STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195201	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks of Houma	1701 Polk Street Houma, LA 70360

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34608 Based on record reviews and interviews, the facility failed to document and address complaints voiced by the Resident Council during the facility's Resident Council meetings for 3 of 3 Resident Council meeting minutes reviewed. Findings: Review of the facility's Grievances-Residents policy, dated 03/1993 and revised on 05/2024 revealed, in part, the minutes of each Resident Council meeting should be recorded and future meetings should indicate progress made on each suggestion/recommendation, and/or the reason(s) for rejection if changes suggested could not be implemented. Further review of the policy revealed the grievance official was responsible for overseeing the grievance process, which included receiving, investigating and tracking grievances. Review revealed concerns which could not be promptly resolved should be treated as a grievance. Further review revealed the administrator or grievance official would conduct an impartial investigation of the allegations and would discuss the findings and recommendations within five working days of receiving the complaint. Review revealed the resident had the right to review the grievance and obtain a written decision regarding the grievance. In interview during a meeting held by the surveyor with members of the Resident Council on 03/11/2025 at 10:00AM, Resident #72 indicated the facility did not respond to the resident council's concerns discussed during the meetings regarding the taste and quality of food served from the kitchen. Resident #72 further indicated food concerns were discussed for the last three months and the food had not improved. Resident #15, Resident #59, and Resident #75 all agreed the taste and quality of the food served from the kitchen was discussed monthly for the last three months. Resident #72, Resident #15, Resident #59, and Resident #75 indicated there had been no follow-up from administration regarding the concerns of the taste and quality of food, and there had been no improvements in the taste and quality of food served from the kitchen. In an interview on 03/11/2025 at 10:15AM, Resident #72 indicated the food was over cooked, was under cooked, not seasoned, or was of poor quality overall. Resident #72 further indicated S4Dietary Manager was present at the Resident Council meetings and told the resident council members that the kitchen was short of staff at the time. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/12/2025 at 9:45AM, Resident #20 stated she attended the Resident Council meeting the last three months, and residents expressed concerns regarding the taste and quality of the food served. Resident #20 further indicated there were times when the beans were still hard and not cooked, the salads offered only had lettuce, and/or the food was just not cooked properly. Review of the Resident Council's meeting minutes for the months of January, February, and March 2025 revealed, in part, there were no documentation of the Resident Council's concerns regarding the taste and quality of food served from the kitchen as discussed in the resident council meetings. Review of the facility grievance logs from 12/2024 to 03/2025 revealed, in part, there were no documented grievances regarding the taste and/or quality of food served from the kitchen. In an interview on 03/11/2025 at 10:20AM, S5Activity Director indicated she was responsible for documenting the residents' concerns discussed during the resident council meetings. S5Activity Director further indicated residents discussed food displeasures during the meetings, but she did not document the concerns because she considered the concerns personal dislikes and not a generalized issue. In an interview on 03/11/2025 at 11:40AM, S6SocialWorker indicated she did not have any documented grievances regarding the taste and quality of food served from the kitchen. In an interview on 03/11/2025 at 5:45PM, S2Director of Nursing (DON) indicated she had recently received several complaints from residents regarding food served from the kitchen. S2DON further indicated she reported the concerns to S1Administrator. In an interview on 03/11/2025 at 5:52PM, S1Administrator indicated the resident council concerns regarding the taste and quality of food served from the kitchen should have been documented in the Resident Council meeting minutes. S1Administrator further indicated the residents' concerns should have been treated as a grievance with an investigation and response given to the residents.

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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. 22609 Based on observations and interviews, the facility failed to: 1. Contain a used resident wash basin (Resident #31); and, 2. Maintain the smoking area in a clean manner (Resident #20). This deficient practice was identified for 2 (Resident #31 and Resident #20) of 31 (Resident #1, Resident #2, Resident #4, Resident #5, Resident #6, Resident #11, Resident #22, Resident #28, Resident #31, Resident #32, Resident #35, Resident #38, Resident #42, Resident #49, Resident #52, Resident #57, Resident #60, Resident #66, Resident #67, Resident #72, Resident #75, Resident #81, Resident #101, Resident #105, Resident #106, Resident #109, Resident #111, Resident #112, Resident #163, Resident #165, Resident #363) sampled residents observed during the initial pool process. Findings: 1. Observation on 03/10/2025 at 9:05AM revealed Resident #31's name was written on a wash basin which was under the sink on the floor of Resident #31's shared bathroom and not contained. Observation on 03/10/2025 at 3:45PM revealed Resident #31's name was written on a wash basin which was under the sink on the floor of Resident #31's shared bathroom and not contained. In an interview on 03/10/2025 at 3:52PM, S7Certified Nursing Assistant (CNA) indicated the wash basin was for Resident #31. S7CNA further indicated Resident #31's wash basin should not have been on the bathroom floor and should be contained in a plastic bag. In an interview on 03/10/2025 at 4:14PM, S2Director of Nursing indicated Resident #31's wash basin should not have been on the bathroom floor and should have been contained in a plastic bag. 2. In an interview on 03/10/2025 at 9:56AM, Resident #20 complained to the surveyor that the smoking area was dirty. Resident #20 then pointed to a cigarette that was on a window ledge and cigarette ashes all over the window ledge. Observation on 03/10/2025 at 9:58AM revealed a cigarette and cigarette ashes were present on the window ledge. Observation further revealed the smoking patio wall had an unknown black substance. Observation on 03/11/2025 at 10:25AM revealed a cigarette and cigarette ashes were present on the window ledge. Observation further revealed the smoking patio wall had an unknown black substance on the surface. