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	05/19/2026

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

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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 ensure a resident who was unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 4 (#3, #86, #91, #104) of 4 (#3, #86, #91, and #104) residents reviewed for ADLs. Findings: On 05/19/2026, a review of the facility's policy titled AM Care Policy and Procedure with a last reviewed date of 09/05/2025, read in part: Policy: AM care will be provided to all residents daily and as needed. Procedure.7. Shave resident if applicable.12. Assist resident with combing and brushing hair. Resident #3 Review of Resident #3's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, other intervertebral disc degeneration, obstructive and reflux uropathy, and venous insufficiency (chronic) (peripheral). Review of Resident #3's Significant Change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/26/2026, revealed in part: Section C the resident had a BIMS score of 09 indicating his cognition was moderately impaired. In Section GG the resident was dependent on staff for personal hygiene care. Review of Resident #3's care plan revealed a focus area dated 08/23/2025 that read in part, The resident requires staff assistance for ADL care. Interventions in part: Assist the resident with hygiene and grooming tasks. On 05/17/2026 at 12:46 pm., an observation was made of Resident #3. The resident was awake and lying in bed. His fingernails on both hands were dirty with a dark brown caked substance underneath the outgrown portion of his nails. The resident stated he could not remember the last time his fingernails were cleaned. On 05/18/2026 at 10:00 a.m., a second observation was made of the resident in his bed. The resident's fingernails remained dirty with a dark brown caked substance underneath the outgrown portion of his nails. Resident #3 stated staff did not clean his nails. On 05/18/2026 at 10:20 a.m., an observation of Resident #3's nails and an interview was conducted with S2DON. She confirmed Resident #3's nails were dirty and stated the resident's nails should have been cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #86 Review of Resident #86's clinical record revealed she was admitted to the facility on [DATE] and had diagnoses that included, but not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and cardiomegaly. Review of Resident #86's care plan dated 11/13/2025 read in part, resident requires staff assistance for ADL care. Interventions read in part: Assist the resident with hygiene and grooming tasks. Review of Resident #86's Quarterly MDS (Minimum Data Set) dated 02/10/2026 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicates severe problems with thinking and memory. On 05/17/2026 at 12:23 p.m., an observation was made of the resident in the dining room on the memory unit. The resident's hair was observed with a greasy appearance, disheveled, and uncombed. On 05/18/2026 at 8:32 a.m., a follow up observation of the resident was conducted while the resident was in her room. Further observation revealed the resident's hair remained uncombed and greasy. Attempted an interview with the resident, but resident was not interviewable. Resident #91 Review of Resident #91's clinical record revealed he was admitted to the facility on [DATE] and had diagnoses that included, but not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, muscle weakness, contracture of muscle, right lower leg, and contracture of muscle left lower leg. Review of Resident #91's care plan dated 07/10/2024 read in part, resident requires staff assistance for ADL care. Assist resident with hygiene and grooming tasks. Interventions read in part: Assist the resident with hygiene and grooming tasks. Review of Resident #91's Annual MDS (Minimum Data Set) 03/24/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicates severe problems with thinking and memory. On 05/17/2026 at 1:44 p.m., an observation was made of Resident #91 while he was in his room. The resident's hair was uncombed and matted in the back of his head. On 05/18/2026 at 12:35 p.m., another observation of Resident #91 was conducted while the resident was in his room. The resident's hair remained matted on the back of his head. Attempted an interview with the resident, but the resident was not interviewable. On 05/18/2026 at 12:36 p.m., an observation and interview was conducted with S16LPN who was the nurse on the unit. S16LPN observed and confirmed that Resident #86 and #91's hair was uncombed. She stated staff was supposed to comb the residents' hair after they had gotten them dressed for the day. Resident #104 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, AM Care Policy and Procedure with a review date of 09/05/2026, read in part Policy: AM care will be provided to all residents daily and as needed. Procedure:. 