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	12/18/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observation, interviews, and record review, the facility failed to ensure 1 (#49) of 35 sampled residents was safe to perform self-administration of medication. Findings: On 12/18/2024, a review of the facility's policy titled Self- Administration of Medications which was last reviewed on 10/09/2024, read in part, Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; Policy Interpretation and Implementation: 1. As part of their overall evaluation, the staff and/or practitioner will assess each resident's mental and physical, abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and/or practitioner will perform a more specific skill assessment, 3. If the team determines that a resident cannot safely self-administer, the nursing staff will administer the resident's medications. 4. The staff will document their findings and the choices of residents who are able to self-administer medications. Review of Resident #49's health record revealed she was admitted to the facility on [DATE] with a diagnosis of Gastro-Esophageal Reflux Disease. Review of Resident #49's physician orders revealed an order dated 11/17/2023, Aluminum-Magnesium-Simethicone Oral Suspension 200-200-20 mg(milligrams)/5ml(milliliters) (Alum (Aluminum) & Mag (Magnesium) Hydrox(Hydroxide)-Simethicone). Give 30ml by mouth with meals related to Gastro-Esophageal Reflux Disease without Esophagitis. Review of Resident #49's Minimum Date Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/17/2024, revealed she had a BIMS (Brief Interview for Mental Status) score of 10, indicating moderate cognitive impairment. Review of Resident #49's record revealed no assessment, physician's orders, or careplan for self-administration of medication. On 12/16/2024 at 9:40 a.m., an observation and interview was conducted with Resident #49. A medicine cup containing a thick, white substance was observed on the bedside table. Resident #49 stated that she had not taken her Maalox yet, but intended to take it, referring to the medicine cup with the thick liquid. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/16/2024 at 9:51 a.m. with S18LPN (Licensed Practical Nurse), she confirmed she had left the medicine cup on the resident's bedside table. She stated the medication was Mylanta, and the resident preferred to drink it in intervals. She further stated that she should not have left the resident's medication at her bedside. During an interview and record review on 12/18/2024 at 9:03 a.m. with S2DON (Director of nursing), she confirmed that Resident #49's record did not contain an assessment or a physician's order for Resident #49 to self- administer her own medications. She also confirmed that self- administration of medication was not included in her the resident's plan of care. S2DON also confirmed Resident #49 did not have the appropriate documentation to prove the resident could safely self-administer her medications and the nurse should not have been left Mylanta at the resident's bedside.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 39826 Based on record review and interview, the provider failed to document, investigate, and maintain documentation of complaints voiced during the facility's resident council meetings that were conducted on 07/09/2024 and 10/08/2024. This had the potential to effect a census of 112 residents in the facility. Findings: Review of the facility's policy titled Grievance/ Complaint Filing, with a last review date of 10/09/2024 revealed in part . 8. Upon receipt of a grievance or complaint, the designee will review and investigate the allegations and submit a written report of the findings to the administrator within 5 working days of receiving the complaint or grievance. 12. The person filing the complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. a. The administrator or his designee will make a report within 5 working days of the filing of the grievance with the facility. b. A written summary will be provided to the resident upon request regarding any corrective action taken by the facility. On 12/16/2024 11:19 a.m., during meeting conducted with members of the resident council, Resident # 82 expressed the complaints that the residents voiced during the July and October 2024 meetings about the facility not passing of ice that was not totally resolved. He stated, they do pass ice sometimes, but not consistently. They will correct the issue for a couple weeks but fail to keep it up. After we report it again it gets resolved for a few days then falls back to not being passed for days. Resident # 55 confirmed the inconsistency of passing the ice. On 12/17/2024 at 10:00 a.m., an interview was conducted with Resident #15 who stated the facility's staff were inconsistent with passing ice. She further stated it would be much better if they would pass ice and water on a schedule so the residents wouldn't feel like they were bothering someone by asking them to go get ice. On 12/17/2024 at 2:40 p.m., during an interview and review of the Resident Council meeting minutes from 07/09/2024 and 10/08/2024, S12AD (Activity Director) revealed she did not write up the complaints about no ice being passed as a grievance because it was just one resident in each meeting that complained. S12AD stated she provided the resident with ice and water then informed the CNA (Certified Nurse Assistant) supervisor. On 12/17/2024 at 2:50 p.m., an interview was conducted with S13CNASup (Certified Nurse Assistant Supervisor) who failed to remember if she ever heard the complaint about no ice being passed in the facility. S13CNASup confirmed she had no documentation of any complaints expressed about residents not receiving ice.