

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Maison DE Lafayette		STREET ADDRESS, CITY, STATE, ZIP CODE 2707 Kaliste Saloom Road Lafayette, LA 70508	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123</p> <p>Based on observations and interviews, the facility failed to treat each resident with respect, dignity and care by:</p> <ol style="list-style-type: none"> the facility failed to ensure residents were assisted with meals in a dignified manner as evidenced by staff standing over Residents #122, #138, and #563 while assisting them to eat, the facility failed to ensure that a resident with a urinary catheter had a privacy bag or covering over their urine collection bag for dignity for Resident #128. <p>Findings:</p> <p>On 06/12/2024, a review of the facility's policy titled Assistance with meals with a revision date of 01/17/2024, read in part, Policy Statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals.</p> <p>Resident # 122</p> <p>Review of the Resident #122's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer's Disease, Dementia, Contracture Right Hand, and Contracture of Muscle Left Hand.</p> <p>Resident # 138</p> <p>Review of the Resident #138's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Senile Degeneration of Brain, Dementia, Other Lack of Coordination, and Major Depressive Disorder.</p> <p>Resident # 563</p> <p>Review of the Resident #563's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Other Frontotemporal Neurocognitive Disorder, Major Depressive Disorder Recurrent Severe with Psychotic Symptoms, and Unspecified Dementia.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/10/2024 from 8:05 a.m. until 8:15 a.m., observations were conducted of S15CNA (Certified Nursing Assistant) in the dining room. She was observed at the feeding table standing up and feeding Resident #122, Resident #138, and Resident #563 during the that time frame. An interview was conducted with S15CNA, and she stated she was standing up feeding the residents because it was easier for her to feed them. When asked if she should be standing up while feeding the resident she stated oh, no I need to be sitting.</p> <p>On 06/12/2024 at 11:44 a.m., an interview was conducted with S2DON (Director of Nursing). She stated that staff should not stand over residents while feeding and assisting them with meals.</p> <p>49176</p> <p>Resident #128</p> <p>Review of Resident #128's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to .Cerebral Infarction, Obstructive and Reflux Uropathy, and Retention of Urine.</p> <p>Review of Resident #'s 128's June 2024 physician's orders revealed an order dated 05/24/2024 that read: Indwelling foley catheter 16F (French)/30CC (cubic centimeters).</p> <p>Review of Resident #128's current care plan revealed in part .The resident had a urinary catheter that had been re-inserted on 05/24/2024.</p> <p>On 06/10/2024 at 6:20 a.m., an observation was made of Resident #128 in his room. The resident was lying in his bed with his urinary catheter drainage bag hanging underneath the bed. The drainage bag was half filled with urine. There was no privacy bag or covering on the catheter drainage bag.</p> <p>On 06/10/2024 at 8:08 a.m., a second observation was made of Resident #128 in his room. The resident was sitting in his wheelchair with his urinary catheter drainage bag hanging off the left of the wheelchair. There was urine in the drainage bag and visible to others in the hall. There was no privacy bag or covering on the catheter drainage bag.</p> <p>On 06/10/2024 at 8:34 a.m., an interview and observation was made of Resident #128's drainage bag with S20LPN (Licensed Practical Nurse). She confirmed the resident's catheter drainage bag should have had privacy bag or covering over it and it did not.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on observation, and interview the Facility failed to promote and facilitate residents' self-determination through support of the residents' choice about aspects of his or her life in the facility that were significant to the resident for 2 (#25, #35) out 5 (#2, #25, #35, #63, and #106) residents investigated for choices as evidence by:</p> <ol style="list-style-type: none"> 1. failure to remove completed food trays from resident's room for Resident #25; 2. failure to support food choices for Resident #35 <p>Findings:</p> <p>Resident #25</p> <p>Review of Resident #25's medical record revealed an admitted [DATE] with diagnoses which included in part, Type 2 Diabetes Mellitus, Major Depressive Disorder, recurrent severe without psychotic features.</p> <p>Review of Resident #25's annual Minimum Data Sets (MDS) assessment dated [DATE] revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.</p> <p>On 06/10/2024 at 7:35 a.m., an observation was conducted in Resident #25's room, which revealed two food trays. Further review of the food trays revealed that the food trays were from breakfast and lunch dated 06/09.2024.</p> <p>On 06/10/2024 at 7:36 a.m., an interview was conducted with Resident #25 who stated that he did not like when staff left the food trays in his room, because it attracted roaches. The resident stated that this was not the first time, and it happened often.</p> <p>On 06/11/2024 at 2:23 p.m., an interview was conducted with S4CNA (Certified Nursing Assistant) who confirmed that she was assigned to the resident on Sunday 06/09/2024. She stated that food trays were picked up as soon as the residents completed their meal. She stated that she was aware that Resident #25 did not like his food trays to be left in his room, because of roaches. She confirmed that she should have picked up the breakfast and lunch trays on, 06/09/2024, and had not.