7. Shave resident if applicable . Review of Resident #104's Electronic Health Record (EHR) revealed that she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysarthria, anxiety disorder, depression, and cognitive communication deficit. Review of Resident #104's annual MDS, with an assessment reference date of 05/06/2026, Section C revealed a BIMS (Brief Interview for Mental Status) score of 15, which indicated Resident #104 was cognitively intact. Review of Section GG revealed in part:.Personal hygiene: The ability to maintain personal hygiene. shaving. dependent. Review of Resident #104's care plan revealed in part, that the resident required staff assistance for Activities of Daily Living (ADL) care. The interventions read in part: . Assist the resident with hygiene and grooming tasks. Further review of Resident #104's care plan revealed in part: . resident had a communication problem related to aphasia, dysarthria with an intervention that read: resident is able to communicate by using: communication board, gestures. On 05/17/2026 at 9:00 a.m., an interview and observation was conducted with Resident #104. An observation of Resident #104 revealed white and black facial hair on her neck, cheeks, chin, and around her mouth. The hair on her neck were long enough to cover her skin. The hair on her cheeks were long enough to curl. The hair on her chin and around her mouth appeared as stubble. Resident #104 was unable to speak and used head nods to communicate. The resident nodded her head up and down to indicate yes when asked, do you know you have long hair on your face? The resident nodded her head up and down to indicate yes when asked, would you like staff to shave your face? The resident nodded her head up and down to indicate yes when asked, does the hair on your face bother you? The resident was asked was your last shower yesterday, 05/16/2026, and resident nodded her head up and down to indicate yes. Resident #104 was asked if staff shaved her face yesterday, 05/16/2026, and she turned her head left to right and back to left to indicate no. The resident was asked if she would have wanted staff to shave her face yesterday, and she nodded her head up and down to indicate yes. On 05/18/2026 at 12:00 p.m., an interview and observation was conducted with Resident #104 and S23LPN. S23LPN observed the resident standing at the foot of the resident's bed, and confirmed Resident #104 had excessive long hair on her neck, hair on her cheeks that curled, and hair around her mouth. S23LPN confirmed the resident should have been shaved when she received a shower on Saturday, 05/16/2026, but was not. Resident #104 was asked if she would have wanted to be shaved when she had a shower on Saturday, 05/16/2026, and she nodded her head to indicate yes. On 05/18/2026 at 1:00 p.m., an interview and observation was conducted with Resident #104 and S2DON. S2DON confirmed Resident #104 had long hair on her face and she needed to be shaved now. Resident #104 was asked if she would have wanted to be shaved when she had a shower her Saturday, 05/16/2026, and she nodded her head to indicate yes.

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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 observations, interview, and record review, the facility failed to store food in accordance with professional standards for food service as evidenced by:1. S8DA failing to cover exposed facial hair while serving food to residents,2. Food items in the facility's kitchen cooler and freezer were unlabeled, opened, and undated;3. lack of cleanliness of the facility's kitchen;4. Failing to ensure kitchen equipment was in good repair; and5. Failing to ensure foods on the food service line were at appropriate temperatures.This deficient practice had the potential to affect the 102 residents who consumed foods from the kitchen.Findings:1. Review of the facility's policy titled, Employee Sanitation Practices with a last reviewed date of 09/05/2025, revealed in part .3. Proper Work Attire .b. The food service employee observes the following dress standards: i. Wears a clean hat or other hat restraint. Employees will facial hair wear a bear restraint .On 05/17/2026 at 8:25 a.m., S8DA was observed serving the breakfast meal to residents with his mustache and facial hair exposed. On 05/17/2026 at 8:38 a.m., S7DA and S8DA both confirmed S8DA's facial hair needed to be covered.2. Review of the facility's policy titled, Food Storage Labeling with a last reviewed date of 09/05/2025, revealed the facility will store and label all foods to ensure safety and quality. Procedures: 1. All temperature controlled foods and ready-to eat foods that are prepared in the facility shall be labeled with the food name, date, and time of storage and use by or discard date.7. Food is stored in containers that are sealable, leak proof, durable and undamaged.The initial kitchen tour was conducted with S12Cook on 05/17/2026 at 8:42 a.m. An observation of food storage in the facility's walk in cooler revealed one and one half bags of shredded lettuce not labeled or dated, one half bag of shredded lettuce undated, lettuce wilted with brown areas, and the cooler fan had visible lint on its exterior surface. An observation of food storage in the facility's walk in freezer revealed two opened/unlabeled clear plastic