

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Consolata Rehab and Wellness Center on the Teche		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, policy review, record review, and interviews, the facility failed to implement and maintain an effective infection control and prevention program by failing to: 1. Implement a system of surveillance that included pathogen data to properly identify possible communicable diseases or infections before they spread. 2. Ensure staff used personal protective equipment according to accepted standards of practice as evidenced by staff not wearing the appropriate Personal Protective Equipment (PPE) while providing high contact care for 2 (#27, #54) residents who were on enhanced barrier precautions. Findings: 1. A review of the facility's policy titled, Surveillance for Infections, with a last reviewed date of 02/26/2026, read in part. Policy Statement: The infection preventionist conducts ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. Data Collection and Recording. 4. For targeted surveillance using facility-created tools, follow these guidelines: c. Monthly: Summarize monthly data for each nursing unit by site and by pathogen (e.g. (for example), Facility-Wide Monthly Infection Report by Site, Facility-Wide Monthly Infection Report by Pathogen, or similar form). A review of the facility's form titled, Infection Surveillance Information Forms for February 2026, March 2026, and April 2026 revealed that not all pathogens from culture results were recorded for infection surveillance. Further review revealed the monthly facility infection control maps for those corresponding months did not contain the use of specific pathogens for surveillance. On 06/10/2026 at 2:45 p.m., an interview and review of infection control records was conducted with S8IC/TXN. She confirmed that there was no evidence that all specific pathogens from lab results, as indicated on the Infection Surveillance Information Forms for February 2026, March 2026, and April 2026, were recorded and used for surveillance on the monthly Infection Control Maps for the corresponding months. She further confirmed that recording and tracking these specific pathogens on the facility monthly maps was the facility's protocol for surveillance of infections. On 06/10/2026 at 3:45 p.m., an interview and review of infection control records was conducted with S1DON. She confirmed the above findings. 2. Review of a facility policy titled Enhanced Barrier Precautions, with revised date of 12/2024, read (continued on next page)		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in part. Policy Interpretation and Implementation: 1. enhanced barrier precautions refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 7. Enhanced barrier precautions employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. 8. Examples of high contact resident care activities requiring the use of gowns and gloves include: d. changing briefs or assisting with toileting; g. changing linens. Resident #27 Review of Resident #27's Electronic Medical Record (EMR) revealed an admit date of 12/11/2025 with diagnoses that included metabolic encephalopathy, gastrostomy, and Kennedy ulcers to right hip and sacrum. Resident has continuous tube feedings. Review of Resident #27's physician orders dated 01/08/2026 read in part, enhanced barrier precautions to be during resident high contact activities every shift. On 06/08/2026 at 2:24 p.m., S6CNA and S7CNA were both observed changing the resident's adult brief without wearing the appropriate personal protective equipment (PPE) by not wearing a gown while providing patient care. Resident #54 Review of Resident EMR revealed an admit date of 04/28/2026 with diagnosis that included peripheral vascular disease, atherosclerosis arteries of left leg with ulceration, and Stage IV pressure ulcer. Review of Resident #54's physician orders dated 04/29/2026 read in part, enhanced barrier precautions to be during resident high contact activities every shift. On 06/08/2026 at 2:31 p.m., S6CNA and S7CNA were observed changing Resident #54's soiled linen