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	04/11/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 22609 Based on observation and interview the facility failed to ensure a resident's bathroom door would close. This was identified for 1 (Resident #144) of 2 Resident (#141 and Resident #144) sampled residents for environment. Findings: In an interview on 04/07/2024 at 10:53 a.m., Resident #144 indicated his bathroom door could not close all the way. Observation on 04/08/2024 at 8:49 a.m. revealed Resident #144's bathroom door was unable to be closed all the way. Observation on 04/08/2024 at 2:05 p.m. revealed Resident #144 bathroom door was unable to be closed all the way. Observation on 04/09/2024 at 10:14 a.m. revealed S4Certified Nursing Assistant (CNA) tried to close Resident #144's bathroom door and was unable to close it all the way. In an interview on 04/09/2024 at 10:15 a.m., S4CNA indicated she could not close Resident #144's bathroom door all the way. In an interview on 04/09/2024 at 10:40 a.m., S5Housekeeping Supervisor indicated the bathroom door cannot close all the way and it should. In an interview on 04/09/2024 at 11:20 a.m., S2Director of Nursing indicated Resident #144's bathroom door did not close and it should.

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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 47327 Based on record reviews and interview, the facility failed to complete and electronically submit resident assessments to CMS (Center for Medicare Service) in a timely manner for 8 (Resident #12, Resident #21, Resident #41, Resident #42, Resident #44, Resident #54, Resident #66, and Resident #70) of 8 (Resident #12, Resident #21, Resident #41, Resident #42, Resident #54, Resident #66, and Resident #70) residents reviewed for resident assessments. Findings: Review of the facility's IQIES (Internet Quality Improvement and Evaluation System) MDS (Minimum Data Set) 3.0 Final Validation Report dated 04/08/2024 revealed, in part, the facility completed and/or submitted the following resident assessments late: Resident #12 Resident #12's Death in Facility Assessment with an ARD (Assessment Reference Date) of 11/06/2023 was completed more than 14 days after the ARD; Resident #21 Resident #21's Quarterly Assessment with an ARD of 02/21/2024 was completed more than 14 days after the ARD and submitted more than 14 days after it was completed; Resident #41 Resident #41's Discharge Assessment with an ARD of 11/20/2023 was submitted more than 14 days after it was completed; Resident #42 Resident #42's Death in Facility Assessment with an ARD of 11/06/2023 was submitted more than 14 days after it was completed; Resident #44 Resident #44's Discharge Assessment with an ARD of 11/21/2023 was completed more than 14 days after the ARD; Resident #54 Resident #54's Quarterly Assessment with an ARD of 02/21/2024 was completed more than 14 days after the ARD and submitted more than 14 days after it was completed; Resident #66 (continued on next page)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #66's Discharge Assessment with an ARD of 12/20/2023 was completed more than 14 days after the ARD and submitted more than 14 days after it was completed; and, Resident #70 Resident #70's Quarterly Assessment with an ARD of 02/07/2024 was completed more than 14 days after the ARD. In an interview on 04/09/2024 at 8:50 a.m., S3MDS Coordinator indicated the above mentioned assessments were not completed and/or transmitted timely and should have been. In an interview on 04/11/2024 at 10:20 a.m., S2Director of Nursing (DON) indicated she was aware the above mentioned assessments were late.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48855 Based on observations, interviews, and record review the facility failed to ensure an enteral feeding bag (which contains an enteral formula for purpose of supplying nutrients directly into the stomach) was properly labeled to include the date and time of initiation and the rate of infusion. This practice was identified for 1(Resident#1) of 1 (Resident #1) sampled for enteral feeding. Findings: Review of Texas Health and Human Services Evidence-Based Best Practice for Nutritional Support revealed, in part, enteral feeding should include a label with resident's name, date and time of initiation, and the infusion rate. Observation on 04/07/2024 at 10:43 a.m. revealed