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	03/18/2026

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record reviews, the facility failed to ensure the physician was immediately notified when there was a significant change in the resident's skin condition for 1 (#3) of 3 sampled residents with pressure ulcers. This deficient practice resulted in an actual physical harm for Resident #3 when S3CNA observed and reported to S4LPN three dime size blisters on the resident's sacrum on 02/14/2026, and S4LPN failed to notify the physician. The physician was notified on 02/18/2026 when the wound was noted as a stage 3 pressure ulcer by S6TxNurse. On 02/18/2026, Resident # 3 was diagnosed with a stage 3 pressure ulcer measuring length 8.1 centimeters (cm) x width 9.2 cm x depth 0.1 cm. The facility implemented corrective actions, which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.Review of the facility's policy titled Skin Program, Pressure Ulcers & Other Wounds revealed the following in part: Risk Assessment & Routine Care for All Residents: Nursing Assistants will check all residents' skin during each episode of care, bathing, etc. Reddened areas will be reported to the licensed nurse. Care of Residents with Wounds (Pressure & Non-Pressure Related):If a resident does develop a reddened area or wound, the licensed nurse will implement the following interventions: Notify resident, family, and physician of reddened area or wound; the notification of the physician will be done during normal physician office hours unless a treatment order is needed. Review of Resident #3's medical record revealed an admission date of 05/06/2024, and diagnoses which included, in part: Pressure Ulcer of Sacral Region, Unspecified Stage, with an onset date of 02/18/2026. Review of Resident #3's Significant Change Minimum Data Set (MDS) Assessment, with an assessment reference date (ARD) of 01/22/2026, revealed the resident was always incontinent of bowel and bladder, dependent for bed mobility, and had no unhealed pressure ulcers. Review of the Resident #3's medical record did not reveal documentation of a skin assessment completed on 02/14/2026. Review of Resident #3's Skin Check dated 02/18/2026 revealed the following in part:Skin Issues - New Issue; Location - Sacrum; Pressure ulcer / Injury; New wound; Stage 3 Pressure ulcer / injury: Full thickness skin loss; in-house acquired; new onset; no signs of infection; no wound pain; staged by in-house nursing; length 8.1 cm, width 9.2 cm, depth 0.1 cm; area 74.52. Review of the nurse's notes dated 02/18/2026 at 3:55 p.m. by S6TxNurse revealed Resident #3 noted with a stage 3 pressure injury to his sacrum. Discovered while doing his body audit. S2NP notified. Responsible Party also notified. New orders in place. Wound Care nurse practitioner (NP) will follow up with the patient on 2/19. Review of the wound care visit report dated 02/19/2026 and signed by S2NP revealed the following in part: Wound #1 Sacral is an acute Stage 3 Pressure Injury Pressure Ulcer. Initial wound encounter measurements are 8.1 cm length x 9.2 cm width x 0.1 cm depth, with an area of 74.52 square (sq) cm. Adipose is exposed. Three open areas in close proximity measured together as 1 wound. Site - sacral. Percent of Slough: 50. Percent of granulation: 40. Treatment Order: Cleanse wound with wound cleanser (pat dry), apply Santyl, apply barrier, and apply a clean dry dressing. On 03/16/2026 at 2:18 p.m., an interview was conducted with S6TxNurse. She said she found Resident #3's sacrum wound on 02/18/2026 during his weekly body audit. S6TxNurse stated when she found the pressure ulcer on 02/18/2026 it was a stage 3. S6TxNurse stated when she called Resident #3's (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	daughter to inform her of the wound on 02/18/2026, his daughter told her Resident #3 had blisters on his buttocks over the weekend. On 03/17/2026 at 11:10 a.m., an interview was held with S3CNA. S3CNA confirmed she worked the day shift on 02/14/2026. S3CNA said she found three dime size fluid filled blisters on Resident #3's buttocks on 02/14/2026. S3CNA said she reported it to the nurse. She said the facility provided a training after this incident related to notifying the nurse immediately when there is a change in the resident's skin and documenting it in the jot book. On 03/17/2026 at 4:06 p.m., an interview was held with S4LPN. She said on 02/14/2026 it was reported to her Resident #3 had a skin condition on his buttocks. S4LPN said the skin was reddened and open, but she did not remember the size. She stated she put skin prep on the area. S4LPN confirmed she did not notify the doctor or Resident #3's responsible party. S4LPN said she did not remember if she documented the findings. S4LPN said she received a written discipline for the incident and had the skin policy reviewed with her. S4LPN said she should have notified the doctor or NP, put orders in the computer, documented her assessment, and notified the Director of Nurses (DON), treatment nurse, and family. On 03/18/2026 at 8:03 a.m., an interview was held with S1CorpRN. S1CorpRN explained when a new wound was found the nurse who finds the wound should contact the physician or NP promptly. S1CorpRN said S4LPN did not report her findings to Resident #3's physician or NP or anyone else. S1CorpRN explained since the incident the CNAs had been educated on recognizing skin issues with prompt notification to the nurse with any concerns, and documentation in the jot book. S1CorpRN said the nurses had been trained on assessing, documenting, and promptly notifying the doctor and family of new or changed wounds. S1CorpRN said S4LPN had a 1:1 training regarding this incident. S1CorpRN said she was reading all nurses notes seven days a week. She said the CNAs have a jot book at the nurse's station where they document resident concerns. S1CorpRN explained when something is written in the jot book, it is copied and brought to the morning meetings to be followed up on. She said huddle meetings are held with the CNAs, and the CNA supervisor brings those concerns to the department heads. S1CorpRN said the staff have been trained