and changing his adult brief without the appropriate PPE. Both S6CNA and S7CNA failed to put on a gown during patient care. On 06/08/2026 at 3:10 p.m., an interview was conducted with S7CNA who stated she was not aware that Residents #27 and #54 were on enhanced barrier precautions. She confirmed that she and S6CNA should have been wearing gowns prior to changing the adult briefs and changing soiled linen. On 06/10/2026 at 8:10 a.m., an interview was conducted with S8IC/TXN who confirmed S6CNA and S7CNA should have been wearing gowns as well as gloves prior to changing Resident #54's soiled linen and changing the resident's adult briefs.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record review, observation and interview, the facility failed to ensure the resident's food was palatable, prepared by methods that conserve nutritive value, and served potentially hazardous food (dairy) in a safe manner as evidenced by: 1. S4Cook failing to prepare food(s) according to the recipe, 2. Resident #38 served spoiled milk on 06/08/2026, and 3. Resident #58 served spoiled milk on 06/08/2026 and 06/09/2026. This deficient practice had the potential to affect the 70 residents who consumed food from the facility's kitchen. Findings: 1. Review of the facility's recipe titled, Mashed Potatoes DHY/Gravy included the following ingredients: potato granules, water, and soft margarine bulk. Further review of the recipe included the following instructions. 1. Prepare mashed potatoes according to package instructions, omitting the salt. On 06/08/2026 at 10:40 a.m., S5Cook was observed preparing mashed potatoes without a recipe. S5Cook poured an undetermined amount of water, potato flakes, milk and salt in a container. She used a whisk and mixed all the ingredients. Then, S5Cook added an undetermined amount of granulated onion powder. She stated she used the onion powder to give the potatoes a little flavor. On 06/10/2026 at 12:30 p.m., an interview was conducted with S4DM. She stated there was a binder that contained the food recipes. She confirmed that the kitchen [NAME] should be using the recipe when preparing food. On 06/10/2026 at 12:35 p.m., an interview was conducted with S5Cook. She confirmed that she didn't use the mashed potato recipe when she prepared the mashed potatoes on 06/08/2026 and should have. 2. On 06/08/2026 at 9:10 a.m., an observation and an interview was conducted with Resident #38. The resident had her breakfast tray on her side table. She had an unfinished glass of milk on her tray. The resident stated that she liked milk, but the milk tasted sour this morning so she did not drink it. A smell test was immediately conducted revealing the resident's milk smelled spoiled. 3. Review of Resident #58's quarterly Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact. On 06/08/2026 at 10:00 a.m., Resident #58 was interviewed and stated the milk he was served this morning for breakfast was not good. He stated his milk tasted spoiled and he was not able to finish drinking it. On 06/09/2026 at 8:44 a.m., Resident #58 was observed sitting in his wheelchair in his room with his breakfast meal tray. Resident #58 had a carton of milk with an expiration date of 06/10/2026 and a sour odor was present. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/2026 at 8:52 a.m., S7CNA was observed as she entered Resident #58's room and he informed S7CNA his milk smelt sour. S7CNA smelled the milk and grimaced indicating that the milk did not smell fresh. On 06/09/2026 at 9:02 a.m., S4DM was observed as she entered Resident #58's room and was informed by S7CNA that the resident's carton of milk smelled sour. S4DM smelled the Resident's carton of milk and grimaced indicating the milk was not fresh. S4DM then emptied the carton of milk down the resident's sink and provided Resident #58 with a cup of milk that did not smell sour and explained she poured his replacement of milk from a gallon. On 06/09/2026 at 11:46 a.m., an interview was conducted with S3ADM who verified S4DM informed her that Resident #58 was served milk that smelled spoiled this morning with his breakfast.		

