STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on interview and record review, the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 resident (#2) out of 7 (#1,#2, #3, #4, #5, #6, #7) sampled residents. Findings: Review of the facility's policy titled Prevention of Pressure Ulcer/Injuries, with a last reviewed date of August 2024, read in part: 1. Evaluate, report, and document potential changes in the skin with weekly skin assessments. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including; type 2 diabetes, pressure ulcer of sacral region, and unstageable pressure induced deep tissue damage of other site. Review of Resident #2's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed section M in part: Resident has a pressure ulcer/injury, at risk for developing pressure ulcers. Review of Resident #2's care plan initiated on 12/12/2024 revealed an intervention to conduct body audit per schedule. Further review of Resident #2's medical record failed to reveal weekly body audits for 12/11/2024 through 12/24/2024. Review of Resident #2's wound assessments revealed a facility acquired, unstageable wound was identified to the resident's sacrum on 12/24/24. On 04/02/2025 at 10:20 a.m., an interview was conducted with S7TN (Treatment Nurse). She stated she completed skin assessments and body audits on all residents weekly. She further stated that these were head to toe assessments, and she assessed the residents' backsides as well. S7TN also stated that weekly skin impairment assessments were conducted on residents who had current skin impairments. A review of Resident #2's weekly skin impairment assessment for the week of 12/17/2024 did not include an assessment of the resident's buttocks and the assessment was for the resident's yeast infection rash. S7TN was asked to provide documented evidence that a body audit was conducted on Resident #2 between his admission assessment on 12/11/2024 and the identification of the unstageable wound to his sacrum on 12/24/2024 and could not provide any documented evidence.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251 Based on record reviews, observations, and interviews, the facility staff failed to recognize and properly respond to a resident who was demonstrating exit seeking behaviors or recognize the Wanderguard alarm to prevent elopement for 1 (Resident #1) of 5 residents investigated for elopement (Resident #1, #4, #5, #6 and #7). This deficient practice resulted in an Immediate Jeopardy on 03/22/2025 at 10:40 a.m. when Resident #1, a moderately cognitively impaired resident, eloped from the facility located in a residential area. On the morning of 03/22/2025, prior to his elopement, Resident #1 asked staff members for the code to the facility's door alarm and expressed that he wanted to go home before exiting the facility undetected by staff. Staff failed to recognize the residents exit seeking behavior and the sound of the wanderguard as he went out of the door. On 03/22/2025 at 10:50 a.m., the facility received a phone call from Resident #1's responsible party that Resident #1 was at his home. Resident #1 walked approximately 0.2 miles from the facility to his home. He was returned to the facility by facility staff 03/22/2025 at 11:12 a.m. and placed into the monitored unit. S1ADM (Administrator) was notified of the Immediate Jeopardy on 03/31/2025 at 5:51 p.m. The deficient practice had the likelihood to cause more than minimal harm to 5 residents identified by the facility as an elopement risk. Findings: Review of Resident #1's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included but not limited to Alzheimer's disease and dementia with other behavioral disturbance. Review of Resident #1's Admission MDS (Minimum Data Set) with an ARD (Assessment Review Date) of 02/28/2025 revealed he had a BIMS (Brief Interview for Mental Status) of 09, indicating his cognition was moderately impaired. Behavioral section of the MDS revealed Resident #1 had no wandering behaviors at the time of the assessment. Further review of his functional abilities section revealed Resident #1 did not use any assistive devices and could walk independently 150 feet. Review of Resident #1's care plan read in part: Focus: Risk for elopement related to impairment cognition and safety awareness secondary to Dementia. Goal: No wandering behaviors; date initiated 02/21/2025. Resident's safety will be maintained initiated 02/21/2025. Interventions read in part: Wander Guard (elopement alarm bracelet) device applied due to risk elopement related to impaired cognition and safety awareness. Monitor every shift for proper placement and functioning of device initiated 02/21/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's current physician orders revealed an order dated 02/25/2025 for Wander guard applied due to risk of elopement related to impaired cognition and safety awareness. Review of Resident #1's elopement assessment dated [DATE] revealed Resident #1 was negative for elopement risk. However, there was a statement documented that read Wander guard device applied to right wrist due to risk of elopement related to impaired cognition and safety awareness secondary to dementia. Monitor q (every) shift for proper placement and functioning of device. Review of Resident #1's incident report completed on 03/22/2025 at 10:50 a.m. by S4ALPN (Agency Licensed Practical Nurse) read in part, this nurse was made aware by the facility staff that Resident #1's responsible party called to advise that Resident #1 had left the facility and was currently at his residence. Facility transportation went and picked up Resident #1 at that location. At approximately 11:15 a.m., this nurse asked resident what happened and Resident #1 stated I left and will not leave again for a few more months. Review of witness statement completed by S8FS (Facility Staff) on 03/22/2025 read in part, the last time I saw him was at 10:30 a.m. Resident #1 came to the desk and asked me to let him out the building. Review of witness statement completed by S5CNA (Certified Nursing Assistant) on 03/22/2025 read in part . Resident #1 came and asked me and S6CNA to let him out because he was ready to go home, so we sent him to the nurse's station to talk to the nurse at the end of the hall and that was the last time I saw him. A little while later after about 10:40 a.m., we started bringing residents to the dining room and then we sat behind the nurse's station. The door alarm started going off, but we did not know where it was coming from. I checked the door and looked outside and then I put the code in to disarm the alarm but I didn't see anyone outside. Review of witness statement completed by S6CNA on 03/22/2025 read in part I was working with S5CNA and we had just finished rounding and went to get something out of our bags when Resident #1 approached and asked if we would let him out because he wanted to go home. We told him we wouldn't and that he would have to ask the nurse at the end of the hall. After that, we went and sat behind the nurse's station. Resident #1 