

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Oak Lane Wellness & Rehabilitative Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews, the facility failed to ensure the residents rights to receive their mail on Saturday. This deficient practice has the potential to affect the census of 74 residents that reside in the facility. Findings: On 07/14/2026 at 9:30 a.m., a resident council meeting was conducted with Residents #7, #15, #21, #28 and #63 who each confirmed they did not receive any mail on Saturdays. On 07/14/2026 at 9:40 a.m., an interview with S7HR confirmed the residents get their mail on weekdays Monday through Friday. She stated the mail was delivered to the facility on Saturday, however, the residents received the mail on Monday morning after the facility's office staff sorted through the mail. On 07/15/2026 at 1:34 p.m., an interview with S6ADM confirmed the residents should be receiving their mail on Saturday.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to store food in accordance with professional standards for food service safety by failing to ensure that cut produce stored in the refrigerator was protected from contamination and that refrigerated produce was labeled and dated. A total of 74 residents consumed meals from the kitchen. Findings: On 07/13/2026, a review of the facility's policy titled, Food Receiving and Storage, with a review date of 05/25/2026, revealed, in part; 8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). On 07/13/2026 at 8:30 a.m., during a kitchen tour with S3DSC, observation of the walk-in cooler revealed a bin containing six whole green bell peppers that were not labeled with a received date or use by date. The same bin contained one cut half head of romaine lettuce in its original bag. The cut surface of the lettuce was exposed, the bag was not fully closed and the lettuce was not labeled with a received date or use by date. S3DSC confirmed that the cut romaine lettuce should have been protected by being fully covered and both the cut lettuce and the whole green bell peppers should have been labeled with received and use by dates and was not.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents and/or residents' RP (Responsible Party) were informed of the risks, benefits, and side effects of psychotropic/antipsychotic medications for 1 (Resident #3) of 5 residents reviewed for unnecessary medications. Findings: A review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring with a last review date of 05/25/2026, read in part, Policy Statement: 3. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. Management: 4. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits as well as proposed interventions/medications. A review of Resident #3's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, unspecified severity with other behavioral disturbance, bipolar disorder, unspecified, depression, unspecified, and anxiety disorder, unspecified. A review of Resident #3's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/22/2026 in Section C - Cognitive, revealed he had a BIMS (Brief Interview for Mental Status) of 12, indicating he was moderately, cognitively impaired. A review of Resident #3's current physician order summary report revealed the following psychotropic medication (prescription drugs that alter brain chemicals to affect mood, thoughts, behavior, or perception) orders: Clonazepam oral tablet 0.5 mg (milligram) give 1 tablet by mouth two times a day for restlessness/agitation related to anxiety disorder, unspecified. Order date 07/11/2026 Depakote Sprinkles oral capsule delayed release sprinkle 125 mg give 2 capsules by mouth three times a day related to bipolar disorder, unspecified. Order date 04/29/2026 Escitalopram oxalate oral tablet 5 mg give 1 tablet by mouth one time a day for isolation related to depression, unspecified. Order date 12/10/2025 Rexulti oral tablet 2 mg give 1 tablet by mouth one time a day for restlessness/agitation related to unspecified dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, unspecified. Order date 04/15/2026 Seroquel oral tablet 50 mg give 1 tablet by mouth at bedtime for target behavior: agitation related to unspecified dementia, unspecified severity, with other behavioral disturbance; bipolar disorder, unspecified; anxiety disorder, unspecified. Order date 06/08/2026 Trazodone HCL (hydrochloride) oral tablet 50 mg give 1 tablet by mouth at bedtime for insomnia related to depression, unspecified, give 1/2 tablet. Order date 06/29/2026 Further Review of Resident #3's electronic medication record failed to reveal documentation that Resident #3 or his RP had been informed in advance of the risks, benefits, and possible alternatives of treatments. On 07/14/2026 at 12:20 p.m., an interview with Resident #3 was conducted. He was unable to state which medications he took and was unaware that he took any mood or behavior altering medications. On 07/15/2026 at 12:35 p.m., an interview and review of Resident #3's physician order summary was conducted with S4DON and S6ADON. Both confirmed that Resident #3 received the above psychotropic medications and that neither he nor his RP had been informed of the risks, benefits, or alternate treatments prior to administration of these medications and should have.