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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 provider failed to prepare, distribute, and serve food in accordance with professional food service standards by failing to ensure staff:1. Wore appropriate hair covering when entering the kitchen2. Label and date all refrigerated food opened; and3. Served potentially hazardous food (dairy) in a safe manner. Findings: 1. On 06/09/2026, a review of the facility's policy titled Hair Restraints (Hair Nets and [NAME] Guards) Policy and Procedure which was last reviewed on 05/01/2026, read in part: Procedure: 1. Requirement for hair restraints.any person entering the dietary department, whether dietary staff and non-dietary personnel, must wear a hair net prior to entry and while in the dietary area. Hair restraints include hair nets, caps, or other approved coverings that fully contain all head hair. [NAME] guards are required for all staff with facial hair (beards, goatees, or long stubble) that may come into contact with food or food-contact surfaces. On 06/08/2026 at 10:30 a.m., an observation was made of two maintenance personnel in the kitchen. One maintenance personnel had a beard. Both maintenance personnel did not have hair protection and the maintenance personnel with a beard didn't have beard protection. On 06/08/2026 at 10:58 a.m., S3ADM confirmed that any staff should wear hair and/or beard protection when they enter the kitchen. 2. Review of the facility's policy titled, Food Procurement, Receiving, Storage, and Date Labeling policy, with a review/revised date 05/01/2026 read in part. 3. Date Marking and Labeling: All refrigerated, ready-to-eat foods that are prepared, opened, or portioned must be labeled. Required Label Information: Food name, Date prepared or opened, and Expiration/discard date. 4. Opened Food Handling: Must be labeled immediately upon opening. On 06/08/2026 at 09:20 a.m., an observation was made of the facility's walk-in cooler. During the observation, a plastic bag with unwrapped slices of cheese was observed on a shelf with no open date. S4DM stated that the bag with the slices of cheese should not have been put in the cooler without an open date. 3. On 06/08/2026 at 10:20 a.m., during the initial pool screening, two residents (Resident #38 and Resident #58) reported to surveyors that they received spoiled milk on their breakfast tray. One resident received a carton of milk and the other resident received a glass of milk. On 06/08/2026 at 10:36 a.m., an interview and observation was conducted with S4DM. She stated that she poured 5-6 glasses of milk from one of the gallons of milk this morning to be served to residents that preferred their milk to be in a glass. An observation was made of a gallon of milk in the walk-in cooler approximately 3/4 empty. It had an open date 06/06/2026 and use by date 06/10/2026. S4DM stated that she had not used this gallon of milk to prepare the 5-6 glasses of milk this morning. She stated that she discarded the gallon she had used after she prepared the glasses of milk. A taste sample of the gallon of milk currenting in the walk-in cooler was performed by this surveyor and determined that the milk tasted spoiled. S4DM performed a smell test of the gallon of milk and confirmed that the milk smelled spoiled. On 06/08/26 at 10:40 a.m., an observation made of S5Cook preparing mashed potatoes. S5Cook used a carton of milk with a used by date of 06/10/2026. A smell test was conducted by this surveyor and determined that the milk smelled sour. S5Cook and S12CH performed a smell test of the milk and they both confirmed that the milk used to make the mashed potatoes had a sour odor and was spoiled. On 06/08/2026 at 10:54 a.m., an interview and observation was conducted with S3ADM. S3ADM was informed of concerns voiced by residents that the milk with 06/10/2026 used by date being spoiled. S3ADM was informed that this surveyor and S4DM had determined that the milk in one of the gallons with the 06/10/2026 used by date tasted and smelled spoiled. S3ADM was also informed that the carton of milk used by S5Cook with a 06/10/2026 used by (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date to make mashed potatoes had a sour smell. A smell test was conducted by S3ADM of the milk from the carton used to make mashed potatoes and four other cartons with a 06/10/2026 use by date. S3ADM stated that she didn't feel that any of the cartons of milk had a sour smell. S3ADM and S4DM were asked what the facility's plan was to ensure that the residents didn't receive any more spoiled milk since it had been determined that some of the milk, both in a gallon and carton, were found to taste and smell spoiled. S3ADM stated that she felt that the staff didn't do anything wrong because the milk had not reached the expiration date and they planned to keep the milk they had left and continue to serve it. On 06/08/2026 at 5:25 p.m., a second interview was conducted with S3ADM. S4DM was present. S3ADM was again asked how the facility was going to ensure that the residents didn't receive spoiled milk with their meal. S3ADM stated again that because the milk was not expired, there was no reason for them to think that the milk was not good. S4DM confirmed that there were 80 cartons of milk remaining and 2 gallons of milk remaining with the 06/10/2026 use by date. She confirmed again that they planned to serve the remaining 80 cartons of milk and remaining 2 gallons of milk with the use by date of 06/10/2026. On 06/09/2026 at 9 a.m., it was reported by a survey team member that Resident #58 had complaints that he received spoiled milk again for breakfast this morning. The surveyor reported that S4DM was made aware that Resident #58's carton of milk smelled sour. S3DM went to the resident's room and smelled the milk in the carton and confirmed that the milk was spoiled. On 06/09/2026 at 9:45 a.m., an interview was conducted with S4DM who confirmed that the remaining 80 cartons of milk with the used by date 06/10/20266 was served for breakfast this morning.