STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195482	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	144 Thad Bailes Rd Leesville, LA 71446

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure a resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of his or her own quality of life for 2 (Resident #2 and Resident #27) of 39 sampled residents. The facility failed to:1. Ensure Resident #2 received incontinence care before meal service, and2. Ensure Resident #27 received her meal along with the other residents at the lunch table. Findings: Review of a facility policy titled “Assistance with Meals” on 09/04/2025 at 10:48 a.m. revealed in part… facility staff will serve resident trays and will help residents who require assistance with eating for dining room residents and residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. Resident #27 Record review revealed an admission date of 03/06/2025 with admitting diagnosis of Unspecified Protein –calorie malnutrition, cognitive communication deficit, other lack of coordination, unspecified dementia moderate without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; altered mental status, unspecified. Review of the resident’s Quarterly MDS (Minimum Data Set) dated 08/07/2025 revealed the resident required substantial/maximal assistance for eating. The resident did not have a BIMS (Brief Interview Mental Status) due to unable to interview due to rarely or never understood. On 09/03/2025 at 11:05 a.m., a dining observation was conducted during lunch on Hall X. Resident #27 was observed sitting at a table throughout the meal service. Residents were observed being served, eating, and then exiting the dining area, while Resident #27 remained un-served. On 09/03/2025 at 11:40 a.m., an interview was conducted with S13CNA. When asked if she was finished serving the Hall X, she stated, “We have to feed Resident #27, so her tray is fixed last.” On 09/03/2025 at 11:48 a.m., an interview was conducted with S12LPN who stated she was unaware Resident #27 had not been served with the other residents at her table. S12 LPN confirmed that all residents seated at the table with Resident #27 had been served and completed their meal and Resident #27 had not been served. Resident #2 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2’s medical record revealed an admission date of 06/02/2023 with diagnoses including, in part…Memory Deficit Following Cerebral Infarction, Parkinson's Disease, Depression, Alzheimer's Disease, Dementia, Muscle Wasting And Atrophy, and Protein-Calorie Malnutrition. Review of Resident #2’s Significant Change MDS with an ARD of 07/14/2025 revealed a BIMS Score of 3, indicating severe cognitive impairment. Resident #2 required substantial/maximal assistance with eating and was always incontinent of bowel and bladder. Observation of Resident #2 on 09/04/2025 at 7:50 a.m. revealed the resident was lying in bed, uncovered, and turned slightly to the left. Resident #2’s brief was bulging posteriorly. There was a strong odor of feces in the room. Observation of Resident #2 on 09/04/2025 at 8:19 a.m. revealed the resident was lying in bed, uncovered, and turned slightly to the left. Resident #2’s brief was bulging posteriorly. There was a strong odor of feces in the room. Interview with S10CNA on 09/04/20225 8:25 a.m. revealed she had just attempted to feed Resident #2 breakfast and stated Resident #2 “did not eat anything”. Observation of Resident #2 on 09/04/2025 at 8:30 a.m. revealed the resident was lying in bed, uncovered, and turned slightly to the left. Resident #2’s brief was bulging posteriorly. There was a strong odor of feces in the room. Observation of resident #2 on 09/04/2025 at 8:35 a.m. accompanied by S9LPN revealed Resident #2’s brief contained feces and there was a strong odor of feces in the room. S9LPN confirmed Resident #2 should have received incontinence care prior to being served/fed his breakfast, but had not been. S9LPN revealed the presence of feces could have contributed to Resident #2 not consuming breakfast, stating “I wouldn’t want to eat if I was sitting in that”. S9LPN confirmed Resident #2’s dignity had not been maintained, but should have been. Interview with S2DON on 09/04/2025 at 2:00 p.m. confirmed Resident #2 should have been provided with incontinence care prior to staff attempting to feed resident breakfast.