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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195156 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2025 |
| NAME OF PROVIDER OR SUPPLIER Willow Wood at Woldenberg Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 3701 Behrman Place New Orleans, LA 70114 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observations, interviews, and record reviews, the facility failed to assess a resident for self-administration of medications for 1 (Resident #6) of 1 (Resident #6) sampled resident investigated for the self-administration of medications.</p> <p>Findings:</p> <p>Review of the facility's Right to Self-Administration Medications policy, dated 12/05/2014 revealed, in part, residents would be assessed on admission, quarterly, annual, and any significant change in condition and as needed for self-administration of medication, if applicable.</p> <p>Review of Resident #6's Quarterly Minimum Data Set with an Assessment Reference Date of 05/06/2025 revealed, in part, Resident #6 had a Brief Interview for Mental Status score of 11, which indicated Resident #6 had moderate cognitive impairment.</p> <p>Review of Resident #6's record revealed, in part, no documented evidence and the facility was unable to present any documented evidence Resident #6 was assessed for the self-administration of medications.</p> <p>Observation on 06/30/2025 at 10:25AM revealed on Resident #6's bathroom counter a gray tray with 1 opened 45 gram tube of Cloderm 0.1% cream, (a cream used to treat topical skin irritation).</p> <p>In an interview on 06/30/2025 at 10:30AM, Resident #6 confirmed she had applied the Cloderm 0.1% cream to her hands several times.</p> <p>Observation on 07/01/2025 at 9:48AM revealed on Resident #6's bathroom counter a gray tray with 1 opened 45 gram tube of Cloderm 0.1% cream. Further observation revealed on Resident #6's bedside table 2 medication cups. One cup had 1 yellow and 1 light green approximately 1 half inch tablet, and the second cup had 5 tablets yellow, green and orange in color. Further observation revealed 1 bottle of pain relief roll on, 2.5 ounces, with the active ingredient lidocaine hydrochloride 4% (topical medication used for pain relief).</p> <p>In an interview on 07/01/2025 at 11:00AM, S7Licensed Practical Nurse confirmed Resident #6 was not assessed to self-administer medications. She further confirmed Resident #6 should not have medications left at her bedside or in her bathroom.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 07/01/2025 at 11:50AM, S2Registered Nurse/Assistant Director of Nursing confirmed Resident #6 was not assessed to self-administer medications and should not have medications left at the bedside and or the bathroom.</p> <p>In an interview on 07/01/2025 at 12:00PM, S1Administer confirmed Resident #6 should not have medications left at the bedside and/or bathroom.</p> | | |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on interview and record review the facility failed to ensure a resident with a new diagnosis of schizophrenia was referred to the appropriate state agency for a Preadmission Screening and Resident Review (PASARR) Level II evaluation as required for 1 (Resident #19) of 1 (Resident #19) sampled residents reviewed for PASARR requirements.</p> <p>Findings:</p> <p>Review of Resident #19's clinical record revealed an admit date of 09/03/2010. Further record review revealed on 02/27/2018, Resident #19 was diagnosed with schizophrenia.</p> <p>Review of Resident #19's annual Minimal Data Set with an Assessment Reference Date of 04/08/2025 revealed, in part, Resident #19 was assessed to have a Brief Interview for Mental Status score of 2 which indicated severe cognitive impairment, and had an active diagnoses of Schizophrenia without a diagnosis of Dementia.</p> <p>Review of Resident #19's medical record revealed, in part, a care plan was developed for alteration in behavior related to psychosis. Further review revealed an approach to place on the Memory Care Unit for consistent ongoing supervision.</p> <p>Review of Resident #19's record revealed, in part, no documented evidence, and the facility could not provide documented evidence a Level II PASARR was completed after Resident #19 was diagnosed with schizophrenia on 02/27/2018.