants pocket.

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
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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 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** Based on record review and interview, the facility failed to ensure that a resident admitted to a facility without pressure ulcers received care to prevent the development of pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 (#54) out 2 (#7, #54) residents investigated for pressure ulcers out of a total sample of 33 residents. Findings:Resident #54. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, dementia, moderate-protein calorie malnutrition, and anorexia. Review of the resident's admission MDS (Minimum Data Set) dated 02/04/2026 revealed the resident was admitted without any pressure ulcers. Further review of the MDS revealed the resident required moderate assistance to roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back on the bed; required substantial to maximal assistance for chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair or wheelchair.Review of the resident's Braden Risk assessment dated [DATE] revealed the resident was at moderate risk for pressure ulcer. Review of the resident's skin evaluation note dated 03/10/2026, that was created by S2DON, revealed there was no documentation concerning skin issues with the resident's heels. Review of the resident's skin evaluation note dated 03/11/2026 revealed, Observation during am care revealed a deep tissue injury (DTI) to right heel; 3.5cm (centimeter) x 3.0cm 100% dark .On 06/02/2026 at 2:20 p.m., an interview was conducted with S2DON. S2DON stated that a skin evaluation was conducted on 03/10/2026 and confirmed that she did not assess the resident's heels. S1DON stated that she could not provide documentation the resident's heels were being floated and that heel boots were being used as an intervention prior to the development of the DTI to resident's right heel. S1DON confirmed the order for floating the heels was after the development of the DTI to the resident's right heel.

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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** Based on record review, observations, and interviews, the facility failed to ensure that a resident who smoked was free from potential accidents and hazards by staff failing to hold resident's lit cigarette for 1 (#15) out of 1 (#15) resident investigated for unsafe smoking. Findings:A review of the facility's smoking policy titled, Smoking Policy, with a last reviewed date of 03/01/2026, read in part.Policy: When the resident requests to smoke, the interdisciplinary team will assess the resident's capabilities and deficits to determine appropriate supervision and assistance.Procedure:.5. Any resident choosing to smoke will be assessed by a member of the interdisciplinary team utilizing the smoking evaluation form. This assessment will be completed upon admission, quarterly, with a change of condition and as needed. Individualized approaches and directions for safety and assistance will be documented in the resident plan of care and communicated to direct care staff.Review of Resident #15's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebrovascular disease, quadriplegia, muscle wasting and atrophy, and diffuse traumatic brain injury. Review of Resident #15's Smoking Safety Evaluation dated 03/03/2026 read in part.Evaluation:.4. Total or limited ROM (range of motion) in arms or hands.checked yes.Insufficient fine motor skills needed to securely hold cigarette.checked yes.Drops ashes on self.checked yes .Concerns:. 11. Unable to hold a cigarette safely.checked yes.Review of Resident #15's care plan read in part .unsafe smoker-wears two aprons when smoking, cigarette is lit and held by staff .A review of Resident #15's facility's document titled, Special Instructions, revealed in part. cigarette must be lit and held by staff .On 06/01/2026 at 1:17 p.m., an observation was made of Resident #15 in the smoking area, smoking a cigarette. The resident was observed with the cigarette held in her right hand.On 06/02/2026 at 12:50 p.m., an observation was made of Resident #15 in the smoking area. S7CNAS was observed handing the resident a cigarette, and lighting the cigarette. Resident #15 was observed smoking a cigarette with the cigarette held in her right hand. S7CNAS and S8CNA were observed monitoring the residents in the area.On 06/02/2026 at 12:55 p.m., an interview was conducted with S8CNA. She stated that Resident #15 was an unsafe smoker and the resident holds her own cigarette. Resident #15 continued to smoke with the cigarette held in her right hand.On 06/02/2026 at 2:06 p.m., an interview was conducted with S7CNAS. She stated Resident #15 was an unsafe smoker. She stated that staff had to light her cigarette, but the resident held her own cigarette to smoke.On 06/02/2026 at 2:08 p.m., a record review and interview was conducted with S9MDS. S9MDS reviewed Resident #15's Smoking Safety Evaluation, care plan, and facility's document titled, Special Instructions and confirmed the above documentation stated cigarette was to be held by staff. She further confirmed the resident should not have held her own cigarette.