STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195536	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Oaks Living Center	4312 Ithaca Street Metairie, LA 70006

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's physical chart did not contain conflicting advance directive documents for 1 (Resident #11) of 3 (Resident #11, Resident #71, Resident #134) sampled residents investigated for advanced directives. Findings: Review of the facility's Advance Directive policy and procedure dated [DATE] revealed, in part, previously revised advanced directives should be removed from a resident's chart and placed in the resident's file in medical records. Further review revealed only the active advanced directive should remain on the chart. Review of Resident #11's physical chart revealed, in part, a Louisiana Physician Orders for Scope of Treatment (LaPOST) form dated [DATE], which indicated Resident #11 was a full code status (a healthcare provider should perform cardiopulmonary resuscitation [CPR] [an emergency procedure that combines chest compressions and rescue breathing to keep blood circulating] if a resident's heart stopped beating or a resident stopped breathing). Further review revealed an Advance Directive Consent form dated [DATE], which indicated Resident #11's code status was Do Not Resuscitate (DNR) (a healthcare provider should not perform CPR if a resident's heart stopped beating or a resident stopped breathing). Review of Resident #11's Electronic Medical Record (EMR) revealed, in part, Resident #11 was a DNR. Review of Resident #11's [DATE] physician's orders revealed, in part, an order dated [DATE] which indicated Resident #11's code status was DNR. Review of Resident #11's care plan, created on [DATE]with a review date of [DATE] revealed, in part, Resident #11's code status was DNR with an approach that included Resident #11's current advanced directive would be located in her medical record. In an interview on [DATE] at 10:39AM, S16Ward Clerk/Certified Nursing Assistant (CNA) indicated Resident #11's physical chart should only contain the most recent advanced directive and code status information. S16Ward Clerk/CNA further indicated outdated and conflicting advanced directive documents could be confusing and should be removed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 9:49AM, S17Licensed Practical Nurse (LPN) indicated Resident #11 was a DNR. S17LPN further indicated if Resident #11 would go into cardiac arrest she would not provide CPR or initiate resuscitation efforts. In an interview on [DATE] at 2:32PM, S2Director of Nursing (DON) indicated Resident #11 should not have more than one advanced directive in her chart. S2DON further indicated the LaPOST dated [DATE], that indicated Resident #11 was a full code should have been removed from Resident #11's chart when the advance directive dated [DATE] was signed and placed in Resident #11's chart. In an interview on [DATE] at 3:00PM, S1Administrator confirmed Resident #11 should not have had contradicting advanced directives in her physical chart.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to ensure the shower room floors were maintained in a clean manner for 2 (Shower room e, Shower room f) of 3 (Shower room d, Shower room e, Shower room f) shower rooms observed for cleanliness. Findings: In an interview on 04/06/2025 at 9:54AM, Resident #44 indicated the shower room was dirty. Observation of Shower room f on 04/06/2025 at 10:06AM revealed the floors had a buildup of an unknown black substance between the floor tiles throughout the floor of Shower room f. Observation of Shower room e on 04/06/2025 at 10:08AM revealed the floors had a buildup of an unknown black substance between the floor tiles throughout the floor of Shower room e. In an interview on 04/06/2025 at 10:12AM, S13Certified Nursing Assistant indicated the floors in Shower rooms e and f were dirty and needed to be cleaned. In an interview on 04/07/2025 at 10:27AM, S14Housekeeping Supervisor confirmed Shower room e and Shower room f had a buildup of an unknown black substance between the floor tiles throughout the floors and needed to be cleaned. In an interview on 04/07/2025 at 10:36AM, S1Administrator confirmed the floors in Shower room e and Shower room f needed to be cleaned. In an interview on 04/07/2025 at 11:36AM, S15Floor Tech/Porter indicated it has been over a month since he cleaned the floors in Shower room e and Shower room f.