</p> <p>In an interview on 07/02/2025 at 10:15AM, S9Social Service Director indicated Resident #19 should did not have a Level II PASARR evaluation completed after a new diagnosis of schizophrenia on 02/27/2018 and should have.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a pressure reducing mattress was inflated for a resident who was identified as at risk for skin breakdown for 1 (Resident #75) of 3 (Resident #51, Resident #75, Resident #80) sampled residents investigated Per the Surveyor Workload Report by Investigation they were investigated for Pressure Ulcer/ Injury.</p> <p>Findings:</p> <p>Review of the facility's policy, Prevention of Pressure Ulcers, revised [DATE], revealed, in part, Pressure Ulcers are usually formed when a resident remains in the same position for extended periods, causing increased pressure or decreased circulation (blood flow) to that area. Further review of the policy revealed preventative measures should include: a change in bed position every 2 hours or more, determining if the resident needs a specialized mattress, if a specialized mattress is needed, use one that contains foam, air, gel, or water, as indicated.</p> <p>Review of Resident #75's Electronic Medical Record revealed, in part, Resident #75 had diagnoses which included: Hemiplegia.</p> <p>Review of Resident #75's Minimum Data Set with an Assessment Reference Date of [DATE] revealed, in part, Resident #75 had a Brief Interview for Mental Status score of 10, which indicated Resident #75's cognition was moderately impaired.</p> <p>Review of Resident #75's Comprehensive Care Plan, revised [DATE], revealed, in part, Resident #75 had the potential for development of a pressure ulcer related to (r/t) incontinence, debility, and health comorbidities with an intervention for a pressure reduction mattress.</p> <p>Observation on [DATE] at 10:28AM revealed Resident #75's air-loss mattress had a low air pressure warning light was activated, which indicated the air-loss mattress was not inflated completely, and the bed frame was palpable when the surveyor applied pressure to the mattress.</p> <p>Observation on [DATE] at 4:30PM revealed Resident #75's air-loss mattress had a low air pressure warning light was activated, which indicated the air-loss mattress was not inflated completely, and the bed frame was palpable when the surveyor applied pressure to the mattress.</p> <p>In an interview on [DATE] at 4:30PM, Resident #75 indicated she had reported to staff she heard the air coming out of the mattress, and the staff informed Resident #75 that the air-loss mattress was plugged in. Resident #75 further indicated staff did not attempt to apply pressure to the mattress to check the inflation of the mattress.</p> <p>In an interview on [DATE] at 7:08AM, S8Licensed Practical Nurse (LPN) indicated Resident #75's nurse on the night shift on [DATE] and observed Resident #75's air-loss mattress had a low air pressure warning light activated. S8LPN further indicated she assessed the problem and identified that the CPR function on Resident #75's air-loss mattress was initiated, which deflated the bed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on [DATE] at 11:08AM, S2Registered Nurse/Assistant Director of Nurses (RN/ADON) confirmed Resident #75 was left lying on a deflated air mattress for over 8 hours on [DATE], and should not have been.</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> ensure the facility completed evaluations after a resident sustained a fall per policy (Resident #17 and Resident #75); ensure a resident's care plan was revised with new individualized interventions after a resident sustained a fall (Resident #17 and Resident #75); ensure oxygen tanks were secured and not free standing (Resident #102). <p>This deficient practice was identified for 3 (Resident #17, Resident #75, Resident #102) of 5 (Resident #6, Resident #17, Resident #31, Resident #75, Resident #102) sampled residents reviewed for accident hazards.