STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195578	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangeline Oaks Guest House	240 Arceneaux Road Carencro, LA 70520

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251 Based on record review and interviews, the facility failed to ensure that a resident's physician and responsible party were immediately notified when the resident was injured for 1 (Resident #5) of 5 (#1, #2, #3, #4, #5) residents reviewed. Findings: On 02/12/2025, a review of the facility's policy with a review date of 01/01/2024 titled, Accidents and Incidents - Investigating and Reporting read in part, Policy Interpretation and Implementation, 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included in the Report of Incident/Accident form: g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom. Review of Resident #5's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, anxiety disorder, fibromyalgia and osteoarthritis, unspecified. Review of Resident #5's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/11/2024 revealed she had a BIMS (Brief Interview for Mental Status) of 14, indicating she was cognitively intact. Review of the facility's Incident Report dated 01/04/2025 revealed Resident #5 had an incident and was hit in the head with her room door by staff on 01/04/2025 at 11:25 AM. Further review of the facility's incident report revealed the physician and responsible party was notified on 01/06/2025. Review of Resident #5's medical record did not reveal the physician and responsible party were notified of the incident that occurred on 01/04/2025 until 01/06/2025. On 02/11/2025 at 3:45 PM, an interview was conducted with Resident #5. She stated that she did recall the incident when she was hit in the head with the door by a nurse. Resident #5 stated that she was at her door bent over when the nurse walked in and the door hit her on the head which caused her to also hit her head on the wall. (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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Evangeline Oaks Guest House		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Arceneaux Road Carencro, LA 70520	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/2025 at 10:55 AM, an interview was conducted with S3LPN (Licensed Practical Nurse). She stated that on 01/06/2025 Resident #5 was complaining of a headache and wanted to be sent to the emergency room for evaluation because she had been hit in the head with the door when a nurse had entered her room on yesterday. She stated that she called Resident #5's nurse practitioner and responsible party and neither were aware of the incident. On 02/12/2025 at 1:46 PM, a phone interview was conducted with S4ALPN (Agency Licensed Practical Nurse). She stated that she did not notify the physician or responsible of Resident #5's incident because she was unware that Resident #5's head was hit. On 02/12/2025 at 3:15 PM, an interview was conducted with S1DON (Director of Nursing). She stated that according to the incident report dated 01/04/2025, Resident #5 was hit in the head with the door by staff. S1DON stated that the responsible party and physician were not notified until 01/06/2025 and should have been notified on 01/04/2025 when the incident occurred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195578	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangeline Oaks Guest House	240 Arceneaux Road Carencro, LA 70520

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777 Based on record review and interviews, the facility failed to write a telephone order and obtain a wound culture in a timely manner as ordered by a physician for 1 (#2) out of 5 (#1, #2, #3, #4, #5) sampled residents. Findings: Review of Resident #2 record revealed she was admitted to the facility on [DATE] with diagnosis not limited to, stage 4 pressure ulcer of sacral region, stage 4 pressure ulcer of left elbow, pain, pressure ulcer of her left elbow, sepsis, cachexia, hemiplegia and hemiparesis of left side, and server protein calorie malnutrition. Record review of Resident #2's nurse notes written and dated by S2Treatment Nurse, 10/02/2024 read in part, Upon performing wound care, this nurse noted malodorous odor with moderate amount of serosanguinous drainage from left hip stage III (3) pressure ulcer. Moderate amount of bright green exudate from right upper back stage IV (4) pressure ulcer .This nurse called .wound care clinic .new order per doctor to collect wound culture to left hip and collect wound culture to right upper back . 10/04/2024 Wound culture specimen was picked up per hospital technician. Record review of wound culture from the hospital read in part, Wound Culture, collected 10/04/2024 at 1:20 PM, received at 6:18 PM on 10/04/2024. On 02/12/2025 at 10:15 AM, an interview with S2Treatment Nurse confirmed she was Resident #2's treatment nurse on 10/02/2024. She stated on 10/02/2024 while she was treating Resident #2's wounds, there was a very strong odor from her multiple wounds. S2Treatment Nurse stated she called the Wound Care Clinic and received orders from the physician to culture the wounds and send them to the lab on that day (10/02/2024). On 02/12/2025 at 2:05 PM, Record review of Resident #2's Nurses Notes and Lab results with S1DON (Director Of Nursing) confirmed the nurses notes on 10/02/2024 revealed S2Treatment Nurse received an order from the wound care physician to collect wound cultures and send them to the lab on 10/02/2024. She reviewed Resident #2's labs and confirmed the Resident wound cultures were collected and received at the lab on 10/04/2024 (two days later). S1DON reviewed Resident #2's paper chart and electronic records and could not find the Telephone Order S2Treatment Nurse was to have written for the wound cultures on 10/02/2024. At this time S1DON stated S2Treatment Nurse did not write a telephone order and they did not send the wound cultures to the lab in a timely manner as ordered by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangeline Oaks Guest House	240 Arceneaux Road Carencro, LA 70520

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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251 Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices by failing to ensure there was documentation of an incident that occurred for 1 (Resident #5) of 2 (Resident #3 and #5) residents reviewed for incidents. Findings: On 02/12/2025, a review of the facility's policy with a revised date of 04/2012 titled Guidelines for Charting and Documentation read in part. Purpose, 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care. General Rules for Charting and Documentation, 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations. Nursing Summaries and/or Assessments, 16. Unusual Occurrence/Significant Events. Resident #5 Review of Resident #5's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, anxiety disorder, fibromyalgia and osteoarthritis, unspecified. Review of Resident #5's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/11/2024 revealed she had a BIMS (Brief Interview for Mental Status) of 14, indicating she was cognitively intact. Review of the facility's Incident Report dated 01/04/2025 revealed Resident #5 had an incident and was hit in the head with her room door by staff. Review of Resident #5's nurse's notes dated 01/04/2025 did not reveal any incident had occurred. On 02/11/2025 at 3:45 PM, an interview was conducted with Resident #5. She stated that she did recall the incident when she was hit in the head with the door by a nurse. Resident #5 stated that she was at her door bent over when the nurse walked in and the door hit her on the head which caused her to also hit her head on the wall. On 02/12/2025 at 1:46 PM, a phone interview was conducted with S4ALPN (Agency Licensed Practical Nurse). She stated that she did recall the incident, but was not able to recall the date. S4ALPN stated that she opened Resident #5's door and Resident #5 was at the door with her food tray and the door hit the food tray. She stated that she was not aware that Resident #5's head was hit. On 02/12/2024 at 3:15 PM, an interview and record review was conducted with S1DON (Director of Nursing). She stated recalled the incident involving Resident #5. A review of Resident #5's nurse's notes dated 01/04/2025 did not reveal any documentation that the resident was hit on the head with the door. S1DON stated the nurse should have documented the incident in the nurse's notes.