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on record review and interviews, the facility failed to ensure an alleged injury of unknown source was reported immediately, but not later than two (2) hours after the allegation was made to the State Survey Agency for 2 (#84, #113) out of 3 (#7, #84, #113) sampled residents investigated for falls. The deficient practice had the potential to affect a total census of 112 residents. Findings: On 12/17/2024, a review of the facility's policy titled, Abuse Investigation and Reporting with a last reviewed date of 10/09/2024 revealed the following in part .Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the Facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing of facility .2. All alleged violations of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury Resident #84 Review of Resident #84's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, major depressive disorder, anxiety disorder, and muscle wasting and atrophy. Review of Resident #84's Quarterly Minimum Date Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/11/2024 revealed she had a Brief Interview for Mental Status (BIMS) score of 04 which indicated severe cognitive impairment. Review of Resident #84's electronic health record revealed a nurse note dated 10/15/2024 at 5:44 a.m., that read in part .resident found outside of room door in hallway on the floor. Urine and feces noted on the floor. Barefoot, without a brief on. Resident c/o (complained of) pain to left arm and sob (shortness of breath) . Review of Resident #84's Fall Report revealed the incident occurred 10/15/2024 at 5:00 a.m., that read in part .resident was found outside of room door in hallway on the floor. Urine and feces noted on the floor. Barefoot, without a brief on. Resident c/o pain to left arm and sob. Scheduled transfer to ER (emergency room) . Review of Resident #84's Radiology Interpretation for XR (x-ray) Forearm 2 views left on 10/15/2024 read in part: impacted non-displaced fracture of the distal radius with minimal cortical deformity. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #84's electronic health record revealed a nurse note dated 10/15/2024 at 10:46 a.m., that read in part .Resident returned from ER via van. DX (diagnosis) UTI (urinary tract infection and left radial fracture . On 12/17/2024 at 11:36 a.m., attempted interview with Resident #84 regarding incident on 10/15/24. Resident unable to recall events of incident. Resident #113 Review of Resident #113's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, depression, anxiety disorder, unspecified psychosis, and muscle wasting and atrophy. Review of Resident #113's Significant Change Minimum Date Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/25/2024 revealed he had a Brief Interview for Mental Status (BIMS) score of 04 which indicated severe cognitive impairment. Review of Resident #113's electronic health record revealed a nurse note dated 10/12/2024 at 6:01 a.m., that read in part .staff came out of MCU (memory care unit) while nurses were giving report and stated that resident was sitting on the floor. Resident stated that his feet just left from under him. ROM (range of motion) done. Resident stated that he hit his head. Small bruises noted to top of head. Resident complains of left wrist pain . Review of Resident #113's Fall Report revealed the incident occurred 10/12/2024 at 6:00 a.m., that read in part . staff came out of MCU (memory care unit) while nurses were giving report and stated that resident was sitting on the floor. Resident stated that his feet just left from under him. ROM (range of motion) done. Resident stated that he hit his head. Small bruises noted to top of head. Resident complains of left wrist pain. Notified NP. Will call son. Sending to ER for eval (evaluation). Neuros initiated . Review of Resident #113's Radiology Interpretation for XR Wrist 3 views Lt (left) on 10/12/2024 read in part: acute fracture of the ulnar styloid and distal radial metaphysis. Review of Resident #113's electronic health record revealed a nurse note dated 10/12/2024 at 10:50 a.m., that read in part .Resident returned to facility with transport. Resident in stable condition. Resident has colles splint to left hand, wrist, and forearm. Resident has an acute minimally displaced fracture to left ulnar styloid. On 12/17/2024 at 11:24 a.m., attempted interview with Resident #113 regarding incident on 10/12/24. Resident unable to recall events of incident. On 12/18/2024 at 10:27 a.m., an interview and record review was conducted with S2DON (Director of Nursing). S2DON confirmed Resident #84 had an unwitnessed fall with a fracture on 10/15/2024 and the resident had severe cognitive impairement and unable to state how the incident occured . S2DON also confirmed the incident was not reported to the state agency and should have been. S2DON also confirmed Resident #113 had an unwitnessed fall with a fracture on 10/12/2024 and the resident had severe cognitive impairement and uable to state how the incident occured. S2DON also confirmed the incident was not reported to the state agency and should have been.