</p> <p>Findings:</p> <p>Resident #17</p> <p>Review of facility's policy titled Falls - Clinical Protocol revised October 2010 revealed, in part, Residents should be evaluated for a risk of falling, the staff and physicians would identify pertinent interventions, if the cause was not identified staff would try relevant interventions, based on assessments and the nature or category of falling. For any resident who had fallen, staff would attempt to define possible causes within 24 hours of the fall, based on preceding assessment, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff would monitor and document the individual's response to the fall interventions intended to reduce falling.</p> <p>Review of Resident #17's record revealed, in part, a Fall Risk assessment dated [DATE] with a score of 17, which indicated at risk for falls.</p> <p>Review of Resident #17's care plan revealed, in part, Resident #17's was high risk for falls related to confusion, incontinence, medication effects, cognition, and impulsive behaviors.</p> <p>Review of Resident #17's record revealed, in part, Resident #17 sustained a fall on 02/09/2025, 02/20/2025 and 05/27/2025.</p> <p>Review of Resident #17's record revealed, in part, there was no documented evidence and the facility did not present any documented evidence an evaluation was completed on the above mentioned falls per facility policy.</p> <p>Review of Resident #17's care plan revealed, in part, there was no documented evidence and the facility did not present any documented evidence that Resident #17's care plan was revised to include new individualized interventions after the above mentioned falls.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview on 07/02/2025 at 2:15PM, S2Registered Nurse/Assistant Director of Nursing confirmed there were no documented evidence and the facility could not provide documented evidence of fall evaluations being completed, and Resident #17's care plan revised with new interventions after Resident #17 sustained falls on 02/09/2025, 02/20/2025, and 05/27/2025, and this should have been done.</p> <p>Resident #75</p> <p>Review of Resident #75's Fall Risk Evaluation dated 04/29/2025 revealed, in part, Resident #75 was high risk for falls.</p> <p>Review of Resident #75's progress notes revealed, in part, Resident #75 had falls on 01/20/2025, 03/30/2025, 04/20/2025, and 05/05/2025.</p> <p>Review of Resident #75's fall care plan revealed, in part, there was no documented evidence and the facility did not present any documented evidence that Resident #75's care plan was revised to include new individualized interventions after Resident #75 fell on [DATE], 03/30/2025, and 05/05/2025.</p> <p>Review of Resident #75's record revealed, in part, there was no documented evidence and the facility did not present any documented evidence an evaluation was completed on Resident #75's falls on 03/30/2025, and, or 04/20/2025.</p> <p>In an interview on 07/01/2025 at 2:20PM S2Registered Nurse/Assistant Director of Nursing (RN/ADON) indicated all interventions for Resident #75 would have been in Resident #75's care plan.</p> <p>In an interview on 07/02/2025 at 12:32PM, S2RN/ADON confirmed the facility has no documented evidence that Resident #75's fall on 03/30/2025 and 04/20/2025 were investigated and evaluated for the root cause after the above mentioned falls. S2RN/ADON further confirmed that Resident #75's falls which occurred on 01/20/2025, 03/30/2025, and 05/05/2025 did not have a new interventions in the care plan to prevent further falls.</p> <p>Resident #102</p> <p>Review of the facility's Oxygen Administration policy and procedure, revised October 2010, revealed, in part, portable oxygen cylinders are to be strapped to the oxygen cylinder stands.</p> <p>Observation on 07/01/2025 at 10:58AM revealed, in part, a free standing oxygen tank located in the corner of Resident #102's room, sitting on the floor, and not strapped to an oxygen cylinder stand.</p> <p>Observation on 07/02/2025 at 9:10AM revealed, in part, a free standing oxygen tank located in the corner of Resident #102's room, sitting on the floor, and not strapped in an oxygen cylinder stand.</p> <p>In an interview on 07/02/2025 at 9:13AM, S11Licensed Practical Nurse indicated oxygen tanks should be strapped in an oxygen cylinder stand or in the cage located in the medication storage room off of the floor when not in use.</p> <p>In an interview on 07/02/2025 at 9:15AM, S2Registered Nurse/Assistant Director of Nursing confirmed that oxygen tanks should be strapped in a oxygen cylinder stand or in the cage located in the medication storage room when not in use.</p> | | |

