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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on record review and interview, the facility failed to ensure a resident elopement was reported to the State Survey Agency as required within the specified timeframes for 1 (#7) of 2 (#7 and #8) residents reviewed for elopement. Findings: A review of the clinical record for Resident #7 revealed he was admitted to the facility on [DATE] and had diagnoses, which included Other Neurological Conditions, Aphasia, Cerebral Vascular Accident, Encephalopathy, Alcohol Use, Muscle Wasting and Atrophy to the Left Lower Leg, Lack of Coordination, Unsteadiness on Feet, and Muscle Weakness. A review of the Admission MDS with an ARD of 02/27/2024 revealed Resident #7 had a BIMS of 4, which indicated he was severely cognitively impaired. A review of the Nurse's Notes for Resident #7 revealed the following: 05/20/2024 at 9:45 a.m.- Visitor came into the facility and spoke with S17UC. He asked if the facility had a resident by the name of Resident #7. Visitor stated there was a man at a fast food chain who identified himself as Resident #7. DON and three other nursing staff left in private vehicles. Upon arrival, Resident #7 was observed walking in the parking lot. Signed by S2DON. A review of the facility's Investigation Report involving Resident #7 revealed an incident occurred on 05/20/2024. A visitor came to the facility and reported toS17UC, Resident #7 was found in a parking lot of a fast food chain approximately 1 mile away from the facility. On 06/06/2024 at 2:20 p.m., an interview was conducted with S2DON. She confirmed Resident #7 eloped from the facility on 05/20/2024. She confirmed he left the facility grounds and was found by a good Samaritan over a mile from the facility after being gone for an undetermined amount of 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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/06/2024 at 4:20 p.m., an interview was conducted with S21RD. She stated she was made aware of Resident #7's elopement from the facility around the time the incident occurred. She stated she was unaware S1ADM and S2DON did not have access to the state agency's reporting system and did not report the incident to the State Agency. She stated even if S1ADM or S2DON did not have access to the system, she would have expected them to submit all information via email or fax to State Agency within the acceptable timeframe. On 06/06/2024 at 6:45 p.m., an interview was conducted with S1ADM. He confirmed he was responsible for notifying the state agency of reportable incidents. He confirmed he was immediately made aware of Resident #7's elopement off facility's grounds on 05/20/2024. He confirmed he did not report the elopement to State Agency and should have.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on observation, interviews, and record review, the facility failed to ensure a resident's comprehensive plan of care was implemented for 1(#4) of 8(#1, #2, #3, #4, #5, #6, #7 and #8) residents reviewed in the sample. The facility failed to ensure Resident #4 received the correct diet as ordered by the physician. Findings: Review of the Clinical Record for Resident #4 revealed she was admitted to the facility on [DATE] with diagnoses, which included Dementia, Unspecified Severity, with Behavioral Disturbances and Age-Related Cognitive Decline. Review of the Physician Orders for Resident #4 revealed the following: 05/19/2024- Honey Thick liquid; No straw. Review of the Care Plan for Resident #4 revealed the following, in part: 05/15/2024- Resident is on Honey Thick liquids. Goal: Ensure resident is on Honey Thick liquid. Intervention: Resident should not use straw, No water pitcher at bedside; provide resident with Honey Thick liquids. On 06/10/2024 at 9:30 a.m., an observation was made of Resident #4 drinking through a straw from a pitcher on her bedside table. After Resident #4 was finished drinking, she began coughing and moaning loudly. On 06/10/2024 at 9:32 a.m., an interview was conducted with S16UM. She stated she was Resident #4's nurse. S16UM confirmed Resident #4's bedside pitcher contained regular water with a straw. She stated Resident #4's diet order called for Honey Thickened liquid, with no straw. S16UM confirmed Resident #4 should not have had regular water or a straw, and did. On 06/10/2024 at 1:50 p.m., an interview was conducted with S2DON. She confirmed Resident #4's ordered diet was Honey Thickened liquids with no straw and no pitcher at bedside. She confirmed Resident #4 should not have had a pitcher containing water with a straw at bedside and did. She stated CNA's should have checked Resident #4's orders to verify diet and did not.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on record review and interviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice by failing to ensure device site care orders were obtained and clarified for 2 (#1 and #3) of 5 (#1, #2, #3, #5, and #6) residents reviewed for indwelling devices. This deficient practice resulted in an Immediate Jeopardy situation on 05/02/2024 when Resident #1 was admitted to the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube and a nephrostomy tube. Upon Resident #1's admission, the facility failed to ensure orders were obtained and entered for site monitoring and dressing changes. This resulted in Resident #1 receiving no dressing changes or site monitoring for the PEG and nephrostomy sites from admission through 05/12/2024. On 05/12/2024, Resident #1 was transferred to the local emergency room for an elevated temperature and altered mental status. Resident #1's hospital diagnoses included Sepsis, Nephrostomy associated Urinary Tract Infection (UTI), and Infected PEG tube. S1ADM and S2DON were notified of the Immediate Jeopardy situation on 06/05/2024 at 5:17 p.m. The Immediate Jeopardy was removed on 06/06/2024 at 8:20 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at more than minimal harm for the residents who were admitted or readmitted to the facility. Findings: Review of the facility's Standing Orders revised on 07/07/2023 included: Peg Care: Clean daily with soap and water. Notify NP/MD if any purulent drainage. Review of the facility's undated policy titled Admission Orders revealed the following, in part: Policy Explanation and Compliance Guidelines: 1. The written orders should include at a minimum: c. Routine care orders 2. The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. Review of the facility's undated policy titled Nephrostomy and Cystostomy Tube Care and Maintenance revealed the following, in part: Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The care and maintenance of nephrostomy tubes shall be in accordance with physician orders. The orders shall specify the type and frequency of dressing changes and emptying of collection bags along with any special instructions. Resident #1 Review of Resident #1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Quadriplegia and Traumatic Brain Injury. Review of Resident #1's Physician's Orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), and Nurses' Notes, all dated May 2024, revealed no documentation of PEG tube site care, nephrostomy tube site care, or that monitoring had been completed. Review of Resident #1's Hospital Medical Records, dated 05/12/2024, revealed the following, in part: -Temperature 101.2 -Medical Decision Making Diagnoses: Sepsis, Severe Sepsis, Septic Shock, Nephrostomy associated UTI, infected PEG tube, and Pneumonia. -Patient had a bandage over the left nephrostomy tube that appeared old and crusted. There was also purulent discharge around the PEG site. -Physical Exam: Abdominal: Peg tube in left upper abdomen. There is some purulent type drainage from this. Genitourinary: There is a nephrostomy tube in the left flank. This is covered with a bandage that appears to be quite old. It was crusted and peeling from the skin. There was purulent drainage on the bandage that was dried. Review of Resident #1's Hospital Medical Records dated 05/14/2024 revealed the following, in part: Wound cultures from PEG site growing staph and gram negative rods. Continue Cefepime and Vancomycin. Urinary Tract Infection associated with nephrostomy catheter-urinalysis consistent with UTI. On 06/04/2024 at 8:47 a.m., an interview was conducted with the Case Manager of the local emergency department. She stated Resident #1, a nonverbal resident, was transferred from the facility to the hospital in early May 2024. She stated Resident #1 presented to the hospital with purulent drainage around her PEG tube site and a dressing over the nephrostomy tube site that was old and crusted. On 06/04/2024 at 12:30 p.m., an interview was conducted with S2DON. She stated she was unaware who was responsible for PEG and nephrostomy dressing changes or where it was charted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/04/2024 at 2:02 p.m., an interview was conducted with S6LPN, who provided care to Resident #1 in May 2024. She verified Resident #1 was admitted to the facility with a PEG and nephrostomy tube. She stated floor nurses were responsible for changing PEG site dressings and the wound care nurse was responsible for changing nephrostomy site dressings. She verified there was no order for Resident #1 to have PEG site monitoring or care. She stated if she provided care to Resident #1's PEG site she would have documented it in the nurse's notes. She stated she was unaware if Resident #1 had nephrostomy site care orders since wound care was responsible. She confirmed she did not change Resident #1's nephrostomy site dressing while she was admitted in May and stated if she would have, she would have documented it in the nurse's notes. On 