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to address the needs of a resident experiencing impaired nutrition, by failing to implement physician orders and registered dietician recommendations for 1 (Resident #25) out of 7 residents investigated for nutrition. Findings:Review of Resident #25's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, schizoaffective disorder, bipolar type and major depressive disorder. Review of Resident #25's Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating his cognition was intact.A review of Resident #25's Weights and Vitals Summary revealed a weight of 208.2 pounds on 11/21/2025 and a weight of 179.6 pounds on 05/06/2026. This indicated Resident #25 had a weight loss of 13.74% in 6 months. A review of Resident #25's Order Summary Report revealed the following physician orders in part:-04/23/2026 Add ice cream or pudding to lunch and supper daily,-04/23/2026 House supplement 4 ounces three times a day.A review of a dietary note on 04/22/2026 by the registered dietician revealed recommendations for house supplement 4 oz (ounces) tid (three times daily) and ice cream or pudding with lunch and supper.A review or Resident #25's dietary card for 06/02/2026 for lunch and dinner revealed no instructions for adding ice cream or pudding.A review or Resident #25's April, May, and June 2026 MAR (Medication Administration Record) revealed House Supplement three times a day anorexia 4 ounces with the letter X documented for every day. On 06/02/2026 at 10:45 a.m., an interview and record review was conducted with S10LPN who was assigned to Resident #25. After reviewing the MAR, S10LPN confirmed Resident #25 had an order for house supplement and stated she had not been offering it to the resident. On 06/03/2026 at 11:38 a.m., an interview and observation of Resident #25's lunch tray was conducted with Resident #25. The lunch tray did not contain ice cream or pudding. Resident #25 stated that he only received them sometimes. He also stated that no staff had been offering him a supplement. On 06/03/2026 at 11:42 a.m. an interview was conducted with S14LPN who was assigned to Resident #25. She stated I know for sure, he is not on any supplements when referring to Resident #25. On 06/03/2026 at 11:57 a.m., an interview and review of Resident #25's 06/02/2026 dietary card for lunch and supper was conducted with S3DM. She stated that she was not aware Resident #25 had an order for ice cream or pudding. She confirmed that the resident did not have any instruction for ice cream or pudding on his dietary card for lunch or supper and stated that he had only been receiving this when he had requested it. On 06/03/2026 at 12:10 p.m., an interview and record review was conducted with S2DON. She confirmed that the physician order for a house supplement for Resident #25 was not entered correctly in the software, and this was the reason X's are seen instead of staff initials on the MAR. She stated this was also the reason nurses were not notified by the software, during medication administration, to offer a supplement to the resident. She confirmed the resident should have had ice cream or pudding on his lunch or supper tray per the physician orders and registered dietician recommendations. S2DON stated that the dietary card should have had instructions to add ice cream or pudding with lunch and supper and it did not.

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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** Based on observation, record review, and interview, the facility failed to ensure the resident was receiving continuous oxygen at the ordered flow rate for 1 (#49) out of 33 sampled residents.Findings:Resident #49. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included congestive heart failure. Review of the resident's current physician's orders revealed an order for O2 (oxygen) at 1 Liter per nasal cannula continuously. On 06/03/2026 at 9:40 a.m., the resident was observed sitting up in her wheelchair in therapy room waiting for the physical therapist. During this observation, the resident was observed with oxygen in use at 2 liters per nasal cannula per portable oxygen tank. The portable oxygen tank was observed attached to the back of the resident's wheelchair. On 06/03/2026 at 9:42 a.m., S6LPN observed the resident in the therapy room. S6LPN checked the oxygen tank flow rate setting and confirmed the resident was receiving 2 liters of oxygen and not 1 liter of oxygen as ordered. After reviewing the resident's clinical record, S6LPN confirmed that there was no change in the orders and was not receiving the oxygen flow rate that was ordered.

