STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195606	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Manor Nurse Care Center & Assisted LIV	306 Sydney Martin Road Lafayette, LA 70507

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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, 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 as evidenced by: multiple spots of build up debris and a red sticky substance on the covering of the ice machine;uncovered and expired food items stored in the refrigerator; andexposed hair and facial hair.This deficient practice had the potential to affect the 75 residents who consumed food from the kitchen.Findings:On 01/05/2026, a review of the facility's policy titled, Food Receiving and Storage, with a last reviewed date of 07/29/2025, revealed in part. Refrigerated/Frozen Storage 1. All food stored in the refrigerator or freezer are covered, labeled and dated (use by date).On 01/05/2026, a review of the facility's policy titled, Refrigerator and Freezer, with a last reviewed date of 07/29/2025, revealed in part.Food Preparation Area.5.Hair nets and beard restraints are to be worn while in food preparation areas. On 01/05/2026 at 8:31 a.m., a tour of the facility's kitchen was conducted with S1DM1 (Dietary Manager 1), who stated herself and S2DM2 (Dietary Manager 2) were responsible for the day to day management of the kitchen.On 01/05/2026 at 8:38 a.m., an observation of the ice machine was conducted with S1DM1 and revealed the covering of the ice machine had multiple spots of build up debris and a red sticky substance. S1DM1 confirmed the covering of the ice machine should have been cleaned and was not.On 01/05/2026 at 8:45 a.m., an observation of the refrigerator was conducted with S1DM1 and revealed a container of thickened water with no screw top covering attached. Further observation of the refrigerator revealed a container of thickened orange juice with an opened date of 12/03/2025. S1DM1 confirmed the thickened water should have had a screw top covering, and the thickened orange juice was expired and should have been removed from the refrigerator and discarded. On 01/05/2026 at 12:10 p.m., S4DW (Dishwasher) was observed in the kitchen with his hair and facial hair exposed and was not wearing a hair net or a beard restraint.On 01/05/2026 at 12:12 p.m., S2DM2 confirmed that S4DW should have been wearing a hair net and a beard restraint and was not.On 01/05/2026 at 2:18 p.m., S5Maint (Maintenance) was observed in the kitchen with his hair and facial hair exposed and not wearing a hair net or a beard restraint.On 01/05/2026 at 2:29 p.m., S2DM2 confirmed that S5Maint should have been wearing a hair net and a beard restraint and was not.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, record review, and interviews, the facility failed to ensure that a resident's physician was immediately notified of a change in the resident's skin condition for 1 (#17) resident out 2 (#17, #77) residents investigated for pressure ulcers. Findings:Review of the facility's policy titled Change in a Resident's Condition or Status with a review date of 07/29/2025, read as follows: 1. The nurse will notify the resident's attending physician or physician on call when there has been a: i. specific instruction to notify the physician of changes in the resident's condition. Review of Resident #17's medical record revealed an admission date of 10/08/2024 with diagnoses that included cerebral infarction, prediabetes, and vascular dementia. On 01/05/2026 at 9:59 a.m., an observation was made of Resident #17 with an uncovered, open abrasion on her left facial cheek. On 01/06/2026 at 3:20 p.m., a second observation was made of Resident #17 who remained to have the uncovered, open abrasion on her left facial cheek. Review of Resident #17's medical record revealed there was no evidence that the physician had been notified. On 01/06/2026 at 3:30 p.m., a concurrent observation and interview was conducted with S4LPN (Licensed Practical Nurse) of Resident #17. S4LPN observed the uncovered open abrasion to Resident #17's left facial cheek and stated that she had not noted it when she observed her Resident #17 throughout the day and further confirmed that this was a change in the resident's condition; therefore, the physician should be notified to obtain treatment orders. S4LPN then reviewed Resident #17's medical record and confirmed there was no evidence the physician had been notified of the resident's change in skin condition.On 01/07/2026 at 10:25 a.m., a third observation was made of Resident #17 with the uncovered open abrasion on her left facial cheek. On 01/07/2026 at 3:50 p.m., a concurrent observation, record review and interview was conducted with S5DON (Director of Nursing) of Resident #17. S5DON observed the open abrasion on Resident #17's left facial cheek and confirmed this was a change in the resident's condition that warranted a physician's notification and should have been done by S4LPN when she learned about it on 01/06/2026. S5DON then reviewed Resident #17's medical record and further confirmed there was no evidence of a physician notification.