</p> <p>49176</p> <p>Resident #35</p> <p>Review of Resident #35's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to .Heart Failure, Atrial Fibrillation, Hypertension, Edema and Gastro-Esophageal Reflux Disease.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Quarterly MDS (Minimum Data Set) dated 03/20/2024 revealed the resident has a BIMS (Brief Interview for Mental Status) score of 15 indicating the resident is cognitively intact.</p> <p>Review of Resident #35's June 2024 physician's orders revealed an order dated 02/02/2023 that read: Regular diet, Regular texture, Thin consistency, NAS (no added salt).</p> <p>Review of Resident's #35's Meal ticket dated 06/11/2024 revealed in part .Dislikes: Oats/Oatmeal; Bacon . Special Notes: No oatmeal .bacon .at breakfast.</p> <p>Review of Resident #35's current care plan revealed in part .I have altered diet needs r/t HTN (hypertension), HLD (hyperlipidemia), CAS (carotid artery stenting), heart failure, GERD (gastro-esophageal reflux disease), heartburn, indigestion .Maintain a current list of my food likes and dislikes.</p> <p>On 06/10/2024 at 8:21 a.m., an interview was conducted with Resident #35 who stated that even if a food is listed as a dislike on the meal ticket, the food will still be served on her meal tray. The resident stated that this happens often.</p> <p>On 06/10/2024 at 8:54 a.m., an observation was conducted in Resident #35's room, which revealed her breakfast tray and meal ticket. Resident's breakfast tray consisted of one fried egg, one biscuit and four slices of bacon. Further review of the resident's meal ticket revealed in part .dislikes: bacon .special notes: no oatmeal, grits, bacon or ham at breakfast.</p> <p>On 06/11/2024 at 8:09 a.m., an observation was conducted in Resident #35's room, which revealed her breakfast tray and meal ticket. Resident's breakfast tray consisted of scrambled eggs, one biscuit, two slices of bacon and a container of oatmeal. Further review of the resident's meal ticket revealed in part . dislikes: oats/oatmeal; bacon .special notes: no oatmeal, grits, bacon or ham at breakfast.</p> <p>On 06/11/2024 at 8:24 a.m., an interview and meal ticket review was conducted with S16ADON (Assistant Director of Nursing) who confirmed that Resident #35's meal ticket listed oatmeal and bacon as dislikes and should not be served on resident's breakfast tray. An observation of Resident #35's breakfast tray was conducted in resident's room with S16ADON who confirmed oatmeal and bacon were served for breakfast and should not have been.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observations and interviews, the facility failed to provide a homelike environment for 2 (#1 and #123) out of 9 (#1, #15, #22, #35, #89, #102, #106, #123 and #142) residents investigated for environment, out of a total sample of 59 residents.</p> <p>Findings:</p> <p>On 06/11/2024, a review of the facility's policy titled Homelike Environment with a revision date of 04/03/2024, read in part, Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment .</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Atherosclerotic Heart Disease of Native Coronary Artery without Angina and Recurrent Depressive Disorders.</p> <p>On 06/10/2024 at 7:30 a.m., an observation was conducted of resident #1's bathroom. The left wall of the bathroom was scratched up and peeling, and there were four holes observed in the sheetrock of the wall across from the shower.</p> <p>On 06/10/2024 at 7:34 a.m., an interview and observation of Resident #1's bathroom was conducted with S16ADON (Assistant Director of Nursing). She confirmed the resident's bathroom walls were in disrepair and stated that the maintenance staff was responsible for maintaining the resident's bathroom.</p> <p>On 06/11/2024 at 9:11 a.m., an interview was conducted with S17MaintSup (Maintenance Supervisor). He stated that the administrative staff made Ambassador Rounds of residents' rooms daily and are supposed to report needed repairs to him. S17MaintSup stated he was made aware that the resident's bathroom needed repairs yesterday when the surveyors were in the facility.</p> <p>On 06/11/2024 at 9:35 a.m., a follow-up interview and review of the Ambassador Rounds list was conducted with S16ADON. She stated that each room had an ambassador from the administrative staff who made rounds three times a week and are responsible for turning in their log with identified issues to maintenance. A review of the ambassador list revealed S2DON (Director of Nursing) was the ambassador for Resident #1's room.</p> <p>On 06/11/2024 at 9:45 a.m., an interview was conducted with S2DON. She confirmed that she did not report the maintenance needs for Resident #1's bathroom until yesterday (06/10/2024).</p> <p>46149</p> <p>Resident # 123</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/12/2024, a review of the facility's policy titled Cleaning and Disinfecting Residents' Rooms with a last reviewed date of 04/20/2024 read in part: 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.</p> <p>On 06/10/2024 at 6:09 a.m., an observation was made of Resident #123's bathroom. The shower curtain was observed with multiple scattered black spots. Resident #105 stated that he used the shower independently.