STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195567	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maison Du Monde Living Center	4000 Rodeo Road Abbeville, LA 70510

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents belongings were secured, by failing to inventory, document, and label clothing upon admission for 1(Resident #1) of 4 sampled residents.Findings: On 05/12/2026, a review of the facility's policy titled, Personal Property with a revised date of 08/2025, read in part: Policy Interpretation and Implementation.2. Resident belongings are treated with respect by facility staff, regardless of perceived value.10. The resident's belongings and clothing are inventoried and documented upon admission and updated as necessary. Review of Resident #1's Electronic Health Record (EHR) revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, malignant neoplasm of colon; secondary malignant neoplasm of retro peritoneum and peritoneum; bipolar disorder and pain, unspecified. On 05/11/2026 at 10:16 a.m., an interview was conducted with Resident #1's responsible party (RP).The RP stated she dropped Resident #1 off at the facility on 04/23/2026 for respite care (short term care). The RP further stated that when she returned to pick Resident #1 up on 04/28/2026, he was missing 3 pairs of pajamas, 4 t-shirts, and 3 pairs of socks. On 05/12/2026 at 8:46 a.m., an interview was conducted with S3SSD. She stated that on 04/28/2026, Resident #1's RP reported to her that the resident was missing some clothes. S3SSD stated that on admission, S4AD was responsible for inventorying and labeling Resident #1's clothing and she did not. On 05/12/2026 at 10:48 a.m., an interview was conducted with S4AD. S4AD confirmed she was responsible for inventorying and labeling residents' clothing. S4AD stated it was her fault that Resident #1's clothing was lost and stated she took full responsibility because she should have gone into Resident #1's room, completed an inventory of his clothing and labeled the items.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interviews, and record review, the facility failed to ensure a resident who required assistance, received assistance with activities of daily living (ADLs) to maintain good grooming and personal hygiene for 1 (Resident #1) of 4 sampled residents.Findings:On 05/12/2026, a review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting with a revised date of 03/2025, read in part: Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).c. elimination.Review of Resident #1's electronic health record (EHR) revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, malignant neoplasm of colon; secondary malignant neoplasm of retro peritoneum and peritoneum; bipolar disorder and pain, unspecified. Further review of Resident #1's EHR revealed the resident was blind. Review of Resident #1's discharge return not anticipated Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/28/2026, revealed in Section GG that he required set up or clean up assistance to shower/bathe self and for personal hygiene. Review of Resident #1's admission Care Plan dated 04/23/2026, revealed the following in part: -Self-care deficit r/t (related to) needs assistance with ADLs r/t blindness, multiple disease process. Goals: resident will be clean, dry, dressed neatly, odor free and well-groomed daily this quarter.Resident's needs will be met through staff intervention.Interventions in part: Assist with ADLs as needed; bathe and shampoo hair; encourage resident to change clothes as needed; and provide peri-care (cleaning of the genital and anal areas to maintain hygiene.) as needed. -Alteration in elimination r/t occasionally incontinent of bowel and bladder. Goal: Resident will be clean, dry, and odor free this quarter. Interventions in part: Assist with personal hygiene/peri-care as needed. On 05/11/2026 at 10:16 a.m., an interview was conducted with Resident #1's responsible party (RP).The RP stated she dropped Resident #1 off at the facility on 04/23/2026 for respite care (short term care). The RP further stated that when she returned to pick Resident #1 up on 04/28/2026, the resident was dirty, smelled of urine, his incontinent underwear was full of urine and had stool stains, and his pants were wet with urine. The RP stated the facility could not provide any documentation that the resident received a bath during his 5 days stay at the facility.Review of the facility's Bath/Shower Record revealed no documentation that Resident #1 received a shower/bath during the days he was admitted (04/23/2026 to 04/28/2026). On 05/11/2026 at 2:34 p.m., an interview was conducted with S5SA, who stated she was responsible for showering Resident #1 during his 5 days stay at the facility. S5SA stated she gave Resident #1 a shower on 04/24/2026 and he was scheduled to receive another shower on 04/27/2026. S5SA stated S6CNA who was assigned to care for Resident #1 did not bring him to the shower room. S5SA stated when she was getting off her shift at around 10:30 a.m. on 04/27/2026, she asked S6CNA if the resident was clean and S6CNA stated yes.On 05/11/2026 at 3:03 p.m., an interview was conducted with S6CNA. She stated she was assigned to care for Resident #1 on 04/27/2026 and was aware that he did not receive a shower on 04/27/2026. S6CNA stated that she should have offered Resident #1 a bed bath, but did not. S6CNA confirmed that she did not report to S7LPN that the resident did not receive a shower/bath.On 05/11/2026 at 3:14 p.m., an interview was conducted with Resident #R1 who was Resident #1's roommate. Resident #R1 stated Resident #1 was blind and could not see what he was doing. He further stated staff did not help the resident to the bathroom during his stay at the facility. On 05/11/2026 at 3:16 p.m., an interview was conducted with S7LPN, who stated she was assigned to care for Resident #1 on 04/27/2026. S7LPN stated she was not made aware by S5SA nor S6CNA that Resident #1 did not receive a shower/bath.On 05/12/2026 at 11:39 a.m., an interview was conducted with S8CNA/Driver, who stated she was the CNA (Certified Nursing Assistant) Supervisor during (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's 5 days stay at the facility. S8CNA/Driver stated that if a resident did not get a shower/bath on their scheduled day, the assigned CNA was responsible for notifying the assigned nurse. The assigned nurse should then find out the reason for the resident not getting a shower/bath and document it. S8CNA/Driver stated S5SA worked 8 hours and S6CNA worked 12 hours and there was no reason Resident #1 should not have at least gotten a bed bath.Review of Resident #1's progress notes revealed no documentation regarding his shower/bath on 04/27/2026.On 05/12/2026 at 12:12 p.m., an interview was conducted with S1DON. She stated that she spoke to S5SA and S6CNA on 04/28/2026 after she became aware of Resident #1 not getting a shower/bath on 04/27/2026. S1DON stated S5SA reported that S6CNA did not bring Resident #1 to the shower room. S1DON stated that S5SA was responsible for ensuring Resident #1 got a shower, but S6CNA was aware and she did not give him a bath either. S1DON stated S5SA and S6CNA should have reported the missed shower/bath to S7LPN, and neither of them did.