STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interviews, the facility failed to ensure dietary support personnel had the appropriate competencies and skill sets to safely and effectively carry out the functions of the food and nutrition service. The facility failed to ensure S6HSK, S7HSK, and S8FS were competent to effectively and sanitarily perform the functions of the facility's dishwasher. This deficient practice had the potential to affect any of the 74 residents who received meals from the facility's kitchen. Findings:Review a document titled Cleaning Policies and Procedures no review date read in part: Once utensils and equipment have been cleaned and sanitized, they should be allowed to air dry; the use of towels may re-contaminate sanitized surfaces. An interview was conducted with S10HSKS on 04/13/2026 at 8:31 a.m. S10HSKS stated that since 01/2026 the kitchen staff needed assistance. She stated some staff that work in housekeeping would help in the kitchen on their days off. S10HSKS stated S6HSK, S7HSK, and S8FS helped in the kitchen by washing dishes. S10HSKS stated she had not trained S6HSK, S7HSK or S8FS on the proper procedure of washing dishes. An interview was conducted with S11C on 04/13/2026 at 10:14 a.m. S11C stated staff from other departments had been helping out in the kitchen when they were short staffed. S11C confirmed that staff should not use a towel to finish drying the dishes when the dishwasher is completed. She stated dishes should not be put away wet but a towel should not be used.An interview was conducted with S6HSK on 04/13/2026 at 12:51 p.m. S6HSK confirmed that she helped in the kitchen by washing dishes when S5C was working alone in the kitchen. She stated S9D showed her how to operate the dish washing machine. She confirmed that S9D did not train her in ensuring the temperature of the water was appropriate, and she was not trained on ensuring the chemical reading was adequate for sanitation. S6HSK stated after initiating the wash cycle, when the dishes had completed the rinse cycle, the dishes came out with a lot of steam, but the dishes were not dry completely. She stated S9D instructed her to use a dry towel to ensure the plates and cups were completely dry before she replaced them inside the cabinet. An interview was conducted with S7HSK on 04/13/2026 at 12:57 p.m. S7HSK confirmed on some of her days off, she helped in the kitchen by washing dishes. She stated S9D instructed her how to load the machine and how to clear the rack when the cycle was completed. S7HSK stated S9D had instructed her to use a dry towel to ensure after the completion of the cycle to ensure the dishes were completely dry prior to placing the dishes in the cabinet. S7HSK stated she was not trained on how to check the temperature on the dishwashing machine, or how to check the chemicals for proper sanitation. An interview was conducted with S8FS on 04/13/2026 at 1:05 p.m. S8FS confirmed on some of his days off he helped in the kitchen by washing dishes. S8FS stated S9D had instructed him about the temperature. He stated he was told about the chemicals, but he guessed someone else had checked the chemicals of the dishwasher. He stated he had not checked the temperature or the chemicals for the dishwasher. S8FS stated he used the dry towel to completely dry the plates and cups before he put them in the cabinet.An interview was conducted with S9D on 04/13/2026 at 3:04 p.m. S9D confirmed that he instructed S6HSK, S7HSK, and S8FS on how to use the dishwashing machine. He confirmed that he should not have instructed the above staff to use a dry towel to complete drying the dishes after removing the clean dishes from the rack.

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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Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on record review, observations, interviews, the facility failed to ensure sufficient dietary support personnel were employed to safely and effectively carry out the functions of the food and nutrition service. This deficient practice had the potential to affect any of the 74 residents who received meals from the facility's kitchen. Findings: A review of the facility's dietary schedule for 04/01/2026 - 04/15/2026 revealed on 04/2, 04/03, 04/04, 04/05, 04/08, 04/09, 04/10, 04/11, 04/14, and 04/15 one staff was scheduled for the morning shift. On 04/13/2026 at 8:40 a.m., an observation was conducted in the kitchen. S5C and S11C were observed in the kitchen. An interview was conducted with S11C. She stated many days they had to work short. She stated staff from other departments came to the kitchen to help them. She confirmed that the staff from other departments are not trained on kitchen procedures, but they are just shown how to wash the dishes. On 04/14/2026 at 6:15 a.m., an observation of the kitchen was conducted. S5C was observed preparing breakfast for the residents. Further observation revealed no other dietary staff was in the kitchen or scheduled to be in the kitchen. S5C was observed preparing grits, oatmeal, biscuits, toast bread, eggs, sausage, puree sausage, chopped sausage, and puree eggs. On 04/14/2026 at 6:22 a.m., an interview was conducted with S5C who stated she was working in the kitchen by herself. She confirmed S3DM was aware since 04/13/2026 that she was on the schedule as the only staff for that morning. She added if anyone was supposed to help her, they would have been in the kitchen by now. S5C stated many times when she did not have help in the kitchen, she called S2DON and S2DON would have staff from other departments come to the kitchen to assist by washing the dishes. On 04/14/2026 at 4:20 p.m., an interview was conducted with S13D who stated many times the staff in the kitchen had been working short staffed. She stated staff from other departments come to the kitchen to help wash dishes. S13D confirmed the staff from other departments were not trained in the kitchen.