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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** Based on record review and interview, the facility failed to ensure ongoing assessment and monitoring of the resident's dialysis access sites consistent with accepted professional standards for 1 (#3) out of 1 (#3) resident investigated for dialysis.Findings: Review of Resident #3 electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage renal disease, dependence of renal dialysis, and morbid obesity. A review of a physician Encounter Report dated 03/24/2026, read in part, LIJ (left internal jugular) Vas (Vascular) Cath (Catheter) placed on 01/14/2026. Review of Resident #3's Order Summary Report revealed a physician orders: 1. dated 07/30/2025, Patient to go dialysis every Monday, Wednesday, and Friday at dialysis provider. 2. dated 06/01/2026, Surgical vascular access keep incision clean and dry, cleanse daily with soap and water after the initial post-procedure period and apply a clean dressing daily. As needed. The order did not specify the location of the vascular access site. 3. dated 06/01/2026, Surgical vascular access Keep incision clean and dry, cleanse daily with soap and water after the initial post-procedure period and apply a clean dressing daily until healed. Every day shift 4. dated 02/02/2024, Monitor AV (arteriovenous) fistula right arm every shift. A review of Resident #25's MAR's (Medication Administration Record) and TAR's (Treatment Administration Record) for the months of February, March, April, May, and June 2026 failed to include monitoring of an LIJ (Left Internal Jugular) dialysis access that was placed on 01/14/2026. On 06/02/2026 at 12:30 p.m., an interview was conducted with S10LPN. S10LPN stated that she was the nurse assigned to Resident #3. When questioned about Resident #3's dialysis access sites, she stated that the resident only had a dialysis access site in his right arm. She stated that she is not aware of a chest wall dialysis access. On 06/03/2026 at 12:10 p.m., an interview and record review was conducted with S2DON. S2DON confirmed that Resident #3 had a LIJ (Left Internal Jugular) dialysis access on the left chest wall that was placed on 01/14/2026. She further confirmed that there was also a recent surgical site to the right arm dialysis access. She confirmed that there was no documentation that specified that the LIJ dialysis access was monitored for the months of February, March, April, May, and June of 2026 on the MAR or TAR. S2DON stated that the physician order should have been placed on the MAR (Medication Administration Record) or TAR (Treatment Administration Record) to prompt staff to monitor the access sites. She stated that this was the process for which the nurses would be informed of where the dialysis accesses were located to monitor. S2DON confirmed the process had not been implemented to monitor the LIJ dialysis access.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were accurately documented and maintained in accordance with professional standards of practice for 1 (Resident #2) out of 33 sampled residents.Findings:Review of the facility's policy titled, Colostomy/Ileostomy Care, with a last reviewed date of 03/01/2026 read in part, Documentation: The following information should be recorded in the resident's medical record. 1. The date and time the colostomy/ileostomy care was provided. 2. The name and title of individual(s) who provided the colostomy/ileostomy care. Review of Resident #2's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included but were not limited to: constipation, acquired absence of other specified parts of digestive tract, and encounter for attention to colostomy.Review of Resident #2's physician's orders revealed an order dated 05/28/2025 which read: Colostomy care every day and night shift for colostomy status related to encounter for attention to colostomy. Review of Resident #2's care plan revealed the following in part: Resident has a colostomy with external drainage bag requiring ongoing management with interventions that included in part, colostomy/urostomy care as ordered. Review of Resident #2's January 2026-June 2026 TAR (Treatment Administration Record) revealed the following in part: Colostomy care every day and night shift for colostomy status related to encounter for attention to colostomy with a start date of 5/28/2025. Further review revealed the TAR failed to include the nurse's initials or evidence that the treatment was administered for the following:-January 2026: 3 days on the 7:00 a.m. - 7:00 p.m. shift and 10 days on the 7:00 p.m. - 7:00 a.m. shift.-February 2026: 2 days on the 7:00 a.m. - 7:00 p.m. shift and 11 days on the 7:00 p.m. - 7:00 a.m. shift.-March 2026: 25 days on the 7:00 p.m. - 7:00 a.m. shift-April 2026: 23 days on the 7:00 a.m. - 7:00 p.m. shift.