Resident #31's enteral feeding bag was not labeled with date or time of initiation or the infusion rate of the feeding. Observation on 04/08/2024 at 10:15 a.m. revealed Resident #31's enteral feeding bag was not labeled with the time of initiation or the infusion rate of the feeding. Observation on 04/09/2024 at 9:22 a.m. revealed Resident #31's enteral feeding bag was not labeled with the infusion rate of the feeding. Observation on 04/11/2024 at 9:58 a.m. revealed Resident #31's enteral feeding bag was not labeled with the time of initiation. In an interview on 04/11/2024 at 2:03 p.m., S2Director of Nursing indicated it is professional standard of practice for enteral feeding bag to be labeled to include the date and time of initiation and infusion rate. In an interview on 04/11/2024 at 2:04 p.m., S1Administrator indicated it is professional standards of practice for enteral feeding bag to be labeled to include the date and time of initiation and infusion rate.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48855 Based on observations and interviews, the facility failed to ensure an indwelling urinary catheter (a tubing that goes into the bladder to drain urine) drainage bag and catheter tubing did not touch the floor to prevent infections for 3 (Resident #7, Resident #71, Resident #341) of 3 (Resident #7, Resident #71, Resident #341) sampled residents reviewed for catheter use. Findings: Review of Healthcare Infection Control Practices Advisory Committee, Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009, revised on June 09, 2019 revealed, in part, not to rest the urinary catheter bag on the floor. Resident #7 Observation on 04/07/24 at 10:21 a.m. revealed Resident #7's indwelling urinary catheter drainage bag was hanging from the bedrail and lying on the floor. Observation on 04/08/2024 at 10:04 a.m. revealed Resident #7's indwelling urinary catheter drainage bag was hanging from bedrail and lying on the floor. Observation on 04/08/2024 at 11:55 a.m. revealed Resident #7 indwelling urinary catheter draining bag was hanging from bed rail and lying on the floor. Observation on 04/08/2024 at 2:25 p.m. revealed Resident #7's indwelling urinary catheter drainage bag was hanging from the bedrail and lying on the floor. Observation on 04/09/2024 at 9:34 a.m. revealed Resident #7's indwelling urinary catheter drainage bag was hanging from bedrail and lying on the floor. Resident #71 Observation on 04/08/2024 at 12:24 p.m. revealed Resident #71's indwelling urinary catheter drainage bag was hanging from the bottom of the wheelchair and the catheter tubing was handing down and touching the floor. Resident #341 Observation on 04/07/2024 at 1:43 p.m. revealed Resident #341's indwelling urinary catheter drainage bag and catheter tubing was lying flat on the floor next to the bed. Observation on 04/08/2024 at 9:54 a.m. revealed Resident #341's indwelling urinary catheter drainage bag was hanging from the bottom of the wheelchair. Further observation revealed the bottom of catheter drainage bag was touching the floor and the catheter tubing was handing down and touching the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/09/2024 at 9:14 a.m. revealed Resident #341's indwelling urinary catheter drainage bag and tubing was lying flat on the floor next to the bed. In an interview on 04/09/2024 at 12:25 p.m., S2Director of Nursing indicated a resident's indwelling urinary catheter drainage bag and catheter tubing should not be laying on the floor due to increased risk for infection. In an interview on 04/11/2024 at 2:03 p.m., S1Administrator indicated professional standards of practice was to keep indwelling urinary catheter drainage bags and catheter tubing off the floor. 49259

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49259 Based on observations and interviews the facility failed to ensure staff assisted a resident with transfer assistance timely for 1 resident (Resident #341) of 37 residents (Residents #2 ,#3, #6, #7, #8, #9, #12, #15, #19, #20, #21, #29, #31, #34, #38, #41, #42, #44, #50, #52, #54, #56, #64, #65, #66, #70, #71, #72, #78, #82, #87, #88, #89, #90, #141, #144, and #341) included in the sample. Findings: Observation on 04/09/2024 at 9:14 a.m. revealed Resident #341 pushed call light button for assistance. In an interview on 04/09/2024 at 9:15 a.m., Resident #341 indicated she pushed call light for