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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. Based on record review, observations and interviews, the facility failed to distribute, store, and serve food in accordance with professional standards for food service safety by failing to ensure:1. The food service area remained in a sanitary condition during the meal prep process.2. The ice scoops were stored away properly to prevent or minimize the spread of foodborne illnesses.3. Residents cups were stored inverted or covered.4. Staff monitored equipment to ensure that it was functioning properly.This deficient practice had the potential to affect the 74 residents who were served food from the kitchen. Findings: Review of the facility's policy titled Ice Scoop Storage with no revision date read in part: Policy - ice scoops must be stored and maintained to prevent contamination. Ice is considered a food item and must be protected. Procedure: 1. Approved storage methods - store ice scoops in a clean holder outside the ice machine or in a clean container. 3. Cleaning and Sanitizing - clean and sanitize scoops daily or when contaminated. Storage containers must be cleaned routinely. Review of the facility's policy titled Dishware/Utensils Storage Policy with no revision date read in part: Policy - all dishes, glassware, cups shall be properly cleaned, sanitized, dried, and stored in a manner that protects them from contamination and ensures resident safety. Procedure: 3. Storage requirements - store dishware at least 6 inches off the floor in clean, dry areas, protected from contamination. Items must be stored inverted or covered. On 04/13/2026 at 11:10 a.m., an observation in the kitchen was conducted which revealed a black fan located about two feet away from the prepping table. Upon further observation it was revealed that the fan had small amounts of visible dust on the fan grill and fan blades. S5C was observed cutting a lemon pie and placing its slices into individual white bowls. The black fan was observed blowing directly towards the prepping table where S5C was slicing lemon pie and placing them into small individual bowls. On 04/13/2026 at 11:15 a.m., further observation revealed an uncovered white plastic bucket. The white plastic bucket was observed on the second shelf of a table which was used for prepping and the placement of condiments. Further observation revealed three scoops inside the uncovered bucket. Two large scoops and one small silver scoop. S9D was observed using the large silver scoop to put ice into the residents' drinking cups. After filling the cups with ice, S9D was observed placing the scoop back inside the uncovered white bucket. On 04/13/2026 at 11:25 a.m., continued observation of the kitchen revealed a black shelf which contained residents' cups that were stored facing upward and were not covered. On 04/13/2026 at 11:56 a.m., an interview was conducted with S4IC. S4IC confirmed the black fan should not be directed toward the area where food was prepared, and the fan should have been cleaned and without visible dust. He stated the scoops inside the white bucket should have been covered. She added that ice is considered a food item and the scoops should have been covered while not in use. S4IC stated the cups were supposed to be facing downward, inverted and not facing upward to prevent contamination. On 04/13/2026 at 11:58 a.m., an interview was conducted with S3DM who stated she was not aware that the scoops were supposed to be inside a plastic bag or covered while not in use. She stated she was not aware that cups had to be stored inverted or covered. She confirmed that a fan should not have been utilized in the kitchen area especially during meal prep.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, observation, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure the well-being of residents by failing to provide oversight of the kitchen's practices for safe food service. The deficient practice had the potential to affect the 74 residents who consumed meals prepared from the facility's kitchen. Findings:Review of a document titled Ice Scoop Storage with no revision date read in part: Policy - ice scoops must be stored and maintained to prevent contamination. Ice is considered a food item and must be protected. Procedure: 1. Approved storage methods - store ice scoops in a clean holder outside the ice machine or in a clean container. 3. Cleaning and Sanitizing - clean and sanitize scoops daily or when contaminated. Storage containers must be cleaned routinely. Review of a document titled Dishware/Utensils Storage Policy with no revision date read in part: Policy - all dishes, glassware, cups shall be properly cleaned, sanitized, dried, and stored in a manner that protects them from contamination and ensures resident safety. Procedure: 3. Storage requirements - store dishware at least 6 inches off the floor in clean, dry areas, protected from contamination. Items must be stored inverted or covered. Review of the facility's policy titled Three Compartment sink with no review date read in part. we test the water in our three compartment sink daily for the QAC (Quaternary Ammonium Compounds). Accurate testing requires a minimum of five full pumps of the sanitizer to the 1/2 full sink compartment. We are looking for a reading of 200 p.p.m (parts per million). On 04/13/2026 at 8:35 a.m., a tour of the facility's kitchen revealed a black fan in use. The fan was set at medium speed and dust could be seen on the grill of the fan. S5C was observed standing with her back to the fan as she was slicing a lemon pie on the prep table. S5C was observed placing the slices of lemon pie into individual bowl for the residents. Further observation revealed a black open shelf. Upon this shelf were a stack of clear plastic cups which were not stored invertedly