06/05/2024 at 9:23 a.m., an interview was conducted with S14WC. She stated floor nurses were responsible for changing the dressings on PEG tubes and nephrostomy tubes. She stated all residents had to have a split gauze over the site if they had a PEG tube. She stated the facility had a standing order for PEG tube site care the nurses could enter in the resident's electronic medical record. She stated after the standing order was entered by the nurse, the dressing change would populate on the MAR for the nurses to complete. She stated she was not sure how often nephrostomy tube site dressings were changed because she was not responsible for nephrostomy tube sites. She confirmed she did not change Resident #1's PEG tube or nephrostomy tube dressings while the resident was admitted in May. On 06/06/2024 at 9:53 a.m., an interview was conducted with S5LPN, who provided care to Resident #1 in May 2024. She stated Resident #1 was admitted to the facility with a PEG and nephrostomy tube. She stated she did not know who was responsible for completing nephrostomy site dressing changes. She stated the floor nurses completed PEG site dressing changes. She confirmed she did not change the dressing to Resident #1's nephrostomy site while she was admitted in May. She stated if she completed site care it would have been documented in the residents MAR. She stated S15ADON or S16UM were responsible for entering orders for newly admitted residents. She verified orders should have been entered on admit for PEG and nephrostomy site care. She confirmed when no orders were entered, the floor nurses should have called and obtained an order to care for Resident #1's PEG site and nephrostomy tube site. On 06/06/2024 at 10:38 a.m., an interview was conducted with S11LPN, who provided care to Resident #1 in May 2024. She stated Resident #1 was admitted to the facility with a PEG and nephrostomy tube. She stated wound care nurses were responsible for PEG tube and nephrostomy tube dressing changes. She confirmed she did not change Resident #1's PEG tube or nephrostomy tube dressings while she was admitted in May. She stated if site care was performed, it would have been documented in the residents MAR or TAR. She confirmed all residents with PEG tubes and nephrostomy tubes should have orders to monitor the site and change the dressings. On 06/06/2024 at 1:42 p.m., an interview was conducted with S13LPN, who provided care to Resident #1 in May 2024. She stated Resident #1 was admitted to the facility with a PEG and nephrostomy tube. She stated she never completed a full skin assessment on Resident #1 since she worked overnight. She stated floor nurses were responsible for PEG tube and nephrostomy tube dressing changes. She confirmed she did not change Resident #1's PEG tube and nephrostomy tube dressings while she was admitted in May. She stated dressing changes were documented in the resident's MAR. She stated for any indwelling device, there should be an order to monitor the site and change the dressing. She stated if a resident did not have an order for site care or monitoring, the floor nurse should call the doctor and obtain an order because care would need to be provided to the site(s). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/05/2024 at 11:00 a.m., an interview was conducted with S16UM. She stated for residents who had PEG tubes and nephrostomy tubes, there would be an order which read, Monitor site q (every) shift. She stated nurses should monitor those sites for redness, swelling, tenderness, and drainage. She stated floor nurses were responsible for changing dressings to PEG tube and nephrostomy tube sites. She stated all residents who had PEG tubes had a split gauze dressing to the site. She stated nurses should change PEG tube dressings daily and as needed. She stated orders for nephrostomy dressing changes would come from the doctor. She stated it was the floor nurses responsibility to change the nephrostomy dressing as ordered. On 06/05/2024 at 11:22 a.m., an interview was conducted with S15ADON. She stated the floor nurse was responsible for site care and dressing changes to all indwelling devices, including PEG and nephrostomy tubes. She stated wound care nurses were responsible for wounds only. She stated she was responsible for putting the admission orders in for Resident #1. She stated she did not receive orders to change the dressing for Resident #1's nephrostomy tube upon admission. She confirmed she should have called the doctor to obtain orders for the nephrostomy tube dressing changes and did not. She stated she did not enter orders to monitor the sites for Resident #1's PEG tube and nephrostomy tube and should have. On 06/05/2024 at 2:38 p.m., an interview was conducted with S2DON. She stated S15ADON or S16UM were responsible for putting in orders for newly admitted residents. She stated any resident who had an indwelling device, such as a PEG tube or nephrostomy tube needed to have orders to monitor the site and orders for dressing changes. She stated it was the floor nurses responsibility to change PEG tube and nephrostomy tube dressings. She reviewed Resident #1's physician orders and confirmed the resident did not have orders to monitor the sites or change the dressings for the PEG tube and nephrostomy tube sites. She confirmed when an order was not obtained or entered into the residents electronic medical record, it did not populate in the MAR or TAR for the nurses to complete. She confirmed there was no documentation Resident #1's PEG site and nephrostomy site had been monitored and dressing changes performed. She stated Resident #1's nephrostomy site and PEG site should have been monitored and any concerns reported to the Nurse Practitioner. She confirmed Resident #1 should have had dressing changes completed to the PEG and nephrostomy tube sites. Resident #3 Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Paraplegia and Neuromuscular Dysfunction of Bladder. Review of Resident #3's Quarterly MDS with an ARD of 05/02/2024 revealed the resident had a BIMS of 12, which indicated he was moderately cognitively impaired. Review of Resident #3's Physician's Orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), and Nurses' Notes, all dated February 2024, revealed no documentation of PEG tube site care, nephrostomy tube site care, or that monitoring had been completed. Review of Resident #3's Nurses Notes, dated February 2024, revealed no documentation nephrostomy tube site care or monitoring had been completed. Further review revealed on 02/18/2024 at 9:05 a.m., S12LPN wrote Resident #3's nephrostomy tube was out. The resident stated it had been in for 2 1/2 weeks but had not been connected to a drainage bag and was not in use. He denied being in pain and the on call Nurse Practitioner was notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/05/2024 at 10:10 a.m., an interview was conducted with Resident #3. Resident #3 was fully oriented and able to carry on an appropriate conversation. He stated he had a nephrostomy tube that got pulled out accidentally a few months ago. He stated the nephrostomy tube had been inserted for a few weeks when it came out. He stated the wound care nurse changed the dressing to the nephrostomy site a few times when she was completing his wound care dressing changes because the dressing was crusty and nasty. He stated the nurses did not know they were responsible for changing his nephrostomy tube dressing. He stated the nurses who took care of him did not look at the dressing at all while he had the nephrostomy tube. He stated the nurses thought the wound care nurse was changing the dressing, but if he did not have pressure ulcers, it would have never gotten changed. On 06/05/2024 at 10:50 a.m., an interview was conducted with S14WC. She stated Resident #3 had a nephrostomy tube a few months ago. She stated it was the floor nurses responsibility to change the nephrostomy tube dressings. She stated she remembered changing Resident #3's nephrostomy tube dressing a few times while she was changing his pressure ulcer dressings. She stated she could not recall if there was drainage on the dressing when she changed it. She stated when she did change Resident #3's nephrostomy dressing, she verbally notified the nurse. On 06/05/2024 at 11:30 a.m., an interview was conducted with S6LPN. She stated Resident #3 was completely oriented. She stated Resident #3 had a nephrostomy tube but she did not know when it was taken out. She stated she never changed Resident #3's nephrostomy tube dressing. She stated if she needed to change a dressing she would know because there would be an order for the nurse to change the dressing in the resident's chart. She stated there were no orders to change Resident #3's nephrostomy dressing. On 06/06/2024 at 9:43 a.m., an interview was conducted with S5LPN. She stated Resident #3 was completely oriented. She stated he had a nephrostomy tube but it had been out for a few months. She stated she never changed Resident #3's nephrostomy tube dressing while he had the nephrostomy tube in place. She stated she was unsure who changed the nephrostomy tube dressings. On 06/10/2024 at 3:10 p.m., an interview was conducted with S2DON. She reviewed Resident #3's physician orders from February 2024. She confirmed Resident #3 had a nephrostomy tube during February 2024 and there were no orders to monitor the nephrostomy site or provide dressing changes to it. She verified without a Physician's order, it would not populate on the MAR/TAR for the nurses to change the dressing. She confirmed there was no documentation wound care was performed to Resident #3's nephrostomy tube site while the tube was in place.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47173

