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	05/06/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on observations, interviews, and record reviews, the facility failed to ensure an effective system was in place for staff to identify unsafe smokers and implement interventions including supervision to prevent accident hazards for 2 (#1, #5) of 3 residents reviewed for unsafe smoking. This deficient practice resulted in an Immediate Jeopardy situation for Resident #1 on 04/15/2026 when he was observed smoking in another resident's room while oxygen was in use. Resident #1 was a moderately cognitively impaired resident who was deemed an unsafe smoker upon admission to the facility on [DATE]. After 04/15/2026, not all staff were educated. On 05/03/2026, Resident #1 was noted smoking cigarettes in his room with smoking paraphernalia in his possession. Interviews revealed multiple staff members were unaware Resident #1 was assessed as an unsafe smoker. An observation of Resident #5, an assessed unsafe smoker, on 05/04/2026 revealed the resident had smoking paraphernalia in her possession. The facility failed to ensure staff were aware of which residents were deemed unsafe smokers and implemented designated interventions to prevent accident hazards. This failed system placed all residents in the facility at a likelihood to sustain serious injury, harm, impairment, or death. S1ADM and S5CN were notified of the immediate jeopardy situation on 05/04/2026 at 7:20 p.m. The Immediate Jeopardy was removed on 05/05/2026 at 6:05 p.m., as confirmed by onsite verification through observations, record reviews, and interviews. The facility implemented an acceptable Plan of Removal (POR) prior to survey exit. This deficient practice continued at the potential for more than minimal harm for any of the 109 residents residing in the facility. Findings: Review of facility's undated policy titled, Smoking Policy revealed the following, in part:The facility provides a safe and healthy environment for residents, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents.2. Residents who are assessed as not being able to smoke safely will not be allowed to smoke without supervision.3. If a resident exhibits dangerous behaviors with smoking paraphernalia such as smoking in non-designated areas, smoking in room.the resident will be considered unsafe to maintain smoking paraphernalia and it will be maintained for them at the nurse's station or other specified location. If the resident is non-compliant with this, the resident may be asked for permission to conduct routine room/belonging checks to ensure the safety of the affected resident, other residents, staff, and visitors. These safety interventions will be care planned.4. Residents will not be allowed to smoke in areas or in a manner that creates significant safety hazard for the resident, other residents, staff or visitors.5. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in accordance with his/her care plan.6. Smoking is not allowed in residents' rooms.10. All personnel caring for residents with smoking restrictions will be alerted to the interventions. Review of the facility's undated Smoke Monitor/Smoke Aid Job Summary revealed the following, in part:Responsible for the care of the residents in a designated smoke area of the facility. Knowledgeable of residents who are considered unsafe smokers.Responsibilities2. Responsible for obtaining an updated list of all residents who are unsafe smokers including recommended interventions. Resident #1Review of Resident #1's clinical record revealed he was admitted to the (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	facility on [DATE] with diagnoses, which included Traumatic Brain Injury and Parkinson's Disease. Review of Resident #1's Quarterly MDS with an ARD of 04/22/2026 revealed a BIMS of 12, which indicated he was moderately cognitively impaired. Further review revealed he was independent with ADL's. Review of Resident #1's admission Smoking Evaluation dated 01/16/2026 revealed he was deemed an unsafe smoker. Further review revealed the following in part:Has the resident demonstrated he only smokes in designated areas in or around the facility? No. Requires constant supervision by staff for safety during smoking. Review of Resident #1's current Physician's Orders revealed the following, in part:Resident deemed unsafe smoker-supervision required while smoking. Every 30 minute safety checks. Start date 05/04/2026. Review of Resident #1's current Care Plan revealed a problem was initiated on 02/16/2026 stating the resident was deemed an unsafe smoker who required