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement physician orders to address weight loss by failing to offer a dietary supplement that was ordered for 1 (Resident #8) out of 2 residents investigated for nutrition. Findings: Review of Resident #8's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, type two diabetes mellitus, anorexia, and unspecified protein-calorie malnutrition. A review of Resident #8's Weights and Vitals Summary revealed a weight of 147 pounds on 02/09/2026 and a weight of 141 pounds on 03/13/2026. This was a 4.08% weight loss in 30 days. A review of Resident #8's clinical record revealed a telephone order dated 02/11/2026, which read, Add Glucerna (oral snack/meal replacement) to meals as supplement secondary to low intake. A review of Resident #8's care plan revealed an intervention dated 02/11/2026 which read: add Glucerna to meals as supplement related to low intake as ordered. A review of Resident #8's MAR (Medication Administration Record) did not reveal an order for Glucerna. On 07/13/2026 at 11:30 a.m., an observation was made of Resident #8's lunch. The resident's lunch tray did not have Glucerna dietary supplement on it. On 07/15/2026 at 1:30 p.m., an interview was conducted with S4DON. She stated that dietary did not provide residents with Glucerna on their meal trays. She stated that nurses provided this supplement during medication pass. On 07/15/2026 at 2:50 p.m., an interview and a record review was conducted with S7LPN who was assigned to Resident #8. She confirmed the order for Glucerna was not on the MAR for Resident #8. She also confirmed that she had not offered a Glucerna supplement with each meal to resident #8 as ordered by the physician from 02/11/2026 to present. On 07/15/2026 at 3:50 p.m., an interview and review of Resident #8's dietary card was conducted with S3DSC. She confirmed that the dietary card for Resident #8 did not have instructions for Glucerna. She also confirmed that he had not received it on his meal trays for breakfast, lunch, or dinner. S3DSC stated that dietary did not provide Glucerna to residents on their meal trays. On 07/15/2026 at 3:00 p.m., an interview and record review was conducted with S6ADON/IP. She confirmed that the physician's telephone order for a house supplement for Resident #8 should have been entered on the MAR so nursing staff would be prompted to provide it the resident. S6ADON/IP stated there was no way to confirm the order was implemented since it was not documented on the MAR. She further stated that the nurse taking the telephone order should have recorded it on the MAR so nurses would be notified to offer it during medication pass. S6ADON/IP confirmed that Resident #8 should have been offered Glucerna with meals by the nurse 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure residents received the appropriate amount of oxygen as ordered by the physician for 1 (#2) of 3 residents review for respiratory care Findings:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnosis not limited to chronic obstructive pulmonary disease, cognitive communication deficit, shortness of breath, severe dementia, insomnia, anxiety disorder, and aphasia.Record review of Resident #2's Quarterly MDS (Minimum Data Set) dated 05/21/2026 BIMS (Brief Interview for Mental Status) score was 10 indicating she had moderate cognitive impairment.Record review of Resident #2's active physician order summary dated 07/15/2026 read in part, Oxygen 2 liters per NC (nasal cannula) for SOB (shortness of breath) every shift for related to COPD (chronic obstructive pulmonary disorder).On 07/13/2026 at 1:40 p.m., observed Resident #2 sitting up in her wheelchair in therapy wearing a nasal cannula with the oxygen concentrator set at 3 liters. On 07/13/2026 at 4:15 p.m., observed Resident #2 sitting up in her wheelchair in her room wearing a nasal cannula with the oxygen concentrator set at 3 liters. On 07/14/2026 at 10:30 a.m., observed Resident #2 sitting up in her wheelchair in her room wearing a nasal cannula with the oxygen concentrator set at 3 liters. On 07/14/2026 at 1:28 p.m., observed Resident #2 lying in her bed wearing a nasal cannula with the oxygen concentrator set at 3 liters. On 07/14/2026 at 1:33 p.m., an interview with S9CNA revealed she cares for Resident #2. S9CNA stated Resident #2 has to wear continuous oxygen with a nasal cannula. S9CNA stated the oxygen concentrator should be set at 2 liters. On 07/14/2026 at 1:34 p.m., S7LPN confirmed she was Resident #2's nurse. S7LPN stated the resident has chronic obstructive pulmonary disease and has to wear continuous oxygen per nasal cannula set at 2 liters as ordered by the physician. She confirmed Resident #2's oxygen was on 3 liters and should have been on 2 liters. On 07/15/2026 at 2:13 p.m., S4DON reviewed Resident #2's physician orders and care plan and confirmed Resident #2 should be on continuous oxygen per nasal cannula at 2 liters as ordered by the physician.		

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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 observations, interviews, and record review, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. This was evidenced by staff failing to perform hand hygiene after removing gloves. This deficient practice had the potential to affect 74 residents who resided in the facility. Findings: On 07/14/2026, a review of the facility's policy titled Handwashing/ Hand Hygiene with a reviewed date of 05/25/2026, read in part: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub.or, alternatively, soap.and water for the following situations.m. after removing gloves. On 07/13/2026 at 10:45 a.m., an observation was made of S5CNA wearing gloves while providing care to Resident #39. After completing care, S5CNA removed her gloves and left Resident #39's room. She did not perform hand hygiene. S5CNA then walked down the hallway and entered Resident #72's room. On 07/13/2026 at 10:48 a.m., an interview was conducted with S5CNA. S5CNA confirmed that she had not performed hand hygiene after removing her gloves in Resident #39's room, and before entering Resident #72's room, and stated she should have. On 07/13/2026 at 1:30 p.m., an interview was conducted with S2ADON/IP. She confirmed that staff should perform hand hygiene after removing gloves.		