STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195214	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ferncrest Manor Living Center	14500 Haynes Blvd. New Orleans, LA 70128

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 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 observation and interview, the facility failed to ensure a resident's privacy during incontinence care for 1 (Resident #R4) of 4 (Resident #1, Resident #2, Resident #3, Resident #R4) residents observed for residents' rights. Findings: Observation on 06/24/2025 at 9:43AM revealed S3Certified Nursing Assistant (CNA) was providing incontinence care to Resident #R4 and did not announce that she was providing care to Resident #R4 when the surveyor knocked on the door to Resident #R4's room before entering. Further observation revealed Resident #R4's limbs and incontinence brief could be visualized from the doorway of Resident #R4's room. Further observation revealed that the privacy curtain in Resident #R4's room was not drawn to obstruct visualization of Resident #R4 from Resident #2 (Resident #R4's roommate) while S3CNA provided incontinence care to Resident #R4. In an interview on 06/24/2025 at 11:23AM, S2Dirctor of Nursing (DON) indicated S3CNA should have pulled Resident #R4's privacy curtain and/or provided privacy to Resident #R4 when she provided incontinence care to Resident #R4.

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: 195214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2025

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record reviews, the facility failed to ensure: 1. A resident was positioned as ordered while receiving enteral feedings (a type of liquid nutritional supplement that is typically given through a tube directly inserted into the stomach) (Resident #2); 2. An enteral feeding administration set (tubing used to administer a resident's enteral feeding) for a resident's enteral feeding was changed every 24 hours per the facility policy and physician's order (Resident #2); and, 3. Only qualified staff placed a resident's enteral feeding on hold and/or restarted a resident's enteral feeding (Resident #R4). This deficient practice was identified for 2 (Resident #2, Resident #R4) of 3 (Resident #1, Resident #2, Resident #R4) residents reviewed for enteral feeding maintenance. Findings: Review of the facility's Enteral Feedings-Safety Precautions, last revised on 10/01/2024 revealed, in part, Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) were the personnel responsible for preparing, storing, and administering enteral feedings. Further review revealed the personnel would be trained, qualified, and competent in his/her own abilities. Further review revealed personnel should change a resident's enteral feeding administration sets at least every 24 hours. 1. Review of Resident #2's June 2025 physician's orders revealed, in part, an order dated 06/04/2025 for the head of Resident #2's bed to be elevated to 45 degrees at all times except during care. Observation on 06/23/2025 at 4:12PM revealed Resident #2's enteral feeding was infusing at 20 milliliters (ml) per hour (ml/hr), and the head of Resident #2's bed was elevated to 30 degrees. Observation on 06/23/2025 at 4:51PM revealed Resident #2's enteral feeding was infusing at 20 ml/hr, and the head of Resident #2's bed was elevated to 30 degrees. Observation on 06/24/2025 at 7:33AM revealed Resident #2's enteral feeding was infusing at 20 ml/hr, and the head of Resident #2's bed was elevated to 30 degrees. Observation on 06/24/2025 at 9:45AM revealed Resident #2's enteral feeding was infusing at 20 ml/hr, and the head of Resident #2's bed was elevated to 30 degrees. In an interview on 06/24/2025 at 11:23AM, S2Director of Nursing (DON) indicated the head of Resident #2's bed should have been elevated to 45 degrees as ordered. 2. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ferncrest Manor Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14500 Haynes Blvd. New Orleans, LA 70128	

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's June 2025 physician's orders revealed, in part, an order dated 01/22/2025 for staff to change Resident #2's enteral feeding administration set (tubing) every day. Observation on 06/24/2025 at 11:20AM revealed the administration set for Resident #2's enteral feeding was dated as changed on 06/23/2024 at 12:00AM. Further observation revealed 400-500 ml of Resident #2's enteral feeding had already been infused. In an interview on 06/24/2025 at 11:22AM, S2DON confirmed Resident #2's enteral feeding administration set was dated 06/23/2025 at 12:00AM. S2DON further indicated enteral feeding administration sets should be changed every 24 hours. 3. Observation on 06/24/2025 at 9:43AM while S3Certified Nursing Assistant (CNA) was performing incontinence care to Resident #R4, the alarm to Resident #R4's enteral feeding pump (equipment used to administer a resident's enteral feeding at a set rate) was alarming. Further observation revealed a minute later, the alarm stopped. In an interview on 06/24/2025 at 9:44AM, S3CNA indicated the alarm to Resident #R4's enteral feeding pump was alarming because she had placed Resident #R4's enteral feeding on hold (stopped the infusion of the enteral feeding) while she was performing Resident #R4's incontinence care. S3CNA further indicated Resident #R4's enteral feeding pump had stopped alarming when S3CNA restarted the infusion of Resident #R4's enteral feeding. In an interview on 06/24/2025 at 11:22AM, S2DON indicated S3CNA should not be have placed Resident #R4's enteral feeding on hold or restarted Resident #R4's enteral feeding. In an interview on 06/24/2025 at 12:25PM, S1Administrator indicated it was not in a CNA's scope of practice to place a resident's enteral feeding on hold and/or restart a resident's enteral feeding.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record reviews, the facility failed to maintain accurate records for 1 (Resident #2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for accurate documentation. Findings: Review of the facility's Charting and Documentation policy, last revised on 10/01/2024, revealed, in part, all services provided to a resident shall be documented in the resident's medical record. Review of Resident #2's June 2025 physician's orders revealed, in part, an active order dated 01/22/2025 for staff to check the residual amount of Resident #2's enteral feeding (a type of liquid nutritional supplement that is typically given through a tube directly inserted into the stomach) every 4 hours at 12:00AM, 4:00AM, 8:00AM, 12:00PM, 4:00PM, and 8:00PM. Further review revealed an active order dated 05/22/2025 for staff to administer Jevity 1.5 (an enteral feeding) to Resident #2 at a rate of 40 milliliters/hour (ml/hr) continuously. Further review revealed an additional active order dated 05/26/2025 for staff to administer Jevity 1.5 at a rate of 20 ml/hr continuously. Review of Resident #2's June 2025 electronic Medication Administration Record (eMAR) revealed, in part, no documented evidence Resident #2's enteral feeding residual was checked on 06/08/2025 at 12:00PM, 06/08/2025 at 4:00PM, 06/21/2025 at 8:00AM, and/or 06/22/2025 at 8:00AM. In an interview on 06/24/2025 at 11:23AM, S2Director of Nursing (DON) indicated there should not have been two different physician's orders for the rate of Resident #2's Jevity 1.5 enteral feedings. S2DON further indicated the facility's nurses should have documented when they checked Resident #2's enteral feeding residual in Resident #2's eMAR and had not.