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| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>Based on observation, interviews and record reviews, the facility failed to administer a resident's enteral feeding (intake of food through a tube placed into the stomach) as ordered for 1 (Resident #46) of 1 (Resident #46) sampled resident investigated for enteral nutrition requirements.</p> <p>Findings:</p> <p>Review of the facility's Enteral Nutrition policy with a revision date of 11/2018, revealed, in part, the nurse confirms the administration method and the volume/rate of administrations.</p> <p>Review of Resident #46's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/08/2025 revealed, in part, Resident #46 was indicated for a feeding tube.</p> <p>Review of Resident #46's July 2025 order summary report revealed, in part, an order with a date of 04/17/2025 for Glucerna 1.2 Cal (a tube feeding formula used to provide nutrition) 50 milliliters per hour (mL/hour) via percutaneous feeding tube (PEG tube) over 22 hours.</p> <p>Observation on 07/01/2025 at 3:00PM revealed Resident #46's continuous tube feeding pump was set at 60 ml/hr.</p> <p>In an interview on 07/01/2025 at 3:33PM, S7License Practical Nurse (LPN) confirmed Resident #46's feeding infusion pump was infusing at 60ml/hr., and should be infusing at 50ml/hr.</p> <p>In an interview on 07/02/2025 at 11:10AM, S2Registered Nurse/Assistant Director of Nursing confirmed Resident #46's enteral feeding infusion pump should have been infusing at 50 ml/hr, as ordered.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, interviews, and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Change nebulizer supplies per facility policy (Resident #51); and, 2. Store nebulizer mouthpiece per facility policy (Resident #79). <p>This deficient practice was identified for 2 (Resident #51, Resident #79) of 3 (Resident #23, Resident #51, Resident #79) sampled residents reviewed for respiratory care requirements.</p> <p>Findings:</p> <p>Review of the facility's Nebulizer Machine (a machine that turns liquid medicine into a mist, allowing it to be inhaled directly into the lungs) Cleaning policy and procedure, dated 11/04/2014 revealed, in part, nebulizer machines and equipment should be kept clean and the nebulizer tubing, mouthpiece, and mask should be stored in a plastic bag when not in use. Further review revealed the tubing, mouthpiece and mask should be changed weekly and as needed.</p> <p>Resident #51</p> <p>Review of Resident #51's June 2025 Physician orders revealed, in part, Ipratropium-Albuterol nebulizer solution (a medication primarily used to treat respiratory conditions) 0.5milligram (mg) per 2.5milliliter (ml) inhale orally via nebulizer every 8 hours as needed for wheezing.</p> <p>Review of Resident #51's Care Plan revealed, in part, Resident #51 had shortness of breath with a documented intervention to change all respiratory tubing and equipment per facility policy.</p> <p>Observation on 06/30/2025 at 10:47AM revealed Resident #51's nebulizer mask was stored in a plastic bag on the bedside table and the plastic bag was dated of 05/25/2025.</p> <p>Observation on 07/01/2025 at 10:47AM revealed Resident #51's nebulizer mask was stored in a plastic bag on the bedside table and the plastic bag had a date of 05/25/2025.</p> <p>Review of Resident #51's June 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #1 received Ipratropium-Albuterol nebulizer solution 0.5mg per 2.5ml on 06/01/2025, 06/03/2025, 06/07/2025 and 06/12/2025 per nebulizer.</p> <p>In an interview on 07/01/2025, S6Licensed Practical Nurse (LPN) confirmed Resident #51's nebulizer was stored in a plastic bag and the plastic bag had a date of 05/25/2025.</p> <p>In an interview on 07/02/2025 at 9:47AM, S4LPN Supervisor indicated Resident #51's nebulizer tubing and mouthpieces should be changed weekly and should be stored in a plastic bag. S4LPN further indicated staff should document the date it was changed on the eMAR.</p> <p>Review of Resident #51's June 2025 and July 2025 eMAR revealed no documented evidence, and the provider did not present any documented evidence, Resident #51's nebulizer tubing and mouthpiece had been changed since 05/25/2025.