STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195598	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Woods Home for the Elderly	1400 Davenport Avenue Mer Rouge, LA 71261

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents have the right to be free from any chemical restraints by having PRN orders for psychotropic drugs exceeding the 14 day limit for 2 (#1 and #7) of 5 residents reviewed for unnecessary medications. Findings: Resident #1 Record review revealed Resident #1 was initially admitted to the facility on [DATE] with a readmit date of 12/17/2025. Resident #1 had diagnoses that included essential (primary) hypertension, unspecified sequelae of cerebral infarction, chronic respiratory failure, depression, anxiety, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, acute on chronic systolic (congestive) heart failure, and myocardial infarction. Review of quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated intact cognition for daily decision making. Review of the March 2026 physician orders revealed an order dated 11/25/2025 for Hydroxyzine HCL 25 mg, give 1 tablet every 6 hours as needed for anxiety. On 03/25/2026 at 8:55 a.m., an interview with S2DON confirmed Resident #1 had an order for Hydroxyzine 25 mg po q 6 hours prn for anxiety dated 11/25/2025. S2DON further confirmed the PRN psychotropic medication was ordered beyond 14 days with no stop date. Resident 7 Review of the record for Resident #7 revealed an initial admission date of 05/13/2024 with a readmit date of 08/05/2025. Resident #7 had diagnoses that included Parkinson's disease, anxiety, insomnia, low back pain, and depression. Review of the 5-day Medicare MDS assessment dated [DATE] revealed Resident #7 had a BIMS score of 15 which indicated intact cognition for daily decision making. Further review of the MDS revealed Resident #7 received an antianxiety medication. Review of the March 2026 physician orders revealed an order dated 08/05/2025 for Lorazepam .5 mg, give two tablets by mouth every 24 hours PRN for anxiety. Review of the March 2026 MAR for Resident #7 revealed documented evidence that the resident received Lorazepam .5 mg, two tablets by mouth on 03/05/2026. (continued on next page)

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	On 03/25/2026 at 8:55 a.m. interview with S2DON confirmed the resident had an order for Lorazepam .5 mg, give two tablets by mouth every 24 hours PRN for anxiety dated 08/05/2025. S2DON further confirmed the PRN psychotropic medication was ordered beyond the 14 days with no stop date.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide assistance for residents who were unable to carry out activities of daily living (ADL) by failing to maintain good grooming and personal hygiene for 3 (#2, #42, #57) of 3 residents reviewed for activities of daily living.Findings:Resident #2Review of the medical record for resident #2 revealed the resident had diagnoses in part of left above the knee amputation, nail dystrophy, atrial fibrillation, atherosclerosis of native arteries of extremities with gangrene, Type 2 Diabetes Mellitus, cardiomegaly, acute kidney failure, and cerebral infarct.Review of the significant change MDS dated [DATE] revealed the resident had a BIMS that was unable to be assessed. The resident was dependent on staff for personal hygiene. Review of the care plan revealed self-care deficit related to resident needs assistance with activities of daily living. Further review revealed the following approaches: resident will be clean, dry, dressed neatly, odor free, and well-groomed daily this quarter. Morning Care- face washed, hair brushed, oral care--includes brushing dentures/teeth, hands washed, and nail care. Evening care- face washed, hair brushed, oral care- includes brushing teeth/soaking dentures, hands washed.Review of the current Physician orders revealed nail care weekly, trimming as needed every day shift every Wednesday and as needed for long or jagged nails. On 03/23/2026 at 9:09 a.m. observation of resident #2's fingernails revealed they were long and had dark substance under the nails. On 03/23/2026 at 3:50 p.m. observation again of resident #2's fingernails revealed they remained long and continued to have the dark substance under the fingernails. On 03/24/2026 at 8:20 a.m. observation of resident #2's fingernails revealed they continued to have the dark substance under the fingernail. On 03/24/2026 1:30 p.m., an interview and observation of resident #2's fingernails with S5CNA Supervisor agreed the fingernails were not clean. Resident #42Review of the record for resident $42 revealed diagnoses in part of cerebral