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record reviews, the facility failed to ensure staff answered call bells to assist residents in a timely manner for 3 (Resident #7, Resident #48, Resident #333) of 24 (Resident #1, Resident #3, Resident #4, Resident #6, Resident #7, Resident #8, Resident #9, Resident #14, Resident #20, Resident #21, Resident #33, Resident #35, Resident #37, Resident #41, Resident #43, Resident #46, Resident #47, Resident #48, Resident #51, Resident #52, Resident #56, Resident #65, Resident #76, Resident #333) initial pool residents reviewed for call bell use. Findings: Resident #333 Review of Resident #333's discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2025 revealed, in part, Resident #333's cognition was moderately impaired and Resident #333 was incontinent of bowel and bladder. In an interview on 04/06/2025 at 9:40AM, Resident #333 indicated on 04/05/2025 she had to wait approximately 6 hours, from 6:00AM to 12:00 PM, to receive incontinence care from staff. Resident #333 further indicated the wait time for staff assistance was approximately 30 to 60 minutes after pressing the call light. Resident #48 In an interview on 04/06/2025 at 9:41AM, Resident #48, who resided in Room j indicated when she pressed the call light button for staff assistance, Resident #48's wait time was usually 45 to 60 minutes. Resident #7 Observation on 04/06/2025 at 9:47AM revealed the call light, in the hallway, above the doorway for Room i started blinking and ringing. Further observation at approximately 9:52AM revealed an announcement from the speaker in the hallway that indicated Resident #7, in Room i, needed assistance from staff. Observation also revealed at 9:58AM, a 2nd announcement from the speaker in the hallway which indicated staff was needed in Room i, and at the same time, a staff member passed the blinking and ringing call light above the doorway of Room i, and entered Room h, which was next to Room i. Further observation revealed at 10:10AM, a staff member passed by the blinking and ringing call light in the hallway above the doorway of Room i, and entered Room j, which was also next to Room i. Observation further revealed at 10:18AM, staff went into Room i to assist Resident #7. In an interview on 04/06/2025 at 9:46AM, Resident #7 indicated when she pressed the call light button for assistance from staff, Resident #7 usually had to wait at least 45 minutes. In an interview on 04/08/2025 at 3:01PM, S2Director of Nursing confirmed that waiting approximately 30 minutes for staff assistance, after the call light button was pressed, was too long for the resident to wait for assistance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to ensure that a medication cart was secured while unattended for 1 (Medication Cart a) of 4 (Mediation Cart a, Medication Cart b, Medication Cart c, Medication Cart d) medication carts observed. Findings: Review of the facility's Medication Administration policy and procedure dated 10/04/2024 revealed, in part, medications must be secured at all times and not left unattended. Further review revealed, medication cart drawers should be locked when not in use. Observation on 04/06/2025 at 9:22AM revealed, Medication Cart a was left unlocked and unattended by S8Licensed Practical Nurse (LPN). In an interview on 04/06/2025 at 9:35AM, S8LPN indicated a medication cart should always be locked if unattended. In an interview on 04/08/2025 at 2:45PM, S2Director of Nursing (DON) confirmed all medication carts should have been locked while unattended. In an interview on 04/08/2025 at 2:50PM, S1Administrator confirmed medication carts should have been locked if left unattended.