</p> <p>On 06/12/2024 at 8:49 a.m., a second observation was conducted of Resident #123's bathroom. The shower curtain remained with multiple scattered black spots and residue.</p> <p>06/12/2024 at 9:01 a.m., an interview was conducted with S8HskSup (Housekeeping Supervisor). She stated shower curtains were removed and sprayed down when soiled or replaced if needed. An observations was then conducted with S8HskSup of the resident's bathroom shower. She observed the multiple scattered black spots that spanned from the top to the bottom of the shower curtain. [NAME] residue and was also observed on the shower curtain. S8HskSup confirmed that the shower curtain had multiple black spots and residue, and that the housekeeping staff was responsible for cleaning the shower curtains.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46149</p> <p>Based on record review and interview, the facility failed to refer residents with newly identified mental disorders to the appropriate state designated authority for review for 2 residents (#16, #125) out of 4 residents (#16, #65, #102, #125) investigated for PASARR (Pre Admission Screening and Resident Review).</p> <p>Findings:</p> <p>Resident #16</p> <p>Review of Resident #16's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, Pyschotic Disorder with Hallucinations and Unspecified Psychosis.</p> <p>Further review of Resident #16's EHR revealed a Level I PASARR screening dated 06/30/2006 that was completed at another facility. A diagnosis of mental retardation or other related conditions was not documented on the screening. A Review of the Level II Evaluation summary and determination notice dated 07/28/2023 revealed in part: Type of Referral - Resident Review . Evaluation Placement Recommendations - The individual does not have a serious mental illness and a level II is not required.</p> <p>On 06/11/2024 at 3:25 p.m., an interview was conducted with S5SSD (Social Services Director) who stated that there was no evidence of a Level I screening other than the Level I screening dated 06/30/2006 that Resident #16 was admitted with. A review of the resident's EHR was then conducted with S5SSD. She confirmed the resident had diagnoses of Unspecified Psychosis and Psychotic Disorder With Hallucinations, and these diagnoses were not included on the resident's the Level I screening completed on 06/30/2006. S5SSD confirmed that an updated Level I screening was not completed when the resident was admitted in 2021 to include those new psychiatric diagnoses.</p> <p>17364</p> <p>Resident #125</p> <p>Review of the resident #125's clinical record revealed the resident was admitted to the facility on [DATE]. Review of the resident's diagnosis list revealed the resident did not have a diagnosis of mental illness upon admission. Further review of the diagnosis list revealed the resident was diagnosed with Dementia without Behavior Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety and Major Depressive Disorder in 2023.</p> <p>Review of the resident's Level 1 PASARR screening dated 04/20/2022 revealed the resident did not have a diagnosis of mental illness.</p> <p>Review of the resident's clinical record revealed diagnoses of mental illness on 02/14/2023 and 05/30/2023. There was no evidence a new Level 1 PASARR screening was done or submitted to the appropriate agency once the resident was diagnosed with mental illness.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/11/2024 at 9:45 a.m., an interview was conducted with S5SSD and S19SSD. Both stated they could not provide evidence that a new Level 1 PASARR screening was done when the resident was newly diagnosed with mental illness.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17364</p> <p>Based on observation, record review and interview, the facility failed to follow the care plan for Resident #72 as evidenced by failing to:</p> <ol style="list-style-type: none"> ensure the resident did not have cigarettes in her possession, follow physician's orders to remove the resident's dialysis dressing for 1 (#72) out of 59 sampled residents. <p>Findings:</p> <p>1. Resident #72. Review of the resident's clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Encephalopathy, End Stage Renal Disease, Anxiety Disorder, Altered Mental Status, and Tobacco Use.</p> <p>Review of Resident #72's medical record revealed in Section O of her MDS that she received dialysis. Further review revealed a physician's order written on 05/20/2024: remove dressings/bandaids over dialysis cannulation site every Mon (Monday), Wed (Wednesday), Fri (Friday) before dinner.</p> <p>On 06/10/2024 at 8:36 a.m., the resident was observed sitting up in wheelchair in the hallway of the hall she resided on. The resident was observed holding a pack of cigarettes on her lap. The resident was observed wheeling herself down the hall. During this observation, an interview was conducted with S22LPN (Licensed Practical Nurse). The LPN stated the resident was an unsafe smoker and should not be holding her cigarettes.</p> <p>Review of the resident's care plan revealed the resident was a smoker with interventions that included: Allow my care team to store my smoking materials .</p> <p>Review of the resident's Smoking Safety Screening assessment dated [DATE] revealed the resident was safe to smoke with supervision. Review of the facility's smokers list identified the resident as an unsafe smoker requiring supervision.</p> <p>Review of the resident's nursing note dated 6/10/2024 08:49 (8:49 a.m.) revealed, Resident noted wheeling herself down the hall with a pack of cigarettes on her lap .