to communicate during these meetings if they see something that is not normal for a resident. S1CorpRN explained they have not had any additional in-house acquired wounds since 02/18/2026. Throughout the survey from 03/16/2026 to 03/18/2026, observations, record reviews, and staff interviews revealed staff received training on the facility's skin program, pressure ulcers, and other wounds policy. Interviews revealed CNAs were knowledgeable of reporting changes in skin condition immediately to their nurse and documenting the information in the jot book. Interviews revealed nurses were knowledgeable of assessing wounds, documenting wounds, and notifying the physician or NP and responsible party of the findings immediately. The facility had implemented the following actions to correct the deficient practice:02/20/2026 - 02/26/2026: Weekly body audits for facility completed with no additional findings.02/21/2026 - 1:1 education with S4LPN.02/23/2026 (started) - 2/26/26 (completed) - CNA and nursing education regarding prompt identification and notification of any wounds identified, turn and reposition every 2 hours, floating of heels. New staff will receive training prior to starting in their position.02/23/2026 (started and completed) - department head rounds with specific details of needed skin care routines for residents (float, turn, heel boots, specialty mattresses, etc.).02/23/2026 (started) - Use of CNA jot book and copies of information to be given to department head nurses daily. Daily monitoring of nurse's notes by regional nurse. Daily CNA huddles to discuss any changes in residents' condition (skin concerns, decreased appetite, increased activities of daily living assistance needed, etc.); if any concerns voiced, CNA supervisor reports concerns to DON immediately; documentation and notifications checked to ensure physician (MD) or nurse practitioner (NP) has been notified and orders received as needed. If proper documentation / notifications have not been completed, notifications would happen at that time and re-education / disciplinary action would occur as needed. This will be an ongoing process. 03/03/2026 - Weekly high risk meeting with discussion of all pressure wounds and treatments. This will be an ongoing process. 03/12/2026 (hired) addition of QA nurse on evening shift 5 days/week to provide for increased facility monitoring. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A portion of her job duties will include ensuring timely rounds of residents, ensuring residents on appropriate turn schedules, heels floated, etc. Facility was in compliance on 02/26/2026. The facility will be conducting on going monitoring for a total of 8 weeks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure staff properly utilized Enhanced Barrier Precaution (EBP) Personal Protective Equipment (PPE) during direct care for 2 (#5 & R1) of 4 residents reviewed for infection control.Review of the facility's titled Enhanced Barrier Precautions dated January 2025 revealed the following, in part: It is the policy of the facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities. Nursing staff will place residents with any applicable conditions or devices on EBP. An order may be obtained. Applicable conditions and devices: (i.e. Wounds and / or indwelling medical devices (e.g. urinary catheters) even if the resident is not known to be infected or colonized with a MDRO. High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care: urinary catheters, and wound care: any skin opening requiring a dressing. Resident #5Review of Resident #5's medical record revealed an admission date of 01/08/2026 with the diagnosis of pressure ulcer of left buttock stage 3. Review of Resident #5's physician's orders dated 01/08/2026 revealed Enhanced Barrier Precautions related to pressure injury. Resident #R1 Review of Resident #R1's medical record revealed an admission date of 11/14/2025 with diagnoses which included, in part: Non-Pressure Chronic Ulcer of the Left Calf, limited to breakdown of skin, Non-Pressure Chronic Ulcer of Unspecified Part of Left Lower Leg, with fat layer exposed, Non-Pressure Chronic Ulcer of Other Part of Left Foot, with muscle involvement without evidence of necrosis, Pressure Ulcer of Left Ankle Stage 3, and Pressure Ulcer of Left Heel Unstageable. Review of Resident R1's care plan dated 11/16/2025 revealed he had an indwelling catheter. On 03/17/2026 at 8:35 a.m., an observation was made of S10TxNurse providing wound care for Resident #5. S10TxNurse wore gloves but no gown while providing wound care. An observation of the resident's door did not reveal signage of EBP. On 03/17/2026 at 10:31 a.m. an observation was made of S7CNA emptying Resident #R1's indwelling catheter. S7CNA was wearing gloves, but no gown. On 03/17/2026 at 10:35 a.m., an interview was held with S7CNA. S7CNA confirmed she had not put on a gown to empty Resident #R1's urinary catheter. An observation of the resident R1's door revealed EBP signage. On 03/17/2026 at 12:29 p.m., an interview was held with S8LPN. S8LPN verified Resident #R1 had wounds and a urinary catheter. On 03/17/2026 at 1:40 p.m., upon entering Resident #5's room, S7CNA was observed changing the resident's brief. S7CNA was wearing gloves, but no gown. S7CNA verified she was not wearing a gown and stated she just forgot. An observation of the sign above Resident #5's bed revealed Enhanced Barrier Precautions. On 03/17/2026 at 3:45 p.m., an interview was held with S10TxNurse. She confirmed she did not have a gown on during Resident #5's wound care. She said she only wore gowns with big wounds or infections. She said Resident #5's wound was not big or infected. On 03/18/2026 at 11:16 a.m., an interview was held with S9DON and S12Adm. S9DON stated all residents with infections, peg tubes, wounds, colostomies, ostomies, urinary catheters, tube feedings, and pressure ulcers should be on enhanced barrier precautions. S9DON stated the process for communication of which residents were on EBP would be to place a sign on the exterior of the resident's door. S9DON confirmed staff should wear a gown and gloves when emptying a urinary catheter or providing wound care.