infarct, hypertension, chronic kidney disease, and depression.Review of the quarterly MDS dated [DATE] revealed resident #42 had a BIMS of 14 indicating the resident was cognitively intact. The resident required supervision or touching assistance with personal hygiene. Review of the care plan revealed self-care deficit related to resident needs assistance with activities of daily living. Further review revealed the following approaches: resident will be clean, dry, dressed neatly, odor free, and well-groomed daily this quarter. Morning Care- face washed, hair brushed, oral care--includes brushing dentures/teeth, hands washed, and nail care. Evening care- face washed, hair brushed, oral care- includes brushing teeth/soaking dentures, hands washed.Review of the current Physician orders revealed nail care weekly, trimming as needed every day shift every Wednesday and as needed for long or jagged nails. On 03/23/2026 at 10:34 a.m. observation of resident #42's fingernails revealed they were long and dirty having a dark substance under the nails. Resident #42 said his fingernails were a little dirty. On 03/24/2026 at 8:30 a.m. observation of resident #42's fingernails revealed they remained long and had a dark substance under them. Resident #42 stated his nails had not been cleaned yet and that he had tried to clean them but didn't get very far with them. On 03/24/2026 at 1:30 p.m. observation of the resident's fingernails and interview with S5CNA Supervisor agreed the resident's fingernails were not clean. Resident #57Review of the record for resident #57 revealed the resident was admitted [DATE] with diagnoses in part of hemiplegia and hemiparesis following cerebral infarct affecting the left non-dominant side, dysphagia, and epilepsy. Review of the 5-day admission MDS revealed resident #57 had a BIMS of 15 indicating the resident was cognitively intact. Further review of the MDS revealed the resident required substantial to maximal assistance with personal hygiene. Review of the care plan revealed the resident had a self-care deficit related to needs assistance with ADL's due to decreased mobility. Further review revealed the following approaches: resident will be clean, dry, dressed neatly, odor free, and well-groomed daily this quarter. Morning Care- face washed, hair brushed, oral care--includes brushing dentures/teeth, hands washed, and nail care. Evening care- (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	face washed, hair brushed, oral care- includes brushing teeth/soaking dentures, hands washed.Review of the current Physician orders revealed nail care weekly, trimming as needed every day shift every Wednesday and as needed for long or jagged nails. On 03/23/2026 at10:16 a.m. observation of resident #57 fingernails revealed they were long and had a buildup of a dark substance under the nail. Resident #57 stated that his fingernails were long and needed to be cleaned. On 03/23/2026 at 3:45 p.m. observation of resident #57 fingernails revealed they remained long with the buildup of the dark substance under the fingernail. Resident #57 stated his fingernails had not been cleaned yet.On 03/24/2026 at 8:20 a.m. observation of resident #57's fingernails again revealed they remained with the same dark substance under the fingernails.On 03/24/2026 at 1:30 p.m. observation of resident #57's fingernails with S5CNA Supervisor revealed the fingernails remained with the same dark substance under the nails and S5CNA agreed the resident's fingernails were not clean. On 03/24/2026 at 2:00 p.m. S2DON was notified of the unclean fingernails for residents #2, #42, and #57.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure it provided routine drugs and biologicals to its residents by failing to have a medication available for administration for 1 (#57) of 2 residents observed during a medication pass.Findings:On 03/24/2026 at 8:50 a.m., a medication pass was observed with Resident #57.Staff S3LPN reported the medication Losartan 50 mg was due at the morning medication pass but it was not available for administration. Review of the March 2026 physician orders confirmed Losartan 50 mg was due to be administered during the morning medication pass.On 03/24/2026 at 10:45 a.m., S2DON was informed that Resident #57's Losartan 50 mg was not available for administration during the morning medication pass.