</p> <p>On 06/11/2024 at 9:54 a.m., an interview was conducted with S2DON (Director of Nursing). She reviewed the resident's clinical record and confirmed the resident was assessed as an unsafe smoker and should not have had the pack of cigarettes in her possession.</p> <p>47965</p> <p>2.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/12/2024 at 7:47 a.m., an observation was made of Resident #72. The resident had an old dressing on her left arm covering her dialysis cannulation site with old blood noted on the dressing.</p> <p>On 06/12/2024 at 9:00 a.m., an observation of Resident #72's dialysis site and an interview was conducted with S22LPN (Licensed Practical Nurse). She confirmed the resident still had a dialysis dressing over her cannulation site and stated that the dressing should have been removed on Monday before dinner.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on record review, observations, and interviews the facility failed to ensure the plan of care had been revised for 2 (#25, #89) of 2 (#25, 89#) residents' comprehensive care plans reviewed.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #25's care plan reflected his refusal to wear an abdominal binder. 2. Resident #89's care plan was revised to reflect their updated code status. <p>Findings:</p> <p>Resident #25</p> <p>Review of Resident #25's Electronic Record revealed an admitted [DATE] with diagnoses that included in part, Ventral Hernia.</p> <p>Review of Resident #25's physician's orders dated 06/2024 revealed an order on 05/06/2024 which read in part abdominal binder for support of hernia on during day/off at night.</p> <p>Review of Resident #25's comprehensive care plan dated 02/02/2018 read in part I am at risk for bowel/bladder incontinence/altered elimination related to ventral hernia. Intervention read in part .abdominal binder for support.</p> <p>Review of Resident #25's MDS (Minimum Data Set) dated 04/03/2024 read in part .Brief Interview for Mental Status (BIMS) score was 13 which indicated the resident was cognitively intact.</p> <p>Review of Resident #25's Treatment Administration Record (TAR) dated 06/2024 read in part 0800 a.m., abdominal binder for support of hernia on during day/off at night. Further review revealed that on 06/10/2024 - 06/12/2024, S3LPN (Licensed Practical Nurse) documented that the resident had the abdominal binder on.</p> <p>On 06/10/2024 at 7:35 a.m., an observation and interview was conducted with Resident #25 in his room. Resident #25 was observed sitting in a chair, and a cantaloupe sized lump was observed in the resident's abdominal area. The resident was asked if he was wearing his abdominal binder, and he stated no. He stated that the abdominal binder caused him increased pain.</p> <p>On 06/11/2024 at 9:47 a.m., a follow up observation and interview was conducted with Resident #25, who was sitting in a chair in his room. He stated that he was not wearing his abdominal binder.</p> <p>On 06/12/2024 at 8:05 a.m., a third observation and interview was conducted with Resident #25 who was sitting in a chair in his room. He stated that he was not wearing his abdominal binder.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Maison DE Lafayette		STREET ADDRESS, CITY, STATE, ZIP CODE 2707 Kaliste Saloom Road Lafayette, LA 70508	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/12/2024 at 11:04 a.m., an interview was conducted with S3LPN who stated that the resident had the ventral hernia for a long time. She stated that Resident #25 had an abdominal binder that was to be worn in the day and taken off at night.</p> <p>On 06/12/2024 at 11:07 a.m., an observation and interview was conducted with Resident #25 and S3LPN in Resident #25's room. S3LPN was asked if she applied Resident #25's abdominal binder on 06/10/2024, 06/11/2024, and 06/12/2024, and she stated that she had not. S3LPN asked Resident #25 to locate his abdominal binder, and the resident stated that he did not remember where he put the binder. He stated that he did not wear the binder because it was painful to him. S3LPN confirmed that she had not applied the abdominal binder on 06/10/2024, 06/11/2024, and 06/12/2024. She stated that she should have informed the physician that the resident was refusing to wear the abdominal binder.</p> <p>46149</p> <p>Resident # 89</p> <p>On 06/12/2024 at 2:32 p.m., a review of the facility's policy titled Advanced Directives with a last reviewed date of 04/03/2024 read in part: 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive.</p> <p>Review of Resident #89's EHR (Electronic Health Record) revealed the resident was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction due to Embolism of Left Posterior Cerebral Artery and Malignant Neoplasm of Cervix Uteri.</p> <p>Review of Resident #89's May 2024 physician's orders revealed an order dated 05/29/2024 that read DNR (Do Not Resuscitate).</p> <p>Review of the resident's Lapost (Louisiana Physician Orders for Scope of Treatment) signed and dated 05/29/2024 read in part: Cardiovascular Resuscitation - DNR/Do not attempt resuscitation (allow natural death).</p> <p>Review of Resident #89's plan of care revealed a focus that read: I am a Full Code; I have signed Advanced Directive, with an initiation dated 06/06/2023.</p> <p>On 06/11/2024 at 12:58 p.m., an interview was conducted with S6MDS and S7MDS who stated that they were responsible for developing and updating Resident #89's plan of care. S6MDS and S7MDS both stated that they were not aware the resident's code status was updated from Full Code to DNR, and the resident's care plan was not revised.