

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 records reviewed, observations, and interviews, the facility failed to ensure the resident's care plan and physician's orders were followed for 3 (#11, #91, and #102) of 34 sampled residents. This was evidenced when: 1. Facility staff failed to administer Resident #11, and Resident #102 their therapeutic diets as prescribed by the physician. 2. Facility failed to maintain right and left ear cushions to nasal cannula for Resident #91 3. Facility staff failed to ensure Resident #102 was assisted in meal set up per her comprehensive care plan, and failed to administer oxygen according to physician orders. Findings: Review of Resident #11's electronic clinical record revealed an admit date of 02/28/2022 with diagnoses that included encephalopathy, dementia, Alzheimer's disease, and dysphagia, oropharyngeal phase. Review of Resident #11's physician orders dated June 2025 revealed the following order: No added salt (NAS) pureed texture, nectar/mildly thick consistency. Review of the resident's care plan initiated 05/03/2022 read in part: resident is on a mechanical soft, NAS diet. Interventions read in part: provide/serve diet as ordered. On 06/02/2025 at 8:35 A.M., an observation of Resident #11's breakfast tray was conducted. The resident was observed eating grits, pureed scrambled eggs, pureed sausage, thickened lemon water, and milk that was not thickened. On 06/02/25 at 8:46 A.M., an observation and immediate interview was conducted with S5LPN (Licensed Practical Nurse) who stated that the milk was not the correct consistency according to the physician orders, and that the milk should have been thickened. On 06/03/2025 at 10:46 a.m. A.M., an interview was conducted with S6DM (Dietary Manager) who stated Resident #11, and was on a puree, nectar thickened liquid diet. She stated when food trays go on the hall, it was the responsibility of the certified nursing assistant to ensure the residents were receiving the correct diet and the correct fluids. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #102 Review of Resident #102's electronic clinical record revealed an admit date of 05/02/2025 with diagnoses which included alcoholic cirrhosis of liver with ascites, dyspnea, and chronic kidney disease stage 5. Review of Resident #102's physician's orders dated June 2025 read in part: Renal (Dialysis) diet regular texture. Further review revealed an order for oxygen via nasal cannula at 3 liters. Review of the resident's care plan dated 05/02/2025 read in part: resident requires staff assistance for Activities of Daily Living (ADL) care. Interventions included in part: assist the resident with their meal tray set up. Further review of the resident's care plan revealed the following: Oxygen therapy, with an interventions for oxygen via nasal cannula at 3 Liters continuous. On 06/01/2025 at 9:00 A.M., an interview was conducted with Resident #102's responsible party who stated that the resident had not received her breakfast tray. On 06/01/2025 at 9:33 A.M., an interview was conducted with S8CNA (Certified Nursing Assistant) who stated that Resident #102's breakfast tray was left on the food cart. She stated that the CNA who distributed the food trays was distracted by another resident and had forgotten to setup the breakfast tray for the resident. On 06/01/2025 at 9:35 A.M., S8CNA was observed assisting Resident #102 with her breakfast meal and giving her orange juice to drink. On 06/01/2025 at 9:40 A.M., an observation and immediate interview was conducted with S7LPN (Licensed Practical Nurse) who confirmed Resident #102 was on a renal diet and should not have been served orange juice. On 06/03/2025 at 11:25 A.M., an interview was conducted with S6DM who confirmed that the resident was on a renal diet, and should not have had orange juice on her meal tray. On 06/02/2025 at 7:35 A.M., an observation was conducted in Resident #102's room. The resident was observed lying in bed, awake, and alert. Further review revealed her oxygen concentrator machine was off, and the resident was not wearing her oxygen. On 06/02/2025 at 8:35 A.M., a second observation was conducted in the resident's room. The resident was alert, and awake. Further review revealed the oxygen concentrator was still off and, she was not wearing her oxygen as ordered by the physician. On 06/02/2025 at 10:14 A.M., a third observation of the resident was conducted in her room. The resident's responsible party was at the bedside. The resident was alert, and confused. On 06/02/2025 at 11:49 A.M., S11CNA checked Resident #102's oxygen saturation level which was 88% (percent) on room air. On 06/02/2025 at 11:56 A.M., S12LPN rechecked Resident #102's oxygen saturation level which was 84% on room air. After S12LPN applied the oxygen to the resident at 3 liters via nasal cannula, her oxygen saturation level increased to 94%. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/02/2025 at 2:35 P.M., an interview was conducted with S12LPN who stated Resident #102 had not had her oxygen on, and she should have had her oxygen on. Resident # 91 Review of Resident #91's admission Record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia and shortness of breath. Review of Resident #91's Order Summary Report revealed the following order dated 08/14/2024, Maintain right/left ear cushion q (every) shift to nasal cannula every shift. Review of Resident #91's Care Plan Report revealed the following in part, the resident has oxygen therapy r/t (related to) ineffective gas exchange. Interventions included in part, maintain bilateral ear cushions to nasal cannula. On 06/02/2025 at 11:29 A.M., an observation was conducted with Resident #91 in her room. Resident #91 was wearing a nasal cannula. There were no ear cushions were noted to the right or left side of nasal cannula. On 06/02/2025 at 12:21 P.M., a second observation was conducted with Resident #91 in her room. Resident #91 was wearing a nasal cannula. There were no ear cushions were noted to the right or left side of nasal cannula. On 06/02/2025 at 1:42 P.M., a third observation was conducted with Resident #91 in her room. Resident #91 was wearing a nasal cannula. There were no ear cushions were noted to the right or left side of nasal cannula. On 06/02/2025 at 2:09 P.M., an interview, record review and observation of Resident #91 was conducted with S10LPN (Licensed Practical Nurse). S10LPN confirmed that Resident #91 had a physician's order to maintain right and left ear cushions to nasal cannula. S10LPN confirmed that resident did not have right and left ear cushions on her nasal cannula.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that residents who were unable to carry out activities of daily living (ADLs) received assistance with incontinent care for 2 (#61 and #72) of 8(#3, #31, #43, #57, #61, #72, #82, and #92) residents investigated for ADL care. Findings: Resident #61 On 06/03/2025, a review of the facility's policy titled Incontinence Care Policy and Procedure effective 11/17/2015, read in part: Purpose .4. To prevent infection. Policy: Incontinence care will be performed as needed .11. Replace incontinence pad or apply disposable diaper as necessary. Review of Resident #61's Electronic Health Record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to atherosclerosis of coronary artery bypass graft without angina pectoris, type 2 diabetes, and overactive bladder. Further review revealed a diagnosis of urinary tract infection with an onset date of 05/31/2025. Review of Resident #61's quarterly Minimum Data Set (MDS) dated [DATE], revealed in section C that the resident had a brief interview for mental status (BIMS) of 14, indicating her cognition was intact. Further review revealed in section H that the resident was frequently incontinent of urine and always incontinent bowel. Review of Resident #61's care plan revealed a focus area dated 12/21/2024 the resident requires staff assistance for ADL care and interventions which read in part, assist the resident with hygiene and grooming tasks. Further review revealed a focus area dated 06/01/2025 the resident has a urinary tract infection and interventions which read in part, check at least every 2 hours for incontinence. During an interview with Resident #61 on 06/02/2025 at 9:12 A.M., she stated that she was changed before she went to sleep last night (06/01/2025) and no one had changed her since then. The resident also stated that she had asked someone (unable to state who) who came in to change her roommate about an hour ago to ask her Certified Nurse Assistant (CNA) to come in and change her because her brief was wet and no one came. During an interview with S4CNA on 06/02/2025 at 9:17 A.M., she stated she started her shift at 6:00 A.M., and confirmed that she had not checked or changed Resident #61's incontinent brief. She further stated that no one told her the resident needed to be changed. During an interview with S2ADON (Assistant Director of Nursing) on 06/02/2025 at 9:36 A.M., she stated that CNAs are supposed to round on all their residents as soon as they start their shift. S2ADON stated that S4CNA should have known better. Resident #72 Resident #72 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Parkinson's disease without dyskinesia, benign prostatic hyperplasia, muscle weakness, difficulty in walking and other lack of coordination. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #72's Annual Minimum Data Set (MDS) dated [DATE], revealed in section C that he had a brief interview for mental status (BIMS) of 14, indicating his cognition was intact. Further review revealed in section GG that the resident was dependent in toileting hygiene, and required substantial/maximal assistance in personal hygiene. Review of Resident #72's care plan revealed a focus area dated 11/13/2024 The resident requires staff assistance for ADL care r/t (related to) Parkinson's disease with interventions in part, assist the resident with hygiene . Further review revealed a focus area dated 11/13/2024 The resident has bladder incontinence, with interventions in part: Brief use: The resident uses disposable briefs .change PRN (as needed) check as required .Incontinent: Check as required for incontinence . During an observation of Resident #72 on 06/01/2025 at 9:53 A.M., the resident was lying in bed wearing a hospital gown. The resident stated that the last time a CNA (Certified nursing Assistant) checked his brief and changed him was around 5 A.M. Resident #72 was asked if he was wet and he stated, probably. On 06/01/2025 at 9:59 A.M., an observation of Resident #72 and an interview was conducted with S5LPN (Licensed Practical Nurse). She checked the resident's brief and stated it was wet, taped the wet brief back on the resident and told him she was going to get his CNA to change him. S5LPN stated that CNAs are supposed to round on their residents every 2 hours. During a follow-up interview with S5LPN on 06/03/2025 at 11:03 A.M., she stated that she should have changed Resident #72 on 06/02/2025 at 9:59 A.M. after she opened his brief to check him. S5LPN stated she did not think about it.		

