

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

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Form Approved OMB
No. 0938-0391

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 07/01/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to ensure a resident shower room and resident shower equipment were maintained in a sanitary manner for 3 (Shower Room X, Shower Room Y, Shower Room Z) of 6 shower rooms observed for environment requirements. Findings: Observation on 06/29/2026 at 8:45AM of Shower Room c revealed a shower chair had an unknown tan substance on the shower chair's seat support bar. Observation on 06/29/2026 at 8:56AM of Shower Room b revealed the shower-tub had an unknown pink substance in the inner bowl of the shower-tub. Observation on 06/29/2026 at 9:53AM of Shower Room d revealed a shower chair had an unknown pink substance on the shower chair's seat support bar and to the legs of the shower chair. Observation on 06/30/2026 at 9:59AM of Shower Room c revealed a shower chair had an unknown tan substance on the shower chair's seat support bar. Further observation revealed an unknown brown substance was dried on the surface of the shower wall behind the shower chair. Observation on 06/30/2026 at 10:28AM of Shower Room b revealed the shower-tub had an unknown pink substance in the inner bowl of the shower-tub. Observation on 06/30/2026 at 10:36AM of Shower Room d revealed a shower chair had an unknown pink substance on the shower chair's seat support bar and to the legs of the shower chair. In an interview on 06/30/2026 at 9:53AM, S8Certified Nursing Assistant (CNA) indicated the CNAs were supposed to clean the shower chairs after each use. In an interview on 06/30/2026 at 10:53AM, S9CNA indicated it was her responsibility to clean the shower rooms and shower chairs between giving residents baths. In an interview on 06/30/2026 at 12:29PM, S3Assistant Director of Nursing (ADON) indicated it was the facility's policy to clean the shower rooms and the shower room equipment before and after each resident's use. S3ADON further indicated the above mentioned unknown substances in Shower Room X, Shower Room Y, and Shower Room Z should not have been present on the residents' shower equipment, the residents' shower wall, or the residents' shower-tub. In an interview on 06/30/2026 at 12:30PM, S1Administrator indicated the above mentioned unknown substances in Shower Room X, Shower Room Y, and Shower Room Z should not have been present on the residents' shower equipment, the residents' shower wall, and/or the residents' shower-tub.		

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's medication was administered as ordered by a physician for 1 (Resident #8) of 25 sampled residents investigated for compliance with physician orders. Findings: Review of the Louisiana State Legislature- Title 37: Professions and Occupations, Revised Statute (R.S.) 37:961, last amended in 2020, revealed, in part, the practice of practical nursing means the performance for compensation of any acts, in the care, treatment, or observation of persons who are ill, injured, or infirm and for the maintenance of the health of others and the promotion of health care, including the administration of medications. Review of the facility's Licensed Staff (Registered Nurse/Licensed Practical or Vocational Nurse) job description, dated 07/01/2015 and revised on 12/03/2019, revealed, in part, an essential job duty of licensed staff included preparing and administering medications as ordered. Review of the facility's Administering Medications policy and procedure, revised on 04/2019, revealed, in part, medications were administered in accordance with prescriber orders within one hour of the prescribed time. Review of Resident #8's electronic medical record (EMR) revealed, in part, Resident #8 was admitted to the facility on [DATE] with diagnoses, which included, atrial fibrillation (an irregular heartbeat), hypertension (high blood pressure), hyperlipidemia (an excessive amount of fats in the blood), gastro-esophageal reflux disease without esophagitis ([GERD] excessive stomach acid in the throat), hypokalemia (low potassium level in the blood), right femur neck fracture (a serious break in the upper part of the thigh bone), and nonrheumatic aortic stenosis (narrowing of a heart valve). Review of Resident #8's June 2026 physician's orders revealed, in part, Resident #8 should have been administered the following medications:- one tablet of amiodarone hydrochloride (HCl) (a medication used to treat atrial fibrillation) 200 milligrams (mg) by mouth;-one tablet of amlodipine besylate (a medication used to lower high blood pressure) 10 mg by mouth; -one tablet of atorvastatin calcium (a medication used to treat hyperlipidemia) 80 mg by mouth; -one tablet of famotidine (a medication used to treat GERD) 40 mg by mouth; -one tablet of losartan potassium (a medication used to lower high blood pressure) 50 mg by mouth; -two tablets of potassium chloride (Cl) extended release (ER) (a medication used to treat hypokalemia) 10 milliequivalents (mEq) by mouth;-one tablet of apixaban (a medication used to prevent blood clots) 5 mg by mouth; and,-one tablet of ranolazine ER (a medication used to treat ongoing chest pain) 500 mg by mouth. Review of Resident #8's June 2026 Electronic Medication Administration Record (eMAR) revealed, in part, the following medications were scheduled to be administered at 8:00AM and/or 9:00AM to Resident #8 on 06/30/2026:-one tablet of amiodarone HCl 200 mg at 9:00AM; -one tablet of amlodipine besylate 10 mg at 8:00AM; -one tablet of atorvastatin calcium 80 mg at 8:00AM;-one tablet of famotidine 40 mg at 9:00AM; -one tablet of losartan potassium 50 mg at 8:00AM;-two tablets of potassium Cl 10 mEq at 8:00AM; -one tablet of apixaban 5 mg at 9:00AM; and,-one tablet of ranolazine ER 500 mg at 9:00AM. Further review of Resident #8's above-mentioned eMAR revealed no documentation the above-mentioned medications scheduled for administration at 8:00AM and/or 9:00AM on 06/30/2026 were administered. Review of Resident #8's EMR revealed, in part, no documentation of the reason Resident #8's above-mentioned medications were not administered on 06/30/2026. In an interview on 06/30/2026 at 12:29PM, Resident #8's responsible party (RP), indicated Resident #8 had not received her morning medications on 06/30/2026. Resident #8's RP further indicated Resident #8 was not administered her medications prior to leaving for her scheduled medical appointment at 9:30AM. In an interview on 06/30/2026 at 12:35PM, S11LPN indicated Resident #8 had a scheduled medical appointment on 06/30/2026 at (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:30AM. S11LPN further indicated she (S11LPN) had not administered Resident #8's medications which were scheduled to be administered at 8:00AM and 9:00AM, prior to Resident #8 leaving for her scheduled medical appointment on 06/30/2026 and should have. In an interview on 07/01/2026 at 8:05AM, S10Certified Nursing Assistant Transportation indicated Resident #8 left the facility on [DATE] at approximately 9:00AM for Resident #8's scheduled medical appointment. In an interview on 07/01/2026 at 9:01AM, S12LPN indicated Resident #8 should have been administered Resident #8's above-mentioned medications on 06/30/2026, prior to Resident #8 leaving for her scheduled medical appointment. In an interview on 07/01/2026 at 11:41AM, S2Director of Nursing (DON) indicated resident medications should be administered one hour before to one hour after the scheduled administration time. S2DON further indicated she had nothing to present to dispute the above-mentioned deficient practice. In an interview on 07/01/2026 at 11:42AM, S1Administrator was informed of the above-mentioned findings and had nothing to present to dispute the above-mentioned deficient practice.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident with diabetes (a chronic condition where your blood sugar is too high) and peripheral vascular disease (a slow circulation disorder where the blood vessels outside your heart and brain become narrow or blocked) received needed foot care for 1 (Resident #9) of 2 sampled residents investigated for foot care. Findings:Review of Resident #9's medical record revealed, in part, a diagnosis of diabetes mellitus and peripheral vascular disease. Review of Resident #9's Significant Change Minimum Data Set with an Assessment Reference Date of 06/03/2026 revealed Resident #9 had a Brief Interview Mental Status Score of 6, which indicated severe cognitive impairment. Further review revealed Resident #9 was dependent on staff for personal hygiene. Review of Resident #9's care plan, dated 11/02/2025, with a goal date of 09/20/2026, revealed in part, Resident #9 required extensive assistance from staff for personal hygiene. Review of Resident #9's progress note dated 06/30/2026 at 9:02PM revealed, in part, S6Licensed Practical Nurse documented Resident #9's toenails were overgrown, approximately a 1/2 inch long, and extended over the nail beds. Review of the facility's podiatry lists revealed Resident #9 was not evaluated by the podiatrist when the podiatrist came to the facility on [DATE], 03/26/2026, 04/16/2026, and 06/25/2026. Observation on 06/30/2026 at 3:41PM revealed Resident #9's bilateral 2nd and 3rd toenails were approximately a 1/2 inch long and curled over the nail bed. Further observation revealed Resident #9's left first/great toenail was approximately 1/2 inch thick and black and brown in color. Further observation revealed Resident #9's right first toe/great toenail was approximately