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	06/03/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure a resident's call light was within reach for 2 (#57 and #58) of 34 residents reviewed during the initial pool. Findings: Review of the facility's undated policy titled Call Lights: Accessibility and Timely Response revealed the following, in part:Policy:The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside. to allow residents to call for assistance.Policy Explanation and Compliance Guidelines:4. Staff will ensure the call light is within reach of resident. Resident #57Review of Resident #57's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Generalized Muscle Weakness, Greenstick Fracture of Shaft of Humerus Right Arm with Routine Healing, and Other Abnormalities of Gait and Mobility. Review of Resident #57's Quarterly MDS with an ARD of 04/23/2026, revealed a BIMS of 14, which indicated she was cognitively intact. Further review revealed Resident #57 had a functional limitation affecting one side of her upper and lower extremity, was always incontinent of bowel and dependent on staff assistance for toileting hygiene. Review of Resident #57's current Care Plan revealed the resident had a history of Greenstick Fracture to Right Arm. Interventions included to ensure the resident's call light is within reach. An observation was made on 06/01/2026 at 8:56 a.m. of Resident #57 in her room. She was lying in bed and her call light was observed inside the resident's laundry basket out of reach. An interview was conducted at this time and Resident #57 stated she was not sure where her call light was and it had been missing for a while. She stated she used her call light when she needed help from staff. She confirmed she could not reach her call light. An observation and interview was conducted on 06/01/2026 at 9:05 a.m. with S6CNA. S6CNA stated Resident #57 used her call light to call staff for assistance and it should be kept in reach. S6CNA observed and confirmed Resident #57's call light was inside her laundry basket and out of the resident's reach. Resident #58Review of Resident #58's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Morbid Obesity Due To Excess Calories, Chronic Combined Systolic and Diastolic Congestive Heart Failure, Generalized Muscle Weakness, and Acquired Absence of Right Leg Below Knee. Review of Resident #58's Quarterly MDS with an ARD of 05/22/2026, revealed a BIMS of 12, which indicated she was moderately cognitively impaired. Further review revealed Resident #58 was always incontinent of bowel and bladder and was dependent on staff assistance for toileting hygiene. Review of Resident #58's current Care Plan revealed the resident was at risk for falls. Interventions included to ensure the resident's call light is within reach. An observation was made on 06/01/2026 at 10:05 a.m. of Resident #58 in her room. She was lying in bed and her call light was observed hanging below the side rail. An interview was conducted at this time and Resident #58 stated she used her call light when she needed staff assistance. She confirmed her call light was out of reach. An observation and interview was conducted on 06/01/2026 at 10:07 a.m. with S8CNA. S8CNA stated Resident #58 used her call light when she needed staff assistance. S8CNA observed and confirmed Resident #58's call light was out of reach. S8CNA confirmed Resident #58's call light should be kept in reach. An observation was made on 06/02/2026 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:20 a.m. of Resident #58 in her room. She was lying in bed and her call light was observed hanging below the side rail near the floor. An interview was conducted at this time and Resident #58 stated she was not able to reach her call light. An observation and interview was conducted on 06/02/2026 at 8:23 a.m. with S10LPN. S10LPN stated Resident #58 used her call light to communicate to staff when she needed to be changed and if she needed assistance. S10LPN observed and confirmed Resident #58's call light was out of reach and should be kept in reach. An interview was conducted on 06/02/2026 at 2:35 p.m. with S2DON. S2DON was made aware of the above findings. S2DON confirmed if a resident can use their call light, then their call lights should be kept in reach.