opened bag of frozen diced chicken, and one opened bag of frozen chicken. S12Cook confirmed the items should have been labeled, dated and sealed.On 05/17/2026 at 8:55 a.m., S6DM arrived and was informed of the above findings.3. On 05/17/2026 at 9:45 a.m., an observation was made of the fryer with visible particles present in grease. The fryer was on the side of the six burner stove. An observation was made of the stainless steel wall, behind the stove and fryer, with visible lint and residue on the walls.On 05/17/2026 at 11:13 a.m., an observation was made of ice machine #2. Behind the ice machine was visible lint on the wall, and two plastic resident pitchers were on observed on the floor.On 05/18/2026 at 8:38 a.m., a second observation was made of ice machine #2. Visible lint remained on the walls and floor behind the ice machine. Two plastic resident pitchers remained on the floor behind the ice machine.On 05/19/2026 at 9:10 a.m., a third observation was made of ice machine #2. Visible lint remained on the walls and floor behind the ice machine. Two plastic resident pitchers remained on the floor behind the ice machine.On 05/19/2026 at 9:15 a.m., S6DM confirmed two plastic resident pitchers were behind ice machine #2 and lint on the wall behind the ice machine was present. S6DM stated housekeeping was responsible for cleaning that area.4. On 05/17/2026 at 11:19 a.m., an observation was made of the kitchen's steam table located in the communal dining room. The steam table had six turn knobs used to regulate the temperature of food. Three of the six turn knobs were missing.On 05/17/2026 at 11:38 a.m., S6DM confirmed food items were located on the steam table where the three turn knobs were missing.On 05/19/2026 at 8:10 a.m., a follow up observation revealed S7DA serving breakfast menu items from the steam table. The steam table remained with three of the six turn knobs missing. On 05/19/2026 at 9:21 a.m., an interview was conducted with S11Maintenance. S11Maintenance reviewed work orders and confirmed there was no work order request regarding the steam table's missing knobs.5. Review of the facility's policy titled, Tray Assembly and Service, with a last reviewed date of 09/05/2025, revealed: 1. All menu items required for the meal service are placed on the steam table or serving line. 2. Hot food is placed on the steam table after being processed to the recommended temperature, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is held at minimum of 135 degrees F. (Fahrenheit)Review of the facility's policy titled, Monitoring Temperatures of Cooked Foods, with a last reviewed date of 09/05/2025, revealed:.2b. Check temperature when food is placed in hot holding equipment. If below 135 degrees F, reheat to 165 degrees F for 15 seconds and place back in the holding equipment.On 05/17/2026 at 11:30 a.m., S6DM was observed measuring the temperature of the lunch meal menu items on the steam table with a thermometer. During food temperature monitoring, S6DM identified the pureed chicken, mashed potatoes and pureed vegetables were held at 130 degrees F. On 05/19/2026 at 9:15 a.m., a final observation of identified noncompliance was reviewed with S6DM. S6DM confirmed grease in fryer with food particles, S6DM confirmed the lint and debris visible on the wall behind the stove and fryer. S6DM further confirmed the cooler fan with lint exposed on exterior of fan. S6DM reported she put in a work order for the cooler fan to maintenance on 04/24/2026 but it had not been cleaned. S6DM verified she did not request a work order for the kitchen steam table's three missing knobs and should have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection. This was evidenced by:A dirty trash can on Resident #115's bed.Staff failing to perform appropriate hand hygiene during medication administration; andStaff failing to follow enhanced barrier precautions (EBP) for Resident #33 and Resident #78.Findings: 1. On 05/17/2026 at 10:49 a.m., an observation was made of Resident #115's room. The resident was not in her room. There was a yellow wet floor sign at the entrance to the room. Resident #115's bed was made and a black trash can with a white plastic bag liner was observed on the resident's bed. On 05/17/2026 at 10:49 a.m., an observation of Resident #115's room was conducted with S20HK and S21CNA. They both confirmed the above observation and stated the trash can should not be on the resident's bed. S20HK stated she had placed the trash can on the resident's bed and should not have done so. On 05/18/2026 at 9:50 a.m., an interview was conducted with S3ADON/IP. She was asked whether it was good practice to place a dirty trash can on the resident's bed. S3ADON/IP stated that was not o.k. She stated something (germs) could have been transferred to the resident's bed from the dirty trash can. 2. The facility's Hand Hygiene Policy and Procedure read in part,.Purpose: 1. To provide guidance and procedure to hand hygiene when providing direct care to residents. 2. To reduce the potential transmission of germs to residents. 