STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195203	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldon Health Care Center	2401 Idaho Street Kenner, LA 70062

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 0842 Level of Harm - Potential for minimal 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 interviews and record reviews, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADL) was documented as provided for 3 (Resident #1, Resident #2, Resident #3) of 4 sampled residents reviewed for charting completion and accuracy. Findings:Resident #1Review of Resident #1's Care Plan dated 02/18/2026 revealed, in part, Resident #1 required staff assistance with activities of daily living with staff to provide assistance with oral care, eating, and showering. Review of Resident #1's February 2026 Documentation Survey Report v2 revealed, in part, there was no documented evidence staff provided Resident #1 with bathing assistance or eating assistance on the day shift for 02/13/2026 and 02/18/2026. Review of Resident #1's March 2026 Documentation Survey Report vs revealed, in part, there was no documented evidence staff provided Resident #1 with bathing assistance or eating assistance on the day shift on 03/25/2026. Review of Resident #1's clinical record did not reveal any alternate documentation to support the above-mentioned ADLs were provided or that the facility ensured the completion of the documentation required for Resident #1's ADLs. Resident #2Review of Resident #2's care plan revised on 03/04/2026 revealed, in part, Resident #2 required staff assistance with activities of daily living, including assistance with meals, oral care, and toileting/incontinence care. Review of Resident #2's February 2026 Documentation Survey Report v2 revealed, in part, there was no documented evidence staff provided the resident with eating assistance on the day shift for 02/13/2026; the evening shift on 02/10/2026, 02/13/2026, 02/16/2026, 02/17/2026, and 02/25/2026; and the night shift on 02/10/2026, 02/16/2026, and 02/28/2026. There was also no documented evidence staff provided oral hygiene assistance on the day shift for 02/13/2026; the evening shift on 02/10/2026, 02/13/2026, 02/16/2026, 02/17/2026, and 02/25/2026; and the night shift on 02/10/2026, 02/16/2026, and 02/28/2026. Additionally, there was no documented evidence staff provided toileting assistance on the day shift for 02/13/2026; the evening shift on 02/10/2026, 02/13/2026, 02/16/2026, 02/17/2026, and 02/25/2026; and the night shift on 02/10/2026, 02/16/2026, 02/26/2026, and 02/28/2026. Review of Resident #2's clinical record did not reveal any alternate documentation to support the above-mentioned ADLs were provided or that the facility ensured the completion of the documentation required for Resident #2's ADLs. Resident #3Review of Resident #3's care plan revealed, in part, the resident required staff assistance with activities of daily living due to limited mobility, including bathing/showering, eating, oral hygiene, and toileting/incontinence care. Review of Resident #3's January 2026 documentation survey V2 report revealed no documented evidence staff provided required ADL assistance as care planned. Further review revealed there was no documented evidence of bathing on 01/22/2026 and 01/27/2026; eating assistance on the day shift on 01/22/2026, 01/23/2026, 01/26/2026, and 01/27/2026, the evening shift on 01/15/2026, and the night shift on 01/14/2026 and 01/15/2026; oral hygiene assistance on the day shift on 01/22/2026, 01/23/2026, 01/26/2026, and 01/27/2026, the evening shift on 01/15/2026, and the night shift on 01/14/2026 and 01/15/2026; and toileting assistance on the day shift on 01/22/2026, 01/23/2026, 01/26/2026, and 01/27/2026, the evening shift on 01/15/2026, and the night shift on 01/15/2026. Review of Resident #3's clinical record did not reveal any alternate documentation to (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195203	A. Building B. Wing	04/14/2026

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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 - Potential for minimal harm Residents Affected - Some	support the above-mentioned ADLs were provided or that the facility ensured the completion of the documentation required for Resident #3's ADLs. In an interview on 04/14/2026 at 3:16PM, S1Administrator verified the above-mentioned findings, and indicated the ADLs were not documented by staff as having been performed and should have been. In an interview on 04/14/2026 at 3:27PM, S2Director of Nursing confirmed the above-mentioned findings, and indicated the ADLs were not documented by staff as having been performed or refused and should have been.