</p> <p>(continued on next page)</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview on 07/02/2025 at 10:10AM, S3Registered Nurse/Infection Preventionist (RN/IP) indicated nebulizer tubing and mouthpieces should be changed per the facility policy. S3RN/IP further indicated there was no documented evidence Resident #51's nebulizer tubing and mouthpiece had been changed since the date of 05/25/2025.</p> <p>Resident #79</p> <p>Review of Resident #79's Physician's orders dated 06/26/2025 revealed, in part, Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/ml 1 vial inhale orally every 6 hours as needed for wheezing.</p> <p>Observation on 06/30/25 at 11:19AM revealed, Resident #79 had an uncontained nebulizer mask lying on Resident #79's lap.</p> <p>Observation on 07/01/2025 at 10:49AM revealed, in part, Resident #79's nebulizer mask was stored uncontained on the bedside table.</p> <p>Observation on 07/02/2025 at 8:48AM revealed, in part, Resident #79's nebulizer mask was stored uncontained on the bedside table.</p> <p>Review of Resident #79's July 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #79 received Ipratropium-Albuterol nebulizer solution 0.5mg per 2.5ml on 07/01/2025 and 07/02/2025 per the nebulizer.</p> <p>In an interview on 07/02/2025 at 9:10AM S10Licensed Practical Nurse confirmed Resident #79's nebulizer mask should be stored in a plastic bag when not in use.</p> <p>In an interview on 07/02/2025 at 9:15AM S2Registered Nurse/Assistant Director of Nursing confirmed nebulizer masks should be stored in a plastic bag when not in use.</p> <p>Based on observations, interviews, and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Change nebulizer supplies per facility policy (Resident #51); and, 2. Store nebulizer mouthpiece per facility policy (Resident #79). <p>This deficient practice was identified for 2 (Resident #51, Resident #79) of 3 (Resident #23, Resident #51, Resident #79) sampled residents reviewed for respiratory care requirements.</p> <p>Findings:</p> <p>Review of the facility's Nebulizer Machine (a machine that turns liquid medicine into a mist, allowing it to be inhaled directly into the lungs) Cleaning policy and procedure, dated 11/04/2014 revealed, in part, nebulizer machines and equipment should be kept clean and the nebulizer tubing, mouthpiece, and mask should be stored in a plastic bag when not in use. Further review revealed the tubing, mouthpiece and mask should be changed weekly and as needed.</p> <p>Resident #51</p> <p>(continued on next page)</p> | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #51's June 2025 Physician orders revealed, in part, Ipratropium-Albuterol nebulizer solution (a medication primarily used to treat respiratory conditions) 0.5milligram (mg) per 2.5milliliter (ml) inhale orally via nebulizer every 8 hours as needed for wheezing.</p> <p>Review of Resident #51's Care Plan revealed, in part, Resident #51 had shortness of breath with a documented intervention to change all respiratory tubing and equipment per facility policy.</p> <p>Observation on 06/30/2025 at 10:47AM revealed Resident #51's nebulizer mask was stored in a plastic bag on the bedside table and the plastic bag was dated of 05/25/2025.</p> <p>Observation on 07/01/2025 at 10:47AM revealed Resident #51's nebulizer mask was stored in a plastic bag on the bedside table and the plastic bag had a date of 05/25/2025.</p> <p>Review of Resident #51's June 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #1 received Ipratropium-Albuterol nebulizer solution 0.5mg per 2.5ml on 06/01/2025, 06/03/2025, 06/07/2025 and 06/12/2025 per nebulizer.</p> <p>In an interview on 07/01/2025, S6Licensed Practical Nurse (LPN) confirmed Resident #51's nebulizer was stored in a plastic bag and the plastic bag had a date of 05/25/2025.</p> <p>In an interview on 07/02/2025 at 9:47AM, S4LPN Supervisor indicated Resident #51's nebulizer tubing and mouthpieces should be changed weekly and should be stored in a plastic bag. S4LPN further indicated staff should document the date it was changed on the eMAR.</p> <p>Review of Resident #51's June 2025 and July 2025 eMAR revealed no documented evidence, and the provider did not present any documented evidence, Resident #51's nebulizer tubing and mouthpiece had been changed since 05/25/2025.