Based on record review and interviews, the facility failed to ensure a cognitively impaired resident, who exhibited exit-seeking behaviors, was adequately supervised to prevent unsafe wandering and elopement for 1 (#7) of 2 (#7 and #8) residents reviewed with wander guards.

This deficient practice resulted in an immediate jeopardy situation for Resident #7, a severely cognitively impaired resident with exit seeking behaviors, on the morning of 05/20/2024. At approximately 9:05 a.m., a Good Samaritan alerted the facility that Resident #7 was in a parking lot. After being alerted to Resident #7's elopement from the facility, staff located the resident in a parking lot, 1.1 miles away from the facility, across a high trafficked four-lane divided highway next to the interstate.

The facility implemented corrective actions which were completed by 05/28/2024, prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.

Findings:

Review of the clinical record for Resident #7 revealed he was admitted to the facility on [DATE] with diagnoses of Other Neurological Conditions, Aphasia, Cerebral Vascular Accident, Alcohol Use Unspecified with Withdrawal and Encephalopathy.

Review of the Admit 5 day Assessment MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 02/27/2024, revealed Resident #7 had a BIMS (Brief Interview for Mental Status) of 4 which indicated severe cognitive impairment. Further review revealed Resident #7 wore a wander guard daily.

Review of the Elopement Risk assessment dated [DATE] revealed Resident #7 had an Elopement Risk Score of 11. A score of 9 or greater indicated the resident was at risk for elopement. Resident #7 had intermittent confusion and wandered around the facility. Resident #7 required assistance with ambulation. A wander guard was placed for safety.

Review of the current Care Plan for Resident #7 revealed the following:

Start Date: 02/06/2024- Resident is at risk for elopement.

Updated: 05/01/2024- Resident noted removing wander guard. Wander guard replaced.

Updated: 05/20/2024- Resident was observed walking in the parking lot at a fast food chain with a bag of clothes.