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to treat each resident with respect and dignity by failing to ensure the room door was closed and privacy curtain was drawn while performing perineal care (peri-care) for 2 (Residents #27 and #54) of 2 residents investigated for dignity. Findings: Review of Resident #27's Minimum Data Set (MDS) quarterly dated 04/16/2026 revealed his Brief Interview for Mental Status (BIMS) was 00, which indicated severe cognitive impairment. Functional Ability - personal hygiene; dependent on staff. Review of Resident #54's Minimum Data Set (MDS) dated [DATE] read in part: Brief Interview for Mental Status (BIMS) score of 09, which indicated severe problems with thinking or memory. Functional Abilities- toileting hygiene dependent; personal hygiene (combing hair, shaving) partial/moderate assistance is needed from staff. On 06/08/2026 2:24 p.m., an observation of S6CNA and S7CNA providing peri-care to Resident #54 who was the roommate of Resident #27. Staff were observed changing the resident's soiled linen and adult brief. Further observation revealed S6CNA and S7CNA had not closed the room door, or pulled the privacy curtain between the residents' beds, and the window blind remained up. Resident #27 genitalia was exposed. On 06/08/2026 at 2:50 p.m., an observation of S6CNA and S7CNA in Resident #27's room was conducted during peri-care. Resident #54 was in his bed during this time. Further observation revealed S6CNA and S7CNA were providing peri-care to Resident #27 while the room door was left open, privacy curtain between was not utilized, and the window blinds remained up. Resident #54's genitalia was exposed. On 06/08/2026 at 3:00 p.m., an interview was conducted with S7CNA who confirmed she and S6CNA should have pulled the privacy curtain, closed the blinds and closed the door prior to providing peri-care to the residents.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure the soft touch call light device was within reach for 1 (Resident #27) of 38 sampled residents. Findings: Review of Resident #27's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, metabolic encephalopathy, aphasia, paranoid schizophrenia, and dysphagia. Review of Resident #27's Minimum Data Set (MDS) quarterly dated 04/16/2026 revealed his Brief Interview for Mental Status (BIMS) was 00, which indicated severe cognitive impairment. Review of Resident #27's care plan, dated 02/17/2026, revealed, in part, resident has an ADL (Activities of Daily Living) self-care performance deficit. Intervention read in part: encourage me to use bell to call for assistance. On 06/8/2026 at 9:00 a.m., an observation was conducted of the resident lying in bed in his room. Further observation revealed the soft touch call bell was draped on the bed rails behind the resident. Resident not able to reach or see the call bell. On 06/08/2026 at 2:10 p.m., a second observation in the resident's room revealed resident's soft touch call bell was out of resident's view and reach. On 06/09/2026 at 8:11 a.m., a third observation of the resident in his room revealed soft touch call bell was draped on the bed rails behind the resident and out of reach of resident. On 06/10/2026 at 8:00 a.m., a fourth observation was conducted in the resident's room. The soft touch call bell was observed still draped on the outside of the bed rail, out of the resident's sight and reach. An interview was conducted with S8IC/TXN who stated the soft touch call bell should have been within the resident's reach. She stated that the resident is physically capable of utilizing the soft touch call bell.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews, and record reviews, the facility failed to ensure the resident's rights to confidentiality of medical records for 1 (Resident #44) out of a sample of 38 residents. Findings: On 06/09/2026 at 8:38 a.m., an observation was made of a computer screen on a medication cart on Hall B. Resident #44's medication administration record (MAR) was observed on the computer which was facing the hall. The MAR contained the resident's prescribed medication. Two residents were observed walking by the cart with the computer visible in their line of sight. S10LPN walked out of a resident's room and confirmed that she did not apply her computer privacy screen when she left to go in the resident's room and should have. On 06/10/2026 at 2:45 p.m., an interview was conducted with S1DON and S2ADON. They both confirmed that S10LPN should not have left Resident #44's MAR information on her computer without applying the privacy screen.		