3. To reduce the risk of healthcare provides acquiring germs form resident direct care. Policy: Hand hygiene shall be performed.3. Before and after direct resident contact for which hand hygiene is indicated by acceptable professional practice. On 05/17/2026 at 09:35 a.m., S14LPN was observed administering medications to the residents on the hall. She was observed touching the door knob to Resident # 56's room and opened the door. She looked in the room and then returned back to her medication cart. She started dispensing the resident's medications without performing hand hygiene. A bottle of hand sanitizer was observed on the right side of S14LPN's medication cart. While dispensing Resident #56's medications, she was observed touching her nose and computer screen without sanitizing her hands afterwards. Then, S14LPN filled a drinking cup with water and went in Resident #56's room to administer the medications. She returned to her cart to prepare the next resident's medication without sanitizing her hands before preparing the medications. On 05/17/2026 at 09:38 a.m., S14LPN was observed going into Resident #100's room to give the resident his medications. She was observed going to the foot of the resident's bed and touching the handle at the foot of the bed to adjust the resident's head of his bed up before giving him his medications. After administering Resident #100's medication, she returned to the foot of the bed and touched the handle again to adjust the resident's head of his bed. S14LPN returned to her medication cart and started preparing medications for the next resident without sanitizing her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/17/2026 at 09:43 a.m., S14LPN was observed going into Resident #40's room to administer the resident her medication. She returned to her medication cart and started to prepare the next resident's medication without sanitizing her hands. On 05/17/2026 at 09:50 a.m., an interview was conducted with S14LPN. She confirmed that she had not performed hand hygiene between administering medications to Resident #56, Resident #100 and Resident #40 and she should have. On 05/18/2025 at 12:33 p.m., an interview was conducted with S3ADON/IP. S3ADON/IP confirmed that the nursing staff should perform hand hygiene between residents during medication administration. 3. Resident #33 A review of the facility's policy titled Enhanced Barrier Precautions Policy & Procedure, with a last reviewed date of 09/05/2025, read in part: Purpose: To prevent the spread of potential infection by implementing Enhanced Barrier Precautions (EBP). Procedure: 4. For residents for whom EBP are indicated, EBP is employed when performing the following. a. Dressing b. bathing/showering c. Transferring. 5. PPE is to be applied prior to performing the high-contact resident activity according to below. b. Put on a gown and gloves. A review of the facility's policy titled Hand Hygiene Policy and Procedure, with a last reviewed date of 09/05/2025, read in part: Definition(s); Hand Hygiene – Hand hygiene means cleaning your hands by using either hand washing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol based hand sanitizer including foam or gel) . Policy: Hand hygiene shall be performed:. 7. Before and after assisting a resident with meals. A review of Resident #33's EMR (Electronic Medical Record) revealed an admission date of 02/28/2022, with diagnoses that included, but were not limited to, anemia with chronic kidney disease, type 2 diabetes mellitus with chronic kidney disease, and Alzheimer's disease. A review of Resident #33's current care plan revealed in part: The resident has a clinical condition. that warrants enhanced barrier precautions. On 05/17/2026 at 9:25 a.m., an observation was conducted of Resident #33 being transferred from his bed to his wheelchair by S28CNA and another Certified Nursing Assistant (CNA) from another hall. S28CNA and the CNA that came from the other hall did not wear gowns during the resident transfer. The other CNA from the other hall left immediately after the transfer and was unable to interview. On 05/17/2026 at 9:36 a.m., an interview was conducted with S28CNA. S28CNA confirmed she did not wear a gown when transferring Resident #33 from his bed to his wheelchair. On 05/18/2026 at 9:35 a.m., a second observation and interview was conducted of Resident #33's care. S21CNA entered Resident #33's room and walked over to his bedside table beside his bed to feed Resident #33 his breakfast. When she was about to pick up the lid of the insulated plate on Resident #33's food tray, she was asked if she had used hand sanitizer or washed her hands before feeding Resident #33. S21CNA stated no. S21CNA stated was too busy to use hand sanitizer or wash her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/18/2026 at 2:17 p.m., an interview was conducted with S26LPNTX. S26LPNTX confirmed Resident #33 was on EBP. S26LPNTX confirmed an EBP sign was on the wall at the entrance of Resident #33's room. S26LPNTX confirmed the EBP sign read, Enhanced Barrier Precautions, when providing high contact care. staff must wear. a gown. gloves.when transferring. S26LPNTX confirmed staff should wear a gown and