Intervention:

04/22/2024- Q1 hour checks

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	05/1/2024- Electric monitoring device attached to resident's wheelchair due to him removing off of person 05/20/2024- Resident assisted back to the facility by staff, kept in high traffic areas and relocated to a facility with a secure unit. Review of the Nurse's Notes for Resident #7 revealed the following: 04/22/2024 at 7:59 p.m.- Nurse found Resident #7 in room with window open. Resident #7 had wheelchair folded up and was trying to shove wheelchair through window. Nurse asked resident what he was doing and Resident #7 stated, I am leaving. Situation was reported to NP and DON. Resident #7 was moved closer to nurse's station and hourly checks were implemented. Signed by S16UM. 04/23/2024 at 12:10 p.m.- Resident #7 requires redirection when attempting to wander off unit. Signed by S19LPN. 05/01/2024 at 2:27 p.m.- Resident #7 was noted removing wander guard from leg. Staff aware and replaced wander guard. Signed by S20MDS. 05/20/2024 at 9:45 a.m.- Visitor came into the facility and spoke with S17UC. He asked if the facility had a resident by the name of Resident #7. Visitor stated there was a man at a fast food chain who identified himself as Resident #7. DON and three other nursing staff left in private vehicles. Upon arrival, Resident #7 was observed walking in the parking lot with a bag of clothes and a plastic shower rod (as if it were a cane). Resident #7 was brought back to the facility. Wander guard was not on Resident #7. Resident #7 was placed in a high traffic area near the main nurse's station. Resident #7 was transferred to sister facility. Signed by S2DON. 05/20/2024 at 12:03 p.m.- Resident #7 keeps repeating, I want to get out of here. Signed by S16UM. Review of a written statement from S18LPN revealed the following: On 05/20/2024, I made rounds on residents. Resident #7 at 7:00 a.m. was in room and in bed. At 8:00 a.m. I saw Resident #7 ambulating down the hall and I assumed he was going to the dining room for breakfast. Review of a written statement from S17UC revealed the following: On 05/20/2024, around 8:45 a.m. Resident #7 came to the Nurse's Station to leave. I redirected him down the hall. I observed him going down the hall. Review of the facility's Incident Reports revealed Resident #7 was found off of the facility's premises on 05/20/2024 at 9:05 a.m. by a Good Samaritan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER White Oak Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Westfork Baton Rouge, LA 70816	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/06/2024 at 5:45 p.m., an interview was conducted with S17UC. She stated Resident #7 frequently stated he wanted to leave the facility. She stated Resident #7 kept taking his wander guard off so facility staff placed it on his wheelchair. She stated on the morning of 05/20/2024, Resident #7 attempted to get out of the front door while sitting in his wheelchair. She stated the alarm went off and the doors locked so the resident could not get out of the building. She stated Resident #7 went to her and told her he wanted to leave. She stated she walked Resident #7 back to his room which was the last time she saw him. On 06/06/2024 at 5:48 p.m., an interview was conducted with S16UM. She stated Resident #7 frequently made comments he wanted to leave the facility. She stated Resident #7's wander guard was placed on his wheelchair because he kept taking it off of his ankles. She stated on the morning of 05/20/2024 around 8:30 a.m. a Good Samaritan entered the facility and notified them Resident #7 was off premises at a nearby fast food chain's parking lot. On 06/06/2024 at 2:20 p.m., an interview was conducted with S2DON. She confirmed Resident #7 eloped from the facility on 05/20/2024. She confirmed Resident #7 left the facility grounds and was found by a Good Samaritan over a mile away from the facility after being gone for an undetermined amount of time. She confirmed the Good Samaritan came to the facility to let them know the location of their resident. On 06/06/2024 at 6:45 p.m., an interview was conducted with S1ADM. He stated staff relied on the wander guard to prevent elopement. He confirmed Resident #7 left the building and the facility's premises without being noticed or without staff realizing. He confirmed there had not been enough supervision present to prevent Resident #7's elopement and should have been. The facility had implemented the following actions to correct the deficient practice: 1.) 05/20/2024-Resident was returned to the facility safely. Head-to-toe assessment was performed, resident without injury. 2.) 05/20/2024- Resident was placed in high traffic area by unit clerk in line of site and was later transferred to another facility with a secure unit. 3.) 05/21/2024- All residents with wander guards were assessed to ensure wander guards were in place and functioning properly. Staff was in-serviced on hourly census checks for residents at risk for elopements. 4.) 05/21/2024- Nursing staff to perform hourly census checks for residents with wander guards. DON/Designee to perform weekly checks for wander guard functionality, elopements are discussed weekly in high-risk meeting. The elopement binders are reviewed weekly. Throughout the survey from 06/04/2024 to 06/10/2024, staff were observed making frequent rounds. Observations were made of the front door alarming and staff responding appropriately. Interviews with random staff revealed staff had received training on elopement and the importance to ensure all residents with wander guards had them on and were checked hourly.

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NAME OF PROVIDER OR SUPPLIER: White Oak Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 2828 Westfork Baton Rouge, LA 70816	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on interviews and record review, the facility failed to ensure PRN orders for psychotropic medications were limited to 14 days and indicated the duration for 2 (#2 and #5) of 8 (#1, #2, #3, #4, #5, #6, #7, and #8) residents reviewed for unnecessary psychotropic medications. Findings: Resident #2 Review of Resident #2's clinical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #2's June 2024 Physician's Orders revealed an order written on 05/17/2024 for Risperdal 2 mg tablet , one tablet by mouth every twelve hours as needed (PRN) for agitation. Further review revealed the PRN medication had no stop or duration date. Review of Resident #2's June 2024 Medication Administration Record (MAR) revealed Risperdal 2 mg tablet by mouth every twelve hours as needed was started on 05/17/2024. Further review revealed the PRN medication had no stop or duration date. Resident #5 Review of Resident #5's clinical record revealed the resident was admitted to the facility on [DATE] and admitted to a local hospice agency on 05/21/2024. Review of Resident #5's June 2024 Physician's Orders revealed an order written on 05/23/2024 for Ativan 1 mg tablet, one tablet by mouth every 4 hours as needed (PRN) for anxiety/insomnia/nausea/shortness of breath. Further review revealed the PRN medication had no stop or duration date. Review of Resident #5's June 2024 Medication Administration Record (MAR) revealed Ativan 1 mg tablet by mouth every four hours as needed was started on 05/23/2024. Further review revealed the PRN medication had no stop or duration date. On 06/10/2024 at 1:50 p.m., an interview was conducted with S2DON. She reviewed Resident #2 and #5's Physician orders and MAR. She confirmed Risperdal and Ativan were psychotropic medications and ordered PRN for longer than 14 days with no end date or duration documented. 47173