supervision while smoking. On 04/15/2026, Resident #1 was found smoking in another resident's room who had oxygen in use. At that time Resident #1 was removed from the room and escorted outside. The facility initiated hourly checks and to intervene as necessary to protect the rights and safety of others. On 05/03/2026, Resident #1 was smoking in his room. The facility confiscated the cigarettes and instructed Resident #1 on smoking risks and hazards. The facility also implemented daily room checks for smoking paraphernalia and increased safety rounds to every 30 minutes. Review of Resident #1's Nurse's Note revealed S13LPN documented on 04/15/2026 a 3:30 p.m., Resident #1 was found smoking in another resident's room that had oxygen in use. Resident #1 was escorted out of the building and made aware there was no smoking ever allowed in the facility. Resident #1 was informed to always go outside and smoke. S12RN documented on 05/03/2026 at 9:52 a.m., Resident #1 was smoking in his room. Resident #1 confirmed he was smoking and aware he was not supposed to. Cigarettes were confiscated. Resident stated another resident lit the cigarette, but didn't know who. Review of Resident #1's electronic Task Flowsheet dated 04/16/2026 through 05/04/2026 revealed hourly safety checks had been documented as completed by CNA staff. On 05/05/2026 at 9:52 a.m., an interview was conducted with S13LPN. She stated Resident #1 was an unsafe smoker. She stated there was a list of safe and unsafe smokers at the nurse's station for staff to reference. She stated unsafe smokers were not supposed to have cigarettes or lighters in their possession. She stated some of the residents would ask other residents for cigarettes. She stated, on 04/15/2026, Resident #1 was caught smoking in another resident's room by S14LPN. She stated she was assigned to Resident #1 that shift, and after she was notified, she told Resident #1 smoking was only allowed on the smoking patio and he shook his head like he understood. She stated Resident #1 was oriented to self and situation but was also confused. She stated after this incident, safety checks were initiated every hour for the resident. S13LPN stated it was both hers and Resident #1's assigned CNA's responsibility to ensure they were completing hourly rounding for Resident #1 to make sure he was safe and not smoking. On 05/05/2026 at 10:35 a.m., an interview was conducted with S14LPN. She stated, on 04/15/2026, she saw Resident #1 standing in another resident's room with a lit cigarette. She stated Resident #1 had a lit cigarette in his hand, and he was standing behind the other resident, who had oxygen in place via nasal cannula. She stated the other resident's oxygen concentrator was beside him. She stated that resident had a back door to his room, which led to the outdoor patio. She stated she walked Resident #1 out the back door, had him extinguish his cigarette, and then walked him around to his assigned nurse, S13LPN. She stated she was unaware if Resident #1 was a safe or unsafe smoker as she had never been assigned to care for him. She stated unsafe smokers were not allowed to have cigarettes and lighters in their possession. She stated it was dangerous for Resident #1 to be next to the other resident with a lit cigarette since that resident was wearing oxygen. She stated after the incident, she notified S1ADM of what happened. She stated there was a list of the residents who were safe and unsafe smokers at the nurse's station for staff to reference. On 05/04/2026 at 12:02 p.m., an interview was conducted with S10HK. She stated, on 05/03/2026, she walked past Resident #1's room, and the whole room was smoky and smelled like cigarette smoke. She stated she reported it to S12RN. She stated this morning, she was notified (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide drinks consistent with resident preferences for 1 (#R7) of 1 resident observed for drinking preferences. The facility failed to provide Resident #R7 coffee when he requested it. Findings: Review of Resident #R7's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #R7's Quarterly MDS with an ARD of 02/20/2026 revealed a BIMS of 8, which indicated he was moderately cognitively impaired. On 05/05/2026 at 12:25 p.m., an observation was made of Resident #R7 self-propelling himself out of his room in his wheelchair, holding a drinking tumbler. He waved his drinking tumbler in the air. When asked if he wanted coffee, he shook his head yes. At that time, S4LPN was observed down the hall. S4LPN was notified Resident #R7 wanted coffee. S4LPN shook her head and stated no. On 05/05/2026 at 