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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 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** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's comprehensive plan of care was implemented for 1 (#57) of 25 residents reviewed in the final sample. The facility failed to ensure Resident #57's urinary catheter securement device was in place at all times.Findings: Review of the facility's undated policy titled Physician Services/Physician Orders revealed the following, in part:Policy Interpretation and Implementation:3. Staff will follow and implement all physician orders in accordance with plan of care. Resident #57Review of Resident #57's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Neuromuscular Dysfunction of Bladder and Other Disorders of Urinary System. Review of Resident #57's Quarterly MDS with an ARD of 04/23/2026, revealed the resident had an indwelling catheter. Review of Resident #57's current Physician Orders revealed the following, in part:Start date: 01/06/2026-Urinary Catheter: Change Suprapubic Catheter securement device every day shift starting on the 6th and ending on the 6th every month related to Neuromuscular Dysfunction of Bladder. Review of Resident #57's current Care Plan revealed the resident was had an Indwelling Suprapubic Catheter, Neurogenic Bladder, and risk for infection. An observation was made on 06/01/2026 at 9:15 a.m. of S6CNA and S7CNA performing ADL care for Resident #57. Resident #57's suprapubic catheter tubing was observed stretched out in the resident's abdominal fold with no securement device. An observation was made on 06/02/2026 at 7:45 a.m. of S9WC performing catheter care for Resident #57. Resident #57's suprapubic catheter tubing was observed stretched out in the resident's abdominal fold with no securement device. An interview was conducted on 06/02/2026 at 8:10 a.m. with S9WC. She confirmed Resident #57's suprapubic catheter tubing did not have a securement device and should have. She stated the purpose of catheter securement device was to prevent the catheter from being pulled on or pulled out. An interview was conducted on 06/02/2026 at 8:17 a.m. with S10LPN. She verified she was the nurse assigned to Resident #57 on 06/01/2026 and 06/02/2026. She was made of aware of the observations on 06/01/2026 and 06/02/2026 of no securement device to Resident #57's suprapubic catheter. She stated Resident #57's catheter should have been secured at all times to prevent it from being pulled on or out. An interview was conducted on 06/02/2026 at 12:55 p.m. with S6CNA. She confirmed on 06/01/2026, Resident #57's catheter had no securement device. She stated Resident #57's catheter should have been secured so it does not get pulled on or out. An interview was conducted on 06/02/2026 at 2:35 p.m. with S2DON. She stated Resident #57's suprapubic catheter should be secured to prevent the catheter from being pulled on or out. She confirmed physician orders for Resident #57's catheter should have been followed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility failed to ensure services provided, as outlined in the comprehensive care plan, met professional standards of quality by nursing staff failing to observe and ensure a resident consumed medications for 2 (#34 and #59) of 32 residents reviewed in the initial pool. Findings: Resident #34 Review of Resident #34's Clinical Record revealed an admission date of 11/28/2025 and diagnoses, which included Type 2 Diabetes Mellitus, Chronic Venous Hypertension, Hypertensive Heart Disease, Heart Failure, Gastroesophageal Reflux Disease, Major Depressive Disorder, Constipation, Polyosteoarthritis, Chronic Back Pain, and Morbid Obesity. Review of Resident #34's Quarterly MDS with an ARD of 03/06/2026 revealed he had a BIMS of 15, which indicated intact cognition. Review of Resident #34's current Physician Orders revealed the following: Lasix 40mg by mouth daily, Losartan Potassium 50mg by mouth daily, Metoprolol Succinate Extended Release 25mg by mouth daily, Multivitamin tablet by mouth daily, Pantoprazole Sodium Delayed Release 25mg by mouth daily in the morning, Sennosides 8.6mg give 2 tablets by mouth daily, Glipizide 5mg by mouth twice daily, and Wellbutrin 150mg by mouth twice daily. Further review revealed Resident #34 was ordered to receive Methocarbamol 750 mg and Acetaminophen Extra Strength 500mg two tablet by mouth every eight hours as needed for pain. Resident #34 did not have an order for medication self-administration or to leave medications at the bedside. Review of Resident #34's MAR dated 06/01/2026 revealed a check mark with initials, which indicated the following medications were administered at 8:00 a.m.: Lasix 40mg, Losartan Potassium 50mg, (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol Succinate Extended Release 25mg, Multivitamin tablet, Pantoprazole Sodium Delayed Release 25mg, Sennosides 8.6mg 2 tablets, Glipizide 5mg, and Wellbutrin 150mg. An observation and interview was conducted of/with Resident #34 on 06/01/2026 at 8:55 a.m. Resident #34 was seated in his wheelchair in his room next to