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: [NAME], RUBY (7) Ford, [NAME] - Advance Directives No NotesBRITT, RUBY (7) Ford, [NAME] - RESIDENT NOTE [DATE] 1:42 PM Record Review: Res admitted on [DATE] and re-entered on [DATE], DOB [DATE], 93yo, W/F, DNR with selective treatment code status, DX: Traumatic Subdural Hemorrhage without Loss of Consciousness, subsequent encounterDX in part:Transient Cerebral Ischemic Attack, Unspecified, Unspecified Dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Cognitive Communication DeficitMDS:Annual MDS with ARD date of [DATE] revealed in part.Section C: BIMS 99, indicating severe impaired cognitionSection E: No behaviorsSection GG: Eating-setup or clean-up assistance; oral hygiene-dependent; toileting hygiene-dependent; shower/bathe self-dependent; upper body assistance-substantial/maximal assistance; lower body assistance-dependent; putting on/taking off footwear-dependent; personal hygiene-supervision or touching assistance; roll left to right- substantial/maximal assistance; sit to lying-partial/moderate assistance; lying to sitting on side of bed-substantial/maximal assistance; sit to stand-substantial/maximal assistance; chair/bed to chair transfer-substantial/maximal assistance; tubs/shower transfer-substantial/maximal assistance; wheel 50 feet with two turns-partial/moderate assistance; wheel 150 feet-partial/moderate assistanceCare Plan:Date initiated on [DATE] and next review date of [DATE].XXX[DATE]-Care Plan reviewed and revealed in part.Problem: Resident/RP has elected a FULL CODE status Interventions:Inform all Care givers of FULL CODE status Notify MD and family as soon as possible begin CPR and call 911 Review code status with family Q and each CP changeOrders:[DATE]-DNR (DO NOT RESUSCITATE) *WITH SELECTIVE TREATMENT*every shiftMDS nurse, LPN Interview on [DATE] @ 2:46 p.m.[NAME] stated resident has a code status of DNR. She also viewed the Care Plan section in resident electronic chart showed resident had a Full Code status. She acknowledged the code status recently changed to DNR status and the Care Plan was incorrect.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident #9) of 39 sampled residents. Review of Resident #9's medical record revealed an admission date of 11/16/2023 with diagnoses including Dysphagia, Cerebral Infarction, and Unspecified Convulsions.Review of Resident #9's Significant Change MDS with an ARD of 08/13/2025 revealed a BIMS score of 3, indicating severe cognitive impairment. Resident #9 experienced coughing or choking during meals or when taking medications. Review of Resident #9's Physician's Orders revealed the following, in part. 08/08/2025 May perform oral suctioning.Review of Resident #9's Care Plan revealed Resident #9 was not care planned for suctioning.Interview with S2DON on 09/04/2025 at 2:00 p.m. confirmed Resident #9 should have been care planned for suctioning, but was not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interviews, the facility failed to ensure the plan of care had been revised for 1 (Resident #7) of 39 resident care plans reviewed. Findings: Review of facility's Advance Directives policy on 09/03/2025 at 2:38 p.m. revealed the following in part.The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. Resident #7Record review revealed an admission date of 06/21/2021 and re-entered on 12/14/20222 with admitting diagnosis of Traumatic Subdural Hemorrhage without Loss of Consciousness, subsequent encounter. Annual MDS (Minimum Data Set) dated 08/01/2025 revealed a BIMS (brief interview of mental status) score of 99 which indicated Resident #7's cognition was severely impaired. Review of Resident #7 Care Plan with initiate date of 06/20/2023 and next review date of 11/07/2025 revealed a problem of Resident #7 had elected a Full Code status with an intervention to inform all caregivers of full code status.Review of Resident #7 Physician Orders on 09/03/2025 at 1:42 p.m., revealed an order of DNR (Do Not Resuscitate) with selective treatment every shift started on 06/03/2025.During an Interview on 09/03/2025 at 2:46 p.m. with S15LPN (Licensed Practical Nurse) revealed Resident was a DNR status. After reviewing the care plan S15LPN confirmed Resident #7's care plan had not been updated to reflect the DNR status ordered on 06/03/2025.

