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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure:1. Staff used Enhanced Barrier Precautions (EBP) when providing care to residents (Resident #21, Resident #27, Resident #47); and,2. Staff followed infection control guidelines during wound care (Resident #57).This deficient practice was identified for 3 (Resident #21, Resident #27, Resident #47) of 5 sampled residents observed with EBP, and 1 (Resident #57) of 4 sampled residents observed during wound care. Findings:1. Review of the facility's Enhanced Barrier Precautions (EBP) Policy and Procedure, last revised on 03/2024, revealed EBP involves gown and gloves use during high-contact resident care activities for residents known to be colonized or infected with Multi-drug Resistant Organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices), wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities such as: bathing/showering, providing hygiene, changing briefs or assisting with toileting, and/or device care. Resident #21 Review of Resident #21's Care Plan revealed Resident #21 had an indwelling catheter (a medical device used to drain the bladder) with a goal for Resident #21 to show no signs or symptoms of urinary infection through the next review date. Further review revealed an intervention was to ensure EBP was followed. Observation on 03/23/2026 at 10:22AM revealed S6Certified Nursing Assistant (CNA) brought Resident #21 into shower room a on a shower bed. Further observation revealed Resident #21 had an indwelling urinary catheter. Further observation revealed S6CNA and S7CNA proceeded to give Resident #21 a shower without the use of a gown. Observation on 03/24/2026 at 1:30PM revealed an enhanced barrier precautions sign outside of the door of Resident #21's room. Observation further revealed gowns were available for use behind Resident #21's door inside the room. In an interview on 03/23/2026 at 3:12PM, S7CNA confirmed she was not wearing a gown when she showered Resident #21 and she should have. In an interview on 03/24/2026 at 1:27PM, S6CNA confirmed she was not wearing a gown when she showered Resident #21, and she should have been. In an interview on 03/25/2026 at 12:46 PM, S2Director of Nursing (DON) indicated that staff should (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 - Some	use a gown and gloves when providing residents, who have indwelling catheter, a bath or a shower. Resident #27 Review of Resident #27's care plan with a target date of 04/03/2026 revealed Resident #27 had a stage 2 pressure ulcer (open wound caused by unrelieved pressure to the skin) to Resident #27's sacrum (upper buttock area). Further review revealed an intervention of, in part, staff were to implement EBP. Observation on 03/23/2026 at 10:00AM revealed, in part, S4CNA removed Resident #27's bed linen, removed Resident #27's soiled diaper, and performed incontinence care to Resident #27 without wearing a gown. In an interview on 03/23/2026 at 10:10AM, S4CNA indicated she was only required to wear gloves when performing high contact resident care activities. S4CNA further indicated she was only required to wear a gown if a resident had Covid (viral infection). S4CNA further indicated the EBP sign hanging outside of Resident #27's door was only if the resident was sick. Resident #47 Review of Resident #47's care plan with a target date of 03/23/2026 revealed Resident #47 had an indwelling urinary catheter with an intervention of, in part, staff were to implement EBP. Observation on 03/23/2026 at 9:30AM revealed an EBP sign was posted outside of Resident #47's room. Observation on 03/23/2026 at 9:35AM revealed S5CNA performed incontinence care to Resident #47 and lifted Resident #47's catheter drainage bag and held it while Resident #47 pulled up his pants without wearing a gown. Observation on 03/23/2026 at 9:38AM revealed S4CNA entered Resident #47's room to assist with care. Further observation revealed S4CNA then emptied Resident #47's catheter drainage bag without wearing a gown. 2. Review of the facility's Hand Hygiene policy and procedure, latest revision date of 01/2024, revealed, in part, hand hygiene should be performed and gloves changed before and after every procedure. Review of the facility's Dressing Change policy and procedure, latest review date of 08/2021, revealed, in part, after removing a dressing, remove gloves, and perform hand hygiene. Further review revealed cleanse the area as ordered and dry the wound. Further review revealed then perform hand hygiene apply new gloves and apply the dressing. Resident #57 Review of Resident #57's March 2026 physician orders revealed Resident #57 was to have the right dorsal foot (top of the right foot) wound cleaned with normal saline, the nurse was to apply bacitracin (topical antibiotic used to treat or prevent infections) ointment, then cover the wound with a clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, and the dressing was to be changed every three days and as needed until healed. Observation on 03/24/2026 at 1:35PM of Resident #57's wound care completed by S3Treatment Nurse revealed, in part, S3Treatment Nurse removed Resident #57's dressing from Resident #57's right foot. S3Treatment Nurse then cleaned the wound with normal saline, at which time S3Treatment Nurse identified a second wound to the right dorsal foot, which was distal (closer to the toes of the foot) to the previously identified wound. S3Treatment Nurse then cleaned the second newly identified wound with the same gauze S3Treatment Nurse used to clean the first wound. Further observation revealed S3Treatment Nurse did not remove her gloves nor perform hand hygiene between wounds. Further observation revealed S3Treatment Nurse then performed hand hygiene applied new gloves, used her gloved hands to remove loose skin from Resident #57's toes. Further observation revealed S3Treatment Nurse then without removing gloves or performing hand hygiene, grabbed the new dressing, touching the surface which was placed against Resident #57's skin with the same gloved hands. In an interview on 03/24/2026 at 1:46PM, S3Treatment Nurse indicated she should have changed her gloves, performed hand hygiene, and used a new gauze between cleaning the two wounds. S3Treatment Nurse further indicated she should have removed her gloves and performed hand hygiene after removing the dry skin on Resident #57's toes and prior to applying the new dressing. In an interview on 03/26/2026 at 11:33AM, S2Director of Nursing (DON) was informed of the above mentioned findings, and S2DON indicated S3Treatment Nurse should have changed her gloves, performed hand hygiene, and used a new gauze for cleaning each wound. S2DON further indicated S3Treatment Nurse should have also changed her gloves and performed hand hygiene after touching the skin between Resident #57's toes and applying the new dressing. In an interview on 03/26/2026 at 11:41AM, S1Administrator was made aware of the above mentioned findings, and indicated he had no further evidence to present for the above-mentioned findings.