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123</p> <p>Based on record review, observations and interview, the facility failed to provide appropriate and sufficient services, treatment and care according to standards of professional practice for 1 (#33) of 1 (#33) residents that were reviewed for urinary catheter or UTI (urinary tract infection) out of a total of 59 sampled residents. The facility failed to ensure Resident #33's urinary catheter bag was below the level of the resident's bladder.</p> <p>Findings:</p> <p>Resident # 33 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Bladder Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms</p> <p>A review of Resident #33's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/17/2024 revealed he had a BIMS (Brief Interview for Mental Status) score of 15, suggesting his cognition was intact.</p> <p>On 06/10/2024 at 8:32 a.m., an observation was conducted of the resident in his wheelchair with his urinary catheter bag hung on the right side on the arm of the wheelchair, and not below his bladder.</p> <p>On 06/10/2024 at 7:40 a.m., an observation was conducted of the resident sitting in his wheelchair. His urinary catheter bag was hanging on the right side on the arm of the wheelchair.</p> <p>On 06/10/2024 at 8:32 a.m., an interview and observation was conducted with S14LPN (Licensed Practical Nurse). She stated the Resident had a history of refusing catheter care in the past but for the past couple of months he had not refused any catheter care. S14LPN observed Resident #33 in his room in his wheelchair and confirmed his urinary catheter bag was hanging on the right side on the arm of the wheelchair above his bladder. She stated the urinary catheter bag should have been below the bladder.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observations, record review and interviews, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding by failing to ensure insertion site of the gastric tube was cleansed as ordered for 1 (#54) resident investigated for tube feeding, out of a total sample of 59 residents</p> <p>Findings:</p> <p>Resident #54 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Malignant Neoplasm of Overlapping Sites of Oropharynx and Carcinoma In Situ of Skin of Right Upper Limb. The resident had a PEG (Percutaneous Endoscopic Gastrostomy) tube for enteral feeding.</p> <p>A review of Resident #54's MDS (Minimum Data Set) revealed in section K that he had weight loss and was receiving 26-50% tube feeding.</p> <p>A review of Resident #54's June 2024 physician's orders revealed an order written on 10/23/2023: Cleanse the PEG site with soap and water, pat dry, apply split gauze qd (every day).</p> <p>On 06/10/2024 at 6:58 a.m., an observation and interview were conducted with Resident #54 in his room. The resident stated he was losing weight and receiving enteral bolus feeding. The resident's PEG tube site had a dressing dated 06/07/2024, indicating it hadn't been changed in three days.</p> <p>On 06/20/2024 at 7:07 a.m., an interview and review of Resident #54's physician's orders was conducted with S21 LPN (Licensed Practical Nurse) who confirmed the dressing needed to be changed daily. S21LPN made an observation of the resident's feeding tube site and confirmed that the dressing was dated 06/7/2024, indicating it had not been changed in three days.</p> <p>On 06/10/2024 at 7:09 a.m., an interview and observation of Resident #54's feeding tube site dressing was conducted with S13ADON (Assistant Director of Nursing) who confirmed the dressing had not been changed in three days and should have been changed daily.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on observations, record review, and interviews, the facility failed to ensure medications were stored properly and not available for resident's use as evidenced by eye drops left at the bedside for 1 (#2) out of 59 final sampled residents. The deficient practice had the potential to affect a census of 164.</p> <p>Findings:</p> <p>Resident #2 was admitted on [DATE] with diagnoses that included in part, Preglaucoma, and Occipital neuralgia.</p> <p>Review of Resident #2's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/28/2024 revealed a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment.</p> <p>On 06/12/2024 at 12:34 p.m., review of the facilities Medication Administration policy and procedure with a review date of 04/03/2024 read in part Policy Interpretation and Implementation:</p> <p>27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p> <p>Review of the 06/2024 physicians orders revealed an order on 05/27/2024 for Dorzolamide HCL - Timolol Ophthalmic solution 2-0.5% instill one drop in both eyes at bedtime.</p> <p>On 06/10/2024 at 6:26 a.m., an observation was conducted of Resident #2's room that revealed eye drops on the top of her dresser. The bottle of eye drop medication was observed. The bottles contained a clear substance, and the label read in part Dorzolamide HCL- Timolol Ophthalmic solution 2-0.5%.</p> <p>On 06/10/2024 at 6:28 a.m., an interview was conducted with Resident #2 who stated that she administers her own eye drops sometimes, and sometimes the nurse would administer her eye drops.</p> <p>On 06/10/2024 at 7:00 a.m., a second observation was conducted of Resident #2's room which revealed two bottles of eye drops medication at the resident's bedside.