STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195633	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lady of the Oaks Retirement Manor	1005 Eraste Landry Road Lafayette, LA 70506

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149 Based on interviews and record review, the facility failed to protect the residents' rights to be free from neglect by failing to provide incontinence care for a dependent resident for 1 (#3) resident out of 3 (#1, #2, #3) sampled residents. Findings: Review of the facility's policy titled Abuse- Prevention and Prohibition Policy and Procedure with a last reviewed date of 03/25/2023 read in part 6. Neglect means failure of the facility, its employees or service providers to provide adequate medical care or goods and services to a resident to avoid, physical harm, pain, mental anguish, or emotional distress. Review of Resident #3's medical record revealed she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting left non dominant side and aphasia following cerebral infarction. Review of Resident #3's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating she was cognitively intact. Further review of the residents MDS assessment Section GG- Functional Abilities revealed the resident was coded as dependent and required the assistance of 2 or more staff for toileting. Review of Section H - Bowel and Bladder revealed the resident was always incontinent of bowel and bladder. Review of Resident #3's care plan initiated on 07/16/2024 revealed the resident required staff assistance for ADL (Activities of Daily Living) care with an intervention to assist the resident with hygiene and grooming tasks. Review of a grievance form dated 01/24/2025 completed by S2ADON (Assistant Director of Nursing) on behalf of Resident #3 revealed the following in part: On 01/23/2025, resident crying in room at approx. (approximately) 2:20 p.m.; asked resident to help describe issue by picture board or nod yes or no during questioning when trying to find out cause of resident crying. When asked if CNA (Certified Nursing Assistant) upset her she nodded yes. When asked if CNA left her wet during shift she nodded yes. Steps taken to investigate complaint: Watched facility camera, CNA did not make rounds on resident for over four hours . Summary of Pertinent Findings or Conclusions Regarding Concerns: CNA assigned to hall was S3CNA. CNA assisted resident at 9:44 a.m., and did not make scheduled 2 hr (hour) rounds. CNA went in room at 1:29 p.m. and turned light off and left room and did not return. (continued on next page)

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
	195633	A. Building B. Wing	02/18/2025

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/17/2025 at 12:40 p.m., an interview was conducted with S3CNA who confirmed that she cared for Resident #3 on 01/23/2025 from 6:00 a.m.-2:00 p.m. She stated that later in the shift, the resident called for her incontinence brief to be changed, but she had no help at the time. She then explained to the resident that because she required two person assistance, she would have to get help. She turned off the call light alert in the room, exited the resident's room, and continued to complete other tasks. S3CNA stated she had gotten side-tracked as other lights were going off, and did not go back to change Resident #3. S3CNA further stated she could have asked the nurse she observed on the hallway passing medications, the DON (Director of Nursing), ADON (Assistant Director of Nursing), or other CNAs from other halls for assistance, but did not. S3CNA stated she did not go back to change the resident before clocking out at the end of her shift. On 02/17/2025 at 2:56 p.m., an interview was conducted with S2ADON (Assistant Director of Nursing) who confirmed she investigated Resident #3's grievance. Through video evidence, it was revealed S3CNA went into the resident's room at 9:44 a.m., and did not go back to the resident's room to complete two hour rounds as she was supposed to do. Also, she went into the resident's room at 1:29 p.m., turned off the call light alert, and left the room and did not return. S2ADON further stated that S3CNA told her that she was completing other tasks, did not change Resident #3, and failed to go back and change the resident before clocking out. S2ADON confirmed S3CNA was not the only CNA on the hall that shift, and another CNA or the nurse was available to assist her. On 02/17/2025 at 3:05 p.m., an interview was conducted with Resident #3. Resident #3 was nonverbal. When asked if S2ADON spoke with her about a CNA (S3CNA) leaving her wet in January 2025, she nodded yes. She also nodded yes when asked if she had to wait for extended periods of time to be changed. Resident #3 nodded yes when asked if she was upset when the S3CNA didn't come back to change her, and nodded yes when asked if that made her sad. When asked if things had improved after making the complaint with the facility, Resident # 3 shook her head no. On 02/18/2025 at 3:25 p.m., a joint interview was conducted with S1DON (Director of Nursing) and S2ADON. Both S1DON and S2ADON stated that CNAs were required to round on residents every two hours, and that S3CNA should have rounded on the resident again after her initial rounds at 9:44 a.m. They also acknowledged that when Resident #3 called to be changed at 1:29 p.m., S3CNA should not have turned the call light off in the resident's room until the task was completed. S1DON stated the CNAs were trained to leave the call light on until the task was complete so that if the task could not be completed, another staff member would be alerted that the resident still needed assistance. On 2/18/2025 at 3:25 p.m., and interview was conducted with S4CNA who stated that she worked on 01/23/2025 as a floater CNA. She stated that she was available to assist any of the nurses, CNAs, or residents if they asked for help. On 02/18/2025 at 3:35 p.m., an interview was conducted with S5LPN (Licensed Practical Nurse). S5LPN stated that she was Resident #3's nurse on 01/23/2025. She stated that she overheard S3CNA being informed that Resident #3's light was on for assistance, however S3CNA did not ask her for assistance with changing the resident. She was then told that Resident #3 had not been changed, and was informed that S3CNA had clocked out prior to changing Resident #3's soiled brief.