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on record review and interviews, the facility failed to ensure it was free of significant medication errors for 1 (#1) of 8 (#1, #2, #3, #4, #5, #6, #7, and #8) residents reviewed for medications. The deficient practice had the potential to effect the 84 residents residing in the facility receiving medications. Findings: Review of the facility's undated policy titled Medications-Administering revealed the following, in part: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame. Review of Resident #1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Unspecified Convulsions and Traumatic Brain Injury. Review of Resident #1's Discharge MDS with an ARD of 05/12/2024 revealed the resident was unable to complete the BIMS interview. Review of Resident #1's Physician Orders dated May 2024 revealed the following, in part: Vimpat 200mg/20ml vial. Administer 20ml via PEG tube every 12 hours daily. Order date: 05/02/2024. Start date: 05/02/2024. Review of Resident #1's MAR dated May 2024 revealed the following, in part: Vimpat 200mg/20ml vial. Administer 20ml via PEG tube every 12 hours daily at 5:00 a.m. and 6:00 p.m. Order date: 05/02/2024. Start date: 05/02/2024. Further review of Resident #1's MAR revealed Vimpat was not administered on the following dates and times: 05/02/2024 at 6:00 p.m. 05/03/2024 at 5:00 a.m. and 6:00 p.m. 05/04/2024 at 5:00 a.m. and 6:00 p.m. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/05/2024 at 6:00 p.m. 05/06/2024 at 6:00 p.m. 05/07/2024 at 5:00 a.m. and 6:00 p.m. 05/08/2024 at 5:00 a.m. 05/09/2024 at 5:00 a.m. and 6:00 p.m. 05/10/2024 at 5:00 a.m. and 6:00 p.m. On 06/05/2024 at 1:30 p.m., an interview was conducted with a facility contracted Pharmacist. She stated the first request made by the facility for Resident #1's Vimpat was on 05/08/2024 and was delivered and signed for on 05/10/2024. On 06/05/2024 at 11:30 a.m., an interview was conducted with S6LPN. She verified she was assigned to Resident #1 on 05/02/2024, 05/03/2024, 05/06/2024 and 05/07/2024. She stated Resident #1 had an order for Vimpat to be given. She stated the Vimpat was unavailable during her shifts. She stated she did not remember the date but she sent a fax to the facility's pharmacy requesting the Vimpat. She stated she never received the Vimpat from the pharmacy so she did not administer the medication to Resident #1. On 06/06/2024 at 9:53 a.m., an interview was conducted with S5LPN. She verified she was assigned to Resident #1 on 05/08/2024, 05/09/2024, and 05/10/2024. She stated Resident #1 had an order for Vimpat to be given. She stated the Vimpat was unavailable during her shifts so she did not administer it. She stated she did not remember the date but she thought she sent a fax to the facility's pharmacy requesting the Vimpat. She stated the facility kept a record of all medication requests faxed to pharmacy and it would be in the pharmacy binder if she requested it. On 06/06/2024 at 10:38 a.m., an interview was conducted with S11LPN. She verified she was assigned to Resident #1 on 05/04/2024, 05/05/2024, and 05/06/2024. She stated Resident #1 had an order for Vimpat to be given. She stated the Vimpat was not available during her shifts so she did not administer it. She stated when a medication was unavailable, she would call the pharmacy or send a fax requesting it. She stated the nurses put all confirmation faxes in a binder which was kept at the nurse's station. She stated she did not recall calling the pharmacy to request Resident #1's Vimpat. She stated if she would have sent a fax requesting it, there would have been documentation in the pharmacy binder. On 06/06/2024 at 11:04 a.m., an interview was conducted with S12LPN. She verified she was assigned to Resident #1 on 05/04/2024 and 05/05/2024. She stated Resident #1 had an order for Vimpat to be given. She stated Resident #1's Vimpat was not available at the facility so she did not administer it during her shifts. She stated when a resident was out of a medication, she called the pharmacy to verbally request it. She stated she called the facility's pharmacy to verbally request the Vimpat for Resident #1. (continued on next page)

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	195488	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/06/2024 at 11:35 a.m., an interview was conducted with another facility contracted Pharmacist. She verified Resident #1's Vimpat was requested from the facility on 05/08/2024. She confirmed there was no documentation the facility verbally requested or sent a fax requesting Resident #1's Vimpat before 05/08/2024. On 06/06/2024 at 1:42 p.m., an interview was conducted with S13LPN. She verified she was assigned to Resident #1 on 05/03/2024, 05/07/2024, 05/08/2024, 05/09/2024, and 05/10/2024. She stated Resident #1 had an order for Vimpat to be given. She confirmed she did not administer Resident #1's Vimpat during those shifts because it was unavailable. On 06/06/2024 at 1:15 p.m., an interview was conducted with S2DON. She stated when the nurses had not received Resident #1's Vimpat by 05/03/2024, they should have notified her. She confirmed she did not receive notification from any nurse about Resident #1's Vimpat not being delivered by pharmacy or administered to Resident #1 from 05/02/2024 to 05/10/2024. She stated the process for when a medication was not available was to send a fax to pharmacy to request it, then put the fax confirmation in the pharmacy binder. She confirmed she looked and could provide no evidence Resident #1's Vimpat was requested from pharmacy by the nursing staff. She reviewed Resident #1's MAR dated May 2024, confirmed the missing doses, and stated it was unacceptable for Resident #1 to go without seizure medication.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

47173

Based on an observation, interviews and record review, the facility failed to meet the nutritional needs of residents in accordance with established national guidelines by failing to:

1) Follow the approved menu in regard to meals served;

2) Record and archive deviations/substitutions of menu.