</p> <p>On 06/10/2024 at 7:53 a.m., an interview was conducted with S3LPN (Licensed Practical Nurse) who confirmed that the eye drops should not have been left at the resident's bedside. She stated the resident had not been assessed for self-administration of the medication.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</p> <p>Based on observations and interviews, the facility failed to provide a nourishing, palatable, well-balanced diet to meet the nutritional needs of 2 (#51 and #92) of 26 (#s 4, 5, 6, 14, 15, 17, 18, 28, 35, 49, 50, 51, 54, 62, 64, 83, 92, 104, 112, 122, 134, 138, 140, 142, 153, and 563) residents investigated for dining.</p> <p>Findings:</p> <p>On 06/12/2024, a review of the facility's policy titled, Frequency of Meals, with a revision date of 04/03/2024, read in part, Policy Statement: Each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes .Policy Interpretation and Implementation 1. The facility will serve at least three (3) meals or their equivalent daily at scheduled times .Breakfast 7:30 a.m.</p> <p>Resident #51:</p> <p>Review of Resident #51's electronic record revealed an admitted [DATE] with diagnoses that revealed in part, Acute Kidney Failure, Vitamin D Deficiency, Chronic Congestive Heart Failure, Hypomagnesemia, Celiac Disease, Hypokalemia, Anemia, Unspecified Protein-Calorie Malnutrition and Celiac Disease.</p> <p>Review of Resident #51's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired.</p> <p>Review of Resident #51's electronic record revealed a diet order on 05/21/2024 for Mechanical soft with chopped meat, extra gravy with meat, regular liquids.</p> <p>On 06/10/2024 at 8:40 a.m., an interview was conducted with Resident #51. She reported that she had not received her breakfast tray yet that morning. She stated that she had just requested a breakfast tray because she was leaving for a doctor's appointment. She stated that a CNA (Certified Nursing Assistant) had just notified her that the kitchen was out of plates and eggs.</p> <p>On 06/11/2024 at 9:50 a.m., an interview was conducted with Resident #51. She stated that she did not get breakfast yesterday on 06/10/2024 before her appointment. Resident #51 stated that she left about 8:45 a.m. She did not eat until she returned, and lunch was served.</p> <p>On 06/12/2024 at 8:23 a.m. an interview was conducted with S18CNA. She was working the morning of 06/10/2024 on Resident #51's hall. She stated that Resident #51 asked her for a breakfast tray before she went to her appointment on 06/10/2024. She stated the kitchen informed her that they had run out of dishes. She confirmed that Resident #51 did not get her breakfast tray on the morning of 06/10/2024 before her appointment. She confirmed that Resident #51 left for her appointment around 8:50 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>47965</p> <p>Resident #92:</p> <p>Resident #92 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to, Interstitial Pulmonary Disease and Peripheral Vascular Disease. The resident was on a Consistent Carbohydrate Diet, Regular Texture, Thin Consistency.</p> <p>On 06/10/24 at 8:36 a.m., an interview was conducted with the resident in her room. The resident was sitting in her wheelchair and her family member was there to take her to a doctor's appointment. The resident and family member stated that she was going to her appointment without breakfast because breakfast was late. They also stated that meals were frequently late and cold. The resident left for her doctor's appointment without eating breakfast.</p> <p>On 06/10/24 at 8:41 a.m., an interview was conducted with S18CNA. She stated that breakfast was late.</p> <p>On 06/11/2024 at 1:53 p.m., an interview was conducted with S21LPN. S21LPN stated that Resident #92 should have gotten her breakfast by 8:00 a.m. He further stated that after 8:00 a.m. breakfast was considered late.</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>44269</p> <p>Based on interviews, observations and record review, the facility failed to ensure there was enough dietary staff to provide residents' meals within 45 minutes of the facility's scheduled meal times for 57 residents who consumed meals from Kitchen 3.</p> <p>Findings:</p> <p>On 06/12/2024, a review of the facility's policy titled, Frequency of Meals, with a revision date of 04/03/2024, read in part, Policy Statement: Each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes .Policy Interpretation and Implementation 1. The facility will serve at least three (3) meals or their equivalent daily at scheduled times .Breakfast 7:30 a.m., Lunch 11:30 a.m .</p> <p>On 06/10/2024 at 8:15 a.m., an interview was conducted with S23DS (Dietary Supervisor) stated the facility has one main kitchen (Kitchen 1) where all of food was prepared and two other kitchens (Kitchen 2 and Kitchen 3) used to distribute meals.</p> <p>On 06/10/2024 at 8:30 a.m., an interview was conducted with S11DM (Dietary Manager) stated S12Cook was responsible for Kitchen 3.</p> <p>On 06/10/2024 at 8:41 a.m., an interview was conducted with S18CNA (Certified Nursing Assistant). She stated that breakfast was late for Hall A.</p> <p>On 06/10/2024 at 8:50 a.m., an interview was conducted with Resident #142 who stated she had not yet received her breakfast tray.</p> <p>On 06/10/2024 at 10:45 a.m. an interview was conducted with Resident #15 who stated she had not received her breakfast tray until almost 9:00 a.m. Resident #15 further stated breakfast was that late more often than not.