STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195523	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Maison Nursing & Rehabilitation Center, LLC	15704 Medical Arts Plaza Hammond, LA 70403

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 - Few	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 record reviews and interviews, the facility failed to develop a comprehensive person centered care plan, which addressed the type of feeding assistance needed for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for comprehensive person centered care plans.Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Sequelae of Cerebral Infarction, Dysphagia, Need for Assistance with Personal Care, Specified Forms of Tremor, Hereditary and Idiopathic Neuropathy, and Muscle Weakness. Review of Resident #1's most recent comprehensive person centered care plan revealed no documented evidence of feeding assistance interventions. An observation was made on 09/03/2025 at 8:32 a.m. of S3CNA providing feeding assistance to Resident #1. Resident #1 noted to have bilateral upper extremities resting on bed while S3CNA delivered food and hydration to Resident #1's mouth without his assistance. An interview was conducted on 09/03/2025 at 8:35 a.m. with S3CNA. S3CNA confirmed Resident #1 was dependent upon staff to feed him all meals. An interview was conducted on 09/03/2025 at 8:45 a.m. with S2LPN. S2LPN confirmed Resident #1 was dependent upon staff to feed him all meals. An interview was conducted on 09/04/2025 at 8:45 a.m. with S4CNA. S4CNA confirmed Resident #1 was dependent upon staff to feed him all meals. An interview was conducted on 09/04/2025 at 8:50 a.m. with S5LPN. S5LPN confirmed Resident #1 was dependent upon staff to feed him all meals. An interview was conducted on 09/04/2025 at 9:25 a.m. with S6TD. S6TD stated she had provided Occupational Therapy services to Resident #1. S6TD stated Resident #1 was dependent upon staff to feed him all meals. An interview was conducted on 09/04/2025 at 9:50 a.m. with S7CCC. S7CCC stated she was responsible for Resident #1's comprehensive person centered care plan. S7CCC confirmed Resident #1 did not have any interventions care planned for feeding assistance and should have. An interview was conducted on 09/04/2025 at 11:20 a.m. with S1DON. S1DON confirmed residents requiring feeding assistance should have a comprehensive person centered care plan that reflected individualized feeding interventions to ensure the resident received proper care and support.

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