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to ensure all care and services were provided according to accepted professional standards of clinical practice. The facility failed to:1. Ensure proper physician orders were obtained for oxygen therapy requirements for 1 (Resident #100) of 2 (Resident #73 and Resident #100) residents reviewed for respiratory care; and 2. Ensure a wound dressing was properly labeled with the date/time of the treatment and initials of who performed the wound care for 1 (Resident #100) of 2 (Resident #63 and Resident #100) residents review for skin conditions. Findings: Review of a facility policy on 09/03/2025 at 3:17 p.m. titled, Oxygen Administration with a revision date of 02/2025 revealed the following in part .The purpose of this procedure is to provide guidelines for safe oxygen administration, and infection prevention associated with respiratory therapy goals. Preparation; 1. Verify that there is a physician's order for this procedure. Equipment and Supplies: 2. Nasal cannula, nasal catheter, mask (as ordered). Review of an undated facility policy on 09/03/2025 at 3:30 p.m. titled, Wound Care revealed the following in part . The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: 12. Dress wound. Pick up sponge and apply directly to the area. [NAME] tape with initials, time, and date and apply to the dressing. Review of Resident #100's medical record revealed an admission date of 07/03/2025, which included diagnoses in part . Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Unspecified Protein-Calorie Malnutrition, Personal History of other Malignant Neoplasm of Skin, Hypoxemia, and Chronic Diastolic (Congestive) Heart Failure. Review of Resident #100's Annual MDS with an ARD of 07/10/2025 revealed a BIMS of 13, which indicated intact cognition. Resident #100 required partial/moderate assistance with eating and oral hygiene and substantial/maximal assistance with toileting hygiene, personal hygiene, and shower/bathing. Resident #100 was at risk for developing pressure ulcers and had skin tears present at the time of this assessment. Review of Resident #100's current physician's orders (as of 09/03/2025) revealed the following active orders .(Start date: 07/15/2025) Respiratory: oxygen at 2 liters per nasal cannula as needed for shortness of breath (SOB)/hypoxia as needed related to Chronic Diastolic Congestive Heart Failure. No other current/active oxygen physician orders viewed at this time. (Start date: 09/05/2025) Laceration to posterior left lower extremity/calf, steri-strips in place: cleanse wound cleanser, pat dry, apply triple antibiotic ointment, cover with non-adherent dressing and wrap with kerlix every day shift every 3 day(s). Review of Resident #100's plan of care revealed the following in part . (Initial date: 07/03/2025) Focus: The resident has a cerebral vascular accident affecting the left side. Interventions: Oxygen as ordered. (Initial date: 07/03/2025) Focus: The resident has shortness of breath related to hypoxia and Congestive Heart Failure. Interventions: 07/15/2025- Resident noted with shortness of breath and decreased oxygen saturation. New order received for oxygen at 2 liters per nasal cannula PRN (as needed) for shortness of breath/hypoxia. (Initial date: 07/03/2025) Focus: The resident is at risk for impaired skin integrity related to fragile skin. Interventions: 09/02/2025- skin tear to left lateral lower leg- treatment as ordered. Review of Resident #100's medical record revealed nursing progress notes in part .08/22/2025: A nurse wrote: Resident continues on oxygen continuously. The resident received oxygen therapies on the following dates: 08/20/2025, 08/21/2025, 08/22/2025, 8/23/2025, 8/24/2025, 08/25/2025, 08/26/2025, 08/27/2025, 08/28/2025, 08/29/2025, 08/31/2025, 09/01/2025, and 09/02/2025. In an interview on 09/02/2025 at 10:00 a.m., Resident #100 revealed he used oxygen continuously. Observed oxygen in progress and oxygen concentrator set at 3 liters via nasal cannula. Resident #100's daughter was at the bedside and showed the surveyor Resident #100's wound dressing to the left lower leg. Observed the left lower leg (shin area) wound dressing wrapped loosely with gauze, undated, unlabeled, and soaked with red blood. Observed wet red blood on the bed linens where Resident #100's left leg was placed in the bed. In an interview on 09/03/2025 at 12:30 p.m., Resident #100 revealed the staff did not change his wound dressing to his left lower leg today (09/03/2025). Observed the left lower leg and viewed an undated/unlabeled, loose fitting gauze dressing with a moderate amount of dried bright red blood. Observed resident with oxygen in progress and the oxygen concentrator set at 3 liters running continuously. Resident #100 stated he wore oxygen throughout the evening and all day long. Resident #100 stated he was blind and bedbound and unable to adjust the oxygen settings himself. In an interview on 09/03/2025 at 12:45 p.m., S4 LPN accompanied the surveyor to Resident #100's room. S4 LPN confirmed Resident #100's left lower wound dressing was loose and saturated with dried red blood. S4 LPN assessed the dressing further and confirmed it was unlabeled/undated and had no

