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	07/29/2025

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 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. Based on record review and interview, the provider failed to implement the plan of care by not following physician orders to obtain laboratory testing as ordered for 1 (#2) out of 3 (#1, #2, #3) sampled residents. Review of Resident #2's medical record revealed his most recent readmission to the facility was on 02/04/2025 with diagnoses which included: essential hypertension, type 2 diabetes mellitus, benign prostatic hyperplasia, and hyperlipidemia. Review of Resident #2's order summary report revealed laboratory orders dated 02/25/2025 for the following: Lipid panel q (every) 6 months (June/December); and PSA (Prostate Specific Antigen) and urine for microalbumin yearly (June). Further review of Resident #2's medical record failed to reveal evidence a Lipid panel, PSA and urine for microalbumin were obtained during the month of June.On 07/29/2025 at 10:30 a.m., an interview and record review of physician orders and laboratory testing results was conducted with S1DON (Director of Nursing). She confirmed Resident #2 had orders to obtain a Lipid panel every 6 months (June/December), and a PSA and urine for microalbumin yearly (June). She reviewed the file for laboratory results and confirmed those tests were not obtained as ordered.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents that were unable to carry out activities of daily living received personal hygiene (incontinent care) per their care plan for 1 (#1) out of 3 (#1-#3) sampled residents. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, hypertension, and copd (chronic obstructive pulmonary disease). Review of the resident's annual MDS (Minimum Data Set) dated 06/11/2025 revealed the resident's BIMS (Brief Interview Mental Status) score was 13 for being cognitively intact. Further review of the annual MDS revealed the resident had limited ROM (Range of Motion) on one side; used a wheelchair for mobility device; was dependent for toileting and personal hygiene. The resident was dependent for mobility. The resident was assessed to be incontinent for bowel and bladder. Review of the resident's care plan revealed that it addressed alteration in elimination related to bowel and bladder incontinence and to check every 2 hours for dryness and assist with personal care. On 07/28/2025 at 9:30 a.m., the resident was observed sitting up in wheelchair in the dayroom for an activity. On 07/28/2025 at 10:45 a.m., the resident was observed participating in activities in the dayroom. On 07/28/2025 at 11:00 a.m., the resident was observed sitting up in her wheelchair in the dayroom after activities. S4CNA (Certified Nursing Assistant) was then observed bringing the resident to the dining room for lunch. There was no observation of staff bringing the resident back to her room for incontinent care prior to lunch. On 07/28/2025 at 12:15 p.m., S5CNA and S6CNA were observed transferring the resident from her wheelchair to the bed with the use of the lifter with 2 person assist. The resident's pants were observed to be soaking wet when resident was lowered down in bed. S5CNA and S6CNA both confirmed the resident's pants was soaking wet. S6CNA stated the resident should have been toileted every 2 hours to ensure the resident was not wet. S6CNA stated she cleaned and changed the resident around 6:30 a.m. or 7:00 a.m. and that she did not change the resident again until now after lunch, which was approximately over 5 hours ago. On 07/28/2025 at 4:15 p.m., an interview was conducted with S1DON (Director of Nurses). S1DON stated the residents should be checked or rounded on every 2 hours and as needed for incontinent episodes. S1DON stated that checking for incontinent episodes requires the CNAs to bring the resident back to their room in order to check for incontinent episodes. On 07/29/2025 at 8:15 a.m., an interview was conducted with S3CNAS (Certified Nursing Assistant Supervisor). S3CNAS stated the CNAs should be toileting Resident #1 every 2 hours and that means the resident should be brought to her room and put in bed with the use of the lifter and incontinent care be provided. S3CNAS confirmed S5CNA and S6CNA informed her that the resident was not brought to her room for incontinent care that morning and was brought after lunch and at that time the resident was soaking wet.

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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 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 observation, record review, and interview, the facility failed to ensure the resident was receiving continuous oxygen as ordered for 1 (#1) out of 3 (#1-#3) sampled residents.Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, hypertension, and copd (chronic obstructive pulmonary disease).Review of the resident's annual MDS (Minimum Data Set) dated 06/11/2025 revealed the resident's BIMS (Brief Interview Mental Status) score was 13 for being cognitively intact. Review of the resident's care plan revealed that it addressed the resident was at risk for edema and sob (shortness of breath) related to copd. Interventions included administer respiratory therapy treatments, assess for signs and symptoms of respiratory distress, and oxygen as ordered.Review of the resident's current physician's orders revealed an order for oxygen at 2L/NC (two liters nasal cannula) continuously to keep sats (oxygen saturation) greater than 92% for hypoxia. The order was started on 07/22/2025.Review of the resident's nurse's note dated 07/28/2025 at 11:00 a.m. revealed, Resident observed in dining room with no oxygen on per n/c as ordered.On 07/28/2025 at 9:30 a.m., the resident was observed sitting up in wheelchair in the dayroom for an activity. An oxygen tank was observed inside the oxygen tank holder that was attached to the back of the resident's wheelchair. The oxygen was not in use during this observation. On 07/28/2025 at 10:45 a.m., the resident was observed participating in activities in the dayroom. The resident was not using oxygen during this observation.On 07/28/2025 at 11:00 a.m., the resident was observed being brought to the dining room for lunch by S4CNA (Certified Nursing Assistant). The oxygen tank was observed inside the tank holder that was attached on the back of the resident's wheelchair. S4CNA was asked if the resident used oxygen. S4CNA responded that she did not know if the resident used oxygen. The resident was not using oxygen during this observation.On 07/28/2025 at 11:05 a.m., an observation and interview were conducted with S2LPN (Licensed Practical Nurse). S2LPN confirmed the oxygen tank was inside the tank holder on the back of the resident's wheelchair. S2LPN checked the oxygen tank and verified it was empty. On 07/28/2025 at 11:10 a.m., S2LPN reviewed the resident's physician's orders and confirmed the resident had orders for continuous oxygen at 2 liters per nasal cannula. S2LPN confirmed the resident was not receiving continuous oxygen as ordered.On 07/28/2025 at 4:15 p.m., an interview was conducted with S1DON (Director of Nursing) and she confirmed the resident should have had continuous oxygen in use per the physician's orders.