a 1/4 inch thick and yellow/brown in color. Further observation revealed Resident #9's bilateral 4th and 5th toenails extended about a 1/4 inch past the nail bed. Observation on 06/30/2026 at 3:49PM with S6Licensed Practical Nurse revealed Resident #9's bilateral 2nd and 3rd toenails were approximately a 1/2 inch long and curled over the nail bed. Further observation revealed Resident #9's left first/great toenail was approximately 1/2 inch thick and black and brown in color. Further observation revealed Resident #9's right first/great toenail was approximately a 1/4 inch thick and yellow/brown in color. Further observation revealed Resident #9's bilateral 4th and 5th toenails extended about a 1/4 inch past the nail bed. In an interview on 06/30/2026 at 3:52PM, S6Licensed Practical Nurse indicated Resident #9's toenails were thick and curled over the nail bed. S6Licesned Practical Nurse further indicated Resident #9 needed to be evaluated by a podiatrist. Observation on 06/30/2026 4:16PM with S5Clinical Coordinator/Minimum Data Set Licensed Practical Nurse and S2Director of Nursing revealed Resident #9's bilateral 2nd and 3rd toenails were approximately a 1/2 inch long and curled over the nail bed. Further observation revealed Resident #9's left first/great toenail was approximately 1/2 inch thick and black and brown in color. Further observation revealed Resident #9's right first/great toenail was approximately a 1/4 inch thick and yellow/brown in color. Further observation revealed Resident #9's bilateral 4th and 5th toenails extended about a 1/4 inch past the nail bed. Observation 07/01/2026 at 11:43AM with Resident #9's Hospice Nurse revealed Resident #9's bilateral 2nd and 3rd toenails were approximately a 1/2 inch long and curled over the nail bed. Further observation revealed Resident #9's left first toe/great toenail was approximately 1/2 inch thick and black and brown in color. Further observation revealed Resident #9's right first/great toenail was approximately a 1/4 inch thick and yellow/brown in color. Further observation revealed Resident #9's bilateral 4th and 5th toenails extended about a 1/4 inch past the nail bed. In an interview on 07/01/2026 at 11:44AM, Resident #9's hospice nurse indicated Resident #9 needed to be evaluated by a podiatrist and have her toenails cut. In an interview on (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/01/2026 at 3:30PM, S7Licensed Practical Nurse indicated Resident #9 needed to be evaluated by a podiatrist. In an interview on 07/01/2026 at 1:20PM, S2Director of Nursing indicated she did not have any additional evidence to dispute the above-mentioned deficient practice for Resident #9.		

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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 observations, interviews, and record reviews, the facility failed to store raw chicken in a sanitary manner for 1 (Cooler a) of 2 walk-in coolers observed in the kitchen. Findings: Review of the facility's Food Receiving and Storage policy and procedure, revised on 10/2017, revealed, in part, food services would maintain clean food storage areas at all times. Further review revealed uncooked and raw animal products would be stored separately in drip proof containers to prevent contamination. Review of the facility's June 2026 Dietary Cleaning Schedule revealed, in part, walk-in coolers should be cleaned daily. Observation of Cooler a on 06/29/2026 at 9:00AM revealed plastic bags of raw chicken lying in a shallow tray on the bottom shelf on the right side of Cooler a. Further observation revealed the plastic bags were hanging over the edge of the tray and a bloody liquid substance was dripping on to the floor of the cooler and down the wheels of the shelf. Further observation revealed the bloody liquid substance was pooled along the floor on the right side of the cooler. Observation of Cooler a on 06/29/2026 at 4:20PM revealed plastic bags of raw chicken lying in a shallow tray on the bottom shelf on the right side of Cooler a. Further observation revealed the plastic bags were hanging over the edge of the tray and a bloody liquid substance was dripping on to the floor of the cooler and down the wheels of the shelf. Further observation revealed the bloody liquid substance was pooled along the floor on the right side of the cooler. Observation of Cooler a on 06/30/2026 at 10:57AM with S13Executive Chef revealed plastic bags of raw chicken lying in a shallow tray on the bottom shelf on the right side of Cooler a. Further observation revealed the plastic bags were hanging over the edge of the tray and a bloody liquid substance was dripping on to the floor of the cooler and down the wheels of the shelf. Further observation revealed the bloody liquid substance was pooled along the floor on the right side of the cooler. In an interview on 06/30/2026 at 10:58AM, S13Executive Chef, confirmed the above mentioned bloody liquid substance was raw chicken juice and should have been contained in a leak proof container and should not have been allowed to drip on the floor of Cooler a for multiple shifts. S13Executive Chef further indicated the floors in the cooler were not kept in a sanitary manner and should have been. In an interview on 07/01/2026 at 11:42AM, S1Administrator indicated raw chicken juice should not have been allowed to drip onto the floor of the cooler. S1Administrator further indicated the cooler should have been maintained in a sanitary manner.