STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195578	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evangeline Oaks Guest House	240 Arceneaux Road Carencro, LA 70520

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that a resident's physician and responsible party were immediately notified when the resident was injured for 1 (Resident #2) of 10 (#1-#9 and #R1) sampled residents. Findings:Review of the facility's policy with a review date of 01/01/2024 titled, Accidents and Incidents - Investigating and Reporting read in part, Policy Interpretation and Implementation, 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included in the Report of Incident/Accident form: g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom.Review of Resident #2's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, end stage renal disease, dependence on renal dialysis, type 2 diabetes and atrial fibrillation. Review of the facility's Incident Report dated 06/21/2025 revealed Resident #2 had an incident described as a fall during staff assist on 06/21/2025 at 7:00 a.m. Further review of the facility's incident report revealed the wrong physician and wrong responsible party were notified on 06/21/2025.On 08/25/2025 at 7:27 a.m., a phone interview was conducted with S4LPN (Licensed Practical Nurse). She stated that on the morning of 06/21/2025, she recalled the fall incident involving Resident #2 and the facility's van driver. S4LPN confirmed she did not immediately notify the resident's responsible party because she believed she had 72 hours to notify the resident's family and physician. On 08/27/2025 at 4:30 p.m., an interview was conducted with S1DON (Director of Nursing) and S2ADM (Administrator). Both confirmed they were familiar with the staff assisted fall involving Resident #2 and the facility van on 06/21/2025. Both verified S4LPN failed to notify the correct physician and the resident's responsible party.

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

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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 policy review, interviews and record reviews, the facility failed to file a grievance for 1 (Resident #2) out of 10 (#1-#9 and #R1) sampled residents.Findings:Review of the facility's policy and procedure titled, Grievances/Complaints, Filing, with a revised date of April 2017 revealed, in part: Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care not furnished.Grievances and/or complaints may be submitted orally or in writing.Upon receipt of a grievance and/or complaint, the Grievance officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint.Review of Resident #2's electronic medical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses, but were not limited to, end stage renal disease, dependence on renal dialysis, type 2 diabetes and atrial fibrillation. On 08/27/2025 at 9:52 a.m., a phone interview was conducted with Resident #2's appointed representative. She reported Resident #2 called her and told her he fell while in his wheelchair on the lift of the van prior to leaving the facility for his scheduled dialysis on Saturday morning 06/21/2025. Resident #2's representative stated she was really, really upset because the facility hadn't notified her until the night of 06/21/2025. She stated she went to the facility on Monday morning, 06/23/2025 and spoke to S1DON (Director of Nursing) in person about her concerns.Review of the facility's grievance log from June 2025 until August 25, 2025 failed to include a grievance filed for Resident #2.On 08/27/2025 at 3:40 p.m., an interview was conducted with S1DON. She confirmed she did speak with Resident #2's appointed representative in person on Monday 06/23/2025. S1DON verified Resident #2's representative was upset that she was not notified of the accident involving Resident #2 and the van lift prior to the resident's scheduled dialysis on Saturday 06/21/2025. S1DON denied filing a grievance.