gloves when providing high contact care to Resident #33. On 05/18/2026 at 2:35 p.m., an interview was conducted with S3ADON/IP. S3ADON/IP confirmed all staff should wear gowns and gloves when transferring a resident who was on EBP, and confirmed that all staff should wash their hands or use hand sanitizer before feeding residents. Resident #78 A review of Resident #78's EMR revealed an admission date of 09/05/2022 with diagnoses that included, but were not limited to, ileostomy status, encephalopathy, conjunctivitis, and urinary tract infection. A review of Resident #78's most current care plan revealed the resident had a clinical condition (i.e. chronic wound, etc.) and or medical device (i.e. urinary catheter, feeding tube, central line, tracheostomy, etc.) that warrants enhanced barrier precautions. On 05/18/2026 at 9:45 a.m., an observation and interview was conducted of care being provided to Resident #78. S29CNA was observed washing Resident #78's face, chest and stomach with a warm wash cloth. S29CNA did not wear a gown during patient care. S29CNA stated I do not consider these people as germs and I am not afraid of germs. S29CNA confirmed she should have worn a gown when providing care to Resident #78. On 05/18/2026 at 10:05 a.m., an observation was made of S29CNA and S30LPNS transferring Resident #78 from his bed to his wheelchair. S30LPNS asked S29CNA if there were any gloves in the room and S29CNA stated no. S30LPNS and S29CNA then transferred Resident #78 from his bed to his chair. S29CNA did not wear a gown when transferring Resident #78. S30LPNS did not wear a gown or gloves when transferring Resident #78. On 05/18/2026 at 2:17 p.m., an interview was conducted with S26LPNTX. S26LPNTX confirmed Resident #78 was on EBP. S26LPNTX confirmed an EBP sign was on the wall at the entrance of Resident #78's room. S26LPNTX confirmed the EBP sign read, Enhanced Barrier Precautions, when providing high contact care. staff must wear. a gown. when transferring. S26LPNTX confirmed staff should wear a gown when providing high contact care to Resident #78. On 05/18/2026 at 2:35 p.m., an interview was conducted with S3ADON/IP. S3ADON/IP confirmed all staff should use gowns and gloves when transferring, dressing, and bathing a resident who was on EBP.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to file a grievance for a complaint of missing clothes for 1 (Resident #96) of 1 resident reviewed for grievances. Findings: A review of the facility's training, Safeguarding Resident Rights In Nursing Facilities provided to all staff during the orientation process revealed in part, If a resident reports a concern, the organization must promptly attend to and resolve the matter. Examples of complaints can include: loss of personal property. Notify your supervisor about complaints. A review of the facility's policy, Grievance Policy and Procedure with a review date of 09/05/2025 revealed in part, Procedure: take immediate action, Documentation: 1. Document grievances made by a resident. A review of Resident #96's electronic health record (EHR) revealed an admission date of 04/07/2020 with diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic nephropathy, peripheral vascular disease, and chronic obstructive pulmonary disease. A review of Resident #96's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 had a Brief Interview for Mental Status score of 14 which indicated he was cognitively intact. On 05/17/2026 at 9:40 a.m., an interview was conducted with Resident #96. He stated he could not find 3 pair of pants, 2 shirts, and 1 pair of underwear last week. He stated he told someone in laundry about the missing clothes last week, but could not remember who he told. A review of the facility's resident grievance/ complaint log for the month of May 2026 revealed no grievance filed for Resident #96. On 05/18/2026 at 10:10 a.m., an interview was conducted with S15HK. S15HK confirmed Resident #96 was missing clothes and housekeeping had been looking for his things since last week. On 05/18/2026 at 10:55 a.m., an interview was conducted with S5SSD. S5SSD confirmed there was no grievance filed on behalf of Resident #96 during the month of May 2026. On 05/18/2026 at 11:06 a.m., an interview was conducted with S17HKSUP. S17HKSUP stated she did not know Resident #96 complained of missing clothes. S17HKSUP confirmed that if a resident complained of missing clothing last week, it should have been reported to the housekeeping supervisor the same day it was reported to the staff member. On 05/17/2026 at 11:10 a.m., an interview was conducted with S13HK. S13HK confirmed Resident #96 told her he was missing clothes on Thursday, 05/14/2026. She confirmed she did not document Resident #96's complaint of missing clothes. She stated that her supervisor was at work that day but she did not tell her supervisor. On 05/18/2026 at 12:10 p.m., an interview was conducted with S1ADM. S1ADM confirmed a grievance should have been filed on the same day a complaint was made by Resident #96 for missing clothes. S1ADM confirmed housekeeping should have filed a grievance the same day the complaint was made.