This deficient practice had the potential to affect the 77 Residents who receive meals prepared by the facility kitchen.

Findings:

Review of the facility's undated titled, Menu Substitution, revealed in part, the following:

Policy:

To provide a substitute when an uncontrolled situation has temporarily made an item unavailable, decisions on menu substitutions will be made after discussion with the dietary professional whenever possible.

2. All changes to the menu will be recorded on the Menu Extension Sheets and the Substitution Sheet. The date, menu item, substitution and reason for the substitution will be recorded on the Menu Substitution Sheet.

3. Menu changes should be evaluated monthly by the dietary professional and an appropriate plan of action made to prevent further changes.

4. Records of menu substitutions are retained for 12 months.

On 06/06/2024 at 9:00 a.m., an observation was made of Resident #2's meal tray which included 1 sausage patty, grits, 1 boiled egg, 1 carton of 2%milk, biscuit, grape jelly and butter. The meal ticket on Resident #2's tray read pancakes, blueberry sauce, sausage patty, hot cereal, orange juice, 2% milk and beverage of choice. Resident #2 stated meals were often served not following the menu on the meal ticket.

On 06/06/2024 at 9:15 a.m., an interview was conducted with S23LPN. She observed and confirmed Resident #2's meal ticket read- Pancakes, blueberry sauce, sausage patty, hot cereal, orange juice, 2% milk and beverage of choice. She confirmed Resident #2 did not receive what was on his meal ticket and should have.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/06/2024 at 9:30 a.m., an interview was conducted with S22DM. She stated she did not serve pancakes for breakfast on 06/06/2024. She stated the facility's food delivery truck did not consistently deliver ordered food items, sometimes missing deliveries twice a week. She stated she substituted food items if food items were not delivered. On 06/10/2024 at 10:20 a.m., an interview was conducted with S22DM. She confirmed she did not record menu substitutions and was not able to provide the revised served menu. S22DM confirmed she should have documented the menu changes and have the facility's Registered Dietician sign off on the revised menu and did not. On 06/10/2024 at 3:45 p.m., an interview was conducted with S1ADM. He confirmed if a meal or meal item was substituted, it should be recorded and the facility's Registered Dietician made aware.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47173 Based on record review, observation and interview, the facility failed to store food in accordance with professional standards for food service safety. This had the potential to effect 77 residents who were served meals from the kitchen. Findings: Review of the facility's undated policy titled, Storage: Dry Food revealed in part, the following: Dry food storage pertains to those foods not likely to support bacterial growth in their normal state. These foods include: d. Dried beans Procedure: 1. Store dry foods in a cool dry place . 2. Dry foods can be contaminated, even if they don't need refrigeration. On 06/06/2024 at 9:30 a.m., a tour of the kitchen was made with S22DM. During the tour, an observation was made of sprouted red beans with a large amount of mold in a 5 gallon clear plastic container. Through interview, S22DM stated the red beans must have gotten wet. S22DM confirmed the above observation and stated the red beans should have been discarded.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46975 Based on interviews and record reviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to ensure all admission orders were obtained, clarified, and entered into the resident's electronic medical record. The facility failed to ensure Resident #1 had physician orders for PEG and nephrostomy site care. This deficient practice resulted in an Immediate Jeopardy situation on 05/02/2024 when Resident #1 was admitted to the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube and a nephrostomy tube. Upon Resident #1's admission, the facility failed to ensure orders were obtained and entered for site monitoring and dressing changes. This resulted in Resident #1 receiving no dressing changes or site monitoring for the PEG and nephrostomy sites from admission through 05/12/2023. On 05/12/2024, Resident #1 was transferred to the local emergency room for an elevated temperature and altered mental status. Resident #1's hospital diagnoses included Sepsis, Nephrostomy associated Urinary Tract Infection (UTI), and Infected PEG tube. S1ADM and S2DON were notified of the Immediate Jeopardy situation on 06/05/2024 at 5:17 p.m. The Immediate Jeopardy was removed on 06/06/2024 at 8:20 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at more than minimal harm for the residents who were admitted or readmitted to the facility. Findings: Cross Reference F684 On 06/04/2024 at 12:30 p.m., an interview was conducted with S2DON. She stated she was unaware who was responsible for PEG and nephrostomy dressing changes or where it was charted. On 06/05/2024 at 11:00 a.m., an interview was conducted with S16UM. She stated for residents who had PEG tubes and nephrostomy tubes, there would be an order which read, Monitor site q shift. She stated nurses should monitor those sites for redness, swelling, tenderness, and drainage. She stated floor nurses were responsible for changing dressings to PEG tube and nephrostomy tube sites. She stated all residents who had PEG tubes had a split gauze dressing to the site. She stated nurses should change PEG tube dressings daily and as needed. She stated orders for nephrostomy dressing changes would come from the doctor. She stated it was the floor nurses responsibility to change the nephrostomy dressing as ordered. She stated every morning herself, S14WC, S15ADON and S2DON met together for a morning meeting and discussed all newly admitted residents and reviewed their orders to ensure they were appropriate. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/05/2024 at 11:22 a.m., an interview was conducted with S15ADON. She stated she was responsible for putting the admission orders in for Resident #1 and ensuring they were correct. She stated she did not receive orders to change the dressing for Resident #1's nephrostomy tube upon admission. She confirmed she should have called the doctor to obtain orders for the nephrostomy tube dressing changes and did not. She stated she did not enter orders to monitor the sites for Resident #1's PEG tube and nephrostomy tube and should have. On 06/05/2024 at 2:38 p.m., an interview was conducted with S2DON. She stated S15ADON or S16UM were responsible for putting in orders for newly admitted residents. She stated any resident who had an indwelling device, such as a PEG tube or nephrostomy tube needed to have orders to monitor the site and orders for dressing changes. She reviewed Resident #1's physician orders and confirmed the resident did not have orders to monitor the sites or change the dressings for the PEG tube and nephrostomy tube sites. She confirmed when an order was not obtained or entered into the residents electronic medical record, it did not populate in the MAR or TAR for the nurses to complete. She confirmed there was no documentation Resident #1's PEG site and nephrostomy site had been monitored and dressing changes performed. She stated Resident #1's nephrostomy site and PEG site should have been monitored and any concerns reported to the Nurse Practitioner. She confirmed Resident #1 should have had dressing changes completed to the PEG and nephrostomy tube sites.