</p> <p>In an interview on 07/02/2025 at 10:10AM, S3Registered Nurse/Infection Preventionist (RN/IP) indicated nebulizer tubing and mouthpieces should be changed per the facility policy. S3RN/IP further indicated there was no documented evidence Resident #51's nebulizer tubing and mouthpiece had been changed since the date of 05/25/2025.</p> <p>Resident #79</p> <p>Review of Resident #79's Physician's orders dated 06/26/2025 revealed, in part, Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/ml 1 vial inhale orally every 6 hours as needed for wheezing.</p> <p>Observation on 06/30/25 at 11:19AM revealed, Resident #79 had an uncontained nebulizer mask lying on Resident #79's lap.</p> <p>Observation on 07/01/2025 at 10:49AM revealed, in part, Resident #79's nebulizer mask was stored uncontained on the bedside table.</p> <p>Observation on 07/02/2025 at 8:48AM revealed, in part, Resident #79's nebulizer mask was stored uncontained on the bedside table.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195156 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2025 |
| NAME OF PROVIDER OR SUPPLIER Willow Wood at Woldenberg Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 3701 Behrman Place New Orleans, LA 70114 | |
| 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) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #79's July 2025 electronic Medication Administration Record (eMAR) revealed, in part, Resident #79 received Ipratropium-Albuterol nebulizer solution 0.5mg per 2.5ml on 07/01/2025 and 07/02/2025 per the nebulizer.</p> <p>In an interview on 07/02/2025 at 9:10AM S10Licensed Practical Nurse confirmed Resident #79's nebulizer mask should be stored in a plastic bag when not in use.</p> <p>In an interview on 07/02/2025 at 9:15AM S2Registered Nurse/Assistant Director of Nursing confirmed nebulizer masks should be stored in a plastic bag when not in use.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195156 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2025 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews, and record review, the facility failed to serve food in a sanitary manner for 1 (Resident #51) of 10 (Resident #10, Resident #26, Resident #41, Resident #50, Resident #51, Resident #54, Resident #74, Resident #83, Resident #88, Resident #92) sampled residents investigated for dining observation.</p> <p>Findings:</p> <p>Review of the 2022 Food Code U.S. Food and Drug Administration revealed, in part, employees were to prevent cross-contamination of ready-to-eat food with bare hands, and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.</p> <p>Observation on 07/01/2025 at 12:01PM revealed S5Certified Nursing Assistant (CNA) served Resident #51 her lunch tray. S5CNA brought Resident #51's lunch tray to her room. S5CNA, with bare hands, removed Resident #51's insulated cover off of her plate and revealed a lunch which consisted of chicken tenders, french fries, and a can of soda. S5CNA placed Resident #51's lunch tray on Resident #51's bedside table. S5CNA then repositioned Resident #51's feet with bare hands. S5CNA, with bare hands, picked up a chicken tender off of Resident #51's plate and placed it in Resident #51's hand. S5CNA then opened Resident #51's soft drink and 2 packets of ketchup. Observation then revealed Resident #51 dropped the chicken tender on her bedside table and S5CNA, with bare hands, picked up the chicken tender and placed it on Resident #51's plate.</p> <p>S5CNA did not perform hand hygiene during the above documented observation.</p> <p>At no time during the above documented observation did S5CNA perform hand hygiene.</p> <p>In an interview on 07/01/2025 at 12:07PM, S5CNA confirmed she touched Resident #51's food with bare hands and she should not have.</p> <p>In an interview on 07/02/2025 at 9:47AM, S4Licensed Practical Nurse (LPN) Supervisor indicated staff should not touch a resident's food with bare hands during meal service.</p> <p>In an interview on 07/02/2025 at 10:06AM, S3Registered Nurse / Infection Preventionist (RN/IP) indicated it was not appropriate for a staff member to touch a resident's food with bare hands.</p> <p>In an interview on 07/02/2025 at 11:06AM, S2RN /Assistant Director of Nursing indicated S5CNA should not have touched Resident #51's food with bare hands.</p> | | |