

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER White Oak Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868</p> <p>Based on record review and interviews, the facility failed to ensure nursing staff notified the NP of a residents fall outside, which required a care plan update, for 1 (#5) of 3(#3, #4 and #5) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of the facility's undated Policy Titled, Falls- Resident, revealed the following, in part:</p> <p>Actual Falls 1. When a resident falls, the charge nurse will access . and notify the physician for the appropriate orders.</p> <p>Review of the facility's undated Policy Titled, Change in a Resident's Condition or Status revealed the following: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on call physician when there has been: a. An accident or incident involving the resident.</p> <p>Review of Resident #5's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included History of Falling.</p> <p>Review of Resident #5's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/06/2024 revealed Resident #5 was assessed by the facility to have a BIMS (Brief Interview Mental Status) of 3, indicating the resident was severely cognitively impaired.</p> <p>Review of Resident #5's Fall Risk Assessments, dated 01/01/2024 through 02/24/2025, indicated Resident #5 was identified by the facility to be a high fall risk.</p> <p>Review of Resident #5's Nursing Notes, dated 02/15/2025 through 02/16/2025, revealed no documented evidence S16RN notified the physician or family of Resident #5's fall during the weekend of 02/15/2025 through 02/16/2025.</p> <p>On 02/25/2025 at 9:25 a.m., an interview was conducted with S16RN. She confirmed she was the day shift charge nurse during the weekend of 02/15/2025 through 02/16/2025. S16RN stated Resident #5 had an unwitnessed fall the weekend of 02/15/2025 through 02/16/2025. She stated the process for a resident fall included the following: completing an incident report, and notifying the family and NP. She confirmed she did not complete an incident report, notify the family or the NP.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/24/2025 at 11:59 a.m., an interview was conducted with S11LPN. She confirmed she worked the day shift on the weekend of 02/15/2025 through 02/16/2025 and was assigned to Resident #5. She stated the process for a resident fall included the following: completing an incident report, and notifying the family and NP. She confirmed she was not made aware Resident #5 had a fall on the weekend of 02/15/2025 through 02/16/2025 and therefore did not complete an incident report, notify the family or notify the NP.</p> <p>On 02/25/2025 at 12:28 p.m., an interview was conducted with S8ADON. She stated the process for a resident fall included the following: completing an incident report, and notifying the family and NP. She confirmed S16RN should have completed an incident report and notified the family and NP.</p> <p>On 02/25/2025 at 1:50 p.m., an interview was conducted with S1DON. He stated the process for a resident fall included the following: completing an incident report, and notifying the family and NP. He confirmed he was not aware of the fall and should have been. He further confirmed S16RN should have notified the family and NP.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868</p> <p>Based on record reviews and interviews, the facility failed to ensure that each resident's comprehensive Minimum Data Set (MDS) assessments were completed in a timely manner for 1 (R1) of 8 (#1, #2, #3, #4, #5, #6, #7 and R1) resident records reviewed for comprehensive assessments. The facility failed to ensure that the resident admission assessment was completed within the 14-day requirement.</p> <p>Findings:</p> <p>R1</p> <p>Review of R1's admission MDS assessment with an Assessment Reference Date (ARD) of 02/12/2025, revealed an admitted [DATE]. Further review of the Admit MDS revealed the MDS had a status of in progress.</p> <p>On 02/25/2025 at 1:34 p.m., an interview was conducted with S2MDS. She reviewed R1's admission MDS and confirmed R1 was admitted to the facility on [DATE]. She further confirmed R1's admission MDS was still in progress, and was not completed in the required timeframe.</p> <p>On 02/25/2025 at 1:50 p.m., an interview was conducted with S1DON. He reviewed R1's admission MDS and confirmed R1 was admitted to the facility on [DATE]. He further confirmed R1's admission MDS was still in progress, and was not completed in the required timeframe.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>52097</p> <p>Based on observations, interviews, and record review, the facility failed to ensure interventions for falls were implemented as identified on the care plan for 1 (#3) of 3 (#3, #5, and #7) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of Resident #3's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed the resident had diagnoses which included Paraplegia and Unspecified Injury at T7-T10 Level of Thoracic Spinal Cord.