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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, and interview, the facility failed to store food in accordance with professional standards for food service, and ensure sanitary conditions were maintained in the kitchen as evidenced by: 1. opened food items in the walk-in cooler not labeled with the date and time, name of food; and 2. expired food in the walk-in cooler and walk-in deep freezer. This facility had a census of 106 residents. Findings: On 06/01/2025, a review of the facility's policy titled, Storage of Refrigerated Food, with a last revision date of July 2012, revealed in part . Policy Statement: The facility ensures the quality and safety of refrigerated foods through accepted storage practices. Procedure: .4. All non-hazardous, opened foods are labeled name of food and date stored. 5. All hazardous foods are labeled with name of food and date to be discarded or date stored . On 06/01/2025, a review of the facility's policy titled, Storage of Frozen Food, with a last revision date of July 2012, revealed in part . Policy Statement: The facility ensures the quality and safety of frozen foods through accepted storage practices. Procedure .5. Food taken out of original containers is put in a clean, sanitized container with a tight fitting lid. No food is left uncovered .9. Frozen foods are used or discarded on or before the expiration date . On 06/01/2025 at 8:33 A.M., a tour of the facility's kitchen was conducted with S1DS (Dietary Supervisor), who stated that she was responsible for the day to day management of the kitchen. On 06/01/2025 at 8:45 A.M., an observation of the walk-in cooler was conducted with S1DS and revealed the following items were opened and not labeled with the date and time they were opened: a large container of mayonnaise, a large bag of sliced cheddar cheese, a large bag of shredded cheddar cheese, a carton of whole milk, and a large bag of shredded lettuce. The lettuce was observed with discoloration and texture changes that indicated the food was spoiled. Further review of the walk in cooler revealed the following items: two plastic gallon bags of taco shells dated 05/18/2025, and a tray of small covered plastic containers of red liquid that was not labeled, dated 05/24/2025. At that time, S1DS confirmed the food items listed above were opened, and not labeled with the date and time they were opened, and should have been. She also confirmed the shredded lettuce, taco shells, and tray of red liquid was spoiled/expired and should have been discarded. On 06/01/2025 at 8:52 A.M., an observation of the walk-in freezer was conducted with S1DS and revealed the following: a plastic gallon bag with an opened bag of hash browns with an expiration date of 03/11/2025, and a large, unsealed, bag of cut okra with an expiration date of 05/07/2025. At that time, S1DS confirmed the food items listed above were expired and should have been discarded.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to provide a safe homelike environment for 1 (#100) out of 6 (#21, #24, #38, #61, #92, and #100) residents sampled for environment. Findings: A review of Resident #100's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, muscle weakness and Chronic Obstructive Pulmonary Disease. A review of Resident #100's admission MDS (Minimum Data Set) dated 03/07/2025 revealed a BIMS (Brief Interview for Mental Status) of 5, indicating her cognition was impaired. On 06/01/2025 at 9:06 A.M. an observation was conducted of Resident #100. A black wire was hanging down from the ceiling and over the resident's bed. The connector was exposed and near the resident while she was lying down in bed. Resident #100 stated the black wire has been like this since she moved into this room a few weeks ago. On 06/02/2025 at 2:36 P.M., a second observation was conducted of Resident #100's environment while she was lying in her bed. A black wire was hanging down from the ceiling and over the resident's bed. The plug in was exposed and near the resident while she was lying in bed. On 06/02/2025 at 3:16 P.M., an interview was conducted with S4CNA (Certified Nursing Assistant). S4CNA stated if there were any environmental concerns, they were instructed to notify the nurse and then put it in the maintenance log. An observation was conducted of Resident #100's environment with S4CNA. She confirmed there was a black wire hanging down from the ceiling, and the plug- in was exposed and near the resident while she was lying in bed. S4CNA was asked if she had noticed the black wire before this observation, and she stated its been there. Resident #100 stated that the wire had been there and sometimes it touched her when she laid in bed. S4CNA confirmed that she did not tell the nurse about the wire or put it in the maintenance log and should have. S4CNA confirmed this was not a homelike environment and the black wire should not have been exposed and near the resident. On 06/02/2025 at 3:17 P.M., an interview was conducted with S13MS (Maintenance Supervisor). He stated he was responsible for all repairs the facility requires regarding the environment, including checking residents' beds and anything electrical. He denied conducting rounds on residents' rooms periodically. He stated he fixed things that were listed on the maintenance log. An observation was conducted of Resident #100's room with S13MS. He confirmed that there was a black wire hanging from the ceiling that almost touched the resident's bed. He confirmed this was not a homelike environment, and the black wire should have been put in the ceiling and should not have been hanging down.		