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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 record reviews, observation, and interviews, the facility failed to ensure the resident's physician's orders for providing pudding with meals were followed for 1 (Resident #4) of 38 sampled residents. Findings: Review of Resident #4's electronic clinical record revealed an admit date of 01/02/2025 with diagnoses that included dementia with other behavioral disturbance, abnormal weight loss, mild protein calorie malnutrition. Review of Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Review of Resident #4's physician orders dated 06/09/2026 revealed the following orders: Diet: Regular - mechanical soft. Pudding with all meals. On 06/10/2026 at 8:57 a.m., an observation was conducted in Resident #4's room. Further observation revealed his breakfast tray contained a mechanical soft diet of grits, sausage, eggs, milk, orange juice, and water. The resident had not been provided with pudding. On 06/10/2026 at 9:44 a.m., an interview was conducted with S2ADON who stated Resident #4's diet was changed on 06/09/2026 to include pudding with all meals. She confirmed the resident was supposed to have pudding on his breakfast tray the morning of 06/10/2026 and he did not. On 06/10/2026 at 10:31 a.m., an interview was conducted with S4DM (Dietary Manager) who stated when a resident's diet is changed, a new diet slip is provided, and the order is entered into the computer. S4DM stated she was aware that Resident #4's diet had changed, and he was supposed to receive a pudding on all his meal trays. She confirmed Resident #4 had not received a pudding on his breakfast tray that morning of 06/10/2026 and he should have.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure that residents who are unable to carry out activities of daily living (ADL) receive the necessary services to maintain grooming and oral hygiene. This is evidenced by the facility failing to ensure: Resident #27 was shaven and maintained good oral hygiene. Resident #54's adult brief and linen were clean. Findings: Review of a document titled, Activities of Daily Living (ADL), Supporting with a revision date of 04/2025, which read in part: Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 1. Resident #27 was admitted [DATE] with diagnoses that included: metabolic encephalopathy, aphasia, [NAME] pressure Ulcer to the right hip and sacrum, Type 2 Diabetes Mellitus, and dysphagia. Review of Resident #27's care plan dated 04/23/2026 read in part, ADL self-care performance deficit. Intervention read in part, oral care daily. Review of physician orders dated 06/09/2026 read in part apply Aquaphor to bilateral upper and lower extremities daily related to dryness. Review of a quarterly Minimum Data Sets (MDS) dated [DATE] read in part, cognitive skills for daily decision - severely impaired. Oral care - dependent on staff. Personal hygiene. On 06/08/2026 at 9:43 a.m., an observation of the resident revealed he was unshaven, face was dry, and lips were cracked with moderate amount of dry skin noted. On 06/08/2026 at 11:53 a.m., another observation was conducted which revealed resident remained unshaven, had cracked lips and a moderate amount of dry skin noted to lips and face. On 06/08/2026 at 3:00 p.m., an interview was conducted with S6CNA (Certified Nursing Assistant) who stated she was the aid for the hall and was responsible for caring for the residents. She stated she was supposed to provide oral hygiene to the resident and groom him but had not provided the care today. On 06/10/2026 at 8:00 a.m., an interview was conducted with S8IC/TXN (Infection Control/Treatment Nurse) who confirmed the resident was supposed to have oral care daily and he was supposed to be shaven once weekly. On 06/10/2026 at 1:38 p.m., an interview was conducted with S1DON (Director of Nursing) who confirmed staff should have been monitoring and shaving the resident at least weekly. 