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	195488	A. Building B. Wing	06/10/2024

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 44590 Based on interviews and record review, the facility failed to ensure the administrator reported to and was accountable to the governing body. S1ADM failed to ensure the facility's QAPI program was maintained. This deficient practice had the potential to affect a census of 87 residents. Findings: A review of the facility's undated policy, Quality Assurance and Performance Improvement (QAPI), as of 06/10/2024, revealed, in part, the following: 11. Governance and leadership: a. The governing body and/or executive leadership is responsible and accountable for the QAPI program. b. Governing oversight responsibilities include, but are not limited to the following: ii. Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities. iii. Ensuring the program is sustained during transitions in leadership and staffing. c. The QA Committee shall communicate its activities and the progress of its subcommittee PIPs to the governing body at least quarterly. A review of the facility's QAPI Committee Members revealed, in part, the following: Medical Director; Administrator; Director of Nursing; Assistant Director of Nursing; MDS Nurse(s) Dietary Manager; Maintenance Manager; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Housekeeping Manager; and Human Resources Manager. An interview was conducted on 06/10/2024 at 3:05 p.m. with S1ADM. He confirmed S2DON was responsible for the facility's QAPI Program. He confirmed he did not have anything to do with the QAPI Program since he began this position. A review of the facility's QAPI Program was attempted on 06/10/2024 with no documentation provided for review. An interview was conducted on 06/10/2024 at 3:10 p.m. with S2DON. She confirmed she was responsible for the facility's QAPI Program. She confirmed the facility had not held their quarterly QAPI Committee Meetings with the Medical Director since the previous administrator left in February 2024. An interview was conducted on 06/10/2024 at 3:45 p.m. with S10RCN. She confirmed S2DON was expected to report to her. She confirmed quarterly QAPI Committee Meetings with the facility's Medical Director in attendance should have been conducted per company policy. She confirmed corporate was not made aware the facility had not been conducting meetings per company policy. An interview was conducted on 06/10/2024 at 4:45 p.m. with S21RD. She stated the facility's governing body contracted the management company she worked for to manage and run the facility's day to day operations. She stated the management company, on behalf of the governing body, expected S1ADM to report to her. She confirmed S1ADM had not made her aware the facility was not conducting QAPI Meetings per company policy and should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 44590 Based on record review and interview, the facility failed to complete a facility-wide assessment to determine what resources were necessary to care for the residents competently during both day-to-day operations and emergencies. This deficient practice had the potential to affect a census of 87 residents. Findings: Review of the facility's CMS 672, dated 06/10/2024, revealed, in part, the following: Total Residents (F78): 87 A. Bladder Status Indwelling or external catheter: 10 Occasionally or frequently incontinent of bladder: 45 Occasionally or frequently incontinent of bowel: 39 B. Mobility Ambulation with assistance or assistive device: 4 C. Mental Status Documented signs and symptoms of depression: 6 Documented psychiatric diagnosis: 26 Dementia or Alzheimer's disease: 5 Behavioral healthcare needs: 15 D. Skin Integrity Pressure ulcers: 14 Receiving preventative skin care: 83 E. Special Care Hospice Care: 4 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER White Oak Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Westfork Baton Rouge, LA 70816	

