STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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 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. Based on observations, interviews, and record review, the facility failed to ensure services provided, as outlined in the comprehensive care plan, met professional standards of quality by nursing staff failing to observe and ensure a resident consumed medication for 1 (#10) of 7 residents reviewed for medication administration.Findings: Review of Resident #10's Clinical Record revealed an admission date of 02/05/2025 and diagnoses, which included Hypertensive Heart Disease and Peripheral Vascular Disease. Review of Resident #10's Quarterly MDS with an ARD of 11/12/2025 revealed a BIMS of 15, which indicated intact cognition. Review of Resident #10's current Physician Orders revealed the following, in part: Lasix oral tablet 40 mg by mouth twice daily at 5:00 a.m. and 12:00 p.m. Review of Resident #10's MAR dated 12/01/2025 revealed the following, in part:Lasix 40 mg by mouth at 12:00 p.m. with a check mark and initials indicating S7LPN administered Resident #10's Lasix at 12:00 p.m. An observation was made of Resident #10 on 12/01/2025 at 3:55 p.m. She had a white tablet in a medication cup on her bedside table. An interview was conducted with Resident #10 at that time. She stated she woke up from a nap and the tablet was on her bedside table. She identified the white pill as her Lasix. She stated she did not take her Lasix if it was after 1:00 p.m. because she would urinate all night. She stated, since she woke up after 1:00 p.m., she decided not to take her Lasix. An observation was made of Resident #10 with S7LPN on 12/01/2025 at 4:00 p.m. S7LPN confirmed Resident #10 had a white tablet in a medication cup on her bedside table. S7LPN identified the white tablet in the medication cup as Resident #10's 12:00 p.m. Lasix. An interview was conducted with S7LPN on 12/01/2025 at 4:02 p.m. She confirmed she left Resident #10's Lasix at her bedside this afternoon. She confirmed she should have observed Resident #10 consume her Lasix to ensure it was taken. An interview was conducted with S3DON on 12/02/2025 at 2:33 p.m. She confirmed nurses should witness the resident consume their medications. She confirmed medications should never be left at the bedside.

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