

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER The Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 McKeen Place Monroe, LA 71201	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 2 (#3 and #37) of 2 (#3 and #37) residents reviewed for Activities of Daily Living (ADL) care. The facility [NAME] to 1) ensure resident hand mitts were changed when dirty and 2) ensure that resident finger and toenails were kept clean and trimmed.</p> <p>Findings:</p> <p>Resident #3</p> <p>Review of the Nail Management Policy and Procedure revealed the nail management was the regular care of the toenails and fingernails to promote cleanliness and skin integrity of tissues to prevent infection and injury from scratching by fingernails or pressure of shoes on toenails. Further review of the policy revealed that debris was to be removed from under the nails with an orange stick while soaking and to trim the nails with a clipper, straight across for the toenails, rounded for the fingernails.</p> <p>Review of resident's record revealed he was admitted to the facility on [DATE] with diagnoses including a personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, severe vascular dementia, primary open-angle glaucoma, cerebral palsy and a Stage 4 pressure ulcer of the right hip.</p> <p>On 06/11/24 at 11:14 a.m., an observation revealed resident #3 was lying in his bed. Further observation revealed resident #3's right hand had a mitt covering the hand. The outside the mitt (palm area) had a large area of an old, dried reddish-brown colored stain that covered approximately two thirds of the palm of the mitt.</p> <p>On 06/11/2024 at approximately 11:40 a.m., S3Licensed Practical Nurse (LPN) was notified of the findings regarding the stain on resident #3's hand mitt. After observing the mitt with S3LPN, she confirmed that the hand mitt was unclean and needed to be changed. She then reapplied the dirty hand mitt.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 195542	Facility ID: 195542 If continuation sheet Page 1 of 6

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/11/2024 at 4:35 p.m., S2Director of Nursing (DON) was notified of the observation of resident #3's right hand mitt being stained. During an observation with S2DON, she removed the dirty hand mitt from resident #3's hand and a visual inspection of resident's right hand revealed the skin on the inside palm of the hand was crusty and dirty. Further observation revealed the resident's fingernails were jagged, long, and untrimmed. S2DON confirmed that resident #3's mitt needed to be changed, the resident's fingernails needed to be trimmed and cleaned, and resident #3's hand needed to be cleaned.</p> <p>On 06/12/2024 at approximately 4:00 p.m., S1Director of Operations was notified of the findings regarding resident #3.</p> <p>Resident #37</p> <p>Review of resident #37's record revealed he was admitted to the facility on [DATE] with diagnosed including Parkinson's disease, vascular dementia, and shortness of breath.</p> <p>On 06/10/24 at 9:00 a.m., an observation revealed resident #37 lying in his bed. Further observation revealed the resident's toe nails to both feet were jagged and long.</p> <p>06/11/2024 at approximately 4:20 p.m., S2DON was notified of the findings. After an observation with S2DON, she confirmed that resident #37's toe nails needed to be trimmed.</p> <p>On 06/12/2024 at approximately 4:05 p.m., S1Director of Operations was notified of the findings regarding resident #37.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (#3) of 3 (#3, #30, and #60) residents investigated for pressure ulcers. The facility failed to prevent pressure ulcers from developing as evidenced by resident #3 having six unidentified pressure ulcers.</p> <p>Findings:</p> <p>Record review revealed resident#3 was admitted to the facility on [DATE] with diagnoses including a personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, severe vascular dementia, primary open-angle glaucoma, cerebral palsy and a Stage 4 pressure ulcer of the right hip.</p> <p>During wound care on 06/12/2024 at 8:45 a.m. with S5Wound Care Nurse (WCN) and S6WCN, a visual inspection of resident #3's right feet revealed one deep tissue injury to the posterior area of the great toe, the lateral part of the great toe, and heel. Observation of the left foot revealed there was one deep tissue injury to the lateral part of the 5th toe, posterior part of the lateral 5th toe, and left ankle. There was pillow underneath the resident's legs, however, the tips of his feet toughing and in direct contact with the bed mattress. S5WCN and S6WCN confirmed they were unaware of resident #3's six deep tissues to his feet. Further inspection of the resident's feet revealed there was an area between resident #3's toes on the left foot that had a thick, flaky, and crusty buildup of peeling skin. S5WCN and S6WCN both confirmed that confirmed that resident #3's toes needed to be cleaned.</p> <p>On 06/12/2024 at 9:58 a.m., an interview with resident #3's floor nurse, confirmed she too, was not aware of resident #3's six newly identified pressure ulcers to the feet as no one had reported them to her.</p> <p>On 06/12/2024 at 10:15 a.m., during an interview with S1Director of Operations, he was notified of the findings regarding resident #3's six newly identified pressure ulcers.</p> <p>During an interview on 06/12/2024 at approximately 3:45 p.m., S2Director of Nursing was notified of the findings regarding resident #3's six newly identified pressure ulcers.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>Based on record review, observations, and interviews, the facility failed to provide adequate supervision to prevent accidents and ensure the resident's environment remained free of hazards for 1 (#62) of 3 (#31, #37, #62) residents reviewed for safe smoking.</p> <p>Findings:</p> <p>Review of the facility's Smoking Policy with a revision date of 2023 revealed in, part:</p> <p>This facility shall establish and maintain safe resident smoking practices, to incorporate smoking safely and take into account non-smoking residents.