</p> <p>Review of Resident #3's Quarterly MDS with an ARD of 11/20/2024 revealed a BIMS of 14, which indicated he was cognitively intact.</p> <p>Review of Resident #3's current Care Plan revealed the following:</p> <p>Problem: The resident is at risk for falls.</p> <p>Intervention: 11/16/2024-Fall mat.</p> <p>On 02/24/2025 at 9:00 a.m., an observation was made of Resident #3 in his room. No fall mat was observed at bedside.</p> <p>On 02/25/2025 at 8:42 a.m., an observation was made of Resident #3 in his room. No fall mat was observed at bedside.</p> <p>On 02/24/2025 at 2:58 p.m., an interview was conducted with Resident #3. He stated he fell out of his bed in November and December. He stated no ongoing safety interventions, including use of a fall mat, were implemented post-accidents.</p> <p>On 02/25/2025 at 8:35 a.m., an interview was conducted with S3LPN. She stated she was assigned to Resident #3. She stated a fall mat had not been implemented for Resident #3.</p> <p>On 02/25/2025 at 10:15 a.m., an interview was conducted with S5CNA. She stated she was assigned to Resident #3. She stated Resident #3 had fall interventions in place, including use of a fall mat. She further stated the fall mat was only utilized during transfers.</p> <p>On 02/25/2025 at 1:45 p.m., an interview was conducted with S2MDS. She stated Resident #3 had a history of falling. She confirmed Resident #3's care plan featured fall interventions including, use of a fall mat. She stated fall mats should be placed on the floor, at bedside to minimize risk of injury. She stated she expected nurses and CNAs to ensure the fall mat was in place at all times, not just during transfers.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/25/2025 at 2:05 p.m., an interview was conducted with S1DON. He confirmed Resident #3 had a history of falling. He reviewed Resident #3's care plan and confirmed fall mats should be placed on the floor, at bedside to minimize risk of injury. He stated he expected nurses and CNAs to ensure the fall mat was in place at all times, not just during transfers.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's comprehensive plan of care was developed within 7 days after completion of the comprehensive assessment for 1 (#1) of 7 (#1, #2, #3, #4, #5, #6, #7) residents reviewed for care plans.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Care Plans-Comprehensive, revealed the following, in part:</p> <p>Policy</p> <p>It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>7. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment.</p> <p>Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE].</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) revealed an Assessment Reference Date (ARD) of 01/10/2025.</p> <p>Review of Resident #1's current Care Plan on 02/24/2025 at 8:40 a.m., revealed a baseline care plan and included the following:</p> <p>Focus: Baseline Careplan Summary</p> <p>Interventions/Tasks:</p> <p>ADL Assistance Needed: no task or interventions listed</p> <p>Fall Risk Interventions: no task or interventions listed</p> <p>Nutritional Services/Diet: no task or interventions listed</p> <p>Resident's expectations regarding outcome of nursing home visit and expectations to return to the community: no task or interventions listed</p> <p>Skin Care/ Wound Prevention Measures: no task or interventions listed</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further Review of Resident #1's Care Plan revealed no comprehensive plan of care had been developed.</p> <p>On 02/25/2025 at 1:34 p.m., an interview was conducted with S2MDS. She stated she was responsible for completing residents' MDS assessments and care plans. She stated a comprehensive care plan was to be completed within 7 days after a residents Admission MDS assessment. She reviewed Resident #1's Admission MDS assessment and verified the ARD was 01/10/2025. She stated Resident #1 should have had a comprehensive care plan completed by 01/17/2025 and did not.</p> <p>On 02/25/2025 at 1:53 p.m., an interview was conducted with S1DON. He reviewed Resident #1's Admission MDS assessment and verified the ARD was 01/10/2025. He reviewed Resident #1's current care plan and confirmed the comprehensive care plan was not completed by 01/17/2025.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868</p> <p>Based on observations, interviews and record review the facility failed to provide adequate supervision for 1 (#5) of 3 (#5, #6, and #7) residents reviewed for wandering. The facility failed to ensure staff appropriately supervised Resident #5 who was assessed to be a wanderer, unsafe smoker, and a high fall risk.