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	02/24/2026

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, observations, and interviews the facility failed to ensure the resident's care plan and physician's orders were followed for 1 (#1) of 3 sampled residents as evidenced by failing to ensure Resident #1 wore heel lift boots while in bed. Findings: Review of Resident #1's EHR (Electronic Health Record) revealed an admission date of 12/22/2005 and had diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and type 2 diabetes. Review of Resident #1's care plan revealed the following goals and interventions in part: Potential for skin breakdown r/t (related to) decreased mobility and incontinence, dx (diagnosis) hemiplegia - Interventions: heel lift boots while in bed. Review of Resident #1's physician's orders revealed the following order dated 03/24/2025 that read: Heel lift boots while in bed every day shift. On 02/23/2026 at 2:50 p.m., an observation was made of Resident #1 in bed. The resident was not wearing heel lift boots at this time. On 02/24/2026 at 9:11 a.m., a second observation was made of Resident #1 in bed. The resident was not wearing heel lift boots at this time. On 02/24/2026 at 10:55 a.m., a third observation was made of Resident #1 in bed. The resident was not wearing heel lift boots at this time. S6CNA entered the resident's room. S6CNA was asked if the resident was supposed to have on heel lift boots while in bed. She stated that she really did not know if he was supposed to have them on and did not know where they were in the room. On 02/24/2026 at 11:00 a.m., an interview was conducted with S7LPN who stated she was the resident's nurse for this shift. S7LPN was asked if Resident #1 was supposed to be wearing heel lift boots while in bed, and she stated she was not very familiar with his care because she was not normally assigned to the resident. Resident #1's orders were reviewed with S7LPN. She confirmed that the resident had an order for heel lift boots while in bed and further confirmed that he should have had them on, but they were not.

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

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 02/24/2026
NAME OF PROVIDER OR SUPPLIER Evangeline Oaks Guest House		STREET ADDRESS, CITY, STATE, ZIP CODE 240 Arceneaux Road Carencro, LA 70520	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, interview and record review, the facility failed to ensure licensed agency nurses had specific competencies and skills sets necessary to appropriately administer wound care to 1 resident (#2) out of 2 resident's reviewed for wound care in a sample of 3 residents. Findings:Review of Resident #2's EHR (Electronic Health Record) revealed an admission date of 06/14/2017 and diagnoses including, but not limited to: Pressure ulcer of sacral region stage 4, type 2 diabetes, and UTI (Urinary Tract Infection).Review of Resident #2's physician's orders revealed the following order dated 01/20/2026, that read: Sacrum - cleanse with wound cleanser, apply gentian violet to wound then apply collagen and silver alginate to wound bed, cover with dry dressing and prn (as needed). On 02/24/2026 at 8:41 a.m., an observation was made of S4TNAgency perform Resident #2's wound care. S5CNA was also present during the wound care observation. There was a sign posted on the outside of the resident's door that read: Enhanced Barrier Precautions. Providers and staff must also: Wear gloves and a gown for the following High- Contact Resident Care Activities .Wound care. S4TNAgency and S5CNA did not wear gowns during Resident #2's wound care. During the wound care observation, S4TNAgency removed Resident #2's soiled dressing. S4TNAgency then removed her used gloves, placed them on the bedside table, and then put on clean gloves. S4TNAgency did not perform hand hygiene between glove changes. S4TNAgency proceeded to clean the resident's wound with wound cleanser and then applied gentian violet to the resident's wound. She did not change her gloves and/or perform hand hygiene after cleansing the resident's wound. At this time, Resident #2 began to have a bowel movement. S4TNAgency removed her gloves and placed them on the bed sheet. She did not perform hand hygiene. She left out of the resident's room and returned with wipes and gloves. S4TNAgency proceeded to put on clean gloves and began to clean the resident's bowel movement. She did not perform hand hygiene prior to putting on clean gloves. S4TNAgency cleansed the resident's bowel movement, removed her gloves, placed her used gloves on the bed sheet, and applied clean gloves. She did not perform hand hygiene after removing her used gloves. She then placed a clean brief under the resident, removed her gloves, and applied clean gloves. S4TNAgency did not perform hand hygiene prior to putting on clean gloves. S4TNAgency then applied silver alginate and collagen to the resident's wound. At this time, the resident began having a second bowel movement. She removed her gloves, placed them on the bed, and left out of the room. She did not perform hand hygiene after removing her used gloves before exiting the room. She returned to the room, applied clean gloves, but did not perform hand hygiene. S4TNAgency proceeded to clean the resident's bowel movement, then removed her used gloves and applied clean gloves. She did not conduct hand hygiene between glove changes. S4TNAgency then placed the resident's clean dressing to the wound.On 02/24/2026 at 9:25 a.m., an interview was conducted with S4TNAgency. S4TNAgency confirmed that she did not bring hand sanitizer into Resident #2's room during the wound care observation. She confirmed that she did not conduct hand hygiene using hand sanitizer or wash her hands using soap and water between glove changes, and that she knew that she was supposed to sanitize or wash her hands between glove changes. S4TNAgency also confirmed that after cleansing the resident's wound, she did not change her gloves and proceeded to apply gentian violet to the resident's wound. S4TNAgency also confirmed that she placed soiled gloves on the resident's bed, and did not discard them in the trash after changing her gloves and should have.On 02/24/2026 at 11:55 a.m., another interview was conducted with S4TNAgency. She stated that she had been doing wound care for all residents for the last two weeks, and she was not trained on the facility's policies and/or procedures when she began doing treatments at the facility. She stated that she was not able to shadow or obtain direction from the nurse doing treatments prior (continued on next page)

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	195578	A. Building B. Wing	02/24/2026

