

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Allen Oaks Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interviews, the facility failed to designate an individual as Infection Preventionist who was responsible for the facility's infection prevention and control program who has completed specialized training in infection prevention and control. Findings: In an interview on 06/17/2026 at 12:45 p.m., S7 RN TX revealed she oversees the Infection Prevention and Control Program. S7 RN TX confirmed she does not have the Infection Preventionist training. In an interview on 06/17/2026 at 2:51 p.m., S2 DON confirmed S7 RN TX oversees the Infection Prevention and Control Program and does not have the Infection Preventionist training but should have.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based interview and record review, the facility failed to ensure a resident was free of chemical restraints for 1 (Resident #8) of 5 residents reviewed for unnecessary medications by failing to ensure: 1. A new order was obtained for an as-needed (PRN) psychotropic drug after 14 days; and 2. Indications of use were documented for the administration of a PRN psychotropic drug Review of the facility's undated policy titled, Antipsychotic Medication Use revealed in part . Antipsychotic medications may be considered for residents with dementia, but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosages for the shortest period of time and are subject to gradual dose reduction and re-review. 14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. Review of Resident #8's medical record revealed an admission date of 11/25/2019 with diagnoses that included, in part. Unspecified Dementia Severe with Psychotic Disturbance, Depression, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Review of Resident #8's Quarterly MDS with ARD of 04/06/2026 revealed Resident #8 had a BIMS score of 5, indicating severe cognitive impairment. Review of Resident #8's 06/2026 active orders revealed in part. Ativan Oral Tablet 2 MG (Lorazepam) Give 2 mg by mouth every 8 hours as needed for target behavior: skin picking, agitation, restlessness related to depression, unspecified. Start date: 02/12/2026 and End date: Indefinite. 1. In an interview on 06/16/2026 at 2:59 p.m., S2 DON revealed that per the facility policy and procedure, PRN psychotropic drugs can only be ordered for 14 days at a time. Resident #8's 06/2026 medication administration record (MAR) was reviewed with S2 DON. S2 DON confirmed Resident #8's PRN Ativan order did not have a stop date and should have. S2 DON confirmed that Resident #8's PRN Ativan order should have been discontinued after 14 days, but was not. 2. Review of Resident #8's 05/2026 MAR documentation revealed in part. Ativan oral tablet 2 MG by mouth every 8 hours as needed for target behavior: Skin picking, agitation, restlessness, related to depression. 05/19/2026: No behaviors observed. Administered 08:46 p.m. 05/23/2026: No behaviors observed. Administered 08:15 a.m. 05/23/2026- No behaviors observed. Administered 08:14 p.m. 05/24/2026: No behaviors observed. Administered 08:30 p.m. Review of Resident #8's 05/2026 progress notes revealed no documentation of the behaviors that prompted the above listed PRN Ativan 2mg administrations. Review of 05/2026 MAR for behavior monitoring every shift revealed no behaviors documented for 05/19/2026, 05/23/2026, or 05/24/2026. In an interview on 06/17/2026 at 10:58 a.m. Resident #8's 05/2026 MAR was reviewed with S2 DON. S2 DON confirmed that the above documentation indicated no behaviors were observed for the above listed PRN Ativan medication administrations. In an interview on 06/17/2026 at 11:20 a.m. S2 DON confirmed that behaviors should have been documented, reflecting the need for PRN Ativan on the MAR, but were not. S2 DON confirmed Resident #8's medical record did not have any documentation reflecting the indications of use for the above PRN doses of Ativan, but should have		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure menus were followed to meet the nutritional needs of residents. This failure had the potential to affect every resident who received meals from the kitchen, 3 residents on puree diets, and Resident #36 of 27 sampled residents. The facility failed to: Ensure the appropriately sized scoops were used to serve meal trays; Ensure pureed menus were followed; and Follow menu preferences for Resident #36. #1 & #2 Findings: Review of a policy with a revision date of April 2007 titled, Kitchen Weights and Measures revealed in part. Policy Statement: Food Services staff will be trained in proper use of cooling and serving measurements to maintain portion control. 