STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195584	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allen Oaks Nursing and Rehab Center	909 East 6th Avenue Oakdale, LA 71463

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observations, and record review, the facility failed to ensure a resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of his or her own quality of life by failing to apply a privacy cover to an indwelling catheter urinary drainage bag for 1 (#61) of 1 residents reviewed for dignity. Findings: Review of Resident #61's medical record revealed an admission date of 04/04/2025, with diagnoses that included in part . Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct; Hypospadias, Penile; Encounter for Palliative Care; Presence of Urogenital Implants; Neuromuscular Dysfunction of Bladder; and Retention of Urine. Review of Resident #61's Significant Change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 06/25/2025 revealed a BIMS score of 14, which indicated intact cognition. Resident #61 used an indwelling urinary catheter for urine elimination. Review of Resident #61's current clinical physician's orders revealed an order date of 04/24/2025-catheter care every shift: to keep Foley catheter clean to prevent infection related to Presence of Urogenital Implants. On 06/30/2025 at 9:59 a.m., Resident #61 was observed lying in bed with the door closed. Upon entrance into Resident #61's bedroom, Resident #61's indwelling catheter urinary drainage bag was observed with 200-300ml (milliliters) of yellow urine in the collection bag and without a privacy cover. On 06/30/2025 at 3:44 p.m., Resident #61 was observed sitting up in bed watching television. Upon entrance into Resident #61's bedroom, Resident #61's indwelling catheter urinary drainage bag was observed with about 150ml of yellow urine in the collection bag and without a privacy cover. On 06/30/2025 at 3:52 p.m., in an interview and observation with S5 LPN to Resident #61's bedroom, S5 LPN stated Resident #61's urine output is monitored and flushed every 2 hours. S5 LPN confirmed Resident #61's indwelling catheter urinary drainage bag should have a privacy cover, but had not. S5 LPN stated I'll go look for one right now.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received reasonable accommodation of needs by failing to have an assistive device accessible to 1 (Resident #45) of 26 sampled residents. Findings: On 07/2/2025 at 1:50 p.m., review of the facility policy titled. Assistive Devices and Equipment, with a revision date of July 2017, revealed in part . Our facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents. Devices and equipment that assist with resident mobility, safety, and independence are provided for residents. These include, but are not limited to, walkers. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the residents' plan of care. Review of Resident #45's electronic medical record revealed an admit date of 12/26/2024 with diagnoses that included but not limited to: Malignant Neoplasm of Prostate, Secondary and Unspecified Malignant Neoplasm of Lymph Nodes of Head, Neck, and face, Heart Failure, Acquired Absence of other Right Toes, Cognitive Communication Deficit, Difficulty Walking, Not elsewhere Specified, Other Lack of Coordination, Unspecified Dementia. On 07/01/2025 at 1:43 p.m., review of Resident #45's Quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 04/04/2025, revealed a BIMS Score of 6, indicating severe cognitive impairment. Resident #45 utilized a walker. On 07/01/2025 at 1:28 p.m., review of Resident #45's care plan with start date of 04/21/2025 revealed Resident #45 was a fall risk and had two previous falls on 04/03/2025 and 04/11/2025. Interventions included in part . encourage the resident to use a walker and wear shoes, call for assistance to ambulate due to dizziness and weakness, and ensure the resident has assistive devices and understands how to properly use them. On 06/30/2025 at 09:50 a.m., observation revealed Resident #45 ambulating throughout his room without supervision or an assistive device. Resident #45's gait was shuffled. Resident #45 walker was not present in the room. On 07/01/2025 at 11:37 a.m., observation revealed Resident #45 was lying in his bed awake, alert, and confused. Resident #45's walker was not present in the room. On 07/01/2025 at 11:40 a.m. S5 LPN accompanied the surveyor to Resident #45's room. S5 LPN confirmed Resident #45's walker was not present in the room. S5 LPN stated she worked the day prior and did not see the resident ambulate with a walker. S5 