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on record review and interview, the facility failed to notify the State Long Term care Ombudsman of facility-initiated transfer for 2 (#84, #113) out of 2 (#84, #113) residents in a final sample size of 35. The deficient practice has the potential to affect a census of 112. Findings: Review of Resident #84's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, major depressive disorder, anxiety disorder, and muscle wasting and atrophy. Review of Resident #84's nurse's notes revealed on 10/15/2024 at 6:00 a.m., the resident was transferred to the hospital. Further review of the nurse's notes revealed that on 10/15/2024 at 10:46 a.m., the resident returned from the hospital back to the facility. Further review of the facility's document titled Census List revealed Resident #84 was transferred to the hospital on 10/15/2024, 11/08/2024 and 11/17/2024. Review of the Emergency Transfer Log for October 2024 revealed Resident #84's transfer to the hospital on 10/15/2024 was not identified on the list. Further review of the Emergency Transfer Log for November 2024 revealed Resident #84's transfer to the hospital on 11/08/2024 was not identified on the list. Review of Resident #113's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, depression, anxiety disorder, unspecified psychosis, and muscle wasting and atrophy, and repeated falls. Review of Resident #113's nurses' notes revealed on 10/12/2024 at 7:09 a.m., the resident was transferred to the hospital. Further review of the nurse's notes revealed that on 10/12/2024 at 10:50 a.m., the resident returned from the hospital back to the facility. Further review of the facility's document titled Census List revealed Resident #113 was transferred to the hospital on 08/19/2024, 10/10/2024, 10/12/2024, 10/17/2024, 11/28/2024 and 12/02/2024. Review of the Emergency Transfer Log for August 2024 revealed Resident #113's transfer to the hospital on 08/19/2024 was not identified on the list. Further review of the Emergency Transfer Log for October 2024 revealed Resident #113's transfer to the hospital on 10/10/2024 and 10/12/2024 was not identified on the list. Further review of the Emergency Transfer Log for November 2024 revealed Resident #113's transfer to the hospital on 11/28/2024 was not identified on the list. Further review of the Emergency Transfer Log for December 2024 revealed Resident #113's transfer to the hospital on 12/02/2024 was not identified on the list. (continued on next page)

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Maison Du Monde Living Center	4000 Rodeo Road Abbeville, LA 70510

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2024 at 2:22 p.m., an interview and record review was conducted with S15BOM (Business Office Manager). She confirmed she was responsible for the Emergency Transfer Log and to send it to the State Long Term Care Ombudsman. S3BOM reviewed Resident #84's facility document titled Census List and confirmed the resident was transferred to the hospital on 10/15/2024, 11/08/2024 and 11/17/2024. She then reviewed the Emergency Transfer Log for October 2024 and November 2024 and confirmed the resident was not listed as having been transferred on 10/15/2024 and 11/08/2024. S3BOM reviewed Resident #113's facility document titled Census List and confirmed the resident was transferred to the hospital on 08/19/2024, 10/10/2024, 10/12/2024, 10/17/2024, 11/28/2024 and 12/02/2024. She then reviewed the Emergency Transfer Log for August 2024, October 2024, November 2024 and December 2024 and confirmed resident was not listed as having been transferred on 08/19/2024, 10/10/2024, 10/12/2024, 11/28/2024 and 12/02/2024. S15BOM stated she was not aware that facility initiated transfers for less than 24 hours had to be listed on the Emergency Transfer Log sent to the State Long Term Care Ombudsman.

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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** 49784 Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered careplan for 2 (#17 and #53) residents in a final sample of 35 residents as evidenced by failing to: 1. notify the physician of Resident #17's abnormal CBG (Capillary Blood Glucose) levels as ordered; and 2. develop a focus area and interventions related to a choking incident for Resident #53. Findings: 1. Review of the facility's policy titled, Obtaining a Fingerstick Glucose Level last reviewed on 10/09/2024, revealed in part, Report abnormal results promptly to the supervisor or Attending Physician. Review of Resident #17's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage heart failure, unspecified dementia, and type 2 diabetes mellitus. A review of Resident #17's Order Summary Report, for the month of 08/2024, revealed an order, dated 08/01/2024, Novolin R Injection Solution (Insulin Regular (Human)) Inject as per sliding scale: if 0-150=0 units if <50, administer orange juice; 151-200=2 units; 201-250=4 units; 251-300 = 6 units; 301-350= 8 units; 351-400=10 units; 401-999= 10 units and call MD (Medical Doctor), subcutaneously before meals and at bedtime for DM (Diabetes Mellitus). Review of Resident #17's MAR (Medication Administration Record), for the month of 09/2024, 10/2024, 11/2024, and 12/2025, revealed abnormal CBG levels above 401 for the following dates: a. September 2024: 09/06/2024 at 2000 = 505, 09/21/2024 at 2000 = 467, 09/22/2024 at 2000 = 457, 09/25/2024 at 2000 = 472, 09/27/2024 at 1600 = 439; b. October 2024: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/06/2024 at 1100 = 448, 10/09/2024 at 2000 = 579, 10/12/2024 at 1100 = 403, 10/14/2024 at 2000 = 541, 10/22/2024 at 1600 = 474, 10/23/2024 at 2000 = 459, 10/24/2024 at 2000 = 527, c. November 2024: 11/03/2024 at 2000=558, 11/06/2024 at 2000= 512, 11/12/2024 at 2000 = 426, 11/29/2024 at 2000 = 421, 11/30/2024 at 2000 = 472; d. Deceber 2024: 12/03/2024 at 2000 = 419 12/15/2024 at 2000 = 521. . A review of Resident #17's medical record failed to reveal documentation regarding