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by 1) failing to monitor the heart rate with the administration of metoprolol succinate for Resident #1 and 2) failing to obtain a lipid panel as ordered for Resident #1 of 5 residents reviewed for unnecessary medications.Findings:Record review revealed Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential (primary) hypertension, presence of aortocoronary bypass graft, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified sequelae of cerebral infarction, chronic respiratory failure, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, acute on chronic systolic (congestive) heart failure, and myocardial infarction. Review of the current March 2026 Physician Orders revealed the following: Order dated 12/20/2025 - metoprolol succinate ER 25 mg tablet give 1 tablet by mouth qd (hold for SBP less than 100 or HR less than 60); an order dated 10/16/2025 - atorvastatin calcium 80 mg tablet give 1 tablet by mouth at bedtime; and an order dated 10/17/2025 - lipid panel every 6 months. Review of the February and March 2026 EMAR revealed Resident #1 received metoprolol succinate and atorvastatin as ordered. Further review revealed there was no documentation of Resident #1's heart rate being obtained with the administration of metoprolol succinate. Review of Resident #1's medical record revealed no documented evidence of a lipid panel. On 03/25/2026 at 8:55 a.m. an interview with S2DON confirmed there was no documentation of Resident #1's heart rate being obtained with the administration of metoprolol succinate. On 03/25/2026 at 10:35 a.m. an interview with S2DON confirmed there was no documentation of Resident #1 having a lipid panel drawn.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations and interviews, the facility failed to ensure that its medication error rates are not 5 percent or greater by having a medication error rate of 17% for 2 (#57, #58) of 2 residents observed for a medication pass.Findings:Resident #57On 03/24/2026 at 8:50 a.m., a medication pass was observed with Resident #57.Staff S3LPN reported the medication Losartan 50 mg was due at the morning medication pass but it was not available for administration. This resulted in an error by omission.After the medication pass was completed, review of the March 2026 physician orders revealed there was an additional omission of the medication Xarelto 10 mg which was due on the morning medication pass. Resident #58On 03/24/2026 at 9:20 a.m., a medication pass was observed with S3LPN for Resident #58.After the medication pass was completed, review of the March 2026 physician orders revealed there was an omission of the medications Lisinopril 20 mg and Tamsulosin 0.4 mg.S3LPN administered Vitamin B-12 during the medication pass. Review of the March 2026 physician orders revealed Resident #58 should have received Thiamin (Vitamin B-1). On 03/24/2026 at 10:45 a.m., S2DON was informed of the 5 medications errors and that it resulted in a 17% medication error rate. S2DON also confirmed the 5 medications should have been administered as ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility must establish and maintain an 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.The facility failed to 1) implement enhanced barrier precautions for 1 (#6) of 1 residents reviewed for enhanced barrier precautions and 2) follow facility policy for the cleaning, storage and replacement of piston syringes for 1 (#26) of 1 residents reviewed for tube feedings.Findings: Resident #6 Review of the facility's Enhanced Barrier Precautions policy and procedure (undated) revealed the following in part: It is the policy of this facility to implement Enhanced Barrier Precautions (EBP) to reduce the transmission of multidrug-resistant organisms (MDROs) and other infectious agents among residents. EBP will be applied according with current CDC guidelines and applicable federal and state regulations within the Oak Woods. Definition: Enhanced Barrier Precautions: Infection control interventions that include the use of gown and gloves during high-contact resident care activities for residents known or suspected to be colonized or infected with MDROs. Indications for EBP: EBP should be used for residents who: Are colonized or infected with an MDRO, have wounds, indwelling medical devices (e.g., urinary catheters, central lines, feeding tubes). Staff must wear gloves and gown during high-contact care activities, including: dressing, bathing/showering, transferring, providing hygiene, changing linens, wound care, and device care. Record review revealed Resident #6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia, gastrostomy status, anorexia, displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, generalized muscle weakness, and need for assistance with personal care. Review of Resident #6's current care plans revealed EBP in place related to increase risk for infection related to peg tube. Goal: Resident will not have an infection this quarter. Intervention: apply appropriate PPE before providing care to resident. On 03/23/2026 at 10:35 a.m., an observation outside Resident #6's room revealed signage posted indicating EBP. Surveyor knocked on door and entered Resident #6's room and observed S7CNA was securing a plastic bag that had a soiled brief and wipes. S7CNA was not wearing a gown. S7CNA reported she had just finished providing incontinent care and changed Resident #6's brief. S7CNA reported she wore gloves, but did not wear a gown when she provided incontinent care for Resident #6. Surveyor asked S7CNA about the EBP signage posted outside Resident #6's room. S7CNA reported Resident #6 was not on EBP, they must have forgot to take the sign down. On 03/24/2026 at 9:30 a.m. surveyor informed S2DON of the observation and interview with S7CNA that occurred on 03/23/2026 at 10:35 a.m. S2DON revealed Resident #6 was on EBP related to her peg tube. S2DON confirmed S7CNA should have worn a gown when she provided incontinent care for Resident #6. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Enteral Feeding Policy and Procedure: Cleaning and maintenance of syringes (undated) revealed the following in part: After each use, rinse syringe with warm water immediately. Draw water in and out several times to clean barrel and tip. Allow syringe to air dry completely. Store in a clean container labeled with resident's name. Replace syringe every 24 hours. Resident #26 Review of the medical record for resident #26 revealed an admission date of 12/31/2024. Further review of the record revealed Resident #26 had a gastrostomy tube for feedings. On 03/23/2026 at 8:48 a.m., observation of the piston syringe located at the bedside for Resident #26 revealed the tip was filled will a dark fluid and the bag that contained the syringe also had a dark fluid on the inside of the bag. The date of the bag that contained the syringe was dated 03/06/2026. Interview with Resident #26 confirmed the syringe was used for his gastrostomy tube. On 03/24/2026 at 10:45 a.m., interview with S2DON confirmed the syringe should have been cleaned and stored appropriately and the syringe should be changed daily.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to ensure each resident was assessed using the quarterly review instrument approved by CMS not less frequently than once every 3 months by failing to ensure a quarterly MDS was completed timely for 1 (#18) of 1 residents reviewed for resident assessments.Findings:Review of the medical record for resident #18 revealed she had an admission date of 11/14/2025. The admission MDS was completed on 11/21/2025. The next quarterly MDS was due on 03/07/2026. There was no documentation that a quarterly MDS was completed by 03/07/2026.On 03/25/2026 at 9:20 a.m., interview with S1Administrator confirmed the MDS for Resident #18 was not completed and submitted by the due date.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident needs by having a nurse leave prescription medications at Resident #30's bedside unattended for 1 (#30) of 1 residents reviewed for nurse competency. Findings: Review of the facility's Medication Management Policy and Procedure (undated) revealed the following in part:2. PurposeThe purpose of this policy is to establish standardized procedures for prescribing, ordering, receiving, storing, administering, documenting, monitoring, and disposing of medications in a safe and consistent manner. 6.3 StorageMedications shall be stored securely and in accordance with manufacturer guidelines. Review of the medical record for Resident #30 revealed an initial admission date of 11/05/2025 with a readmit date of 11/17/2025. Resident #30 had diagnoses that included COPD, DM, hypertension, and tremors. Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 had a BIMS score of 15 which indicated intact cognition for daily decision making. Review of the care plan for Resident #30 revealed self-care deficit related to the resident needs assistance with ADLs, and has decreased mobility. On 03/23/2026 at 9:15 a.m. observation of Resident #30 revealed he was in the bed. Further observation revealed 3 pills were observed in a medication cup on his overbed table. On 03/23/2026 at 9:20 a.m. S4LPN observed the medications on Resident #30's overbed table. S4LPN revealed the medications were from the night shift because she had not given Resident #30 any medications. S4LPN confirmed the pills should not have been left at the bedside unattended. On 03/24/2026 at 10:10 a.m. interview with S2DON confirmed the medications should not have been left at the bedside unattended.