</p> <p>This deficient practice resulted in an immediate jeopardy situation on the weekend of 02/15/2025 through 02/16/2025, when Resident #5, a severely cognitively impaired resident identified as a wanderer, unsafe smoker and high fall risk, entered the smoking patio while no staff were present to provide supervision. Resident #5 self-propel himself in his wheelchair through the gate of the smokers' patio onto the sidewalk along the resident patio exterior doors. When Resident #5 attempted to enter back through the gate into the smoking patio, he was unable to maneuver his wheelchair over the uneven concrete. He stood up from his wheelchair and fell on to the concrete walkway. Random Resident #R3 observed Resident #5 fall and was unable to locate the smoking attendant on the smoking patio. Random Resident #R3 went inside the facility and notified S14WC of Resident #5 being on the ground. This failure to provide adequate supervision for Resident #5 created a likelihood of serious injury for Resident #5 when he fell outside on the concrete.</p> <p>S1ADM was notified of the Immediate Jeopardy on 02/26/2025 at 2:15 p.m.</p> <p>This deficient practice continued at a potential for more than minimal harm for the 5 residents residing in the facility identified as moderate to high risk for wandering and elopement.</p> <p>Findings:</p> <p>Review of the facility's undated, Routine Resident Checks policy revealed the following, in part:</p> <p>Staff shall make routine resident checks to help maintain resident safety and well-being.</p> <p>Review of the facility's job description for the Smoke Monitor Attendant, dated 09/20/2024, revealed the following, in part:</p> <p>Responsibilities:</p> <p>4. Responsible for monitoring all residents in the smoking area, monitoring the area, and intervening as needed for any resident safety issues.</p> <p>6. Other assistance and assist all residents when needed.</p> <p>Review of facility's Staff Orientation Packet, revealed the following, in part:</p> <p>The smoking monitor attendant is on duty from 7 a.m. to 7 p.m., seven days per week .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further review revealed the Staff Orientation Packet was signed by S10CNA on 01/16/2025 and S13CNA on 12/03/2024, which indicated they received the training on the aforementioned dates.</p> <p>Review of Resident #5's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included the following; History of Cerebral Infarction, Hemiplegia and Hemiparesis, History of Falling, and Cognitive Communication Deficit.</p> <p>Review of Resident #5's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/06/2024 revealed Resident #5 was assessed by the facility to have a BIMS (Brief Interview Mental Status) of 3, indicating the resident was severely cognitively impaired. Further review revealed he self-propelled himself independently in his manual wheelchair.</p> <p>Review of Resident #5's Elopement Risk Evaluation, dated 02/13/2025, revealed the following, in part:</p> <p>6. Does the resident wander? Yes.</p> <p>8. Does the resident wander aimlessly or non-goal directed (i.e. confused, moves without purpose, may enter others' rooms and explore others' belongings)? Yes.</p> <p>Review of Resident #5's Fall Risk Assessments, dated 01/01/2024 through 02/24/2025, all indicated Resident #5 was identified by the facility to be a high fall risk.</p> <p>A review of Resident #5's Physician Orders, dated February 2025, revealed the following, in part:</p> <p>11/17/2024 - Wanderguard monitoring; check placement and function of wanderguard bracelet every shift.</p> <p>12/18/2024 - Unsafe smoker; smoker/monitor resident every shift.</p> <p>02/13/2025 - Every 30 minute checks due to falls and census checks related to elopement risk.</p> <p>Review of Resident #5's Care Plan, dated 01/01/2025 through 02/24/2025, revealed the following, in part:</p> <p>Problem: Resident #5 is at risk for elopement</p> <p>Interventions:</p> <p>02/13/2025 - Monitor Resident #5 every 30 minutes and keep wander guard in place.</p> <p>Problem: The resident has had an actual fall with no injury.</p> <p>Interventions:</p> <p>01/16/2025 - Resident #5 had an unwitnessed fall, fall mat at bedside when resident in bed;</p> <p>01/19/2025 - Resident #5 had an unwitnessed fall, concave mattress for bed edge definition;</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>01/23/2025 - Resident #5 had a witnessed fall, helmet cap in place while up in wheelchair;</p> <p>02/04/2025 - Resident #5 had a witnessed fall, keep resident in high traffic areas;</p> <p>02/08/2025 - Resident #5 had an unwitnessed fall, activity vest applied while up in wheelchair; and</p> <p>02/13/2025 - Monitor every 30 minutes</p> <p>Review of Resident #5's CNA Task Log, dated 02/01/2025 through 02/26/2025, revealed the following, in part:</p> <p>Task: Census Checks every 30 minutes related to falls and elopement risk.</p> <p>Further review revealed no documented evidence to indicate Resident #5's 30 minute checks were performed as ordered during the timeframe reviewed.