</p> <p>Policy Interpretation and Implementation:</p> <p>All residents shall wear a smoking apron while smoking in the designated smoking area.</p> <p>Any smoking related privileges, restrictions, and concerns (for example, the need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.</p> <p>The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.</p> <p>Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.</p> <p>Smoking articles for residents without independent smoking privileges:</p> <p>Resident's without independent smoking privileges may not have or keep any types of smoking articles except when they are under direct supervision.</p> <p>Smoking shall not be permitted in bed. Violation will result in immediate discharge from the facility.</p> <p>Violation of all or any portion of the smoking policy will result in immediate discharges from the facility.</p> <p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses of type 2 diabetes mellitus, cellulitis of right lower limb, alcohol dependence, noncompliance with medical treatment, repeated falls, hypertension, and nicotine dependence.</p> <p>Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 11, which indicated moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #62's current care plan revealed, a potential for injury related to smoking cigarettes as an unsafe smoker.</p> <p>Inventions: Resident will have a designated smoking area; Resident was assessed to be an unsafe smoker on 04/23/2024.</p> <p>Further review of the care plan revealed 05/06/2024 resident found smoking in his room;</p> <p>06/01/2024 resident caught smoking in his room; 06/06/2024 had care plan meeting with the resident's sister and ombudsman regarding the resident smoking in his room.</p> <p>Review of the Smoking Evaluation Tool dated 06/01/2024 revealed the interdisciplinary team determined resident #62 was an unsafe smoker due to intermittent confusion and smoking in his room.</p> <p>Review of the nurse note dated 04/09/2024 at 10:44 p.m. revealed resident #62 used the call light for assistance and when this nurse walked in the room it had a strong cigarette odor. The nurse asked the resident if he had been smoking in his room and the resident #62 stated that it was just a little butt. The nurse then instructed the resident he cannot smoke in his room.</p> <p>Further review of the nurses notes dated 06/01/2024 at 9:13 a.m. revealed the CNA (Certified Nurse Aide) notified the nurse that resident #62 was sitting in his room smoking a cigarette. This nurse notified the resident this was unacceptable and took the cigarette.</p> <p>Review of the nurse note dated 06/10/2024 at 9:36 p.m. revealed resident #62 is being monitored in the smoking area tonight. Resident #62 was seen putting ashes in the trash can instead of the designated smoking container. The nurse informed the resident to only put ashes in the cigarette container due to the risk and danger with putting them in the trash can. Resident #62 stated he put water in the trash can so it was ok. The nurse moved the trash can and placed designated smoking container close to resident.</p> <p>Observation on 06/10/24 at 09:23 a.m. revealed resident #62 was sitting in a wheel chair in the designated smoking area. Resident #24 was seen lighting a cigarette for resident #62. Further observation revealed resident #62 smoked the cigarette and was placing the cigarette ashes and butt in a garbage can that contained a plastic liner and trash. Resident #62 was not wearing a smoking apron and no staff were present to monitor residents.</p> <p>Interview on 06/11/2024 at 1:40 p.m. with S4LPN (Licensed Practical Nurse) confirmed that resident #62 was observed smoking last night (06/10/2024) and placing ashes in a garbage can. S4LPN stated that she has observed resident #62 on multiple occasions smoking in his room. S4LPN confirmed resident #62 was an unsafe smoker.</p> <p>Interview on 06/12/2024 at 8:15 a.m. with S1Director of Operations confirmed that resident #62 had been identified as an unsafe smoker and that staff had observed the resident smoking in his room on multiple occasions. S1Director of Operations also confirmed that the facility did not follow their policy and procedure in regards to the facility's smoking policy.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>17835</p> <p>Based on observation of the medication pass, review of current physician orders, and interviews, the facility failed to ensure that it is free from medication error rate of five percent or greater by committing 2 errors out 32 opportunities for an error rate of 6.25%.</p> <p>Findings:</p> <p>Observation of the medication pass on 06/11/2024 at 7:24 a.m. for resident #267 revealed the following medication errors.</p> <p>Citracal-D3 200mg (milligrams) - 250 Unit, (Calcium Citrate supplement) 1 tablet daily. This medication was not administered.</p> <p>Review of the June 2024 physician orders for resident #267 revealed an order for Citracal-D3, 200mg-250Unit, 1 tablet daily at 8:00 a.m.</p> <p>Interview on 06/12/2024 at 10:40 a.m. with S3Licensed Practical Nurse (LPN) confirmed that she did not administer the medication Citracal-D3 to resident #267. S3LPN stated that this medication was not available.</p> <p>Observation of the medication pass for resident #267 on 06/11/2024 at 7:24 a.m. revealed S3LPN administered the angiotensin-converting enzyme inhibitor, Lisinopril, 20mg, 1 tablet.</p> <p>Review of the June 2024 physician orders for resident #267 revealed an order for Lisinopril 10mg, one tablet daily.</p> <p>Interview on 06/12/2024 at 12:55 p.m. with S3LPN confirmed that she administered Lisinopril 20mg tablet instead of Lisinopril 10mg. Further interview with S3LPN confirmed that the correct order was for Lisinopril 10mg daily.</p> <p>Interview on 06/12/2024 at 1:50 p.m. with S2Director of Nursing (DON) confirmed that medications are to be administered as ordered. S2 DON was informed of medication errors at this time. S2DON confirmed that she was notified by S3LPN that she did not administer medication Citracal to resident #267 and that resident #267 should have been administer Lisinopril 10mg instead of 20mg.</p>		