his bedside table. There were two clear medication cups containing medications on Resident #34's bedside table. One medication cup contained two round, white, tablets Resident #34 identified as Extra Strength Tylenol. Resident #34 stated the nurse brought him the Tylenol last night and he never took them. The second medication cup contained the following: one large round white tablet, one small round green tablet, one oval red gel capsule, one oval orange tablet, two small round orange tablets, one small round white tablet, one small oval white tablet, one medium oval white tablet, and one oval yellow tablet. Resident #34 identified the second medication cup as his morning medications. He stated the nurse delivered them to his room around 8:00 a.m. There were also two loose tablets, one oval white tablet and one round gray tablet, resting directly on the bedside table. Resident #34 identified the two loose tablets on the table as his wife's medication from last night. Resident #34 stated his wife did not take her evening medications yesterday. An observation was made of Resident #34's room with S5LPN on 06/01/2026 at 9:47 a.m. The medication cup Resident #34 identified as his morning medications was not present. S5LPN confirmed there was one medication cup containing two round white tablets and there were two tablets, one oval white tablet and one round gray tablet, resting directly on the bedside table. S5LPN stated Resident #34's medications should never have been left at the bedside. S5LPN stated the nurses should always observe the resident take medications to ensure they were consumed as ordered. An interview was conducted with Resident #34 on 06/01/2026 at 10:00 a.m. He stated he took his morning medications this morning after surveyor exited his room. He stated the nurse brought them to his room around 8:00 a.m. this morning. He stated the nurse always left his medications at his bedside and he took them when he wanted. An interview was conducted with S13CN on 06/02/2026 at 12:39 p.m. She stated medications should not have been left at the bedside unless the resident had an order to leave them at the bedside. She stated the nurses should observe the resident consume all of their medications prior to exiting the room. Resident #59 Review of Resident #59's Clinical Record revealed an admission date of 12/16/2025 and diagnoses, which included Hypertensive Heart Disease with Heart Failure and Acute or Chronic Diastolic Congestive Heart Failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #59's Quarterly MDS with an ARD of 04/23/2026 revealed a BIMS of 14, which indicated intact cognition. Review of Resident #59's current Physician Orders revealed the following, in part: Lasix Tablet 40 mg Give 1 tablet by mouth one time a day at 8:00 a.m. Review of Resident #59's MAR dated 06/01/2026 revealed the following, in part: Lasix 40 mg by mouth at 8:00 a.m. with a check mark and initials indicating S4LPN administered Resident #59's Lasix at 8:00 a.m. An observation was made of Resident #59 on 06/01/2026 at 9:25 a.m. He had a white tablet in a medication cup on his bedside table. An interview was conducted with Resident #59 at that time. He stated he had taken his morning medication and did not realize there was a tablet left in the medication cup. An observation was made of Resident #59 with S4LPN on 06/01/2026 at 9:45 a.m. S4LPN confirmed Resident #59 had a white tablet in a medication cup on his bedside table. S4LPN identified the white tablet in the medication cup as Resident #59's 8:00 a.m. Lasix. An interview was conducted with S4LPN on 06/01/2026 at 9:45 a.m. She confirmed she had administered Resident #59's 8:00 a.m. medications. She further confirmed nurses were responsible for ensuring residents took all of their medication and she had not. An interview was conducted with S2DON on 06/02/2026 at 3:53 p.m. S2DON stated nurses were responsible for ensuring residents consumed all of their medications before leaving their room. She further confirmed medications should never be left at the bedside.