or covered. On 04/13/2025 at 11:25 a.m., continued observation of the kitchen revealed a white plastic bucket uncovered. The white bucket contained three scoops. Two large scoops and one smaller scoop not covered. A large puddle of water was observed on the floor beneath the ice machine. On 04/13/2026 at 11:30 a.m., review of the facility's form titled temperature log which was used for the food line revealed documentation for 03/28/2026. No other documentation was provided on the facility form. Review of the facility's form titled Daily Kitchen Cleaning Schedule revealed an entry on 04/12/2026 that indicated the dish area and coffee station were mopped. No other documentation was observed on the document. Review of the facility's form titled 3 Compartment QAC revealed on 03/29/2026 and 03/30/2026 S11C documented no strips. No further entries were documented. Review of the facility's document titled Refrigerator Temperature Log dated 03/2026 revealed temperature entries from 03/15/2026 - 03/31/2026. No further entries or documentation were provided. Review of a document titled Coffee/Hot Beverages Temperature Log dated 03/2026 revealed no logged temperatures for 03/012026 - 03/02/2026, 03/04/2026, 03/06/2026 - 03/12/2026, 03/15/2026 - 03/16/2026, 03/19/2026- 02/21/2026, 03/23/2026 - 03/24/2026, 03/26/2026 - 03/31/2026. On 04/14/2026 at 6:34 a.m., observation of S5C utilizing the three-compartment sink. S5C was observed squeezing the soap into the basin of water. When asked why she was squeezing the soap into the water, she stated because the dispenser was not working. She stated it had not been functioning properly for about three months. She added that the facility did not have any strips to test the chemicals since 03/30/2026. She stated she had been requesting more forms to record the temperatures on the food line, but staff had not received them yet. She stated staff had been writing the temperatures on a napkin. On 04/14/2026 at 8:39 a.m., a phone interview was conducted with S14RD. S14RD stated she had little oversight of S3DM. She stated she performs a walk-through of the kitchen checking for cleanliness. She stated she makes her rounds twice monthly. She stated her duties were to review and sign the menus, complete annuals, review the residents who are on tube feedings, and review the residents who had weight loss. She stated she was not aware of the issues in the kitchen. She stated (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she relies on the dietary managers to ensure the kitchen is well maintained and running properly. On 04/14/2026 at 10:04 a.m., an interview was conducted with S3DM. S3DM stated she was not aware that staff had not been conducting the necessary temperature and chemical checks. An observation of the incomplete forms was conducted with S3DM, who asked where the forms had come from. She stated she had not seen these in the kitchen. When asked who oriented her to the kitchen and had oversight, she stated no one oriented her to the kitchen. She stated she used the years of experience to navigate her duties and responsibilities in the kitchen. When asked if she was aware of the three-compartment sink not working properly, she stated she was not aware the three-compartment sink did not function properly. She stated she was not aware staff did not have the strips necessary to test the chemical in the three-compartment sink. She stated someone placed the empty bottle on the top of her desk, so she just ordered a new bottle. She stated she was not aware staff did not have the forms to record the food line temperatures. On 04/14/2026 at 1:09 p.m., an interview was conducted with S1RADM who stated he was not aware of all the different issues that were discussed above. S1RADM confirmed he was not aware that some of the kitchen equipment was not working properly. S1RADM stated that S14RD is contracted with the facility, and she is also responsible for ensuring the dietary manager is doing what she is required of her.

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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 kitchen equipment was maintained in a safe operating condition by failing to ensure:A leak beneath the ice machine was reported to maintenance in a timely manner.Staff monitored equipment to ensure that it was functioning properly. Findings:1. On 04/13/2026 at 11:33 a.m., an observation of the kitchen was conducted which revealed an ice machine that had a large puddle of water pooled beneath the machine. On 04/13/2026 at 11:36 a.m., an observation and interview was conducted with S3DM. S3DM was unaware of the leak beneath the ice machine. On 04/13/2026 at 12:03 p.m., an interview was conducted with S12M. S12M stated that kitchen staff had not reported a leak beneath the ice machine to him, nor did they write it in his maintenance logbook. On 04/14/2026 at 10:50 a.m., an interview was conducted with S5C who stated that the ice machine has had a leak for at least three months. She stated she did not report this to S12M, she thought S3DM would get that taken care of. 2. On 04/13/2026 at 11:33 a.m., further observation of the kitchen revealed the three-compartment sink. S5C was observed squeezing the bottle of soap, which read pot and pan dish soap, into the basin of water. When S5C was asked why she was squeezing the soap into the basin, and not using the machine dispensing the soap automatically, she stated the dispenser had been broken for at least three months. When asked how she knew how much soap to dispense and how much she had actually dispensed, she stated she did not know how much soap she was adding to the basin. On 04/13/2026 at 12:21 p.m., an interview was conducted with S3DM. S3DM was asked if she was aware the three-compartment sink was not working properly, she stated she was not aware the three-compartment sink was not working properly.