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	195633	A. Building B. Wing	05/19/2026

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure residents who had a qualifying diagnosed mental disorder were referred to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 1 (Resident #29) out of 42 sampled residents. Findings: Review of Resident #29's clinical record revealed an admission date of 02/18/2017. The resident's diagnoses included bipolar disorder and major depressive disorder.Review of the resident's PASARR level I evaluation dated 06/22/2020 revealed, . The psychiatric progress note {02/03/2020}, the current diagnostic impression is major depressive disorder . A level II decision is not required . Further review revealed the resident's diagnosis of bipolar disorder was not on the form. Review of the resident's clinical record revealed there was no evidence a PASARR level II was completed with the resident's qualifying diagnosis of bipolar disorder. On 05/18/2026 at 11:02 a.m., an interview was conducted with S5SSD. S5SSD stated that a level II PASARR was not completed because the level II evaluation that was conducted on 06/22/2020 did not include the resident's diagnosis of bipolar disorder and that it should have. S5SSD confirmed that a level II evaluation was not completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement the plan of care per the physician's orders for 1 (#18) of 42 sampled residents, by failing to change Resident #18's left arm dressing, and elevate the resident's swollen left arm while she was in bed. Findings:On 05/19/2026, a review of the facility's policy titled, Care Plan Policy and Procedure, with a last reviewed date of 09/05/2025, read in part: Purpose: The comprehensive plan of care is an interdisciplinary tool used to communicate and address care issues that are relevant to the resident's individual needs. Policy: A comprehensive plan of care will be used to communicate and address care issues that are relevant to the resident's individual needs.A review of Resident #18's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included, but were not limited, to end stage renal disease; chronic diastolic (congestive) heart failure; laceration without foreign body of left forearm; localized swelling, mass and lump, left upper limb; dependence on renal dialysis.A review of Resident #18's current physician's orders revealed the following in part:-04/27/2026 Elevate L (left) arm when in bed every shift for edema.-05/11/2026 WOUNDCARE: Left forearm: Cleanse with wd (wound) cleanser of choice. Pat dry. Apply tao (triple antibiotic ointment) and cover with dcd (an outer wound dressing) one time a day related to laceration without foreign body of left forearm.On 05/17/2026 at 10:11 a.m., an observation was made of Resident #18 in her room. The resident was lying in her bed. The resident's left arm was swollen and was not elevated. The resident had a white dressing with a transparent border dated 5/15 and initial DAOn 05/17/2026 at 10:18 a.m. an observation of Resident #18's arm and an interview was conducted with S9RNS. She confirmed the resident's dressing was dated 5/15 with initial DA. S9RNS stated she would check to see when the dressing was due to be changed but she did not return to the resident's room before surveyor left the resident's room. On 05/18/2026 at 8:40 a.m., a second observation was made of Resident #18 in her bed. The resident's left arm remained swollen and was not elevated.On 05/18/2026 at 8:47 a.m., an observation of Resident #18's left arm and an interview was conducted with S19CD and S22CC. They both confirmed the swelling in the resident's left arm and acknowledged the resident's left arm was not elevated. On 05/18/2026 at 9:00 a.m., an interview was conducted with S24CNA. S24CNA stated she was not aware of the swelling in Resident #18's arm or that her arm needed to be elevated. She stated the nurse was supposed to make her aware of the resident's care plan needs and the nurse did not inform her. On 05/18/2026 at 9:11 a.m., an interview was conducted with S25LPN. She stated the swelling in the resident's left arm was an ongoing problem and staff should elevate her left arm while she was in bed. She confirmed she had gone in the resident's room to administer her morning medications, but did not elevate her left arm. S25LPN was asked how Certified Nursing Assistants (CNAs) were made aware of interventions that should be carried out, and she stated through nurses communication. S25LPN stated she did not communicate to S24CNA this morning (05/18/2026) regarding the resident's arm needing to be elevated. On 05/18/2026 at 9:24 a.m., an interview was conducted with S26LPNTX who was responsible for providing the resident's wound care. She confirmed she had worked on Friday 05/15/2026 and that she changed the resident's dressing and labeled it with the date and her initial (05/15 DA). She stated that it should have been changed on 05/16/2026 and again on 05/17/2026 by the weekend treatment nurse, because it is scheduled to be changed daily. S26LPNTX further stated the resident was admitted with her arm swollen and weeping and confirmed the resident had an order to elevate her left arm while she was in bed. On 05/18/2026 at 10:12 a.m., an interview was conducted with S2DON. She stated that all staff had access to residents care plans to know what to do and carry out orders.