12:28 p.m., an observation and interview was conducted with S15OT walking toward Resident #R7. S15OT told Resident #R7 he could not have coffee because it was not coffee time. She stated Resident #R7 could only have coffee at the coffee times posted. She stated Resident #R7 did not ask for water, and he only wanted coffee all day. She further stated he could not have coffee all day because then he would be going to the restroom all day. S15OT was observed telling Resident #R7 that it was currently 12:30 p.m. and at 1:30 p.m. the residents were having a party and he could get coffee then. On 05/06/2026 at 8:09 a.m., an interview was conducted with S4LPN. She verified she was assigned to Resident #R7 on 05/05/2026. She stated when residents wanted coffee, there was a coffee station at the front of the facility with coffee times posted. She stated Resident #R7 was aware of when the coffee times were. She confirmed she told Resident #R7 he could not have coffee yesterday. She stated most of the time, Resident #R7 took two sips of coffee then would throw it on the ground. She confirmed residents should be able to have coffee whenever they wanted. On 05/06/2026 at 9:30 a.m., an observation was made of the coffee sign posted by the coffee station. The coffee sign revealed the following:Come enjoy a hot fresh cup of coffee daily Monday through Sunday7:00 a.m. to 8:00 a.m.10:00 a.m. to 10:30 a.m. On 05/06/2026 at 11:22 a.m., an interview was conducted with S2DON. She stated there was a coffee shop the residents could get coffee at during the coffee hours. She stated after those hours, residents could tell their CNA or nurse, and that staff member could go get the resident coffee from the kitchen. She stated residents should be able to have coffee whenever they wanted.

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	05/06/2026

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being for each resident residing in the facility. The facility failed to have an effective system in place for staff to identify unsafe smokers and implement safety interventions for 2 (#1 and #5) of 3 residents assessed as unsafe smokers. Findings: Cross Reference F689Review of facility's undated policy titled, Smoking Policy revealed the following, in part:The facility provides a safe and healthy environment for residents, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents.2. Residents who are assessed as not being able to smoke safely will not be allowed to smoke without supervision.3. If a resident exhibits dangerous behaviors with smoking paraphernalia such as smoking in non-designated areas, smoking in room.the resident will be considered unsafe to maintain smoking paraphernalia and it will be maintained for them at the nurse's station or other specified location. If the resident is non-compliant with this, the resident may be asked for permission to conduct routine room/belonging checks to ensure the safety of the affected resident, other residents, staff, and visitors. These safety interventions will be care planned.4. Residents will not be allowed to smoke in areas or in a manner that creates significant safety hazard for the resident, other residents, staff or visitors.5. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in accordance with his/her care plan.6. Smoking is not allowed in residents' rooms.10. All personnel caring for residents with smoking restrictions will be alerted to the interventions. Review of the facility's undated Smoke Monitor/Smoke Aid Job Summary revealed the following, in part:Responsible for the care of the residents in a designated smoke area of the facility. Is knowledgeable of residents who are considered unsafe smokers.Responsibilities2. Responsible for obtaining an updated list of all residents who are unsafe smokers including recommended interventions. Review of the facility's undated policy, titled, Administrator revealed the following, in part: Job summary: The Administrator directs and coordinates all activities of the nursing home, in carrying out its objective of providing the best possible care for each resident, in striving to recreate a sense of security.for the residents. Qualifications: 5.) Willingness to accept responsibility for activities of the nursing home. Responsibilities: 1.) Efficient functioning and coordination of all departments. 