6. Staff will be trained in the appropriate measurement and type of serving utensil to use for each food. Signs or posters explaining coded measurement indicators on utensils will be prominently displayed for reference. Review of a policy with a revision date of April 2007 titled, Standardized Recipes revealed in part. Policy Statement: Standardized recipes shall be developed and used in the preparation of foods. Interview on 06/15/2026 at 10:36 a.m., S11 [NAME] stated there are 3 residents on puree diets. Observation on 06/15/2026 at 11:12 a.m., revealed S11 [NAME] preparing puree diet meal trays using a 2oz scoop of pureed rice, approximately 4.5 oz of beans, 3 oz of pureed sausage, and one container of yogurt for each of the 3 residents. Observation on 06/15/2026 at 11:20 a.m., revealed the menu for Diet Extensions, Monday Week 5 for Regular/Pureed as follows: Red Beans and Sausage, Steamed Rice, Sliced Carrots, Cornbread, and Bread Pudding. Observation on 06/15/2026 at 11:20 a.m., revealed Residents receiving puree diets were not served carrots. Interview on 06/15/2026 at 4:00 p.m., S6 DM confirmed the 3 residents on a puree diet did not receive carrots or any other vegetable on their lunch trays but should have. Review on 06/15/2026 at 11:20 a.m. of the menu revealed residents were to receive 6 oz of red beans and sausage. Observation on 06/15/2026 at 12:20 p.m., S6 DM prepared meal trays using a 4oz scoop to serve the red beans and sausage. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/15/2026 at 2:20 p.m., S6 DM confirmed residents should have received 6 oz of red beans and sausage and that she had not used the appropriate scoop size for serving. #3 Findings: Review of Resident # 36's medical record revealed an admission date of 12/18/2020 with a re-entry date of 12/10/2022 with the following diagnoses in part, Combined Systolic and Diastolic (Congestive) Heart Failure; Chronic Kidney Disease, Stage 4; Hypertensive Heart Disease; and Morbid (Severe) Obesity. Review of Resident #36's 06/2026 Physician Orders dated 05/29/2024 revealed Resident #36 was on a regular diet. Review of Resident #36's Quarterly MDS (Minimum Data Sets) with an ARD of 04/14/2026 revealed a BIMS (Brief Interview of Mental Status) score of 15 which indicated Resident #36 was cognitively intact. Review of Resident # 36's Dietary Manager assessment dated [DATE] revealed in part, dislikes: oatmeal and all veggies (vegetables). Interview on 06/15/2026 at 9:55 a.m., Resident #36 stated that she eats in her bedroom and staff never serve her the correct food according to her meal ticket. Resident #36 stated her meal ticket reads no veggies and she continued to receive veggies on her meal trays. Resident #36 stated she doesn't like eating vegetables which is why her meal ticket read no veggies. Interview and observation on 06/16/2026 at 11:26 a.m. of Resident #36's lunch meal tray. Resident #36 was served cucumbers and onions. Observation of Resident #36's meal ticket read in part, no veggies. Interview on 06/16/2026 at 12:00 p.m., S6 DM (Dietary Manager) stated that Resident #36 has voiced multiple complaints about the food and that she tries to honor her likes and dislikes. S6 DM stated Resident #36 doesn't like any vegetables to be served to her and will become very upset if she is served any vegetables. S6 DM accompanied surveyor to Resident #36's room and observed that Resident #36 was served cucumbers and onions. S6 DM stated Resident #36's meal ticket had no veggies listed on it and she shouldn't have been served vegetables. S6 DM confirmed Resident #36 should've been served according to her meal preference and was not.		