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure services provided met nursing professional standards for medication administration by failing to ensure medications were not left at the bedside for 2 (#40 and #61) out of 42 sampled residents. Findings:Resident #40. Review of Resident #40's EHR (electronic health record) revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, radiculopathy, lumbar region, chronic obstructive pulmonary disease, Type 2 diabetes mellitus without complications, paroxysmal atrial fibrillation, anxiety disorder, and cardiomyopathy, unspecified. Review of Resident #40's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating the resident's cognition was intact. Review of Resident #40's MAR (Medication Administration Record) for May 2026 revealed S14LPN administered the resident's 8 a.m. (morning) medications on 05/17/2026. On 05/17/2026 at 08:50 a.m., an observation was made of S14LPN administering Resident #40's medication. S14LPN left a medication cup with the resident's morning medications on the resident's bedside table and exited the resident's room and did not observe the resident swallow the medications.05/17/2026 at 10:00 a.m., a review of Resident #40's electronic health record was conducted and revealed that Resident #40 had not been assessed and approved for self-administration of medication. 05/17/2026 at 10:21 a.m., an interview was conducted with Resident #40. The resident stated sometimes the nurses would use short cuts because they are so overwhelmed and leave her medications on her bedside table for her to take herself. Resident #61. Review of Resident #61's EHR (electronic health record) revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unilateral primary osteoarthritis, left knee, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, generalized anxiety disorder, and dysphagia following cerebral infarction. Review of Resident #61's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident's cognition was intact. Review of Resident #61's MAR (Medication Administration Record) for May 2026 revealed S14LPN administered the resident's 8 a.m. (morning) medications on 05/17/2026. On 05/17/2026 at 08:53 a.m., an observation was made of S14LPN administering Resident #61's medication. S14LPN left a medication cup with the resident's morning medications on the resident's bedside table and exited the resident's room and did not observe the resident swallow the medications.On 05/17/2026 at 10:00 a.m., a review of Resident #61's electronic health record was conducted and revealed that Resident #61 had not been assessed and approved for self-administration of medication.On 05/17/2026 at 12:41 p.m., an interview was conducted with Resident #61. She stated that some of the nurses will leave her the cup with her medications for her to take herself. On 05/17/2026 at 10:30 a.m., an interview was conducted with S14LPN. She stated that she left Resident #40 and Resident #61's medications with the residents because she doesn't have to watch them take their medications. S14LPN stated that she was not aware of any facility policy that stated that medications cannot be left with the resident to take on their own. On 05/19/2026 at 2:50 p.m., an interview was conducted with S2DON. She confirmed that S14LPN should not have left medications with the residents to take on their own. Stated that the nurse should have remained with the residents to ensure they took all of their medications.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review and interview, the facility failed to ensure staffing information was complete, accurate, and posted daily. The facility's census was 105.Findings: On 05/17/2026 at 8:43 a.m., an observation was made of the staffing information posted on the bulletin board that was dated Wednesday, 05/13/2026. Daily Nursing Assignment log was dated 05/17/2026, however the posted information was not complete or accurate and failed to include a census number and the hours of services to be provided. Staff member S27CNA was listed on the day shift Daily Nursing Assignment log dated 05/17/2026 but was unaccounted for on the hall. On 05/17/2026 at 8:45 a.m., an interview was conducted with S9RNS, who revealed that she was not aware that S27CNA was not present at the facility. On 05/17/2026 at 8:57 a.m., S9RNS informed the surveyor that S27CNA called in but it was not reported to her. S9RNS further stated that an overall accurate daily staffing posting had not been posted and she had not seen one. On 05/17/2026 at 8:59 a.m., S10WC confirmed the daily staffing had not been posted. She stated that the night shift was supposed to post it and confirmed it wasn't posted.