5.) Adopts and enforces rules and regulations for the health care and safety of recipient, patients and others and the protection of their personal property and civil rights. Resident #1 Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE] with diagnoses, which included Traumatic Brain Injury and Parkinson's Disease. Review of Resident #1's Quarterly MDS with an ARD of 04/22/2026 revealed a BIMS of 12, which indicated he was moderately cognitively impaired. Further review revealed he was independent with ADL's. Review of Resident #1's admission Smoking Evaluation dated 01/16/2026 revealed he was deemed an unsafe smoker. Further review revealed the following, in part:Has the resident demonstrated he only smokes in designated areas in or around the facility? No. Requires constant supervision by staff for safety during smoking. Review of Resident #1's current Physician's Orders revealed the following, in part:Resident deemed unsafe smoker-supervision required while smoking. Review of Resident #1's current Care Plan revealed a problem was initiated on 02/16/2026 stating the resident was deemed an unsafe smoker who required supervision while smoking. On 04/15/2026, Resident #1 was found smoking in another resident's room who had oxygen in use. At that time Resident #1 removed from room and escorted outside. The facility initiated hourly checks and to intervene as necessary to protect the rights and safety of others. On 05/03/2026, Resident #1 was smoking in his room. The facility confiscated the cigarettes and instructed Resident #1 on smoking risks and hazards. The facility also implemented daily room checks for smoking paraphernalia and increased safety rounds to (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	every 30 minutes. On 05/04/2026 at 11:36 a.m., an interview was conducted with S3CNA. He stated the Smoking Monitors had a list of all residents who were safe and unsafe smokers outside. He stated Resident #1 was a safe smoker, so he did not require supervision while smoking. He stated all unsafe smokers required supervision. He stated safe smokers could go outside and smoke at any time of the day without supervision, including Resident #1. He stated Resident #1 could have gotten cigarettes from another resident. On 05/04/2026 at 3:15 p.m., an interview was conducted with S11CNA. She stated Resident #1 went outside to smoke all of the time. She stated Resident #1 was a safe smoker. She stated the Smoking Monitor had a list outside with all the safe and unsafe smokers. On 05/04/2026 at 11:18 a.m., an interview was conducted with S8SM. She stated she was a Smoke Monitor. She stated it was her responsibility to oversee the safety of smoking residents on the smoking patio. She stated every morning when she arrived for her shift, she received a list which notified her which residents were safe and unsafe smokers. She stated she reviewed the list daily. She stated Resident #1 was a safe smoker and he smoked fine by himself. She stated this was the facility's smoking process in which she received training upon hire in March 2026. She stated she had not received any additional training since hire. A copy of the facility's smoking list was observed with S8SM. The smoking list revealed Resident #1's name and beside his name read Resident deemed unsafe smoker-supervision required while smoking with a revision date of 02/17/2026. S8SM stated she did not know Resident #1 was an unsafe smoker and his status must have changed recently and no one told her. On 05/05/2026 at 8:40 a.m., an interview was conducted with S9SM. He stated he was a Smoke Monitor. He stated he had been working at the facility since November 2025 and received training on the facility's smoking process upon hire. He stated he had not received any additional training since hire. He stated he knew which residents were safe and unsafe smokers by looking at the smokers list, which was printed out each morning and given to him. He stated he looked at the list each day. He stated all unsafe smokers were not allowed to have cigarettes or lighters in their possession, and required supervision while smoking. He stated Resident #1 was a safe smoker when he was admitted to the facility. He stated Resident #1 was found in another resident's room smoking last month and was deemed unsafe after that. He stated Resident #1 used to smoke all throughout the day, but over the last few weeks, had been only smoking in the afternoon. Review of the In-Service Sign-In sheet provided by the facility related to Accident and Hazard Prevention dated 04/15/2026 revealed the following, in part:-Smoking Monitoring-watch residents smoke-Report burn holes in clothes/wheelchairsFurther review revealed of the 20 staff members who signed the in-service, S8SM, S9SM, S3CNA, S11CNA, S16LPN, and S12RN were not included. On 05/05/2026 at 10:08 a.m., an interview was conducted with S19CNAS. She stated she was responsible