2. Review of Resident #54's clinical record revealed an admit date of 04/28/2026 with diagnoses that included atherosclerosis arteries of left leg with ulceration of heel and midfoot, peripheral vascular disease, and protein-calorie malnutrition. Review of Resident #54's admission MDS dated [DATE] revealed a BIMS score of 09, which indicated severe problems with thinking or memory. Functional Ability - personal hygiene: partial/moderate assistance. Toileting hygiene: dependent helper does all the effort. On 06/08/2026 at 9:43 a.m., an observation of the resident was conducted in his room. Further review revealed resident was lying on a bed spread which was being used as a incontinence pad. The bed spread had a moderate amount of a dry, dark substance, and the resident's adult brief had a light brown substance on the outside. On 06/08/2026 at 1:07 p.m., a follow up observation was conducted. The resident bed linen was observed again with a dry, dark colored substance noted on the bed spread, and a light brown substance on the outside of the adult brief. On 06/08/2026 at 3:00 p.m., an interview and observation was conducted with S6CNA who confirmed the resident had a brown substance in front of his adult brief, and a dry dark substance on the bed spread. She confirmed she should have changed the soiled linen and brief.		

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NAME OF PROVIDER OR SUPPLIER Consolata Rehab and Wellness Center on the Teche		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, by failing to ensure a resident who complained of nausea and vomiting received medication ordered by the physician to treat these symptoms for 1 (Resident #57) of 38 sampled residents. Findings: Review of Resident #57's electronic health record (EHR) revealed that she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to bilateral primary osteoarthritis of knee, anxiety disorder, pain unspecified, drug induced constipation and major depressive disorder. Review of Resident #57's quarterly Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed in Section C that the resident had a Brief Interview for Mental Status of 15, indicating her cognition was intact. On 06/08/2026 at 9:15 a.m., an observation and an interview were conducted with Resident #57. The resident was sitting in her recliner chair with the head laid back. Resident #57 stated she was not feeling well. She stated she had diarrhea, nausea, and vomiting since yesterday and was still having some diarrhea and some nausea. Resident #57 stated she asked the day shift nurse (06/07/2026) for some nausea medicine and was told they were out of her nausea medicine. The resident stated she still had not received it. The resident stated the last time she vomited was around 4 p.m. on 06/07/2026. She stated she ate some breakfast this morning (06/08/2026) and was trying to stay still so she didn't throw up. During the interview, Resident #57 got up with urgency and stated she had to go to the bathroom due to diarrhea. Review of Resident #57's current physician orders revealed an order written on 06/02/2026 for Ondansetron HCL (Hydrochloride) Oral Tablet 8 mg (milligram) Give 8 mg orally every 6 hours as needed for nausea; vomiting. Review of Resident #57's June 2026 Medication Administration Record (MAR) revealed Ondansetron HCL Oral tablet 8 mg with a start date of 06/02/2026 was given once on 06/02/2026. No other doses were administered. Review of Resident #57's 06/2026 progress notes revealed no entry to indicate Resident #57's nausea was identified and treated by a nurse. On 06/08/2026 at 9:52 a.m., S14RD wrote in part: Rt (resident) reported N/V/D (nausea, vomiting, diarrhea) yesterday (06/07/2026) with minimal intake. On 06/09/2026 at 10:08 a.m., an interview was conducted with S13CNA. She stated she worked on Sunday (06/07/2026) and Monday (06/08/2026) and Resident #57 was sick. She stated the resident threw up in her garbage can on Sunday (06/07/2026) and also had diarrhea. S13CNA stated she reported it to S11LPN and was not sure if the nurse gave the resident any medication for her nausea. On 06/09/2026 at 12:35 p.m., an interview was conducted with S11LPN. She stated she cared for Resident #57 on the day shift on Sunday 06/08/2026. S11LPN stated she received a call from Resident #57's Responsible Party (RP) around lunch time on 06/07/2026 notifying her that the resident had called and was complaining of nausea. She stated she checked the medication cart and the resident did not have Zofran (Ondansetron) in the cart. She stated it was her first time at the facility so she asked S15LPN who told her