STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195536	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Oaks Living Center	4312 Ithaca Street Metairie, LA 70006

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, the facility nursing staff failed to document assistance provided with bathing, oral care, and eating for 1 (Resident #1) of 3 residents reviewed for activities of daily living care provided. Findings:Review of Resident #1's Quarterly Minimum Data Set with an Assessment Reference Date of 12/09/2025 revealed, in part, Resident #1 had a diagnosis of Parkinson's disease (a progressive neurological disorder that affects movement) and required substantial/maximum assistance from staff with bathing, oral hygiene, and eating. Review of Resident #1's care plan revealed, in part, Resident #1 required assistance with Activities of Daily Living and staff were to assist Resident #1 with bathing, hygiene, and eating. Further review revealed Resident #1 had essential tremors (involuntary shaking in the hands) and staff were to monitor and document Resident #1's ability to perform Activities of Daily Living. Review of Resident #1's December 2025 Documentation Survey Report v2 revealed, in part, there was no documented evidence staff provided bathing assistance to Resident #1 on 12/15/2025, 12/22/2025, and 12/29/2025. Further review revealed there was no documented evidence staff provided oral care assistance to Resident #1 for the day shift on 12/06/2025, 12/25/2025, 12/26/2025, 12/28/2025, 12/31/2025; and the evening shift on 12/25/2025, 12/17/2025, 12/22/2025, 12/23/2025, 12/24/2025, and 12/29/2025. Further review revealed there was no documented evidence staff provided eating assistance to Resident #1 for the day or evening shift on 12/06/2025, 12/25/2025, 12/26/2025, 12/28/2025, and 12/31/2025; and the night shift on 12/15/2025, 12/17/2025, 12/22/2025, 12/23/2025, 12/24/2025, and 12/29/2025. Review of Resident #1's January 2026 Documentation Survey Report v2 revealed, in part, there was no documented evidence staff provided bathing assistance to Resident #1 on 01/12/2026. Further review revealed there was no documented evidence staff provided oral care assistance to Resident #1 for the day shift on 01/01/2026, 01/06/2026, 01/10/2026; and the evening shift on 01/08/2026, 01/10/2026, and 01/12/2026. Further review revealed there was no documented evidence staff provided eating assistance to Resident #1 for the day or evening shift on 01/01/2026, 01/06/2026, 01/10/2026; and the night shift on 01/08/2026, 01/10/2026, and 01/12/2026. In an interview on 02/25/2026 at 3:16PM, S1Assistant Director of Nursing verified the above mentioned Activity of Daily Living documentation for Resident #1 was not documented by staff as having been performed and should have.

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