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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 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 policy review, interviews and record reviews, the facility failed to ensure staff provide care and services that meet professional standards of quality as evidenced by failing to perform chest compressions immediately to a resident requiring cardiopulmonary resuscitation (CPR) for 1 (#5) resident out of 10 (#1-#9 and #R1) sampled residents.Findings:Review of Resident #5's electronic medical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Cerebral Infarction (Stroke), weakness, jaw pain, hyperlipidemia, type 2 diabetes mellitus without complications and hypertension. Review of Resident #5's June 2025 physician's orders revealed an order date of 09/25/2024 for full code status.Review of the facility's policy and procedure titled, Emergency Procedure-Cardiopulmonary Resuscitation, with a revised date of April 2016, revealed in part: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), for victims of sudden cardiac arrest.Preparation for CPR. 2. The facility's procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care of facility BLS training material.Emergency Procedure-Cardiopulmonary Resuscitation 1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: .d. Initiate the basic life support sequence (BLS) of events. 2. The BLS sequence of event is referred to as C-A-B (chest compression, airway, breathing). 3. Chest compressions: a. following initial assessment, begin CPR with chest compressions.d. Minimize interruptions in chest compressions.6. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest.Review of the 2010 American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care revealed in part:.Increased focus on methods to ensure that high-quality cardiopulmonary resuscitation (CPR) is performed in all resuscitation attempts. According to an American Heart Association Journal (https://doi.org/10.1161/CIR.0000000000000916), AHA implemented updates to Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care in 2020, which incorporated the importance of minimizing interruptions in chest compressions and ensuring chest compressions provided are of adequate rate and depth. CPR is the single-most important intervention for a patient in cardiac arrest, and chest compressions should be provided promptly. Chest compressions are the most critical component of CPR, and a chest compression-only approach is appropriate if lay rescuers are untrained or unwilling to provide respirations.Review of Resident #5's nursing progress notes revealed an entry dated 06/02/2025 at 7:50 a.m. per S3LPN (Licensed Practical Nurse) read in part: Called into Resident's bedside by CNA (Certified Nursing Assistant) passing food tray. Resident located in bed, nonresponsive and nonreactive to verbal or tactile stimuli. No movements were present. Nonreactive pupil reflex. Grunting breath sounds present. No pulse present. Resident's chart clarified full code. Code Blue initiated. Began CPR at 7:57 a.m. Emergency Medical Services (EMS) arrived at 8:10 a.m. Resident expired on 06/02/2025 at 8:48 a.m.Review of EMS' Pre-Hospital Care Report Summary dated 06/02/2025 revealed the following:Call Received at 07:56:19, EMS Dispatched at 07:56:26, EMS en route at 07:56:31 and arrived on scene at 08:05:55. EMS made contact with Resident #5 at 08:08:55. Chief compliant (primary) was Cardiac Arrest and provider impression was Cardiac Arrest. EMS initiated Protocol 1: Asystole / PEA Protocol. EMS assessment revealed Resident #5 was apneic (breathing had stopped), skin was pale in color and was unresponsive which was not normal for the resident. On 08/26/2025 at 4:06 p.m., an interview was conducted with S7WC (Ward Clerk) who confirmed she was working on the morning of 06/02/2025. S7WC explained S6CNA asked S7WC to go with her because Resident #5 was not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	herself. S7WC reported Resident #5 was observed sitting up, kind of slouched in bed, not responding and her eyes were closed. S7WC stated she exited the resident's room and called 911. S7WC stated S1DON (Director of Nursing) started chest compressions when S1DON arrived to the facility around 8:00 a.m. on 06/02/2025.On 08/26/2025 at 4:12 p.m., an interview was conducted with S6CNA. S6CNA confirmed she was assigned to Resident #5 on the day shift on 06/02/2025. S6CNA explained she was picking up breakfast trays and she went into Resident #5‘s room and observed Resident #5 in her bed and her eyes were open but Resident #5 was not responding. Then S6CNA called S7WC and S3LPN to observe Resident #5. S3LPN then notified S1DON who was on her way to work. S1DON started CPR when she arrived to the facility on [DATE] around 8:00 a.m.On 08/26/2025 at 4:26 p.m., an interview was conducted with S3LPN. S3LPN confirmed she was assigned to Resident #5 on the day shift on 06/02/2025. She explained she was called to Resident #5's room by S6CNA because S6CNA reported Resident #5 was breathing weird and was not acting like herself. S3LPN stated when she went to Resident #5's room, she observed the resident kind of slouched in her bed. S3LPN attempted to arouse Resident #5, but the resident was not responsive. S3LPN reported that she did not start chest compressions immediately. S3LPN explained S7WC called 911 and S1DON started CPR when she arrived to the facility around 8:00 a.m. On 08/27/2025 at 1:42 p.m., an interview was conducted with S1DON (Director of Nursing). S1DON explained S3LPN notified her via text message on 06/02/2025 at 7:52 a.m. that Resident #5 was unresponsive, had labored breathing, and pupils were not reactive. S1DON instructed S3LPN to call 911 and start CPR-chest compressions. S1DON further explained she arrived to the facility on [DATE] at 8:00 a.m. and immediately went to Resident #5's room and performed a sternal rub with no resident response. S1DON then hollered for S7WC to call 911 and then S1DON started chest compressions. S1DON verified S6CNA and S3LPN were CPR certified and should have started CPR immediately after discovering Resident #5 was unresponsive.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, interviews and record reviews, the facility failed to ensure staff maintained current CPR certification for 1 (S3LPN-Licensed Practical Nurse) of 3 (S3LPN, S5LPN and S6CNA-Certified Nursing Assistant) personnel records reviewed.Findings: Review of the facility's policy and procedure titled, Emergency Procedure-Cardiopulmonary Resuscitation, with a revised date of [DATE], revealed in part: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), for victims of sudden cardiac arrest.Preparation for CPR 1. Obtain and/or maintain American Red Cross or American Heart Association certification in BLS/CPR for key clinical staff members who will direct resuscitative efforts. 2. The facility's procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care of facility BLS training material. On [DATE] at 4:26 p.m., an interview was conducted with S3LPN who stated she had BLS certification.A review of S3LPN's personnel record revealed her BLS certification expired 05/2025 but was not renewed until [DATE].On [DATE] at 3:40 p.m., an interview and review of S3LPN's BLS certification records was conducted with S1DON (Director of Nursing). S1DON confirmed S3LPN's BLS certification had lapsed and should have been renewed in 05/2025, but was not.