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 9:45AM, S1Administrator confirmed the smoking patio areas needed to be cleaned.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46361 Based on interviews and record reviews, the facility failed to implement an appropriate fall intervention for a resident to prevent future falls for 1 (Resident #4) of 3 (Resident #4, Resident #32, Resident #49) sampled residents reviewed for falls. Findings: Review of Resident #4's Minimum Data Set with an Assessment Reference Date of 01/14/2025 revealed, in part, Resident #4 had a Brief Interview for Mental Status score of 3, which indicated Resident #3 had severe cognitive impairment, a diagnosis of dementia (memory loss), used a manual wheelchair for mobility, was dependent on staff for transfers, and had 2 or more falls since her prior assessment. Review of Resident #4's incident report dated 02/14/2025 revealed Resident #4 had an unwitnessed fall in her room and was found on the floor in front of her unlocked wheelchair. Review of Resident #4's care plan dated 02/17/2025 and revised on 03/11/2025 revealed, in part, Resident #4 had a history of falls with an intervention implemented on 02/14/2025 for staff to ensure brightly colored tape was applied to Resident #4's wheelchair brakes. In an interview on 03/11/2025 at 2:21PM, Resident #4 was unable to appropriately respond when questioned about the use of the brightly colored tape on her wheelchair brakes. In an interview on 03/12/2025 at 12:12PM, S10Licensed Practical Nurse (LPN) indicated Resident #4 had severe dementia and would not be able to remember to use her wheelchair brakes and/or identify the brightly colored tape on the brake handles as a reminder to use her wheelchair brakes. In an interview on 03/12/2025 at 12:15PM, S3Assistant Director of Nursing (ADON) indicated Resident #4's had poor safety awareness and severe cognitive impairment. S3ADON further indicated Resident #4 would not know how to use her wheelchair brakes and/or identify the brightly colored tape on the brake handles as a reminder to use her wheelchair brakes. In an interview on 03/12/2025 at 2:04PM, S9LPN indicated Resident #4 was definitely not cognitive enough to understand how to use her wheelchair brakes or identify the brightly colored tape on the brake handles as a reminder to use her wheelchair brakes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 22609 Based on observations, interviews, and record reviews, the facility failed to follow the physician's order for oxygen administration for 1 (Resident #165) of 2 (Resident #164, Resident #165) sampled residents investigated for oxygen administration. Findings: Review of the facility's Oxygen-Administration, Concentration, Storage, Assemblage policy revised January 2024 revealed, in part, the procedure was to check the resident's oxygen flowmeter for the correct liter flow. Review of Resident #165's March 2025 Physician's Orders revealed, in part, an order for oxygen at two liters per minute (LPM) per nasal cannula continuously every shift related to chronic obstructive pulmonary disease. Observation on 03/10/2025 at 9:44AM revealed Resident #165's oxygen per nasal cannula was set between 1 and 1.5 LPM on the oxygen concentrator. Observation on 03/11/2025 at 2:09PM revealed Resident #165's oxygen per nasal cannula was set at 1.5 LPM on the oxygen concentrator. In an interview on 03/11/2025 at 2:10PM, S8Licensed Practical Nurse indicated Resident #165's oxygen was set at 1.5 LPM on the oxygen concentrator and should have been at 2 LPM per Resident #165's physician's orders. In an interview on 03/11/2025 at 3:25PM, S2Director of Nursing (DON) indicated the nurses should follow the physician's orders for oxygen administration. In an interview on 03/11/2025 at 4:05PM, S2DON confirmed Resident #165's oxygen order was for 2 LPM.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 46361 Based on interviews and record reviews, the facility failed to ensure a resident's hospice plan of care and certification of terminal illness was obtained from the contracted hospice agency for 1 (Resident #4) of 1 (Resident #4) sampled resident reviewed for hospice services. Findings: Review of Resident #4's Significant Change Minimum Data Set with an Assessment Reference Date of 01/14/2025 revealed, in part, Resident #4 had a life expectancy of less than 6 months and received hospice services. Review of Resident #4's March 2025 Physician's Orders revealed, in part, an order to admit Resident #4 to the contracted hospice agency on 01/03/2025. Review of the facility's Hospice Service Agreement dated 01/03/2025 revealed, in part, the facility was responsible for obtaining the most recent contracted hospice agency's plan of care and physician certification of terminal illness. Review of Resident #4's contracted hospice agency's binder revealed, in part, Resident #4 was admitted to hospice services on 01/03/2025. Further review revealed there was no documented evidence, and the facility was unable to present any documented evidence of Resident #4's physician certification of terminal illness or contracted hospice agency's plan of care. In an interview on 03/12/2025 at 1:43PM, S2Director of Nursing (DON) indicated it was the responsibility of S11Medical Records to ensure all hospice documents were maintained in Resident #4's clinical records. S2DON confirmed Resident #4's contracted hospice agency binder and electronic chart did not contain Resident #4's certification of terminal illness or Resident #4's contracted hospice agency's plan of care as required. In an interview on 03/12/2025 at 1:55PM, S11Medical Records indicated she was responsible to ensure all hospice documents were maintained in Resident #4's clinical record. S11Medical Records further indicated she did not know the specific hospice documents that should have been maintained in Resident #4's clinical record. S11Medical Records confirmed Resident #4's physician certification of terminal illness and contracted hospice agency's plan of care were not in Resident #4's clinical records as required.