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Chemotherapy: 1 Dialysis: 7 IV therapy: 5 Respiratory treatment: 4 Ostomy care: 7 Injections: 21 Tube feedings: 3 Mechanically altered diets: 17 Rehabilitative services: 62 Assistive devices while eating: 6 F. Medications Any psychoactive medication: 39 Antipsychotic medications: 21 Antianxiety medications: 7 Antidepressant medications: 30 Antibiotics: 5 Pain management program: 22 G. Other Who do not communicate in the dominant language of the facility: 1 Review of the facility's Facility Assessment Tool, as of 06/06/2024, revealed, in part, the following: Date of Assessment or Update: 05/14/2024 1.3 Diseases, Conditions, Physical and Cognitive Disabilities: Indicate if you accept residents or if current residents have or may develop, the following common conditions that require complex medical care and management. Additional common diagnoses may be added in blank spaces provided. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Psychiatric/Mood Disorders - Blank; Heart/Circulatory System - Blank; Neurological System - Blank; Vision - Blank; Musculoskeletal System - Blank. Neoplasm - Blank; Metabolic Disorders - Blank; Respiratory System - Blank; Genitourinary system - Blank; Diseases of Blood - Blank; Digestive System - Blank; Integumentary System - Blank; and Infectious Diseases - Blank. 2.1 Resident Support/Care Needs: List the types of care that your resident population requires and that you provide for your resident population. List by general categories, adding specifics as needed. The intent is to identify and reflect on resources needed to provide these types of care. General Care: Highlight and check all that apply. Activities of Daily Living - Blank; Mobility and Fall/Fall with Injury Prevention - Blank; Bowel/Bladder - Blank; Skin Integrity - Blank; Mental Health and Behavior - Blank; Medications - Blank; Pain Management - Blank; (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Infection Prevention and Control - Blank; Management of Medical Conditions - Blank; Therapy - Blank; Other Special Care Needs - Blank; Nutrition - Blank; and Provide Person-Centered/Directed Care: Psycho/Social/Spiritual Support - Blank. 3.1 Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies: Administration - Blank; Nursing Services - Blank; Food and Nutrition Services - Blank; Therapy Services - Blank; Medical/Physician Services - Blank; Pharmacist - Blank; Behavioral and Mental Health Providers - Blank; Support Staff - Blank; Chaplain/Religious Services - Blank; Volunteers/Students - Blank; and Other - Blank. 3.8 Physical Environment and Building/Plant Needs: List physical resources for the following categories. Describe your processes to ensure adequate supplies and to ensure equipment is maintained to protect and promote the health and safety of residents. Services (Waste management, hazardous waste management, telephone, HVAC, dental, barber/beauty, pharmacy, laboratory, radiology, occupational, physical, respiratory and speech therapy, gift shop, religious, exercise, recreational music, art therapy, cafe'/snack bar/bistro.) - Blank; Other Physical Plant Needs (Sliding doors, ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power) - Blank; (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Medical Supplies (Blood pressure monitors, compression garments, gloves, gowns, hand sanitizer, gait belts, infection control products, heel and elbow suspension products, suction equipment, thermometers, urinary catheter supplies, oxygen, oxygen saturation machine, Bi-PAP, bladder scanner) - Blank; and Non-medical Supplies (Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices and computers) - Blank. An interview was conducted on 06/06/2024 at 6:45 p.m. with S1ADM. He confirmed he was responsible for ensuring the facility assessment was completed and reviewed annually. He confirmed the areas documented above were left blank which did not accurately reflect the facility's current population and/or their needs.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44590 Based on record review and interview, the facility failed to develop, implement and maintain an effective, comprehensive, data-driven QAPI (Quality Assurance and Performance Improvement) program focused on indicators of the outcomes of care and quality of life. This deficient practice had the potential to affect a census of 84 residents. Findings: A review of the facility's undated policy, Quality Assurance and Performance Improvement (QAPI), as of 06/10/2024, revealed, in part, the following: Policy: It is the policy of this facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Policy Explanation and Compliance Guidelines: 2. The QA Committee shall be interdisciplinary and shall: b. Meet at least quarterly and as needed . 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. 5. The plan and supporting documentation will be presented to the State Survey Agency . upon request. A review of the facility's QAPI Committee Members revealed, in part, the following: Medical Director; Administrator; Director of Nursing; Assistant Director of Nursing; MDS Nurse #1; MDS Nurse #2; Dietary Manager ; Maintenance Manger; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Housekeeping Manager; and Human Resources Manager. A review of the facility's QAPI Plan and Supporting Documentation was attempted on 06/10/2024 with no documentation produced for review. An interview was conducted on 06/10/2024 at 3:05 p.m. with S1ADM. He confirmed S2DON was responsible for the facility's QAPI Program. He stated he did not have anything to do with the QAPI Program since he began this position, and confirmed he did not have any QAPI documentation. An interview was conducted on 06/10/2024 at 3:10 p.m. with S2DON. She confirmed she was responsible for the facility's QAPI Program. She confirmed she was unable to provide any of the facility's QAPI Meeting Minutes. She confirmed the facility had not held their quarterly QAPI Committee Meetings with the Medical Director since the previous administrator left in February 2024 and was not sure when the most recent meeting would have been held or what was discussed because she could not locate any documentation. She confirmed the facility should be able to produce this documentation and was not able to. She confirmed the facility should have been holding quarterly QAPI Committee Meetings with their Medical Director and they were not. She confirmed the facility's monthly internal QAPI meetings with department heads had not occurred either and should have. An interview was conducted on 06/10/2024 at 3:45 p.m. with S10RCN. She confirmed quarterly QAPI Committee Meetings with the facility's Medical Director in attendance should have been conducted per company policy. She confirmed corporate was not aware the facility had not been conducting meetings per company policy. She confirmed if the facility was not following policy for the meetings, corporate should have been made aware. An interview was conducted on 06/10/2024 with 4:45 p.m. with S21RD. She stated the facility's Governing Body was the Owner/CEO and the CFO. She stated the facility's Governing Body contracted the management company she worked for to manage and run the facility day to day. She stated the management company expected S1ADM to report to her and she had not been aware the facility was not conducting QAPI Meetings per company policy.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 44590 Based on record review and interviews, the facility failed to ensure effective communication was performed as mandatory training for all direct care staff for 3 (S7CNA, S8CNA, S9CNA) of 5 (S5LPN, S6LPN, S7CNA, S8CNA, S9CNA) personnel files reviewed. Findings: Review of the facility's Facility Assessment Tool, as of 06/06/2024, revealed, in part, the following: Date of Assessment or Update: 05/14/2024 3.4 Staff Training, Education and Competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Communication - All staff members are expected to be effective at communicating with each other, with residents, with family members and with other visitors to the facility. Review of the facility's policy titled In-service Training, undated, revealed, in part, the following: Policy Interpretation and Implementation: 1. All personnel will receive ongoing education as required by federal and state laws. 6. The director of nursing will maintain a planned annual schedule of in-services to be provided . 8. It is the responsibility of the director of nursing, or designee, to ensure that in-services and training provided by the facility are adequate to meet current standards of healthcare delivery and meet or exceed state and federal requirements. Review of the facility's In-service titled Staff Meeting held 04/17/2024, revealed, in part, the following: Summary of Contents: Customer Service. No documented evidence S7CNA, S8CNA or S9CNA were present for the training on 04/17/2024. Review of S7CNA's personnel file revealed a hire date of 12/16/2020. Further review of S7CNA's personnel file revealed no documented evidence S7CNA attended the mandatory training offered by the facility regarding effective communication. (continued on next page)

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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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of S8CNA's personnel file revealed a hire date of 03/06/2024. Further review of S8CNA's personnel file revealed no documented evidence S8CNA attended the mandatory training offered by the facility regarding effective communication. Review of S9CNA's personnel file revealed a hire date of 01/10/2024. Further review of S9CNA's personnel file revealed no documented evidence S9CNA attended the mandatory training offered by the facility regarding effective communication. An interview was conducted on 06/06/2024 at 6:35 p.m. with S2DON. She stated she held a staff meeting on 04/17/2024, at which time she provided education regarding effective communication. She confirmed this was the only time she had provided education for direct care staff regarding effective communication. She confirmed all direct care staff were not in attendance and had not received a make-up training; including S7CNA, S8CNA, and S9CNA. She confirmed she did not have any additional trainings scheduled to address effective communication. An interview was conducted on 06/06/2024 at 6:45 p.m. with S1ADM. He confirmed S2DON was responsible for providing all trainings to direct care staff. He confirmed he would expect the facility to provide all trainings as required by state and federal regulations.