

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Avalon Place		STREET ADDRESS, CITY, STATE, ZIP CODE 4385 Old Sterlington Road Monroe, LA 71203	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received reasonable accommodation of needs in accordance with preferences for 1(#28) of 1 sampled residents reviewed for accommodation of needs by failing to provide a manual wheelchair for Resident #28 for mobility when the resident's electric scooter was not functioning. Findings: Record review revealed Resident #28 was admitted to the facility on [DATE]. Resident #28 had diagnoses that included diabetes, peripheral vascular disease, and acquired absence of left leg above the knee. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Review of an annual MDS dated [DATE] revealed Resident #28 used an electric scooter or manual wheelchair for mobility. On 12/01/2025 at 3:16 p.m., an observation and interview were conducted in Resident #28's room. An electric scooter was observed in the room. Resident #28 reported the electric scooter did not have a working battery and the facility did not provide replacement batteries. Resident #28 reported he wanted a manual wheelchair in his room so he could get out of bed and move around. On 12/02/2025 at 4:41 p.m., an observation of Resident #28's room revealed there was not a manual wheelchair available in the room. On 12/02/2025 at 4:49 p.m., an interview with S2DON confirmed Resident #28 did not have a manual wheelchair or a working motorized wheelchair in his room. S2DON confirmed Resident #28 needed a wheelchair for mobility.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure accuracy of the MDS assessment for 2 (#76 and #77) of 3 sampled residents reviewed. Findings: Resident #76 Review of Resident #76's record revealed an admission date of 11/10/2025 with diagnoses including atherosclerotic heart disease of native coronary without angina pectoris, polyneuropathy, chronic systolic (congestive) heart failure, unspecified dementia unspecified severity with other behavioral disturbance, hypertension, and chronic obstructive pulmonary disease. Review of Resident #76's MDS assessments revealed an admission/Medicare 5 day MDS assessment with an ARD of 11/17/2025. Further review of the MDS revealed a BIMS score of 11 indicating moderate cognitive impairment and the resident's current tobacco use was marked as no. Review of Resident #76's smoking assessment dated [DATE] revealed the resident was a safe smoker and her cigarettes and lighter are kept at the nurse's station. Review of Resident #76's current care plan revealed a care plan for potential for injury related to smoking. Interventions included to monitor resident during smoking every shift, do not permit book matches to be used, and cigarettes and lighter kept at the nurse's station. An interview on 12/02/2025 at 2:30 p.m. with S1Administrator confirmed Resident #76 was a smoker. An interview on 12/03/2025 at 10:10 a.m. with S4ADON confirmed Resident #76 was identified as a smoker upon admission. S4ADON confirmed she failed to identify Resident #76 as a smoker on the Admission/5 day Medicare MDS assessment dated [DATE]. An interview on 12/03/2025 at 4:25 p.m. with S5ADON confirmed the facility failed to identify Resident #76 was a smoker on the Admission/5 day Medicare MDS assessment dated [DATE]. Review of the record for Resident #77 revealed an admission date of 10/17/2024 with diagnoses that included Parkinson's Disease, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, pain, and edema. Review of the Significant Change MDS assessment dated [DATE] revealed Resident #77's BIMS score as unable to be assessed. Additionally, the MDS assessment revealed that Resident #77 did not have an ostomy and was dependent with toileting hygiene. Review of Resident #77's Comprehensive Plan of Care revealed an update on 06/28/2025 with a focus of alteration in bowel elimination related to colostomy with interventions that included colostomy care as ordered and monitor for signs and symptoms of skin breakdown daily during daily care. On 12/03/2025 at 2:15 p.m., S2DON confirmed that the MDS was inaccurate as it documented Resident #77 as having no colostomy.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 2 (#55 & #77) sampled residents. The facility failed to ensure: 1) Nursing staff had a documented assessment or rationale for Resident #55 having an x-ray of her foot in the medical record prior to the x-ray being completed 2) Nursing staff completed and recorded an assessment for Resident #77 on 06/17/2025 when she complained of abdominal pain before being transferred to a local hospital on [DATE] for treatment of the abdominal pain. Findings: Resident #55 Review of the record for Resident #55 revealed diagnoses in part of unspecified sequelae of cerebral infarction, biliary cirrhosis, heart failure, diabetes, and gout. Review of Resident #55's, most recent, MDS dated [DATE] revealed the resident's BIMS score was 15 which indicated no cognitive impairment. Review of Resident #55's record revealed an x-ray report dated 08/15/2025 including two views of the left foot to rule out fracture with no additional documentation of the rationale for the x-ray. During an interview on 12/02/2025 at 4:39 p.m., S2DON confirmed the facility had no evidence to show nursing staff completed an assessment of Resident #55 for an X-ray to be completed on 08/15/2025 and there should have