that pharmacy didn't pass on the weekend so she had to wait until Monday. She was asked if she went to the emergency kit and she stated that she asked about an emergency kit and no one was able to tell her if there was one. When asked, S11LPN confirmed she did not call S1DON and left work without giving the resident nausea medication. On 06/10/2026 at 8:15 a.m., an observation of Med Cart A and an interview was conducted with S10LPN. She removed a full blister pack of Ondansetron 8mg Oral tablets with Resident #57's name from the bottom drawer of the cart which she stated was the PRN (as needed) medications drawer. The medication had a delivery date of 06/02/2026. S10LPN stated that the delivery date indicated the date the medication was delivered to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Consolata Rehab and Wellness Center on the Teche		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 East Main Street New Iberia, LA 70560	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility.On 06/10/2026 at 10:28 a.m., an interview was with S1DON who stated the medication was on the cart and available for S11LPN to administer to resident #57. She stated that S10LPN was on call and if S11LPN was unsure she should have called S10LPN.		

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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** Based on observation, interview, and record review, the facility failed to ensure that a resident received necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new pressure ulcers from developing by failing to turn two dependent with pressure ulcers every two hours for 2 (Resident #27 and #54) of 2 residents investigated for pressure ulcers. Findings: Resident #27 A review of Resident #27's clinical record revealed an admit date of 12/11/2025 with diagnoses that included metabolic encephalopathy, disorders of the skin and subcutaneous tissue, type 2 diabetes mellitus, peripheral vascular disease, and [NAME] pressure ulcers to the right hip and sacral area. A review of Resident #27's Care Plan dated 02/17/2026 read, in part: I have an activity of daily living self-care performance deficit. Interventions read, in part: assist rails times two for bed mobility and repositioning. Review of Resident #27's Minimum Data Set (MDS) quarterly dated 04/16/2026 revealed his Brief Interview for Mental Status (BIMS) was 00, which indicated severe cognitive impairment. On 06/08/2026 at 9:30 a.m., resident was observed lying in his bed on his left side. On 06/08/2026 at 11:53 a.m., a second observation was conducted in resident's room. Resident was observed lying on his left side. On 06/08/2026 at 1:10 p.m., a third observation was conducted in the resident's room. Resident was observed lying on his left side. On 06/08/2026 at 2:00 p.m., a fourth observation was conducted in the resident's room. Resident was observed lying on his left side. On 06/08/2026 at 2:20 p.m., a follow up observation of Resident #27 and interview was conducted with S6CNA (Certified Nursing Assistant) who confirmed the resident was supposed to be turned every two hours and she had not turned the resident in two hours. Resident #54 Review of Resident #54's clinical record revealed an admit date of 04/28/2026 with diagnoses that included atherosclerosis arteries of left leg with ulceration of heel and midfoot, peripheral vascular disease, and protein-calorie malnutrition. Review of Resident #54's Care Plan dated 05/17/2026 read, in part: I have an activity of daily living self-care performance deficit. Intervention read in part: trapeze bar to assist with bed mobility and positioning. I need reminding/assistance to reposition at least every two hours. Review of Resident #54's admission MDS dated [DATE] revealed a BIMS score of 09, which indicated severe problems with thinking or memory. On 06/08/2026 at 9:30 a.m., resident was observed lying in his bed on his right side. On 06/08/2026 at 11:53 a.m., a second observation was conducted in resident's room. Resident was observed lying on his right side. On 06/08/2026 at 1:10 p.m., a third observation was conducted in resident's room. Resident was lying on his right side. On 06/08/2026 at 2:00 p.m., a fourth observation was conducted in resident's room. Resident was lying on his right side. On 06/08/2026 at 2:20 p.m., a follow up observation of Resident #54 and interview was conducted with S6CNA (Certified Nursing Assistant) who confirmed the resident was supposed to be turned every two hours and she had not turned the resident in two hours. On 06/10/2026 at 8:00 a.m., an observation of Resident #27 and #54 and interview was conducted with S8IC/TXN (Infection Control/Treatment Nurse) and S9CNA. S8IC/TXN confirmed Resident #27 and #54 were supposed to be turned every two hours. S9CNA stated Resident #27 is supposed to be turned every two hours. She added Resident #54 needs reminding and assistance with turning.