LPN stated the last time she could recall Resident #45 ambulating with a walker was the week prior, and was unsure where Resident #45's walker was located. S5 LPN confirmed Resident #45 required a walker to ambulate safely and should have had a walker present in the room with him, but did not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality by failing to ensure a resident received enteral feedings as ordered by the physician for 1 (#65) of 1 residents reviewed for tube feeding. Total sample size 26. Findings: Review of Resident #65's Clinical Record revealed an admit date of 07/10/2024 with diagnoses which included: Pneumonitis due to Inhalation of Food and Vomit; Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; Heart Failure; Anxiety; Cerebral Infarction; Hyperlipidemia; Aphasia; Hypertension; Dysarthria and Anarthria. Review of Resident #65's Annual MDS with an ARD of 05/24/2025 revealed a BIMS score of 0 indicating Resident #65 rarely/never understood. Resident #65 was dependent for bed mobility, transfers, eating, and toileting. Review of Resident #65's Physician Orders revealed the following, in part: 06/27/2025-Enteral feedings: Osmolite 1.2 at 40 milliliters (ml) /hour via pump Review of Resident #65's Care Plan dated 04/28/2025 read in part: Resident #65 requires tube feeding related to diagnoses of Dysphagia following a Cerebral Vascular Accident. Interventions included: Osmolite 1. 2 at a rate of 40 ml/hour with a 30 ml/ hour water flush. An observation on 06/30/2025 at 10:49 a.m. revealed tube feeding Osmolite 1.2 infusing at 50 ml/ hour continuous via pump. Interview on 06/30/2025 at 03:48 p.m. with S4 LPN confirmed Osmolite 1.2 should have been infusing at 40 ml/hour as ordered by the physician and was not. Interview on 07/01/2025 at 02:10 p.m. with S10 ADON confirmed that physician decreased tube feeding rate during rounds on 06/27/2025. S10 ADON confirmed that Resident #65 should have received Osmolite 1.2 at 40 ml/hour starting on 06/27/2025. Interview on 07/01/2025 at 02:13 p.m. with S2 DON confirmed Osmolite 1.2 should have been infusing at 40 ml/ hour as ordered by the physician and was not.

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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. Based on record review, observations and interviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards. The facility failed to ensure oxygen was administered as ordered by the physician for 1 (#55) of 2 (#14 and #55) residents reviewed for respiratory care. Findings: Review of the facility's policy titled Oxygen Administration, with a revised date of 10/2010 revealed the following in part, Policy: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 4. All assessment data obtained before, during, and after the procedure. Review of Resident #55's medical record revealed an admission date of 10/15/2024 with diagnoses that included in part, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (COPD), Other Disorders of Lung, Dependence on Supplemental Oxygen, and Dyspnea. Review of current Physician Orders for Resident #55 revealed continuous O2 (oxygen) at 2 liters per minute via nasal cannula, every day and night shift related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation with an order date of 11/18/2024. Review of Resident #55's Quarterly Minimum Data Set (MDS) with an ARD (Assessment Reference Date) dated 08/27/2025 revealed the resident has a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Further review revealed Resident #55 requires oxygen therapy. Review of Resident #55's Care Plan revealed in part, Resident #55 has oxygen therapy related to ineffective gas exchange, respiratory illness (COPD, Dyspnea, Pneumonia: reoccurring frequently). Interventions to include: Continuous oxygen at all times, give medications as ordered by physician. Observation on 06/30/2025 at 9:35 a.m., revealed Resident #55 sitting up in a chair in her bedroom. Resident #55 observed with oxygen in progress at 3.5 liters/minute via nasal cannula per oxygen concentrator. Resident #55 stated she wears oxygen via nasal cannula continuously. Observation on 07/01/2025 at 8:39 a.m., revealed Resident #55 sitting up in her recliner with oxygen in progress at 3.5 liters/minute via nasal cannula. Resident #55 stated no one comes to check to see how many liters of oxygen she is on. Observation on 07/01/2025 at 1:37 p.m., revealed Resident #55 sitting up in her recliner with oxygen in progress at 3.5 liters/minute via nasal cannula.