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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. Based on observation and interviews the facility failed to maintain a clean and sanitary kitchen to prevent the likelihood of foodborne illnesses and failed to store, prepare, and serve food in accordance with professional standards for food safety. This deficient practice had the potential to affect all residents who received meals prepared by the kitchen. The facility failed to ensure:Expired Food Items were not available for use; andFoods were not labeled and stored appropriately Findings:Observation of the pantry on 06/15/2026 at 8:28 a.m. accompanied by S6 DM revealed the following expired food items: 3 plastic containers of Herdez Verde salsa with expiration date of January 20262 bags of chocolate frosting mix with an expiration date of 05/15/20261 can of sliced apples with an expiration date of 04/06/2025Observation of the walk-in cooler on 06/15/2026 at 8:28 a.m. accompanied by S6 DM revealed the following expired food items, wilted fruits, and molded fruits:4 quarts of heavy whipping cream with expiration date of 06/10/20263 cartons of thickened water with expiration date of 06/02/20265 wilted fruits (3 oranges and 2 apples) in a cardboard box with molded spots on the box1 box of 6 or more green bell peppers with mold on each.Observation of the refrigerator in the kitchen area on 06/15/2026 at 8:28 a.m. accompanied by S6 DM revealed the following food items that were improperly stored:Large bowl of ranch dressing covered with foil paper-undated and not labeled1/2 large stick of butter-undated and open to air2 covered bowls of labeled pureed dessert-undated1 sandwich wrapped in foil paper-undated and not labeledFindings confirmed with S6 DM at the time of observation.In an interview on 06/15/2026 at 4:00 p.m., S10 RD acknowledged the kitchen should not have expired, molded, wilted, undated, or unlabeled foods available for use.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental disorder to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 2 (Resident #29 and Resident #59) of 2 sampled residents investigated for PASARR. Findings: Resident #29 Review of Resident #29's medical record revealed an admission date of 10/01/2021 with a re-entry date of 07/14/2022 with diagnoses that included in part. Bipolar Disorder and Anxiety Disorder. Further review revealed he was admitted with Bipolar Disorder on 07/14/2022. Review of Resident #29's Level 1 Pre-admission Screening and Resident Review dated 09/29/2021 revealed no mental illness/diagnosis checked, therefore no Level 2 was determined at this time. Further review of Resident #29's record revealed there was no evidence that a new Level 1 Pre-admission Screening and Resident Review or a Level II PASARR was submitted to the appropriate state-designated authority after the new diagnosis of Bipolar Disorder on 07/14/2022. Interview on 06/16/2026 at 2:16 p.m. with S8 SSD revealed she was responsible for sending referrals to the appropriate state-agencies for Level II PASARR evaluations. S8 SSD confirmed Resident #29's Level 1 Pre-admission Screening and Resident Review form on 09/29/2021 did not include his Bipolar Disorder diagnosis and stated that a Level 1 was not resubmitted after this diagnosis. S8 SSD confirmed that Resident #29 should have had a Level II PASARR evaluation completed but did not. Resident #59 Review of Resident #59's medical record revealed an admission date of 03/13/2018 with diagnoses that included in part. Major Depressive Disorder and Generalized Anxiety Disorder. Review of Resident #59's Level 1 Pre-admission Screening and Resident Review dated 09/06/2016 revealed no mental illness/diagnosis checked, therefore no Level 2 was determined at this time. Further review of Resident #59's record revealed there was no evidence that a new Level 1 Pre-admission Screening or a Level II PASARR was submitted to the appropriate state-designated authority after the new diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder on 03/18/2018. Interview on 06/17/2026 12:58 p.m., S8 SSD revealed she was responsible for sending referrals to the appropriate state-agencies for Level II PASARR evaluations. S8 SSD confirmed Resident #59's Level 1 Pre-admission Screening and Resident Review form on 09/06/2016 did not include her diagnoses of (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Major Depressive Disorder and Generalized Anxiety Disorder. S8 SSD confirmed that the Level 1 Pre-admission Screening was not resubmitted after these diagnoses, nor was a Level 2 submitted for evaluation, but should have been.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to include the Medical Director or his designee and Administrator in the Quality Assessment and Assurance (QAA) committee quarterly meeting, as required. The facility's total census was 82. Findings:Review of a facility policy on 06/17/2026 at 5:26 p.m. titled, Quality Assurance and Performance Improvement (QAPI) Plan with a revision date of 04/2014 revealed in part.The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. Review of the facility's documented quarterly Quality Assurance (QA) meeting held on 03/12/2026 revealed S1 ADM and the facility Medical Director did not sign the member sign-in document. There was no other documented evidence of the facility Medical Director nor S1 ADM attending the QA meeting held on 03/12/2026. In an interview on 06/17/2026 at 2:00 p.m., S2 DON revealed she was the facility QAPI Coordinator, conducted the QA meeting on 03/12/2026, and confirmed the above findings. S2 DON confirmed for the QA meeting held on 03/12/2026, the Medical Director and S1 ADM did not attend and S2 DON did not have evidence of them attending the QA meeting, but should have. No other documented evidence was presented during the survey process of the facility Medical Director or S1 ADM in attendance of the QA meeting held on 03/12/2026.		