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident with a Pressure Ulcer received care based on the comprehensive assessment and professional standards of practice to promote healing by failing to ensure the air mattress was properly functioning for 1 (#21) of 2 residents reviewed with pressure ulcers.Findings: Review of Resident #21's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Stage 4 Sacral Pressure Ulcer and Spastic Quadriplegic Cerebral Palsy. Review of Resident #21's Quarterly MDS with an ARD of 04/08/2026 revealed she had a BIMS of 12, which indicated moderate cognitive impairment. Further review revealed Resident #21 was dependent on staff for turning and repositioning. Review of Resident #21's current Physician Orders revealed pressure reducing mattress to bed. Review of Resident #21's current Care Plan revealed the following, in part:Problem: Stage 4 Pressure Ulcer to Sacrum.Interventions: Pressure relieving air mattress to bed. On 06/03/2026 at 9:58 a.m., an observation was made of Resident #21. She was lying in bed turned toward her left side with the use of a wedge. Resident #21's air mattress pump was off and the power cord was unplugged from the wall and lying on the floor under the bed. Resident #21 stated she was uncomfortable. On 06/03/2026 at 10:00 a.m., S12CNA was notified Resident #21 stated she was uncomfortable. S12CNA entered Resident #21's room. On 06/03/2026 at 10:03 a.m., an observation was made of Resident #21. She was lying in bed turned toward her right side with the use of a wedge. On 06/03/2026 at 11:30 a.m., an observation was made of Resident #21. She was lying in bed turned toward her right side with the use of a wedge. Resident #21's air mattress pump was off and the power cord was unplugged from the wall and lying on the floor under the bed. On 06/03/2026 at 12:14 p.m., an observation was made of Resident #21. She was lying in bed on her back with the positioning wedge to the left of her. Resident #21's air mattress pump was off and the power cord was unplugged from the wall and lying on the floor under the bed. Resident #21's air mattress was deflated. An interview was conducted with Resident #21 at that time. She stated she had placed herself on the bedpan, was uncomfortable, and needed assistance getting off the bedpan. On 06/03/2026 at 12:17 p.m., surveyor notified S5LPN and S12CNA of Resident #21 stating she was uncomfortable, was on a bedpan, and needed assistance getting off the bedpan. On 06/03/2026 at 12:18 p.m., an observation was made of S12CNA repositioning Resident #21. S12CNA turned Resident #21 toward her left side with the use of a wedge. Resident #21's air mattress was deflated. Resident #21 was not on a bedpan. On 06/03/2026 at 12:30 p.m., an interview was conducted with Resident #21. She stated her mattress was uncomfortable and it felt like she was lying on the bedframe. On 06/03/2026 at 12:42 p.m., an observation was made of Resident #21 with S14WC and S12CNA present. S14WC and S12CNA both confirmed Resident #21's air mattress pump was off and not plugged in. S14WC confirmed Resident #21's air mattress was deflated. On 06/03/2026 at 12:48 p.m., an interview was conducted with S5LPN. She stated Resident #21's air mattress should have been monitored during rounds to ensure it was on and functioning properly. She confirmed Resident #21's air mattress should have been plugged in, on, and functioning properly at all times. On 06/03/2026 at 12:50 p.m., an interview was conducted with S12CNA. She stated she and the nurse were responsible to ensure Resident #21's air mattress was on and functioning properly. She stated she had not identified the air mattress pump was off or the mattress was not inflated when she provided care for Resident #21. She confirmed Resident #21's air mattress pump should have been on and functioning properly. On 06/03/2026 at 1:21 p.m., an interview was conducted with S14WC. She confirmed Resident #21 had an air mattress related to her Sacral Pressure Ulcer, decreased mobility, and risk for Pressure Ulcers. She confirmed Resident #21's air mattress should always be on and functioning properly. She stated the CNAs and nurses should have checked Resident #21's air mattress and pump during each round to ensure the pump was on and the mattress was properly inflated. She stated the air mattress being deflated with Resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#21 in the bed could potentially lead to worsening of her pressure ulcer and/or additional skin breakdown. On 06/03/2026 at 1:40 p.m., an interview was conducted with S13CN. She confirmed Resident #21's air mattress pump should have been on, functioning properly, and the mattress should have been inflated at all times while Resident #21 was lying in bed. On 06/03/2026 at 2:23 p.m., an interview was conducted with S2DON. She stated air mattresses and air mattress pumps should be checked for proper functioning during the staffs' every two hour rounds.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observations, interviews, and record review, the facility failed to ensure a resident received proper treatment and care to maintain good foot health by failing to maintain proper toenail length for 1 (#34) of 3 residents observed for foot care.Findings: Review of the facility's policy titled, Nail Care revealed the following, in part:Policy: The purpose of this policy is to provide guidelines for the provision of care to a resident's nails for good grooming and health.Policy Explanation and Compliance Guidelines:1. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.3. Principles of nail care:c. if a resident has a toe infection, Diabetes Mellitus or Peripheral Vascular Disease, toenail trimming should be performed by a physician or practitioner. Review of Resident #34's Clinical Record revealed an admission date of 11/28/2025 and diagnoses, which included Type 2 Diabetes Mellitus, Chronic Venous Hypertension with Ulcer and Inflammation of Left Lower Extremity, Chronic Venous Insufficiency, and Morbid Obesity. Review of Resident #34's Quarterly MDS with an ARD of 03/06/2026 revealed a BIMS of 15, which indicated intact cognition. Further review revealed supervision or touching assistance with personal hygiene. Review of Resident #34's current Physician orders revealed daily treatment to a Left Lower Leg Vascular Wound. Review of Resident #34's current Care Plan revealed no documentation pertaining to foot care. Review of Resident #34's Clinical Record revealed no documentation he had been seen by a Podiatrist. An observation was made of Resident #34 on 06/01/2026 at 8:55 a.m. Resident #34's bilateral toenails were thick and long, extending past the tips of his toes. An interview was conducted with Resident #34 at that time. Resident #34 stated nobody had offered to trim his toenails but he needed them cut. Resident #34 stated his toenails were too long. An observation was made of Resident #34 on 06/02/2026 at 9:40 a.m. Resident #34's bilateral toenails were thick and long, extending past the tips of his toes. An interview was conducted with S16CNA on 06/02/2026 at 9:43 a.m. She stated wound care nurses were responsible for all residents' toenail care. She stated there was also a Podiatrist who came to the facility and trimmed toenails. She confirmed Resident #34's toenails were too long and needed to be trimmed. She stated she previously reported to S5LPN Resident #34's toenails needed to be trimmed. An interview was conducted with S5LPN on 06/02/2026 at 9:46 a.m. She stated she was responsible to assess residents' fingernails and toenails to see if they needed to be trimmed. She stated if the resident was Diabetic, she reported to the social worker to have the Podiatrist trim the resident's toenails. She stated she had not identified Resident #34's toenails being too long and needing to be trimmed or reported the need for a podiatrist appointment for Resident #34. An observation was made of Resident #34's toenails with S5LPN on 06/02/2026 at 9:50 a.m. S5LPN confirmed Resident #34's toenails were too long, extended past the tips of the toes, and needed to be trimmed. During the observation, Resident #34's wife was at his bedside. Resident #34's wife stated, his toenails need to be trimmed bad. An interview was conducted with S14WC on 06/02/2026 at 10:32 a.m. She stated she was responsible for trimming Diabetic residents' toenails. She stated she performed wound care on Resident #34's left leg vascular wound daily and noticed his toenails were too long and needed to be trimmed. She explained Resident #34's toenails were very thick and required specialty clippers, which the facility did not currently have. She confirmed Resident #34 was at risk for foot complications. She stated S15SW managed residents' on the Podiatrist's list. She stated she was unsure if Resident #34 was on the Podiatrist's list. An interview was conducted with S15SW on 06/02/2026 at 11:22 a.m. She stated the resident, nurses, or CNAs notified her if any resident needed to be seen by podiatry. She stated she then placed the residents on the Podiatrist's list to be seen at the next visit. She stated the Podiatrist held clinic in the facility one to two times per month. She stated Resident #34 was placed on the podiatry list on 05/29/2026, 06/01/2026, or 06/02/2026. She stated the podiatrist held clinic in the facility on 05/29/2026 so Resident #34 had to be added after that or he would have been seen on 05/29/2026, and he was not. A follow-up interview was conducted with S15SWon 06/03/2026 at 10:34 a.m. She (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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed Resident #34 had not seen the podiatrist since admission to the facility. An interview was conducted with S2DON on 06/02/2026 at 12:30 p.m. She stated the nurses were responsible for assessing fingernails and toenails. She stated if the resident's toenails were thickened or yellow, the Podiatrist would trim them. She stated the Podiatrist held clinic in the facility monthly, and there was a list of residents who needed to be seen. She stated S15SW held the running list of residents needing to be seen by the podiatrist. She was made aware of the condition of Resident #34's toenails. She stated Resident #34's toenails should not have gone that long without trimming.