-May 2026: 21 days on the 7:00 p.m. - 7:00 a.m. shift.-June 2026: 2 days on the 7:00 p.m. - 7:00 a.m. shift. On 06/03/2026 at 9:55 a.m., an interview and a record review of Resident #2's TAR from January 2026 to June 2026 was conducted with S2DON. She confirmed the above physician's order for colostomy care to be provided each shift, and acknowledged the missing initials mentioned above on the resident's TAR. S2DON stated the day and night shift nurses should have documented that they monitored the resident's colostomy by initialing each box on the TAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to implement EBP (Enhanced Barrier Precautions) for a resident with an indwelling medical device for 1 (#3) of 33 residents sampled. Findings:On 06/03/2026, a review of the facility's policy titled Enhanced Barrier Precautions with a last review date of 03/01/2026, read in part, Enhanced Barrier Precautions: Policy Explanation and Compliance Guidelines- 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO (multidrug-resistant organism.) 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: a. dressing, c. transferring. g. device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. Review of Resident #3's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage renal disease, dependence of renal dialysis, and morbid obesity. A review of Resident #3's physician orders failed to reveal an order for EBP.A review of a physician Encounter Report dated 03/24/2026, read in part, LIJ (left internal jugular) Vas (Vascular) Cath (Catheter) placed on 01/14/2026. Review of Resident #3's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating his cognition was intact. On 06/02/2026 at 4:20 p.m., an interview was conducted with Resident #3. He stated that staff had never used gowns when caring for him; only gloves.On 06/03/2026 at 4:26 p.m., an observation and interview of S11CNA and S12CNA was conducted in Resident #3's room. S11CNA and S12CNA transferred Resident #3 from his wheelchair to his bed and changed his clothing, wearing gloves but no gown. A dressing to his left chest wall was visualized. Both S11CNA and S12CNA confirmed they did not wear a gown, and stated that gloves were the only form of PPE required when providing care for Resident #3. On 06/03/2026 at 12:10 p.m., an interview was performed with S2DON. She confirmed that Resident #3 had an indwelling medical device (central line) and had not been placed on EBP per facility policy. She further confirmed that staff should have worn gowns along with their gloves for high contact activities that included dressing and transferring. On 06/03/2026 at 12:20 p.m., an interview was conducted with S13IP. She confirmed that Resident #3 had an indwelling medical device (central line) and had not been placed on EBP per facility policy. She further confirmed that staff should have worn gowns with their gloves for high contact activities that included dressing and transferring.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews, the facility failed to ensure the kitchen equipment was maintained in safe operating condition as evidenced by a leaking faucet on the three-compartment sink and exposed electrical wires on the mixer. Findings: On 06/01/2026 at 9:12 a.m., an observation of the 3-compartment sink was conducted with S3DM (Dietary Manager). The water on the cold-water side could not be fully turned off. When asked about the process of reporting kitchen items in need of repairs, S3DM stated she had a maintenance book. She stated that every morning maintenance checked the book to see if anything needed repairs and signed off on the item once the repairs were completed. A review of the maintenance book with S3DM revealed the last date of requested maintenance on any kitchen item was on 11/28/2025. On 06/01/2026 at 9:13 a.m., a follow-up interview was conducted with S3DM who confirmed the sink faucet had been leaking and she and her staff had failed to inform maintenance that it needed to be repaired. On 06/01/2026 at 9:23 a.m., further observation of the kitchen with S3DM revealed a mixer with exposed electrical wires. The black casing for the electrical wires was split open with green, white, and black wires visible. The black wire was almost disconnected from the electrical port. S5C stated she tried to use the stand mixer on 05/31/2026 and it just made a funny noise and stopped working. She stated the mixer had not been working properly for some time. S5C confirmed she had not notified S3DM or maintenance that the mixer needed repair. On 06/01/2026 at 9:24 a.m., an interview was conducted with S3DM. She confirmed staff should have made her aware of the mixer being in disrepair. S3DM stated it should have also been documented on the maintenance log for repair.