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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. 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 (Pre-admission Screening and Resident Review) evaluation and determination for 1 (#33) of 3 residents investigated for PASARR. A review of Resident #33's record revealed an admission date of 08/15/2024 with diagnoses that included in part, dementia in other diseases classified elsewhere, unspecified severity, with agitation and unspecified psychosis not due to a substance or known physiological condition. Further review revealed she was diagnosed with major depressive disorder on 10/07/2024. A review of Resident #33's Level I Pre-admission Screening and Resident Review dated 07/11/2024 was conducted. Review of Section III, 1. revealed in part, an empty box next to the diagnosis of major depressive disorder. A review of the Resident #33's document Medicaid Program, Notice of Medical Certification dated 07/30/2024 revealed that a Level II decision was not required. On 01/07/2026 at 2:36 p.m., an interview and review of Resident #33's record was conducted with S3ADM (Administrator). S3ADM confirmed that Resident #33 received a qualifying diagnosis after her admission date and after the last PASSAR was completed on 07/11/2024. She further confirmed the facility should have resubmitted for a Level II PASARR evaluation and determination to include the new diagnosis of major depressive disorder and had not.

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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** Based on record review and interview, the facility failed to ensure a resident identified with a mental disorder had an accurately completed PASARR (Pre-admission Screening and Resident Review) on admission for 1 (Resident #57) of 3 residents investigated for PASARR.Resident #57 was admitted to the facility on [DATE] with diagnoses that included in part, unspecified dementia, unspecified psychosis not due to a substance or known physiological condition, depression, and generalized anxiety disorder. A review of Resident #57's PASARR dated 02/24/2025 was conducted. Review of Section III, 1., revealed in part, an empty box next to Other Psychotic Disorder. A review of Resident #57's document Medicaid Program, Notice of Medical Certification dated 02/28/2025 revealed in part that a Level II decision was not required. On 01/07/2026 at 2:30 p.m., an interview and review of Resident #57's record was conducted with S3ADM (Administrator). S3ADM stated that the PASARR dated on 02/24/25 was completed by another facility prior to admit and was the most current PASARR for the resident. S3ADM confirmed that Resident #57 had a diagnosis on admit of unspecified psychosis not due to a substance or known physiological condition, and confirmed that the box next to Other Psychotic Disorder should have been checked on the PASARR. She further confirmed the PASARR dated for 02/24/2025 had not been accurately completed to include this diagnosis upon Resident #57's admission to the facility.

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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** Based on observation, record review, and interview, the facility failed to implement the comprehensive person-centered care plan and a physician order for a concave mattress for 1 (Resident #76) of 27 sampled residents.Review of Resident #76's record revealed the resident was admitted to the facility on [DATE] with diagnoses that include in part, anxiety disorder, unspecified dementia, psychotic disorder with delusions, Alzheimer's Disease, and bipolar disorder. A review of Resident #76's Order Summary Report revealed a physician order dated 10/14/2024 for Concave mattress every shift. A review of Resident #76"s Care Plan Report revealed in part: Focus: I am at risk for falls related to impaired mobility, generalized weakness and multiple medication use. Interventions: Maintain concave mattress to my bed.On 01/06/2026 at 2:12 p.m., an observation was made of Resident #76's empty bed. The mattress looked flat and not concave.On 01/07/2026 at 8:40 a.m., an observation was made of Resident #76's empty bed. The mattress looked flat and not concave.On 01/07/2026 at 1:56 p.m., an observation was made with S6CNA (Certified Nursing Assistant) of Resident #76's empty bed. S6CNA confirmed that Resident #76's mattress was a regular mattress and not a concave mattress.On 01/07/2026 at 2:00 p.m., a review of Resident #76's record, interview, and observation of Resident #76's empty bed was made with S5DON (Director of Nursing). S5DON confirmed that Resident 76's mattress was not a concave mattress. She confirmed that Resident #76 should have a concave mattress according to the physician orders and the comprehensive care plan.