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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, interviews, and record reviews, the facility failed to ensure the kitchen's dishwasher and 3 compartment sink parameters were maintained to correctly sanitize dinnerware. Findings: Observation on 04/08/2025 at 8:10AM revealed after multiple attempts the dishwasher temperature gauge read 90 degrees Fahrenheit (°F). In an interview on 04/08/2025 at 8:11AM, S10Culinary Aide (CA) indicated the dishwasher's water wash temperature was 90°F. S10CA further indicated they were using a sanitizer for the dinnerware. In an interview on 04/08/2025 at 8:12AM, S9Dietary Manager (DM) indicated the dish machine's water temperature was not getting to 150°F as it should. S9DM further indicated the facility needed to install a hot water heater to raise the dishwasher water temperatures, and S9DM was not sure how many parts per million (PPM) the sanitizer needed to be in order to sanitize the dinnerware. S9DM further indicated according to the Dishwasher Temperature Log, the wash temperature should be 150°F and the rinse temperature should be 180°F. Review of the facility's Dishmachine Temperature Log (High Temperature) revealed from 04/01/2025 to 04/07/2025 staff were documenting a wash temperature of 150°F and a rinse temperature of 180°F for breakfast, lunch, and dinner with no documentation of the sanitizer PPM. In an interview on 04/08/2025 at 8:15AM, S9DM first indicated the 3 compartment sink's sanitizer final rinse should be 2 PPM. S9DM then opened the Pot Pan Sink documentation and stated according to the Pot Pan Sink form, the 3 compartment sink should have a reading of 180 to 200 PPM. Observation on 04/08/2025 at 8:16AM revealed the test strip of the 3 compartment sink's sanitizer final rinse was 0 PPM as indicated on the test strip. In an interview on 04/08/2025 at 2:00PM, S9DM indicated the dishwasher's water temp went up to about 146°F earlier but maintained this temperature only for a minute. S9DM indicated the facility had used the dishwasher to wash dishes for the residents. In an interview on 04/08/2025 at 2:10PM, S1Administrator confirmed the above findings and indicated staff were still using the dishwasher to wash the dinnerware.

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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 reviews the facility failed to ensure oxygen personal care items were contained in plastic bags when not in use for 2 (Resident #133, Resident #135) of 6 (Resident #40, Resident #50, Resident #133, Resident #134, Resident #155, Resident #185) sampled residents investigated for oxygen use. Findings: Resident #133 Review of the facility's BIPAP (Bilevel Positive Airway Pressure) and CPAP (Continuous Positive Airway Pressure) Machine Cleaning Policy and Procedure dated 11/04/2014 revealed, in part, store mouthpiece, and mask in plastic bag when not in use. Review of Resident #133's Physician's Orders dated April 2025 revealed, in part, Resident #133 was on Continuous Positive Airway Pressure (CPAP) nightly at bedtime. Observation on 04/06/2025 at 10:32AM revealed Resident #133's CPAP mask and tubing was on the nightstand and was not contained in a plastic bag. Observation on 04/06/2025 at 3:42PM revealed Resident #133's CPAP mask and tubing was on the nightstand and not contained in a plastic bag. In an interview on 04/06/2025 at 3:46PM, S11Licensed Practical Nurse (LPN) indicated Resident #133's CPAP should have been contained in a plastic bag with Resident #133's name and room number written on the bag. Observation on 04/07/2025 at 11:42AM revealed Resident # 133's CPAP mask and tubing was on the nightstand and not contained in a plastic bag. In an interview on 04/07/2025 at 11:46AM, S12LPN indicated Resident #133's CPAP was not in a plastic bag. Resident #135 Review of the facility's Oxygen Concentrator Cleaning Policy and Procedure dated 11/16/2014 revealed, in part, oxygen masks must be stored mask in plastic bag when not in use. Review of Resident #135's Physician's Orders dated April 2025 revealed, in part, Levalbuterol HCCL Nebulization solution (a medication used to relax the muscles of the airway) 0.63miligrams/milliliter inhale orally two times a day for wheezing, Observation on 04/06/2025 at 3:35PM revealed Resident #135's breathing treatment mask was on the nightstand and not contained in a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/06/2025 at 3:45PM, S11Licensed Practical Nurse indicated Resident #135's breathing treatment mask was not in a plastic bag, but should have been contained in a plastic bag with the resident's name and room number written on it. In an interview 04/07/2025 at 2:45PM, S2Director of Nursing indicated respiratory equipment for Resident #133 and Resident #135 should have been contained in a plastic bag.