been documentation of the rationale for the X-ray. During an interview on 12/02/2025 at 4:44 p.m., S1Administrator confirmed the facility had no evidence to show nursing staff completed an assessment for Resident #55 to explain the reason the resident had an X-ray on 08/15/2025. Resident #77 Review of the record for Resident #77 revealed an admission date of 10/17/2024 with diagnoses that included Parkinson's Disease, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, pain, and edema. Resident #77 was a full code. Additionally, the record revealed Resident #77 was admitted to the hospital on [DATE]. Review of the Significant Change MDS assessment dated [DATE] revealed Resident #77's BIMS score as unable to be assessed. Additionally, the MDS assessment revealed that Resident #77 did not have an ostomy and was dependent with toileting hygiene. Review of Resident #77's Comprehensive Plan of Care revealed an update on 06/28/2025 with a focus of alteration in bowel elimination related to colostomy. In an interview on 12/02/2025 at 4:15 p.m., S7LPN reported hospice staff were notified on 06/17/2025 that Resident #77's responsible party voiced concerns related to Resident # 77's status which included shortness of breath, pain, and decreased intake. S7LPN reported that the responsible party suggested that Resident #77 be transferred to the Emergency Department. S7LPN reported not recalling being aware of Resident #77's code status, and it was S7LPN's understanding that the (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decision to transfer the resident to the Emergency Department was the hospice provider's decision. In an interview on 12/02/2025 at 2:40 p.m., S8LPN reported Resident #77 was transferred to the Emergency Department due to a significant change in status. Review of hospital records, with admission date 06/18/2025, revealed that Resident #77 was diagnosed with perforation of the sigmoid colon due to diverticulitis which required surgery that resulted in colostomy placement. On 12/03/2025 at 3:00 p.m., S2DON confirmed that there was no documentation to support that Resident #77 was competently assessed by S7LPN.		

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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 reviews and interviews, the facility failed to inform the resident's physician and /or the resident's representative when a significant change in the resident's physical, mental, or psychosocial status or a decision to transfer or discharge a resident from the facility. The facility failed to:1.) notify the resident's physician and the resident's representative of a change in condition on 09/26/2025 when Resident #72 was transferred to the emergency room, and2.) notify the resident's physician of a change in condition for Resident #77. Findings: Resident #72 Review of Resident #72's record revealed and admission date of 09/02/2025 with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease, chronic atrial fibrillation, idiopathic gout right knee, and hypertension. Review of Resident #72's MDS assessment dated [DATE] revealed a discharge return anticipated MDS was completed. Review of the record revealed Resident #72 was transferred and admitted to the hospital on [DATE]. Further review of the record revealed no documented evidence that the facility notified the resident's physician or the resident's representative of Resident #72's transfer to the local emergency room on [DATE]. An interview on 12/03/2025 at 1:45 p.m. with S5ADON confirmed Resident #72 was transferred to the hospital on [DATE]. S5ADON further confirmed the facility failed to have documented evidence that Resident #72's physician or representative were notified that the resident was transferred to the hospital on [DATE]. Resident #77 Review of the record for Resident #77 revealed an admission date of 10/17/2024 with diagnoses that included Parkinson's Disease, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, pain, and edema. Resident #77 was a full code. Additionally, the record documented Resident #77 was transferred to the hospital on [DATE]. Review of Resident #77's Comprehensive Plan of Care revealed an update on 06/28/2025 with a focus of alteration in bowel elimination related to colostomy. Review of hospital records, with admission date 06/18/2025, revealed that Resident #77 was diagnosed with perforation of the sigmoid colon due to diverticulitis which required surgery that resulted in colostomy placement. In an interview on 12/02/2025 at 4:15 p.m., S7LPN reported hospice staff were notified on 06/17/2025 that Resident #77's responsible party voiced concerns related to Resident # 77's status which included shortness of breath, pain, and decreased intake. S7LPN reported that the responsible party suggested that Resident #77 be transferred to the Emergency Department. S7LPN reported not recalling being aware of Resident #77's code status, and it was S7LPN's understanding that the decision to transfer the resident to the Emergency Department was the hospice provider's decision. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2025 at 3:00 p.m., S2DON confirmed that there was no documentation to support that the physician was notified of Resident #77's status change on 06/17/2025.