</p> <p>On 06/10/2024 at 12:33 p.m., an observation was made of lunch meal trays being delivered on Hall A.</p> <p>On 06/10/2024 at 12:45 p.m., the last lunch tray was observed being delivered to the last resident on Hall A.</p> <p>On 06/11/2024 at 8:40 a.m., an observation was made of the last breakfast tray being delivered on Hall A.</p> <p>On 06/11/2024 at 4:00 p.m., an interview was conducted with S11DM who stated Kitchen 3 did not have good phone reception, and whoever was serving the meals would have to walk to Kitchen 1 if needed more supplies. S11DM agreed that staff not having all necessary food and supplies to complete meal services takes time away from serving times and contributes to late serving times. She explained that she was not involved in the process of how CNAs distribute the meal trays to residents on hall A.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>44269</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure recipes for pureed, and chopped diets were followed. This failure had the potential to contribute to an unpleasant dining experience, decreased intake, altered nutritional needs, and weight loss for the 7 residents who received pureed or chopped meals.</p> <p>Findings:</p> <p>On 06/11/2024 at 11:09 a.m., an observation was made of S23DS (Dietary Supervisor) preparing the lunch meal pureed dessert of a chocolate peanut butter bar. S23DS was observed taking an unmeasured amount of chocolate peanut butter bars and placing them in the food processor and blended the bars. She then stopped blending the mixture and added an unmeasured amount of milk from 1- half pint of milk, then blended the mixture and shortly after stopped blending. S23DS was observed manually breaking the large pieces of bars that had not processed into smaller pieces and then blended the mixture. She then added an unmeasured amount of milk from a half pint of milk, blended mixture, stirred mixture and added unmeasured amount of milk from a second half pint of milk and blended mixture. S23DS never used a recipe to prepare the pureed desserts.</p> <p>On 06/11/2024 at 11:22 a.m., an observation was made of S12Cook preparing the lunch meal's purred black eyed peas. S12Cook was observed placing an unmeasured amount of cooked black eyed peas into the food processor, added an unmeasured amount of milk from 1- half pint of milk and then blended the mixture. S12Cook stated that total number of residents who consumed pureed diets were between 10 or 11. She denied knowledge of a pureed recipe being available to ensure an adequate amount was being served to those residents. S12Cook was then observed adding 1 single serving packet of thickener to the mixture, then blended the mixture, stopped and added a second single serving packet of thickener to the blended mixture. After blending the mixture, S12Cook was then observed separating the mixture into 3 different sized metal serving bins using a disposable plastic spoon. S12Cook failed to measure how much of the mixture was divided up to ensure an adequate amount among the 3 serving steam tables.</p> <p>On 06/11/2024 at 11:33 a.m., S12Cook was observed removing a total of 7 scoops of rice from the main steam table to the food processor to prepare the pureed rice. She added an unmeasured amount of milk from 1- half pint container, blended the mixture, stopped blending, then added more of an unmeasured amount of milk, and continued to blend the mixture without use of a recipe.</p> <p>On 06/11/2024 at 11:39 a.m., an observation was made of S23DS approach S12Cook and informed her that she would need more chopped meat and black eyed peas because there was not enough on the main kitchen's serving steam table.</p> <p>On 06/11/2024 at 12:02 p.m., an observation was made of S12Cook removing an unmeasured amount of black eyed peas from the main kitchen's serving steam table to blend more for chopped diets because S23DS informed her there was not enough. S12Cook failed to use a recipe.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/11/2024 at 3:53 p.m., an interview was conducted with S11DM (Dietary Manager). She stated recipes were located in the main kitchen in designated binders and should be used. She stated S12Cook was filling in and confirmed she should have used the recipes when preparing the lunch meal on yesterday 06/10/2024.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>44269</p> <p>Based on observations, interviews, and record review, the facility failed to ensure environmental staff possessed the necessary qualifications or competencies as evidenced by failing to notify nursing staff when Resident #93 was heard yelling for help.</p> <p>Findings:</p> <p>Review of S9Hsk's (Housekeeping) training revealed the following onboarding training was completed upon hire on 06/06/2024: Stop and Watch In service Form revealed, in part .Environmental and Dining Services Employees do not provide direct patient care, but may come in contact with patients or residents while performing their duties, for example, while cleaning a resident's room or serving a resident's meal . Employees may come in contact with residents, it is important for them to be aware of the types of behavior that could indicate a serious change in a resident's health .It is important that you immediately notify a member of the nursing staff. The facility may have a form for you to complete if you notice a change in a resident's behavior, but the important thing is that you report the change to nursing so they are aware .