for overseeing the Smoke Monitors. She stated the Smoke Monitors were educated on the smoking process and who were safe and unsafe smokers upon hire. She stated the Smoker Monitors were provided with a list of the safe and unsafe smokers daily. She stated the Smoke Monitors should know which residents were safe and unsafe by looking at the list each morning when they received it. On 05/04/2026 at 4:22 p.m., an interview was conducted with S2DON. She stated she began as the interim DON for the facility on 04/16/2026 She stated Resident #1 was an unsafe smoker but able to have cigarettes in his possession. She stated Resident #1 required supervision while smoking. She stated safe smokers could have both cigarettes and lighters but unsafe smokers usually had to have smoking paraphernalia locked up. She stated she was unaware Resident #1 had smoked inside the facility prior to 05/03/2026. On 05/04/2026 at 6:06 p.m., a follow up interview was conducted with S2DON. She confirmed Resident #1 was an unsafe smoker and was not supposed to have any smoking paraphernalia. She stated the intervention put into place for Resident #1 after he was found smoking yesterday was the initiation of safety checks every 30 minutes, which started today on 05/04/2026. She stated Resident #1 was more than likely getting cigarettes from other residents. On 05/05/2026 at 2:20 p.m., an interview was conducted with S1ADM. She stated when a resident was admitted to the facility, the MDS nurse completed the resident's smoking assessment, then the MDS nurse put the (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	resident on the safe or unsafe smoker list, and entered their smoking status into their care plan. She stated smoking aids had an orientation upon hire which included showing them the smoker's box which contained the unsafe smoker's cigarettes and when and how to obtain the smoker's list, which included safe and unsafe smokers. She stated everyone should have known Resident #1 was an unsafe smoker. She stated the Smoke Monitors were supposed to know which residents were safe and unsafe smokers because a new, updated list was printed out each morning and given to them at the start of their shift. She stated the Smoke Monitors should check the smoking list every morning to ensure they knew which residents were safe smokers and which residents were unsafe smokers. She stated these lists were also at the nurse's station so she didn't know how staff could not have known Resident #1 was an unsafe smoker. She stated every staff member should have known Resident #1 was an unsafe smoker because the list was available to them at the nurse's station. She stated she was aware Resident #1 was found smoking in another resident's room, who was actively receiving oxygen. She stated after that incident, Resident #1 was placed on hourly safety checks. She stated unsafe smokers were supposed to be supervised while smoking and were not supposed to have smoking paraphernalia in their possession. She stated she was made aware on 05/04/2026 that Resident #1 smoked in his room over the weekend. She stated the unsafe smoking residents would find a way to acquire smoking paraphernalia and there was nothing she could do to prevent it. Resident #5Review of Resident #5's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Epilepsy, Nicotine Dependence, Lack of Coordination, and Abnormalities of Mobility.Review of Resident #5's current Care Plan revealed the following, in part:Problem: Resident is an unsafe smoker (dated 04/09/2026)Interventions: Resident requires a smoking apron while smoking, and clothes pins/ tips; Resident requires supervision while smoking; the resident's smoking supplies are stored by staff. Review of facility's Smoker's list with interventions as of 05/04/2026 revealed the following: Resident #5 deemed unsafe smoker-required smoke apron, clothes pin to hold cigarette, and supervision while smoking. An interview was conducted on 05/04/2026 at 8:40 a.m. with S8SM. S8SM stated Resident #5 was an unsafe smoker, and required assisted to light her cigarettes and wore a smoking apron. An observation was conducted on 05/04/2026 at 4:30 p.m. of Resident #5. Resident #5 was observed sitting in her wheelchair at the entryway of the dining room holding two whole unlit brown cigarettes. An interview was conducted on 05/04/2026 at 7:20 p.m. with S1ADM. S1ADM confirmed the process for the facility was any smoker deemed unsafe should not have possession of their cigarettes or lighter, and she expected staff to implement interventions for the unsafe smoker per their plan of care and smokers assessment.