</p> <p>On 02/25/2025 at 4:40 p.m., an interview was conducted with Random Resident #R2, a cognitively intact resident. He confirmed he resided in Room C where his bed was located near the outside wall with a window overlooking the outside patio of the facility. He confirmed during the weekend of 02/15/2025 through 02/16/2025, while in his room, he heard someone shouting for help. He stated when he looked out of his bedroom window, he saw Resident #5 lying on the ground on the patio near his exterior door. He confirmed he went to the ward clerk desk and notified the nurse but could not recall her name. He confirmed after he reported the incident, he went outside to the smoking patio and there was no smoking aide present but there were residents out there smoking.</p> <p>On 02/25/2025 at 4:47 p.m., an interview was conducted with Random Resident #R3, a cognitively intact resident. He confirmed he recalled Resident #5 falling during the weekend of 2/15/2025 through 02/16/2025. He stated he went out to the smoking patio after lunch and confirmed a smoking aide was not present. He confirmed he saw Resident #5 self-propel himself out of the dining room door onto the smoking patio then continued through the patio gate onto the concrete walkway that ran alongside the rear of the building. He confirmed he watched Resident #5 self-propel himself to the end of the concrete walkway where he turned himself around and came back towards the smoking patio. He stated when Resident #5 attempted to self-propel himself back toward the gate of the smoking patio, his wheelchair got stuck on the uneven concrete. He stated after Resident #5 got stuck, he stood up and fell down to the concrete sidewalk. He confirmed no staff were present on the patio at the time Resident #5 fell so he went back inside the facility to the ward clerk desk to look for someone to assist Resident #5.</p> <p>On 02/24/2025 at 11:30 a.m., an interview was conducted with S13CNA. She confirmed she worked as the smoking aide during the weekend of 02/15/2025 through 02/16/2025. She confirmed she did not sit out on the smoking patio during her shift that weekend. She confirmed she sat at the ward clerk's desk or the main dining room throughout her entire shift unless an unsafe smoker came to her requesting to smoke. She confirmed she was aware Resident #5 was an unsafe smoker. She was unaware Resident #5 was a wanderer. She confirmed she was not aware Resident #5 had an unwitnessed fall on the smoking patio during the weekend of 02/15/2025 through 02/16/2025 while she was assigned as the smoking aide.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/25/2025 at 4:50 p.m., an observation of the smoking patio located to the rear of the facility was conducted. To the right of the smoking patio revealed a gate with a concrete sidewalk which extended from the gate to the sidewalk of the exterior patio doors for Hall B. It is noted the concrete sidewalk was not flushed together and was slightly elevated on the gate side of the sidewalk.</p> <p>On 02/25/2025 at 9:57 a.m., an interview was conducted with S9LPN. She confirmed Resident #5 self-propelled himself throughout the facility all day in his wheelchair. She confirmed he was assessed by the facility to be a wanderer and required a Wanderguard at all times. She confirmed Resident #5 had frequent falls because he could not remember to ask for staff assistance before attempting to stand or transfer himself. She confirmed Resident #5 was assessed to be an unsafe smoker and required supervision when he was outside smoking. She confirmed Resident #5 required increased supervision from staff due to all of the above and staff were aware to keep an eye on him. She confirmed every day a staff member was assigned to serve as the smoking aide and they were responsible for being outside on the patio to provide supervision and assistance for residents from 7:00 a.m. to 7:00 p.m.</p> <p>On 02/24/2025 at 11:32 a.m., an interview was conducted with S10CNA. She confirmed on the weekend of 02/15/2025 through 02/16/2025, she worked an extra shift as the smoking aide and remained on the smoking patio throughout her entire shift from 7:00 a.m. to 7:00 p.m. She confirmed Resident #5 was a very busy resident who moved himself around the facility all day long and required frequent monitoring every 30 minutes. She confirmed she was not aware Resident #5 had an unwitnessed fall on the smoking patio during the weekend of 02/15/2025 through 02/16/2025.</p> <p>On 02/24/2025 at 1:40 p.m., an interview was conducted with S12CNA. She confirmed there was a staff member assigned to be the smoking aide from 7:00 a.m. to 7:00 p.m. every day. She confirmed the smoking aide was responsible for remaining outside on the smoking patio throughout their shift to provide supervision to any residents who were outside. She confirmed she worked the weekend of 02/15/2025 through 02/16/2025 as Resident #5's CNA. She confirmed Resident #5 was a very busy resident who moved himself around the facility all day long and frequently fell because he could not remember to ask for staff assistance before attempting to stand or transfer himself. She stated on the weekend of 02/15/2025 through 02/16/2025, she was not aware Resident #5 had an unwitnessed fall on the smoking patio during the weekend of 02/15/2025 through 02/16/2025.