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to obtain ordered medications from the pharmacy for 1 (Resident #73) of 5 residents observed during medication administration. Findings: Review of Resident #73's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, type 2 diabetes mellitus without complications, paranoid schizophrenia, and essential (primary) hypertension. Review of Resident #73's current physician orders revealed an order, dated 06/01/2026, for Farxiga oral tablet 10 mg, give 1 tablet by mouth one time a day related to type 2 diabetes mellitus without complications. On 06/09/2026 at 8:50 a.m., an observation was made of S10LPN during morning medication administration. S10LPN administered all of Resident #73's medications except for his Farxiga oral tablet 10 mg (milligram). S10LPN stated the Farxiga was ordered last Monday (06/01/2026) but they still had not received it from the pharmacy. She was asked if the doctor had been notified that Resident #73 had not received his medication, and she stated he was not notified because she had been using Farxiga from another resident who was discharged. She further stated that she used the last one yesterday (06/08/2026). Review of Resident #73's medication administration record (MAR) revealed Farxiga 10 mg oral tablet was administered 06/02/2026 through 06/08/2026. On 06/09/2026 at 10:20 a.m., a follow up interview was conducted with S10LPN. She stated that she called the pharmacy and they reported they had not received the order for Farxiga. S10LPN stated she worked on 06/01/2026 when the order was written and was off for two days. She stated the person who followed her did not follow up with pharmacy. S10LPN was asked if she had notified S1DON and S2ADON that she did not receive Resident #73's medication from the pharmacy and had been using medications from a discharged resident and she stated she did not. On 06/09/2026 at 10:24 a.m., an interview was conducted with S2ADON. She stated she faxed the order when it was written to pharmacy last Monday (06/01/2026). S2ADON stated S10LPN did not report to her that she had not received the Resident #73's Farxiga from the pharmacy. S2ADON was asked if it was normal practice to give another resident's medication to someone else and she stated no. She stated S10LPN should have followed up with pharmacy, made her (S2ADON) aware they were unable to get the medication, and should not have used another resident's medication.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and policy review, the facility failed to appropriately store over the counter (OTC) medications in the locked medication cart. Findings: On 06/08/2026 at 9:33 a.m., an observation was made of an unattended medication cart on Hall B. A bottle of Aspirin 81 mg and a bottle of Geri-Kot 8.6 mg were observed unattended on top of the cart. Two residents walked by the parked cart. S10LPN returned to the cart after 5 minutes and confirmed that she had left the medications on top of the cart and stated that she should have placed the meds in the locked cart. On 06/10/2026, a review of the facility's policy titled Medication Labeling and Storage with a last reviewed date of 02/26/2026, read in part: Policy Statement: The facility stores all medications and biologicals in locked compartments. Policy Interpretation and Implementation: Medication Storage .5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. 06/10/26 at 2:45 p.m., an interview was conducted with S1DON and S2ADON. They both confirmed the nurse was not supposed to have left the medications on the cart unattended. They stated the OTC medications should have been placed in the locked cart.		