</p> <p>On 06/11/2024 at 8:03 a.m., during a random observation of the breakfast meal distribution of trays on Hall A, surveyor heard Resident #93 yelling help. The resident's door was observed closed.</p> <p>On 06/11/2024 at 8:15 a.m., as S9HsK walked to supply closet located directly across from Resident #93's room (Room A), Resident #93 could be heard yelling help. S9Hsk looked at Resident #93's closed door and continued to walk in the opposite direction and began cleaning Room B which was located across and adjacent from Room A.</p> <p>On 06/11/2024 at 8:16 a.m., Resident #93 was heard yelling heeeellllllpppp (more exaggerated).</p> <p>On 06/11/2024 at 8:17 a.m., S9HsK was observed walking out of Room B and had not acknowledged the yelling of Resident #93.</p> <p>On 06/11/2024 at 8:19 a.m., S9HsK was observed standing near her cart in the hallway outside of Room A when Resident#93 was heard yelling heeeeeeellllpppp (more exaggerated). S9Hsk was observed looking up and at the resident's closed door (Room A) without making any type of initiative to further investigate the yelling.</p> <p>On 06/11/2024 at 8:25 a.m., S9Hsk was interviewed while on Hall A. She stated she was newly hired and had been working at the facility for two weeks. She confirmed she completed onboarding training online upon hire on 06/06/2024 which included her job duties. S9HsK explained if she went into a resident's room to clean and a resident was observed on the floor, she would look for the button that was usually located on the resident's bed and would call the nurse. S9HsK reported she would wait until the nurse came to check on resident. S9Hsk confirmed she heard Resident #93 screaming and admitted she should have notified a nurse or CNA (Certified Nursing Assistant) of the yelling of a resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Maison DE Lafayette		STREET ADDRESS, CITY, STATE, ZIP CODE 2707 Kaliste Saloom Road Lafayette, LA 70508	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/11/2024 at 2:41 p.m., an interview was conducted with S8HskSup (Housekeeping Supervisor) who stated she had been staffed at the facility through a contracted agency since 03/04/2024. S8HskSup stated that if housekeeping staff hear or see a resident screaming for help or on the floor, the expectation of the housekeeping staff was to use the resident's call button to call the desk for help and wait with the resident until the nurse arrives to care for the resident. If unable to get to call button, housekeeping staff have been instructed to notify S8HskSup by cell phone. S8HskSup confirmed she had not been notified of S9Hsk hearing Resident #93 screaming help while S9Hsk was cleaning rooms on Hall A and S9Hsk failing to notify nursing staff to investigate the screaming.</p> <p>On 06/11/2024 at 5:25 p.m., an interview was conducted with S1Admin (Administrator) regarding the incident involving Resident #93 screaming for help on Hall A earlier in the morning. He explained that he could not believe that S9Hsk heard the resident screaming and didn't get help from the nurse or a CNA and stated he speculated that S9Hsk must have not interpreted the screaming as a sign of distress.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Maison DE Lafayette		STREET ADDRESS, CITY, STATE, ZIP CODE 2707 Kaliste Saloom Road Lafayette, LA 70508	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44269</p> <p>Based on observation and interviews, the facility failed to protect confidential information for Resident #6 by failing to enable the computer's privacy screen during a treatment being administered to Resident #153. This deficient practice had the potential to affect a total census of 164.</p> <p>Findings:</p> <p>On 06/11/2024 a review of the facility's Policy and Procedure titled, Confidentiality of Information and Personal Privacy, with a revision date of October 2017 and review date of January 2024, read in part .</p> <p>Policy: Our facility will protect and safeguard resident confidentiality of all resident personal and medical records.</p> <p>Policy Interpretation and Implementation:</p> <p>1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .</p> <p>4. Access to resident personal and medical records will be limited to authorized staff .</p> <p>On 06/11/2024 at 10:12 a.m., an observation was made of an unattended treatment cart located outside of Resident #153's room with the computer opened and the screen was visible. Private medical information was visible on the computer screen regarding another resident (#6).</p> <p>On 06/11/2024 at 10:18 a.m., an interview was conducted with S13ADON (Assistant Director of Nursing). She verified that the expectation for treatment carts was the same, as with the medication carts. S13ADON stated that when staff left the carts unattended, the computer screens should be locked to protect the confidentiality of resident's personal and medical information.</p> <p>On 06/11/2024 at 12:32 p.m., an interview was conducted with S10TxLPN (Treatment Licensed Practical Nurse) who stated she was the designated treatment nurse and documented on a computer that was present on the treatment cart. She stated the computer's privacy screen should be locked when left unattended. S10TxLPN explained that to enable the privacy screen on the computer, it had to be manually enabled by pressing the lock icon on the computer. She confirmed she had not locked the computer screen when she left the cart unattended in the hallway, to provide care to Resident #153.</p>		