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to provide pharmaceutical services that assured accurate disposition and/or administration of medications to meet the needs of each resident. The facility failed to: 1. Ensure proper nursing procedures and documentation were completed at the time of wasting/destroying narcotics on 1 (Med Cart 1) of 2 (Med Cart 1 and Med Cart 2) medication carts for Resident #26. 2. Ensure proper nursing procedures for wasting of controlled substances were completed when Resident #60's controlled medication was not administered. Findings: Review of a facility policy on 07/01/2025 at 9:50 a.m. titled, Discarding and Destroying Medications revised on 10/2014 revealed the following part . Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. 6. for unused, non-hazardous controlled substances that are not disposed of by an authorized collector, c. dispose with the solid waste in the presence of two witnesses. e. include the signature(s) of at least two witnesses. 7. destruction of a controlled substance must render it non-retrievable, meaning that the process permanently alters the physical or chemical properties of the substance so that it is no longer available or usable, and cannot be illegally diverted. Review of a facility policy on 07/01/2025 at 9:50 a.m. titled, Controlled Substances revised on 12/2012 revealed the following in part .The facility shall comply with laws, regulations, and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances. 8. When a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given), the medication shall be destroyed and may not be returned to the container. 1. On 07/01/2025 at 9:38 a.m. a controlled medications reconciliation was conducted with S5 LPN of Med Cart 1. Review of Resident #26's document titled, Controlled Substance Count Sheet for Tramadol 50mg tablets revealed one entry on 06/13/2025 at 8:00 a.m. where one tablet was documented as wasted by a nurse. Further review of the document revealed no evidence of a destruction witness signature for the waste entry. S5 LPN confirmed there should had been a witness/second signature when Resident #26's Tramadol tablet was wasted on 06/13/2025, but there was not. 2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/2025 at 9:38 a.m. a controlled medications reconciliation was conducted with S5 LPN on Med Cart 1. Review of Resident #60's blister medication card package for Hydrocodone/APAP 5mg-325mg tablets revealed that tablet #41 was opened/popped and the back of the packaging was taped with clear tape. Further review revealed a white pill was placed back into tablet #41's packaging of the medication card. S5 LPN confirmed that Resident #60's Hydrocodone/APAP 5mg-325mg blister package should never have medications taped back into the package after it has been popped or opened. S5 LPN confirmed tablet #41 should have been wasted appropriately and not placed back into the packaging, but was not. In an interview on 07/01/2025 at 11:43 a.m., S2 DON revealed that the floor nurses are aware of the proper procedures for wasting of controlled substances/narcotics. S2 DON stated there should always be two nurses to witness any wasting/destruction of controlled substances and both nurses are to document in the clinical record. S2 DON confirmed the nurse failed to follow proper nursing procedures for wasting Resident #26's narcotic medications on 06/13/2025. S2 DON revealed that the nurses are never to tape the back of a blister medication package and place a tablet back into the packaging. S2 DON confirmed the nurse failed to follow proper nursing procedures for wasting Resident #60's controlled medications by placing the tablet back into the packaging.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with current accepted professional principles. This deficient practice has the potential to affect all 72 residents residing in the facility. The facility failed to: 1. Ensure expired medications were not available for administration to residents in 1 (Med Room B) of 2 (Med Room A and Med Room B) medication rooms. 2. Ensure controlled substances were properly stored in a permanently affixed compartment and had restricted access until destroyed appropriately. Findings: Review of a facility policy on 07/01/2025 at 9:50 a.m. titled, Controlled Substances revised on 12/2012 revealed the following in part .The facility shall comply with laws, regulations, and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances. Review of a facility policy on 07/01/2025 at 9:50 a.m. titled, Storage of Medications revised on 04/2007 revealed the following in part .the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Review of a facility policy on 07/01/2025 at 9:50 a.m. titled, Discarding and Destroying Medications revised on 10/2014 revealed the following in part . Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. 1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of. 1. On 07/01/2025 at 8:20 a.m., an observation of Med Room B was conducted accompanied by S4 LPN and revealed the following items in the medication room for use: 1. One opened and used tube of Hydrocortisone cream with an expiration date of 04/15/2025. 2. One opened and used tube of Clobetasol Propionate 0.05% cream with an expiration date of 04/22/2025. At the time of observation, S4 LPN confirmed both creams were expired and should have been disposed of properly, but were not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2025 at 8:35 a.m., S2 DON confirmed that Med Room B should not have any expired medications available for usage. 2. Observation on 07/01/2025 at 11:08 a.m. of the facility's narcotic destruction locked box, accompanied by S10 ADON, revealed the box was located on a shelf in S10 ADON's shared office. Interview with S10 ADON at the time of observation confirmed that the locked box was not permanently affixed to any surface. S10 ADON was observed unlocking the narcotic box which revealed the box contained multiple medication cards and bottles of controlled substances. S10 ADON confirmed the narcotics destruction locked box did have controlled medication inside, was not permanently affixed to any surface, and that two other employees had access to the shared office space where the box was stored. S10 ADON revealed she was responsible for the controlled substance destruction process, which included storing, handling, documentation, and destroying of narcotics.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to meet the nutritional needs for residents in accordance with established national guidelines. The facility failed to follow the menu for all residents receiving puree diet. 5 residents in the facility received a puree diet. Findings: On 06/30/2025 at 3:25 p.m., review of facility undated policy titled, Puree Diet, revealed in part . the puree diet is based on the regular diet, therefore, all the same guidelines apply with alterations being made only to allow for ease and chewing and swallowing. On 07/01/2025 at 9:15 a.m., review of facility policy titled, Menus, with revision date of October 2017 revealed in part, Menus meet the nutritional needs of residents in accordance with recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). If a food group is missing from a resident's daily diet, the resident is provided an alternate means of meeting his or her nutritional needs. On 06/30/2025 at 10:00 a.m., observation of the menu posted revealed lunch menu for 06/30/2025 included: meatloaf, black eyed peas, cauliflower and cheese, dinner roll, and lemon glazed cake. On 06/30/2025 at 10:30 a.m., observation revealed S7 [NAME] prepare meatloaf, black-eyed peas, and cauliflower and cheese puree. On 06/30/2025 at 10:52 a.m., an interview with S7 cook confirmed she did not puree glazed cake because pudding was being provided as an alternative for all puree diets. S7 [NAME] confirmed she did not puree dinner rolls for any of the residents who received puree diets. During an interview on 06/30/2025 at 3:52 p.m., S3 Dietary Manager revealed facility cooks did not puree bread and did not provide an alternate for bread when bread is served. S3 Dietary Manager confirmed S7 [NAME] did not follow the menu for all residents that received a puree diet, and should have.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary kitchen and failed to store food in accordance with professional standards for food service safety. This deficient practice had the potential to affect all 72 residents who resided in the facility. The facility failed to ensure: 1. Food items in the refrigerators and freezers were labeled and dated; 2. Dry food items were labeled with an open date and stored in a sealed container; 3. Dishware was clean and stored under sanitary conditions; 4. Staff were wearing hair restraints, including beard restraints, to prevent hair from contacting food. Findings: On 07/01/2025 at 9:50 a.m., review of facility policy titled, Food Receiving and Storage, with revision date of July 2014, revealed in part . Food shall be received and stored in a manner that complies with safe food handling and practices. All food stored in the refrigerator or freezer will be covered, labeled, and dated. 