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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. Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 1(#73) of 1 resident reviewed for respiratory care. The facility failed to ensure respiratory equipment was properly labeled, and stored. Findings: Review of the Facility's Oxygen Administration policy with a revision dated of 02/2025 read in part . the purpose of this procedure is to provide guidelines for safe oxygen administration, and infection prevention, associated with respiratory therapy task. Steps in the procedure: 5. Store in a covered device (i.e. plastic bag, kangaroo pouch) between use. Review of Resident #73's 09/2025 Physician Orders read in part.08/26/2025: Oxygen at 2 liters per nasal cannula as needed for shortness of breath and hypoxia. Observation on 09/02/2025 at 12:30 p.m. revealed Resident #73's nasal cannula lying on the floor, without a bag. Observation on 09/03/2025 at 10:26 a.m. revealed Resident #73's nasal cannula lying on the floor, without a bag. Resident #73 stated that he used the oxygen last night on 09/02/2025. An interview on 09/03/2025 at 10:34 a.m. with S11 LPN confirmed that Resident #73's oxygen tubing was lying in the floor without a bag. S11 LPN stated that all oxygen tubing should be dated and kept in a bag when not in use, but had not been.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation and interview the facility failed to maintain a medication error rate below 5%. A total of 29 medication administration opportunities were observed. This practice had the potential to affect all 145 residents that receive medications in the facility. Observation of medication administration with S9LPN on 09/03/2025 at 7:50 a.m. revealed the following: Pantoprazole DR 40mg tablet was crushed and provided po; Tolterodine ER 4mg capsule was opened and the contents were provided po; and Potassium Chloride ER 10meQ tablet was crushed and provided po.Interview with S9 LPN on 09/03/2025 at 12:40 p.m. confirmed she had crushed a Pantoprazole DR 40mg tablet and a Potassium Chloride ER 10meQ tablet and provided the crushed tablets to a resident. S9 LPN confirmed she had opened a Tolterodine ER 4mg capsule and provided the contents to a resident.Interview with the facility's contract pharmacist on 09/04/2025 at 2:39 p. m. revealed ER and DR medications should not have been crushed or opened and he had not provided any documentation stating that crushing the medication would not adversely affect a resident. The contract pharmacist confirmed the Pantoprazole DR 40mg tablet, Tolterodine ER 4mg capsule, and Potassium Chloride 10meQ tablet should not have been crushed or opened and provided to a resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles. The facility failed to ensure:1. Nursing carts were free of loose pills for 1 (Cart A) of 3 (Cart A, Cart B, and Cart D) carts reviewed; and2. Medications were labeled with the date they were opened.Observation of Cart A on 09/03/2025 at 12:45 p.m., with oversight from S9LPN, revealed the following, in part. 2 unidentified and loose tablets in the bottom of the 2nd drawer of the cart; 3 unidentified and loose tablets in the bottom of the 3rd drawer of the cart; 1 opened Albuterol 90mcg/inh inhaler without an open date; and 1 opened Trelegy Ellipta 100mcg/62.5mcg/23mcg inhaler without an open date.Interview with S9 LPN during the observation confirmed there were 5 unidentified and loose tablets in Cart A, but there should not have been. S9LPN confirmed the Albuterol and Trelegy Ellipta inhalers had been opened and used, but were not labeled with the date they were opened. Interview with the facility's contract pharmacist on 09/04/2025 at 2:39 p.m. revealed Albuterol inhalers are to be discarded 12 months after opened, and Trelegy Ellipta inhalers are to be discarded 6 weeks after opened. The facility's contract pharmacist confirmed the Albuterol and Trelegy Ellipta inhalers should have been labeled with the date they were opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to:1. Ensure Enhanced Barrier Precautions (EBP) were utilized from 1 (Resident #102) of 3 (Resident #1, Resident #76, and Resident #102) residents reviewed for infection control;2. Ensure proper hand hygiene and gloving was followed during meal service on Hall Z;3. Ensure staff followed proper infection prevention and control practices during wound care for 1 (Resident #2) of 3 (Resident #2, Resident #3, and Resident #103) residents reviewed for pressure ulcers. Findings: Review of a facility policy on 09/03/2025 at 2:15 p.m. titled, “Implementation of Standard and Transmission-Based Precautions” dated 03/2024 revealed the following in part…Infection control measures are implemented in attempts to prevent the spread of communicable diseases. 