needing staff to assistance her with being transferred from her bed to her wheelchair. Observation on 04/09/2024 at 9:19 a.m. revealed S7Certified Nursing Assistant (CNA) entered Resident #341's room and turned off Resident #341's call light. . Further observation revealed Resident #341 requested assistance from S7CNA to assist her with being transferred from her bed to her wheelchair. S7CNA replied back to Resident #341 that her CNA would come to help her and exited Resident #341's room. In an interview on 04/09/2024 at 10:19 a.m. Resident #341 indicated that she had not received assistance to transfer from her bed to her wheelchair since she pressed the call light at 9:14 a.m. Observation on 04/09/2024 at 10:22 a.m. revealed Resident #341 was being assisted to wheelchair by S9Physical Therapist. In an interview on 04/11/2024 at 1:35 p.m., S8CNA Supervisor indicated a resident waiting over an hour for assistance was too long. In an interview on 04/11/2024 at 11:50 a.m., S2Director of Nursing (DON) indicated a resident waiting over an hour for a call light request to be answered was too long. S2DON further indicated call lights should not be turned off until the resident's request had been addressed.In an interview on 04/11/2024 at 1150 am [NAME] D DON indicated a resident waiting 1 hour for a call light request to be answered is to long. DON further stated, call lights should not be cleared until the Resident request has been addressed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48855 Based on observations and interviews the facility failed to ensure expired food items were not available for resident consumption. Findings: Observations on [DATE] at 9:22 a.m. in the dry storage area of the facility's kitchen revealed: 1. One half box of dried cranberries had an expiration date of [DATE]. 2. Six packets of Chefs Finest Ranch Salad Dressing had an expiration date of [DATE]; and, 3. One 128 ounce container of Cajun Worchester Sauce with 4 ounces remaining in the container had an expiration date of [DATE]. In an interview on [DATE] at 9:30 a.m., S6Dietary Manager indicated the above mentioned expired food items should not have been made available for resident consumption. In an interview on [DATE] at 9:10 a.m., S1Administrator indicated the above mentioned expired food items should not have been made available for resident consumption.

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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. 48855 Based on record reviews, observation, and interviews the facility failed to perform proper hand hygiene after removing gloves during incontinence care for 1 (Resident #7) of 1 (Resident #7) sampled resident reviewed for incontinence care. Findings: Review of Perineal Care Policy and Procedure with an effective date of 11/17/2015 revealed, in part, proper hand hygiene was to be performed after glove removal. Observation on 04/09/2024 at 10:30 a.m., revealed incontinence care for Resident #7 by S10Certified Nursing Assistant (CNA). Further observation revealed S10CNA acquired cleansing wipes with gloves on and wiped the genitalia of Resident #7. Observation further revealed S10CNA disposed the cleansing wipes then removed her gloves and did not perform hand hygiene. Further observation revealed S10CNA had three gloves on each hand and after she removed the first pair of gloves, S10CNA did not perform hand hygiene. S10CNA then acquired additional cleansing wipes and wiped Resident #7's catheter tubing. Further observation revealed S10CNA removed second pair of gloves and did not perform hand hygiene. Observation further S10CNA then acquired additional cleansing wipes with the third pair of gloves on and wiped Resident #7's buttocks and then put an adult brief on Resident #7 without performing hand hygiene after glove removal. In an interview on 04/09/2024 at 10:50 a.m., S10CNA indicated she did not perform hand hygiene after each glove change. S10CNA further indicated she wore three gloves on each hand at one time because some residents are soiled, and she did want to acquire new pair of gloves every time gloves are soiled. In an interview on 04/09/2024 at 11:00 a.m., S2Director of Nursing (DON) indicated three gloves worn at one time was not proper infection control protocol, and S2DON further indicated proper hand hygiene practice was to perform hand hygiene after every glove removal.