</p> <p>On 02/24/2025 at 4:07 p.m., an interview was conducted with S14WC. She confirmed she worked during the weekend of 02/15/2025 through 02/16/2025. She confirmed during that weekend, after lunch a resident came to her desk in the lobby and reported Resident #5 had fallen outside. She confirmed she could not recall if this occurred on 02/15/2025 or 02/16/2025 but confirmed it was one of those days. She stated S15CNA was at the ward clerk desk when Resident #5's fall was reported.</p> <p>On 02/25/2025 at 4:59 p.m. an interview was conducted with S15CNA. She confirmed she worked during the weekend of 02/15/2025 through 02/16/2025 and was not assigned to Resident #5. She stated she was at the ward clerk desk when Random Resident #R3 reported Resident #5 fell and was on the ground outside the patio area. She stated she reported the fall to S16RN and they went outside together. She stated once they arrived outside, Resident #5 was noted in a sitting position on the ground outside of the gated smoking patio. She confirmed there should be an assigned smoking aide present on the patio every day from 7:00 a.m. to 7:00 p.m. but she could not recall if they were present when Resident #5 fell .</p> <p>(continued on next page)</p>		

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER White Oak Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/25/2025 at 9:25 a.m., an interview was conducted with S16RN. She confirmed she was the day shift charge nurse during the weekend of 02/15/2025 through 02/16/2025. She stated she initially did not recall Resident #5 having an unwitnessed fall during that weekend. She then confirmed Resident #5 did have an unwitnessed fall during that weekend. She confirmed she did not recall who reported the fall to her or who assisted her, but confirmed the fall occurred after lunch around 1:00 p.m. She stated when she arrived outside Random Resident #R2 was near Resident #5. She confirmed Resident #5 was sitting on his bottom on the concrete walkway on the outside of the gated smoking patio. She stated she did not recall if there was a smoking aide on the smoking patio when the fall occurred or if anyone was assigned as the smoking aide that day. She confirmed there was a weekend recently when there was not an assigned smoking aide but could not be sure if it was the weekend of Resident #5's fall.</p> <p>On 02/25/2025 at 12:15 p.m., an interview was conducted with S17WC. She stated she was responsible for the smoking aide schedule. She stated there was a smoking aide assigned for every weekend in January 2025 and February 2025. She stated if the smoking aide did not show up on their assigned day, administration would pull the restorative aide or someone else until they called a worker in to supervise residents on the smoking patio. She further stated the assigned smoking aide should be present on the smoking patio from 7:00 a.m. to 7:00 p.m. She confirmed if the smoking aide was seated at her desk, residents would be able to enter the dining room and exit to the smoking patio without being seen.</p> <p>On 02/25/2025 at 12:28 p.m., an interview was conducted with S8ADON. She stated the smoking aide was assigned daily from 7:00 a.m. to 7:00 p.m. and was expected to be present on the smoking patio during their entire shift to provide supervision for residents outside. She stated the smoking aide should request another staff to relieve them prior to leaving the smoking patio for any breaks so the area was never left unattended. She confirmed if the smoking aide was seated at S17WC's desk, residents would be able to enter the dining room and exit to the smoking patio without being seen.</p> <p>On 02/25/2025 at 1:50 p.m., an interview was conducted with S1DON. He stated the smoking aide was assigned daily from 7:00 a.m. to 7:00 p.m. and was expected to be present on the smoking patio during their entire shift to provide supervision for residents outside. He stated the smoking aide should request another staff to relieve them prior to leaving the smoking patio for any breaks so the area was never left unattended. He confirmed new employees received the smoking policy and the policy/procedure was reviewed during orientation. He stated all CNA's were aware of the rules for the smoking aide, which was to remain on the patio at all times from 7:00 a.m. to 7:00 p.m. He confirmed the smoking patio should have supervision for all residents from 7:00 a.m. to 7:00 p.m. daily. He confirmed Resident #5 would not be safe outside without supervision and was care planned for high traffic areas, which included the smoking patio due to the presence of constant supervision in that area.