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her, and she was not given any direction on how to complete the treatments or provide the wound care other than following the physician's orders. On 02/24/2026 at 12:05 p.m., an interview as conducted with S1Administrator. S1Administrator was asked who was responsible for ensuring agency staff was competent and trained on the facility's policies and procedures. She stated that the previous Director of Nursing was responsible for providing training on the facility's policies and procedures and ensuring agency staff had the required competencies to care for residents. S1Administrator was asked to provide evidence that S4TNAgency had competencies and was trained on the facility's policies and procedures being that she was providing treatments to the whole facility and had been for the last two weeks.The previous Director of Nursing was not available for interview at the time of the survey.On 02/24/2026 at 2:09 p.m., S1Administrator stated that there was no documented evidence that S4TNAgency was trained on the facility's policies and procedures, and no evidence that the facility ensured the she was competent to provide wound care for all residents at the facility.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the nurse maintained infection control practices while administering wound care treatments for 1 resident (#2) out of 2 resident's reviewed for wound care in a sample of 3 residents.Findings: Review of the facility's policy titled Handwashing/Hand Hygiene, with a last review date of 02/05/2026, read in part: Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin;.k. After handling used dressings, contaminated equipment, etc.m. After removing gloves. Review of the facility's policy titled Enhanced Barrier Precautions, with a last reviewed date of 02/05/2026, read in part: 2. EBPs (Enhanced Barrier Precautions) employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.h. wound care (any skin opening requiring a dressing).5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds .6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound. Review of Resident #2's EHR (Electronic Health Record) revealed the resident had diagnoses including, but not limited to: Pressure ulcer of sacral region stage 4, type 2 diabetes, and UTI (Urinary Tract Infection). Review of Resident #2's physician's orders revealed the following order dated 01/20/2026 that read: Sacrum - cleanse with wound cleanser, apply gentian violet to wound then apply collagen and silver alginate to wound bed, cover with dry dressing and prn (as needed). On 02/24/2026 at 8:41 a.m., an observation was made of S4TNAgency perform Resident #2's wound care. S5CNA was also present during the wound care observation. There was a sign posted on the outside of the resident's door that read: Enhanced Barrier Precautions. Providers and staff must also: Wear gloves and a gown for the following High- Contact Resident Care Activities .Wound care. S4TNAgency and S5CNA did not wear gowns during Resident #2's wound care. During the wound care observation, S4TNAgency removed Resident #2's soiled dressing. S4TNAgency then removed her used gloves, placed them on the bedside table, and then put on clean gloves. S4TNAgency did not perform hand hygiene between glove changes. S4TNAgency proceeded to clean the resident's wound with wound cleanser and then applied gentian violet to the resident's wound. She did not change her gloves and/or perform hand hygiene after cleansing the resident's wound. At this time, Resident #2 began to have a bowel movement. S4TNAgency removed her gloves and placed them on the bed sheet. She did not perform hand hygiene. She left out of the resident's room and returned with wipes and gloves. S4TNAgency proceeded to put on clean gloves and began to clean the resident's bowel movement. She did not perform hand hygiene prior to putting on clean gloves. S4TNAgency cleansed the resident's bowel movement, removed her gloves, placed her used gloves on the bed sheet, and applied clean gloves. She did not perform hand hygiene after removing her used gloves. She then placed a clean brief under the resident, removed her gloves, and applied clean gloves. S4TNAgency did not perform hand hygiene prior to putting on clean gloves. S4TNAgency then applied silver alginate and collagen to the resident's wound. At this time, the resident began having a second bowel movement. She removed her gloves, placed them on the bed, and left out of the room. She did not perform hand hygiene after removing her used gloves before exiting the room. She returned to the room, applied clean gloves, but did not perform hand hygiene. S4TNAgency proceeded to clean the resident's bowel movement, then removed her used gloves and applied clean gloves. She did not conduct hand hygiene between glove changes. S4TNAgency then placed the resident's clean dressing to her wound. On 02/24/2026 at 9:25 a.m., (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview was conducted with S4TNAgency. S4TNAgency confirmed that she did not bring hand sanitizer into Resident #2's room during the wound care observation. She confirmed that she did not conduct hand hygiene using hand sanitizer or wash her hands using soap and water between glove changes, and she knew that she was supposed to sanitize or wash her hands between glove changes. S4TNAgency also confirmed that after cleansing the resident's wound, she did not change her gloves and proceeded to apply gentian violet to the resident's wound. S4TNAgency also confirmed that she placed soiled gloves on the resident's bed, and did not discard them in the trash after changing her gloves and should have. On 02/24/2026 at 10:06 a.m., an interview was conducted with S2DON/IC. S2DON/IC confirmed that S4TNAgency should have conducted hand hygiene between glove changes, changed gloves after cleansing the resident's wound, and should not have placed soiled gloves on the resident's bed. She also confirmed used gloves should have been placed in the trash can. On 02/24/2026 at 11:49 a.m., an interview was conducted with S5CNA. S5CNA confirmed that the Resident #2 had a sign for EBP posted on her door, and she did not wear a gown during the resident's wound care. S5CNA stated that she knew she had to wear a gown and gloves when having direct contact with a resident on EBP. On 02/24/2026 at 11:55 a.m., another interview was conducted with S4TNAgency. S4TNAgency was asked if she should have worn a gown during Resident #2's wound care because the resident was on EBP. She stated the resident should not be on EBP, and the sign should have been taken off of the door because the resident's wound was not draining. On 02/24/2026 at 12:01 p.m., an interview was conducted with S3NS who assisted the Director of Nursing with infection control throughout the facility. S3NS stated that because the resident had a chronic stage 4 wound, according to EBP, the treatment nurse and CNA should have worn PPE including gown and gloves during wound care.