1. On 06/30/2025 at 8:47 a.m., observation of the freezer in the kitchen food prep area with S3 Dietary Manager revealed one 1-gallon Ziploc bag of chicken nuggets open and undated. S3 Dietary manager confirmed the 1-gallon bag of chicken nuggets was not sealed and dated, and should have been. On 06/30/2025 at 9:10 a.m., observation of the outdoor walk-in refrigerator with S3 Dietary Manager revealed one 1-gallon tub of mayonnaise open and undated. S3 Dietary manager confirmed the 1 gallon tub of mayonnaise was open and undated, and should not have been. 2. On 06/30/2025 at 8:52 a.m., observation of a flour container in the food prep area with S3 Dietary Manager revealed a scoop stored in the flour container. S3 Dietary Manager confirmed the scoop was stored in the flour container and should not have been. On 06/30/2025 at 9:04 a.m., observation of the pantry with S3 Dietary Manager revealed one 50-pound bag of pinto beans open. S3 Dietary Manager confirmed that pinto beans should have been stored in a sealed container, but were not. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/30/2025 at 10:10 a.m., observation of Dining room [ROOM NUMBER] serving area with S3 Dietary Manager revealed one small bag of powdered substance not labeled and undated. S3 Dietary Manager stated that the powder was powdered creamer. S3 Dietary Manager confirmed that powdered creamer should have been labeled, dated, and in a sealed container, and it was not. 3. On 06/30/2025 at 8:50 a.m., observation of open shelving that stored clean dishware revealed all dishware plates stored face up, 3 visibly dirty plates, and 1 plate visibly dirty with 3 paperclips in the plate. S3 Dietary Manager was present and confirmed 3 dishware plates stored on clean dishware shelving were dirty and should not have been. S3 Dietary Manager confirmed there were paperclips on clean dishware plates and should not have been. S3 Dietary Manager confirmed clean dishware should be stored facedown, and it was not. 4. On 06/30/2025 at 9:00 a.m., observation revealed S8 Dietary Aide was present in the kitchen with facial hair not contained by a hairnet. S3 Dietary Manager confirmed S8 Dietary Aide should have had a hairnet containing facial hair, and did not.

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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. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection by: 1. Failing to store clean unused resident care items in a sanitary manner on Hall Z 2. Failing to ensure opened resident care items were not stored on the clean linen cart on Hall Z after use 3. Failing to practice Enhanced Barrier Precautions for Resident #63. Findings: 1. Observation on 07/02/2025 at 10:18 a.m., of the dirty soiled linen closet on Hall Z accompanied with S6 Laundry revealed 6 clean water basins stored on the top shelf, un-bagged. Observation revealed a large yellow barrel overflowed with dirty and soiled linen next to the shelf. S6 Laundry stated staff brings dirty and soiled linen in this closet to be stored and then washed. S6 Laundry confirmed the 6 water basins were clean, used for resident use, should be bagged, and not stored in this closet on Hall Z. S6 Laundry stated its cross-contamination. 2. Observation on 07/02/2025 at 10:40 a.m., of the clean linen cart on Hall Z with S11 CNA Supervisor revealed 1 pack of opened wipes used for resident care and 2 pink denture cups, which contained baby powder. S11 CNA Supervisor stated anytime staff uses resident care items such as wipes or baby powder it is to be left in the resident's room. S11 CNA Supervisor confirmed the 1 pack of opened wipes and 2 pink denture cups of baby powder should not have been left on the clean linen cart. Observation on 07/02/2025 at 12:20 p.m., of the clean linen cart on Hall Z with S12 CNA stated she gathers resident care items such as wash, wipes, adult briefs, and resident linen from the clean linen cart and places them in a clear bag. S12 CNA stated these items are to remain in the resident's room since all rooms are now private. S12 CNA stated some staff have a habit of using these items, bringing them back out of a resident's room, and placing them back on the clean linen cart. S12 CNA confirmed the 1 bottle of skin and hair cleanser was used for resident care and shouldn't have been placed back on the clean linen cart. 3. Resident #63 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195584	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allen Oaks Nursing and Rehab Center	909 East 6th Avenue Oakdale, LA 71463