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	06/03/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding by failing to ensure tube feeding formula was administered as prescribed for 1 (#77) of 3 residents reviewed for tube feedings.Review of the Clinical Record for Resident #77 revealed he was admitted to the facility on [DATE] with diagnoses, which included Gastrostomy Status.Review of the current Physician Orders for Resident #77 revealed, in part, the following:Enteral: continuous feed: Isosource 1.5 at 70 milliliters an hour.An observation was made on 06/01/2026 at 8:55 a.m. of Resident #77. Observed Resident #77's feeding tube attached to a feeding pump which read an error of Notice pump inactive.An observation was made on 06/01/2026 at 10:46 a.m. of Resident #77. Observed Resident #77's feeding tube attached to a feeding pump which read an error of Notice pump inactive.An observation was made on 06/01/2026 at 11:38 a.m. of Resident #77. Observed Resident #77's feeding tube attached to a feeding pump which read an error of Notice pump inactive.An interview was conducted on 06/01/2026 at 11:39 a.m. with S11LPN. She stated the feeding pump was currently not infusing. She stated the resident had tube feedings ordered continuous and stated it's probably been paused since around 5:00 a.m., and I didn't look at it when I came on shift. She confirmed the tube feeding should not have been paused for that period of time.An interview was conducted on 06/03/2026 at 3:00 p.m. S2DON. She confirmed tube feedings should be administered at the ordered rate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards of practice. The facility failed to properly label respiratory care equipment for 1 (#74) of 2 residents investigated for respiratory care.Findings: Review of the facility's undated policy titled, Oxygen Administration revealed the following in part:Oxygen Administration Safety & Guidelines18. Tubing, cannulas, and masks should be dated and replaced weekly unless otherwise ordered. Review of Resident #74's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease without Heart Failure, and Cough. Review of the Resident #74's Quarterly MDS with ARD of 03/24/2026 revealed a BIMS of 15, which indicated he was cognitively intact. Review of Resident #74's Physician's Orders revealed the following in part: Start: 06/02/2025 - Check Oxygen saturation every shift related to Shortness Of Breath; if saturation lower than 90% notify NP/MD and place on 2 Liters oxygen per nasal cannula. On 06/01/2026 at 8:45 a.m., an observation was made of Resident #74 sitting up in bed. While in the resident's room, an observation was made of resident's portable oxygen canister with tubing attached. Oxygen tubing was not labeled with the date. On 06/01/2026 at 9:10 a.m., an observation and interview was conducted with S5LPN. S5LPN observed and confirmed the tubing connected to Resident #74's portable oxygen canister was not labeled with the change date and should have been. On 06/02/2026 at 3:53 p.m., an interview was conducted with S2DON. S2DON confirmed oxygen tubing should be changed weekly and should be labeled with the change date.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure temperatures were documented for the medication refrigerator in 1 of 1 (Med Room A) medication storage rooms observed. Findings: On 06/01/2026 at 9:15 a.m., an observation was made of Med Room A with S3ADON. Review of the form titled Nursing Refrigerator Checklist dated May 2026, for the refrigerator located in Med Room A revealed no documentation of temperatures for 05/23/2026, 05/24/2026, and 05/29/2026 - 05/31/2026. On 06/01/2026 at 9:20 a.m., an interview was conducted with S3ADON. She reviewed the form titled Nursing Refrigerator Checklist dated May 2026 and confirmed there were no temperatures documented for 05/23/2026, 05/24/2026, and 05/29/2026 - 05/31/2026. She stated night shift nurses were responsible for documenting the medication refrigerator temperatures each night. On 06/03/2026 at 11:48 a.m., an interview was conducted with S2DON. She reviewed the form titled Nursing Refrigerator Checklist dated May 2026 for the refrigerator located in Med Room A and confirmed there were no temperatures documented for 05/23/2026, 05/24/2026, and 05/29/2026 - 05/31/2026. S2DON confirmed the temperatures of the medication refrigerator should have been documented daily by the night shift nurses, and were not.