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide surveyor staff during the survey with the requested complete Quality Assurance and Performance Improvement (QAPI) documentation, including the facility's identified quality concerns necessary to evaluate the effectiveness of the facility's QAPI program as evidenced by the removal of identified quality concerns from the document produced to surveyors. Findings: Review of the facility's undated QAPI Program policy and procedure, revealed, in part, the facility shall develop, implement, and maintain an effective, comprehensive, data-driven QAPI program which identified systems and processes that may have led to avoidable negative outcomes. Further review revealed the QAPI plan and documents generated shall be presented to the state survey agency when needed to determine regulatory compliance. On 07/01/2026 at 9:15AM, S1Administrator and S2Director of Nursing (DON) were presented with a request for the facility's complete QAPI Plan. The facility provide a version of the QAPI plan that did not include identified quality concerns. Subsequent review determined the omitted quality concerns had been removed from the documents provided to the surveyors. Observation on 07/01/2026 at 10:50AM revealed S2DON was using a sharpie marker to redact the specific problems identified by the facility in their QAPI plan. In an interview on 07/01/2026 at 10:52AM, S2DON indicted the information she was redacting from the facility's QAPI plan was the specific practices the facility identified as problematic before providing the plan to the survey team. Review of the facility's QAPI plan entitled, Mock Survey, dated 05/12/2026 through 05/13/2026, revealed, in part, no documentation as to the specific practices identified by the facility which could lead to avoidable negative outcomes. Further review revealed blank spaces in areas where specific identified concerns were documented and subsequently redacted by S2DON. On 07/01/2026 at 3:00PM, S1Administrator and S2DON were presented with a request for documentation of the specific problems the facility's QAPI committee had identified during their QAPI process that showed facility QAPI compliance. In an interview on 07/01/2026 at 3:04PM, S2DON indicated that the specific problems identified by the facility during their QAPI process would not be provided to the state survey team. S2DON further indicated the problems identified by the QAPI committee could be figured out by looking at the training conducted and audit reports. S2DON further indicated she would summarize the identified problems on the QAPI plan. In an interview on 07/01/2026 at 3:15PM, S2DON indicated she handwrote a summary of the problems identified on the original QAPI plan. S2DON further indicated the handwritten summary was not part of the original QAPI plan. Review of the facility's QAPI plan entitled, Mock Survey, presented by S2DON on 07/01/2026 at 3:20PM, revealed, in part, hand written identified problems in the previously reviewed blank space which were inconsistent with the plan of corrections on the same QAPI plan. In an interview on 07/01/2026 at 4:00PM, S1Administrator was informed their QAPI plan/Mock Survey presented to the survey team was incomplete because it did not include the specific problems the facility had identified during its QAPI process, preventing the survey team from determining whether the facility's corrective actions addressed those identified problems. On 07/01/2026 at 4:17PM, S4Quality Improvement Nurse ([NAME]) was presented with a request for the facility's complete QAPI plan which included the specific problems the facility had identified during their QAPI process. In an interview on 07/01/2026 at 4:18PM, S4QIN confirmed the Mock Survey that was presented to the survey team on 07/01/2026 was what the facility had used to identify and correct problems. S4QIN further indicated the facility would not present the state survey agency with the specific problems identified. S4QIN further indicated the state survey agency could figure out what the identified problems were based on the in-service training conducted and the audits performed.		