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/1/2025 at 3:07 p.m., review of facility policy titled, Enhanced Barrier Precautions, dated 05/01/2024, revealed in part . Facility shall ensure that Enhanced Barrier Precautions (EBP) are utilized in the infection control program. Enhanced Barrier Precautions is used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROS to staff hands and clothing. EBP are indicated for residents with any of the following .Indwelling medical devices . even if the resident is not known to be infected or colonized with Multi-drug Resistant Organism (MDRO). Indwelling medical devices include central lines. Review of Resident #63's electronic medical record revealed an admit date of 12/13/2024 with diagnosis that included but not limited to: End Stage Renal Disease, Hypotension, Moyamoya Disease, Paroxysmal Atrial Fibrillation, Presence of other vascular implants and grafts, Encounter for fitting and adjustment of Extracorporeal Dialysis Catheter, Dependence of Renal Dialysis. On 07/01/2025 at 9:33 a.m., review of Resident #63's Significant Change MDS with ARD of 06/21/2025 revealed a BIMS Score of 8, indicating moderate cognitive impairment. On 07/01/2025 at 9:28 a.m., review of Resident #63's July 2025 Physican's Orders revealed an active order for Enhanced Barrier Precautions with initiation date of 12/24/2024. On 07/01/2025 at 9:45 a.m., review of Resident #63's care plan with initiation date of 12/15/2024 revealed Resident #63 was on enhanced barrier precautions for dialysis catheter access with interventions that included: Enhanced Barrier Precautions will be used for dialysis catheter and EBP as instructed, hanging outside of door. On 07/01/2025 at 12:03 p.m., observation of the interior and exterior of Resident #63's room revealed no EBP signage or caddy with appropriate PPE for enhanced barrier precautions. During an interview on 07/01/2025 at 11:37 a.m. Resident #63 stated that staff only applied gloves when caring for him. Resident #63 denied staff wore gowns when caring for him. During an interview on 07/01/2025 at 12:12 p.m., S9 CNA revealed she had been employed at the facility since 2018 and was familiar with the care Resident #63 required. S9 CNA stated Resident #63 did not require any special precautions. S9 CNA confirmed she applied only gloves before caring for Resident #63. On 07/01/2025 at 12:20 p.m., an interview with S4 LPN revealed she has been employed at the facility for about 2 years and was familiar with Resident #63 and the care he required. S4 LPN stated Resident #63 was not on EBP. Resident #63's active orders and care plan were reviewed with S4 LPN during the interview. S4 LPN confirmed Resident #63 had an active order for enhanced barrier precautions. On 07/01/2025 at 12:25 p.m., S4 LPN accompanied the surveyor to Resident #63's room. S4 LPN confirmed enhanced barrier precautions were not in place for Resident #63 and should have been. On 07/01/2025 at 2:30 p.m., S2 DON and S10 ADON acknowledged that Resident #63 should have had enhanced barrier precautions in place and did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195584	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allen Oaks Nursing and Rehab Center	909 East 6th Avenue Oakdale, LA 71463

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interview, the facility failed to maintain an effective pest control program by failing to ensure the facility was free from flies. The deficient practice had the potential to affect 72 residents who resided in the facility. Findings: On 07/01/2025 11:00 a.m., review of facility policy titled Pest Control with revision date of May 2008 revealed in part . Our facility shall maintain an effective pest control program. This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. Observation of the facility's kitchen on 06/30/2025 at 9:06 a.m., accompanied by S3 Dietary Manager, revealed multiple flies observed throughout the kitchen area, with flies landing on the food being prepared and the food prep area. On 06/30/2025 at 10:25 a.m., during a return trip to the kitchen, multiple flies were observed in the kitchen food prep area. On 06/30/2025 at 3:50 p.m., during a return trip to the kitchen area for an interview with S3 Dietary Manager, multiple flies were observed in the kitchen area. S3 Dietary Manager confirmed the kitchen area had a fly problem. S3 Dietary Manager confirmed the kitchen area should be free of pests, but it was not. On 07/01/2025 at 8:00 a.m., observation revealed multiple flies present in Room A. On 07/02/2025 10:04 a.m., observation revealed multiple flies present in Room A. On 07/02/2025 at 12:16 p.m., S1 Admin acknowledged the facility had a current issue with flies in the building.