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure staff performed hand hygiene, proper glove usage, and utilized proper Personal Protective Equipment (PPE) while providing care for 2 (#57 and #77) of 7 sampled residents who were on Enhanced Barrier Precautions (EBP).Findings: Review of the facility's policy dated 03/2024, titled, Enhanced Barrier Precautions revealed the following, in part:Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.2. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds and/or indwelling medical devices such as urinary catheters, feeding tubes.4. High contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing briefs, device care or use, wound care. Resident #57Review of the Clinical Record revealed Resident #57 was admitted to the facility on [DATE] with diagnoses which included Neuromuscular Dysfunction of Bladder and Other Disorders of Urinary System. Review of Resident #57's current Physician Orders revealed the resident had orders for Suprapubic Catheter care and Enhanced Barrier Precautions. An observation was made on 06/01/2026 at 8:56 a.m. of a sign on Resident #57's door which read Enhanced Barrier Precautions Wear gloves and a gown for the following high contact resident care activities: Dressing, Transferring, Providing hygiene, Changing linens, Changing briefs, device care or use: urinary catheter. An observation was made on 06/01/2026 at 9:15 a.m. of S6CNA and S7CNA performing ADL care for Resident #57. Without performing hand hygiene, S6CNA donned gloves, emptied Resident #57's urinary catheter bag into a container and flushed it down the toilet. S6CNA removed the soiled gloves and without performing hand hygiene donned new gloves. Without performing hand hygiene, S7CNA donned gloves, unfastened Resident #57's brief and assisted the resident to turn on her left side. S6CNA cleaned the resident with perineal wipes and removed the brief. Without changing gloves or performing hand hygiene, S6CNA applied a clean brief, assisted S7CNA to turn the resident, change the resident's clothing, and transferred the resident to the wheelchair. Without changing gloves or performing hand hygiene, S6CNA brushed the resident's hair and removed the resident's bed linens. S6CNA and S7CNA removed their gloves and exited Resident #57's room without performing hand hygiene. S6CNA and S7CNA did not don a gown while performing high contact care to Resident #57. An interview was conducted on 06/01/2026 at 9:24 a.m. with S7CNA. S7CNA stated she was not aware Resident #57 was on EBP. S7CNA confirmed Resident #57 had a catheter and she should have donned a gown prior to providing care. S7CNA confirmed she should have performed hand hygiene before and after resident care. An interview was conducted on 06/01/2026 at 9:25 a.m. with S6CNA. S6CNA stated she was not aware Resident #57 was on EBP. S6CNA stated the EBP sign and PPE on Resident #57's room door was used for her former roommate. S6CNA stated Resident #57 had a catheter and she should have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	donned a gown prior to providing care for Resident #57. S6CNA confirmed she did not change her gloves during care or perform hand hygiene before care, when going from dirty to clean, and after removing her gloves and should have. Resident #77 Review of the Clinical Record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses which included Gastrostomy Status. Review of Resident #77's current Physician Orders revealed the resident had orders for PEG tube care and feeding and Enhanced Barrier Precautions.An observation was made on 06/01/2026 at 11:38 a.m. of a sign on Resident #77's door which read Enhanced Barrier Precautions Wear gloves and a gown for the following high contact resident care activities: device care or use: feeding tube. Observed S11LPN enter Resident #77's room with gloves donned and provide direct care to Resident #77's PEG tube. S11LPN never donned a gown.An interview was conducted on 06/01/2026 at 11:39 a.m. with S11LPN. She confirmed she should have donned a gown prior to providing direct care to Resident #77's PEG tube. An interview was conducted on 06/02/2026 at 2:35 p.m. with S2DON. She verified Resident #77 had a PEG tube and was on Enhanced Barrier Precautions. She verified Resident #57 had a suprapubic catheter and was on Enhanced Barrier Precautions. She stated staff should don a gown and gloves when providing high contact care for Resident #57 and Resident #77, and for any residents on Enhanced Barrier Precautions. She confirmed staff should perform hand hygiene before and after providing care to a resident, and before and after glove use/changes. She confirmed staff should change their gloves and perform hand hygiene after performing perineal care and when going from dirty to clean areas.