3. Enhanced-Barrier Precautions (EBP): Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities to transfer MDRO to staff hands and clothing. I. Examples of Enhanced-Barrier Precautions residents: indwelling medical devices-include central lines, urinary catheters, feeding tubes, and tracheostomies/vents. II. Enhanced-Barrier Precautions are indicated during: dressing, bathing/showering, etc. Review of a facility policy on 09/03/2025 at 3:17 p.m. titled, ‘Handwashing/Hand Hygiene” with a revision date of 12/22/2023 revealed the following in part…This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 60%-90% alcohol; or soap (antimicrobial or non-antimicrobial) and water for the following situations: M. After removing gloves. O. Before and after eating or handling food. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 1. Resident #102 Review of Resident #102’s medical record revealed an admission date of 06/05/2009, with diagnoses that included in part… Aphasia Following Cerebral Infarction, Moderate Protein-Calorie Malnutrition, Dementia, Severe, Without Behavioral Disturbance, and Gastrostomy Status. Review of Resident #102’s Quarterly MDS with an ARD of 08/07/2025 revealed a BIMS score of 99, which indicated severe cognitive impairment. Resident #102 was dependent on staff for oral hygiene, toileting hygiene, and shower/bathing. Eating was not attempted for Resident #102 due to medical condition or safety concerns. Resident #102 received 51% or more of proportion of total calories through a tube feeding. Review of Resident #102’s plan of care revealed in part . (Initial Date: 03/29/2024) Focus: At risk for EBP, at increased risk of MDRO acquisition due to peg tube. Interventions: Post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE. Provide patient standard precautions using gowns and gloves during dressing, bathing transferring providing hygiene, changing linens, changing briefs, assisting with toileting, etc. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/02/2025 at 9:32 a.m. revealed an EBP sign posted on the wall of the doorway of Resident 102’s room. In an interview on 09/03/2025 at 1:05 p.m., S4 LPN revealed that residents with EBP require the use of gown and gloves with direct care. These residents included those with a peg tube. S4 LPN stated that staff are to observe the resident’s doorway and note the EBP signage/requirements, obtain PPE supplies (gown and gloves) from the clean linen closet, and then provide direct care to that resident after the gown and gloves are applied. In an interview on 09/03/2025 at 1:43 p.m., S6 CNA revealed she provided care to Resident #102 from 7:00 a.m. – 7:00 a.m. today. S6 CNA stated that she provided a bed bath to Resident #102 every day and during the bed bath she provided oral care, brief change, and a linen change. S6 CNA revealed she worn only gloves when she provided all of the above care to Resident #102 this morning. S6 CNA accompanied the surveyor to the doorway of Resident #102’s room and observed the EBP signage posted. S6 CNA stated, “Oh yeah, I should have worn a gown and gloves when I gave her a bath this morning, but I didn’t.” After further interview, S6 CNA revealed she did not wear the correct PPE (gown and gloves) for all of the EBP residents on her assigned hall (Hall Y) because the PPE was not stored outside of their room door and she did not know where to obtain the PPE supplies. There was a total of 14 residents on the S6 CNA’s assigned hall (Hall Y) who required EBP with direct care. In an interview on 09/03/2025 at 1:58 p.m., S3 IP Nurse revealed that all staff had been educated on the policy and procedures for the use of EBP. S3 IP Nurse stated she expected all staff to wear gown and gloves when direct/physical care is provided to these residents such as bathing, incontinent care, etc. S3 IP Nurse revealed the PPE is stored in the clean linen closet or the rounding cart, which all staff have access to and are aware of. S3 IP Nurse confirmed the CNA should have worn both gown and gloves when providing a bath to Resident #102 and all other residents who had EBP requirement signage posted at their doorway, but did not. In an interview and record review on 09/03/2025 at 3:17 p.m., S3 IP Nurse confirmed there were a total of 14 residents on Hall Y which required EBP PPE during direct/physical care. In an interview on 09/04/2025 at 1:20 p.m., S2 DON confirmed that the CNAs are aware of where to find the PPE for all residents who require EBP and the staff should wear both gown and gloves when providing direct/physical care to those residents. 2. Dining observation on 09/02/2025 at 12:03 p.m. in Hall Z revealed the following in part . S7 CNA observed serving and preparing resident meals with gloves on. Observed S7 CNA, with gloved hands, touch the upper shelves and doors x2 (located behind her), then gather multiple clean plates, gather clean utensils, touch the countertops, touch four lids on each item of food, touch multiple meal tickets, touch her apron, touch her mask, and rinse dishes in the sink .S7 CNA grabbed a bread roll directly and placed it on a resident’s plate. During this observation, S7 CNA had the same gloved hands and no hand hygiene or glove change was observed throughout the process. S7 CNA was observed eight times touching the bread rolls directly with the same contaminated gloves and serving the bread rolls to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195482	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	144 Thad Bailes Rd Leesville, LA 71446