</p> <p>The Immediate Jeopardy was removed on 02/27/2025 at 2:55 p.m., after it was determined through observation, interview, and record review; the facility implemented an acceptable Plan of Removal prior to the survey exit, which included:</p> <p>1. The facility failed to ensure Resident who is at risk for falls and wandering, received adequate supervision on 02/15/2025 and 02/26/2025. All residents who are cognitively impaired, wander, and are at risk for falls are potentially affected by this deficient practice.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. The outside patio fence gate is to remain closed. Starting on 02/27/2025, Administrator/DON/Designee will monitor the smoke patio area by using a monitoring form on 5 random days/week for 8 weeks then randomly to ensure adequate supervision provided to residents. Disciplinary action up to termination will take place if this occurs again. All staff will be in serviced beginning on 02/26/2025 by Administrator/DON/Designee on providing supervision to resident while out on smoke patio, the smoke monitor will remain outside and must be relieved by other staff to leave that area. All staff members will be required to complete the training prior to working their shift. In-service will be completed 02/27/2025, no employee will be allowed to begin their shift until the training, has been received.</p> <p>3. Starting on 02/27/2025, Administrator/DON/Designee will monitor the smoke patio area by using a monitoring form on 5 random days/week for 8 weeks then randomly to ensure adequate supervision provided to residents. Audit reports will be submitted to the Administrator and QAPI committee for review and new interventions implemented as needed.</p> <p>The facility asserts the likelihood for serious harm to any Resident no longer exists as of 02/27/2025.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on record review and interviews, the facility failed to ensure census checks were accurately documented for 2 (#5 and #6) of 3 (#5, #6, and #7) residents reviewed for elopement and wandering.</p> <p>Findings:</p> <p>Resident #5</p> <p>Review of Resident #5's clinical record revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: Cerebral Infarction, Hemiplegia and Hemiparesis.</p> <p>Review of Resident #5's MDS with an ARD of 12/06/2024 revealed a BIMS of 3, which indicated severe cognitive impairment.</p> <p>Review of Resident #5's physician's orders revealed the following, in part:</p> <p>02/13/2025-Q 30 minute checks due to falls and census checks related to elopement risk.</p> <p>Review of Resident #5's Task log, dated 02/13/2025 to 02/15/2025, revealed no documentation of census checks every 30 minutes.</p> <p>On 02/26/2025 at 12:28 p.m., an interview was conducted with S8ADON. She stated if a resident had orders for census checks, it would appear in the CNA Task log and prompt documentation.</p> <p>On 02/25/2025 at 1:50 p.m., an interview was conducted with S1DON. He reviewed Resident #5's physician's orders and confirmed census checks were ordered every 30 minutes to minimize risk of elopement. He confirmed census checks were not documented in the Task log and should have been.</p> <p>Resident #6</p> <p>Review of Resident #6's clinical record revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: Non-traumatic Intracerebral Hemorrhage and Hemiplegia and Hemiparesis.</p> <p>Review of Resident #6's MDS with an ARD of 01/03/2025 revealed a BIMS of 5, which indicated severe cognitive impairment.</p> <p>Review of Resident #6's current physician's orders revealed the following, in part:</p> <p>02/13/2025-Check on Resident every hour for wandering.</p> <p>Review of Resident #6's Task log, dated 02/13/2025 to 02/24/2025, revealed no documentation of census checks every 1 hour.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/26/2025 at 2:42 p.m., an interview was conducted with S4LPN. She stated she was assigned to Resident #6. She stated Resident #6 had a history of wandering. She stated CNAs were responsible for monitoring Resident #6 to minimize risk of wandering and documenting census checks every 1 hour.</p> <p>On 02/27/2025 at 8:40 a.m., an interview was conducted with S7CNA. She stated she was assigned to Resident #6. She stated CNAs were responsible for monitoring Resident #6 to minimize risk of wandering and documenting census checks every 1 hour. She confirmed census checks were not documented in the Task log and should have been.</p> <p>On 02/27/2025 at 11:15 a.m., an interview was conducted with S1DON. He stated CNAs were responsible for monitoring Resident #6 to minimize risk of wandering and documenting census checks every 1 hour. He confirmed census checks were not documented in the Task log and should have been.</p> <p>52097</p>