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the provider failed to ensure the MDS assessments were transmitted to the state in a timely manner for 1 (#2) of 3 sampled residents reviewed. Findings: Review of Resident #2's record revealed an admission date of 05/06/2025. Review of Resident #2's MDS assessments revealed a significant change MDS assessment dated [DATE]. Further review of the MDS history revealed this MDS was not transmitted to the state until 12/03/2025 (during the survey). An interview on 12/03/2025 at 10:00 a.m. with S5ADON revealed the significant change MDS assessment dated [DATE] for Resident #2 was not transmitted to the state until 12/03/2025. S5ADON reported she was not responsible for transmission of the MDS assessments. An interview on 12/03/2025 at 10:10 a.m. with S4ADON confirmed she was responsible for transmitting all of the MDS assessments for the facility into the state system. S4ADON confirmed she failed to transmit Resident #2's significant change MDS assessment dated [DATE] in a timely manner to the state.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview the facility failed to ensure a comprehensive plan of care was developed for 1 (#20) of 1 resident that developed COVID-19. Findings:Review of the record for Resident 20 revealed admitting diagnoses in part of Polyosteoarthritis, Seborrheic Dermatitis, Major Depressive Disorder, Hypertension, History of colon cancer with colostomy placement and Atrial Fibrillation.Review of the Physician orders revealed an order for COVID test as needed and orders dated 11/07/2025 for COVID and FLU swab. Review of the laboratory results for the Respiratory Life Panel with COVID 19 and Influenza A and B testing with results dated 11/10/2025 revealed Resident 20 tested positive for COVID 19. Further review of the Physician orders dated 11/11/2025 revealed orders for Complete Blood Count (CBC), Complete Metabolic Panel (CMP), D-dimer 2 times per week for 3 weeks, Chest Xray 2 times per week for 3 weeks, Vitamin C 1000 milligrams by mouth twice a day for 2 weeks, Zinc Sulfate 220 milligrams by mouth every day for 2 weeks, Augmentin 875/125 milligrams by mouth twice a day for 10 days, and Azithromycin 500 milligrams by mouth give 1 today and then 250 milligrams by mouth every day for 4 days. Further review of the record revealed Resident 20 was placed on COVID isolation. Review of the plan of care for Resident 20 revealed no focus area, goals, or interventions were developed in the plan of care when Resident 20 was diagnosed with COVID on 11/10/2025. On 12/03/2025 at 1:56 p.m., an interview with S2DON confirmed there was no plan of care developed when Resident 20 tested positive for COVID on 11/10/2025.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive plan of care for 1 (#77) of 2 (#20, #77) reviewed for colostomy care. Findings: Review of the facility's Colostomy/Ileostomy Care Policy dated 01/15/2025 revealed, in part: Purpose The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter Documentation The following information should be recorded in the resident's medical record 1. The date and time the colostomy/ileostomy care was provided 2. The name and title of the individual(s) who provided the colostomy/ileostomy care 3. Any breaks in resident's skin, signs of infection (purulent discharge, pain, redness, swelling, temperature), or excoriation of the skin 4. How the resident tolerated the procedure 5. If the resident refused the procedure, the reason(s) why and the intervention taken 6. The signature and title of the person recording the data Reporting 1. Notify the supervisor if the resident refuses the colostomy/ileostomy care 2. Notify the supervisor of any abnormal findings (i.e. breaks in skin, excoriation, signs of infection, etc). 3. Report other information in accordance with facility policy and professional standards of practice. Review of the record for Resident #77 revealed an admission date of 10/17/2024 with diagnoses that included Parkinson's Disease, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, pain, and edema. Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #77's BIMS score as unable to be assessed. Additionally, the MDS assessment revealed that Resident #77 did not have an ostomy and was dependent with toileting hygiene. Review of Resident #77's Comprehensive Plan of Care revealed an update on 06/28/2025 with a focus of alteration in bowel elimination related to colostomy with interventions that included colostomy care as ordered and monitor for signs and symptoms of skin breakdown daily during daily care. Review of the Physician's Orders revealed an order dated 06/28/2025 as follows: Check stoma site every shift for swelling and redness. Change colostomy bag as needed every shift. Review of the June and July 2025 MAR revealed no documentation to support that the order was completed from 06/28/2025-07/07/2025. Review of the nursing notes revealed that Resident #77 was transferred to the Emergency Department for evaluation on 07/07/2025 and returned to the facility on [DATE]. Review of the hospital's discharge summary note with admission date of 07/07/2025 revealed on 07/08/2025 bowel noted to be abnormal in color at ostomy site and questionable gangrene. Consulted surgery. On 07/09/2025, viable tissue underneath the superficial sloughing. Additionally, the discharge summary note revealed that colostomy complication was noted and resolved during the admission. On 12/03/2025 at 3:04 p.m., S2DON confirmed that there was no documentation to support that colostomy care was performed from 06/28/2025-07/07/2025.		