came up to the nurse's station again and asked if we could put in the code to the door and we told him that we didn't know the code and that he had to ask the nurse. After that Resident #1 went down the hall toward the nurse station. On 03/31/2025 at 12:02 p.m., an interview was conducted with S5CNA. She confirmed that she was present and responsible for Resident #1 on 03/22/2025 when he eloped. She stated that Resident #1 followed her in the lounge and asked her to open the door because he was ready to go home. She then told him to go ask the nurse and watched him until he approached the nurse. She stated that Resident #1 had been asking to go home all day, but she thought nothing of it. S5CNA reported that when the alarm went off, she just thought the door had been left opened too long and did not know which door was alarming. She stated that when she went to Hall W's front exit door, she looked outside from the door and did not see anyone so she disarmed the alarm. S5CNA confirmed that she did not know how to identify where an alarm was coming from when it sounded or what should be done when an alarm sounded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/31/2025 at 12:28 p.m., an interview was conducted with S6CNA. She stated that she was also caring for Resident #1 the day he eloped. She stated that when she went by the lounge room to get a drink, Resident #1 asked her for the code to get out because he was ready to go home. She stated that she knew that he was an elopement risk and had a Wander guard bracelet, but did not think that would have left the building. S6CNA said that she told him to go and ask the nurse for the code. She stated that later, when the alarm went off, she did not know what it was or where it was coming from. S6CNA stated that eventually S5CNA went to the exit door and canceled the alarm. On 03/31/2025 at 1:27 p.m., a review of the facility's video surveillance dated 03/22/2025 and interview was conducted with S1ADM (Administrator). Prior to the review of the video, S1ADM advised that the time on the video surveillance had not been set to daylight savings time, therefore, timing would be one hour later than the time stamps on the video. Review of the surveillance revealed that on 03/22/2025 at 09:40 a.m., Resident #1 walked out to the facility following a visitor. There is no audio on the video, however, S1ADM stated that this was when the alarm when off. On 03/22/2025 at 09:41 a.m., a staff member's head poked out from the nurse's station. At 09:42 a.m., S5CNA came from the nurse's station, walked toward Hall W's front exit door, peered through the door's glass from inside of the facility, and reset the alarm and returned back to the nurse's station. At this time, S1ADM confirmed that the two CNA's working with Resident #1, S5CNA and S6CNA, did not know where the alarm sound came from. He stated that the two CNA's had just started working about 2 weeks prior to the incident. He also stated the CNA's could have gotten to Resident #1 quicker had they known where the alarm was coming from. A review of the Elopement Policy with S1ADM was conducted and revealed nothing about alarms, how to respond to an alarm or how to recognize exit seeking behaviors. He stated that he would have to look for a policy on alarms. S1ADM stated that on 03/22/2025, after the incident of elopement, he began an in-service with all staff on the elopement policy, how to identify where an alarm is coming from and how to respond when an alarm activated. Review of the facility's policy with a review date of 08/2024 titled Elopements read in part, Policy Interpretation and Implementation: 1. Staff shall promptly report an resident who tries to leave the premises . 2. If an employee observes a resident leaving the premises .3. If an employee discovers that a resident is missing from the facility .4. When the resident returns to the facility . A request for the facility's policy on alarms/Wander guard was requested on 03/31/2025 at 1:27 p.m., but not provided until a second request was made for a policy and presented approximately 1.5 hours before the notification of Immediate Jeopardy. Review of the facility's policy with a review date of 8/2024 titled Door Guardian WanderguardSystem read in part Policy Statement: The Wanderguard would be used for residents at risk for elopement. Procedure: 5. The Wanderguard notification systems are located at each nurse's station. (Secure Care box located on the wall with door labels and lights). 6. If the notification system starts sounding, locate the alarming door by looking for the light next to the door label that is alerting. Go to the door, look for any residents that may have set off the alarm, once you have determined that no residents are missing, reset the alarm. The Immediate Jeopardy was removed on 04/01/2025 at 1:37 p.m. after it was verified through observations, interviews, and record reviews that the provider implemented an acceptable Plan of Removal prior to the survey exit. The facility implemented the following actions to correct the deficient practice: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195588	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Lane Wellness & Rehabilitative Center	1400 W Magnolia Eunice, LA 70535

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility initiated in-service with staff on 03/22/2025 regarding door alarms within the facility and the Elopement Policy. Staff were educated on how to respond to an activated door alarm. On 03/31/2025, an additional in-service on the Door Guardian, Wander Guard Policy to all staff on duty was conducted. Pictures of the alarming modules located at the nurse's stations were presented to staff for visual recognition. Education continued on 04/01/2025 to all staff as they came for their assigned shifts. The facility continued to educate on 04/01/2025 to all on coming staff members on the policies and procedures for dealing with elopements, residents with elopement risk, alarming doors and how to react and respond accordingly to an alarm. The administrator and/or designee will evaluate new hires and agency staff prior to beginning their shifts on policies and procedures for dealing with elopements, resident with elopement risk, alarming doors and how to react and respond accordingly to an alarm. The charge nurse will evaluate any agency staff to ensure full understanding prior to beginning their shifts. The administrator and/or designee will provide additional monthly education on elopements, elopement risk residents, exit seeking behavior, alarms within the facility and how to properly respond to alarms within the facility to staff for the next 6 months. The DON (Director of Nursing) and/or designee will conduct random weekly audits of staff's knowledge on the policies and procedures on elopements, residents with elopement risk, alarming doors and how to react and respond accordingly for 8 weeks. The Policy on Elopement was revised to include attempted elopements and exit seeking behaviors and how to deal with exit seeking behaviors.