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation revealed the following part .S7 CNA removed her gloves and disposed of them. No hand hygiene observed after disposal of the gloves. S7 CNA took her unwashed bare hands and got clean utensils for the remaining residents to use for meal time. S7 CNA obtained gloves out of her co-workers pocket, applied these contaminated gloves, and finished serving and plating resident meals. S7 CNA was observed touching the bread rolls directly with her contaminated gloves three more times and served the residents their meals. No hand hygiene observed throughout dining procedures observed. In an interview on 09/02/2025 at 1:15 p.m., S7 CNA confirmed all the above findings. S7 CNA confirmed she did not wash her hands, change her gloves, or wash her hands in between touching different surfaces, before touching the bread rolls directly and served the rolls to the residents. S7 CNA confirmed she should have washed her hands after she disposed of her gloves, but did not. S7 CNA confirmed she should not use gloves that came out of her co-worker’s pocket and use them for meal services, but did. S7 CNA confirmed she served 11 total residents without using proper hand hygiene and gloving practices during meal services, but should have. In an interview on 09/03/2025 at 1:39 p.m., S8 DM revealed the following in part .CNAs are educated on proper serving, plating, gloving, and hand hygiene during meal services prepared on the hallways. S8 DM stated the CNAs are to follow the same practices as the dietary staff. S8 DM stated that during meal service, the server is to stay in a front facing field .if the server has to turn around at any point, they are to remove their gloves, wash their hands, and apply new clean gloves before continuing the serving process. S8 DM stated that the CNA who served the meal should use tongs to serve the bread rolls and not touch the bread rolls directly with contaminated gloves. S8 DM stated that if the server touches their face, mask, apron, the counter tops, or cabinets .the server should stop, dispose of their gloves, provide hand hygiene, and reapply clean gloves (not from a co-worker’s pocket) before beginning meal service again. In an interview on 09/04/2025 at 1:20 p.m., S2 DON confirmed the above dining observations and procedures. S2 DON confirmed the CNA serving the meal should have practiced good hand hygiene and gloving by: properly disposing of her gloves, wash her hands, and reapply clean gloves during meal service and before touching the resident’s bread rolls directly, but did not. S2 DON confirmed the CNA serving the meal should not have used gloves that came out of their co-worker’s pocket due to unsanitary issues, but did not. Resident #2 Review of Resident #2’s medical record revealed an admission date of 06/02/2023 with diagnoses including, in part…Alzheimer’s Disease, Dementia, Chronic Kidney Disease, Muscle Wasting and Atrophy, and Malnutrition. Review of Resident #2’s Significant Change MDS with an ARD of 07/14/2025 revealed a BIMS Score of 3, indicating severe cognitive impairment. Resident #2 had a functional limitation in range of motion and was at risk for development of pressure ulcers. Review of Resident #2’s active Physician’s Orders revealed the following, in part… (continued on next page)

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	195482	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/19/2025 Pressure Ulcer of Sacral Region, Unspecified Stage: cleanse with wound cleanser, apply Santyl ointment, calcium alginate, and cover with composite dressing every day; and 08/20/2025 Left upper arm blisters: cleanse with wound cleanser, pat dry, apply triple antibiotic ointment and composite dressing every day. Observation of wound care for Resident #2 with S5 Tx Nurse on 09/04/2025 at 10:45 a.m. revealed she used her gloved hands to move the bedside table, then picked up calcium aginate and placed it onto Resident #2’s pressure ulcer of the sacral region, without changing her gloves. S5 Tx Nurse changed her gloves, then used her gloved hands to move the bedside table, lift her gown, and reach into the pockets of her clothing. S5 Tx Nurse proceeded with wound care of Resident #2’s left upper arm blisters without performing hand hygiene or changing her gloves. Interview with S5 Tx Nurse on 09/04/2025 at 11:00 a.m. confirmed she used her gloved hands to touch the resident’s bedside table, her gown, and her clothing, then performed Resident #2’s wound care without performing hand hygiene or changing her gloves, but should not have.