nurses notifying Resident #17's MD of the abnormal CBG results that were listed. On 12/18/2024 at 3:24 p.m., an interview and record review was conducted with S16CN (Corporate Nurse). A review of Resident #17's Order Summary Report and MARs for the month of 09/2024, 10/2024, 11/2024, and 12/2024 revealed a total of 19 occurrences where Resident #17's CBG levels were greater than 401. S16CN confirmed the physician's orders revealed for a CBG result of 401 and above, to call the MD. She confirmed the resident's physician was not notified for each of the occurrences and should have been. 47540 2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/2024, a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered with a last revision date of 10/09/2024, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy also indicated that the following information is to be documented in the resident care plan: Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem area. Care plan interventions are chosen after careful data gathering and consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Resident #53 Review of Resident #53's record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, paraplegia, dry mouth, ileus, and gastroesophageal reflux disease. Review of Resident #53's most recent annual Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 15, which indicated the resident was cognitively intact. Review of Resident #53's progress notes revealed a note dated 09/06/2024 by S14LPN (Licensed Practical Nurse) read in part, resident said . he was choking on brisket and coleslaw he had for lunch that was caught in his throat and was short of breath. Resident #53 requested to go to the emergency room . Review of Resident #53's CT (Computed Tomography) of the chest w/o (without) contrast dated 09/06/2024 read in part, food in the distal esophagus with fluid present proximally, findings concerning for residual food with impaction . Further review of Resident #53's progress notes revealed a note dated 09/07/2024 by S14LPN read in part, Resident #53 was admitted with esophageal obstruction and will see GI (Gastrointestinal). Review of Resident #53's comprehensive care plan failed to reveal a focus area or interventions related to Resident #53's choking incident on 09/06/2024. On 12/18/2024 at 9:50 a.m. A record review and interview was conducted with S10MDS/LPN (Minimum Data Set Coordinator/Licensed Practical Nurse). S10MDS/LPN confirmed Resident #53 had a choking incident on 09/06/2024 and was transferred to the emergency room for evaluation. She also confirmed the incident on 09/06/2024 should have been in the care plan with interventions, but it was not. On 12/18/2024 at 10:13 a.m., an interview was conducted with S2DON (Director of Nursing) who confirmed Resident #53 had a choking incident on 09/06/2024 and was sent to the emergency room for evaluation. She confirmed this incident should have been developed in the care plan with interventions, but it was not.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on policy review, observations and interviews, the facility failed to ensure that the enteral feeding infused at the ordered rate for one (Resident #63) out of 2 Residents (Resident #63 and Resident #66) investigated for tube feeding. This had the potential to effect 3 residents in the facility who had tube feedings. Findings: Review of the facility's policy titled, Enteral Feedings-Safety Precautions last reviewed on 10/09/2024 revealed in part, the following Preventing errors in administration, 1. Check the enteral nutrition label against the order before administration. Check the following information: g. Rate of administration (ml (milliliters)/hr (hour)). Review of Resident #63's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, unspecified dementia, dysphagia, chronic systolic (congestive) heart failure, and encounter for attention to gastrostomy. Review of Resident #63's physician orders revealed an order dated 10/25/2024 Enteral Feed Order every shift Isosource 1.5 @ 44ml (milliliters)/hr (hour) to provide 1584 total calories every 24 hours, 71g Protein, 1641 ml Free Water & 1896 ml Total fluid volume in 24 hours. On 12/17/2024 at 11:41 a.m., an observation of Resident #63's enteral feeding pump and interview was conducted with S18LPN. S18LPN confirmed that the resident's enteral feeding was running at a rate of 45ml/hour. She confirmed that the enteral feeding rate was ordered to run at 45ml/hour and was not running at the rate ordered.

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41419 Based on observations, record reviews, and interviews, the facility failed to ensure recipes for pureed 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 12 residents who received pureed meals. Findings: Review of a facility document titled Puree Recipe Liquid Addition - Quick Guide that read in part Item - vegetables, breads, desserts, pasta, sandwiches, fish, potato dishes, eggs, port, ham, chicken, steak/beef. Liquid - whole milk and margarine/butter for all listed items except steak/beef use gravy. On 12/16/2024 at 10:55 a.m., S4Cook was observed preparing pureed rice with a pan filled with water, pouring a white powdery substance from a white bag that contained instant puree rice into the water, and continuously stirring with a whisk. S4Cook was asked how much water the pan held, and she stated she did not know. S4Cook stated she just poured the pureed rice into the water and stirred until she achieved the smooth blended consistency she wanted. She stated she did not measure, but she guessed the proper amounts. On 12/16/2024 at 11:00 a.m., an observation of S5Cook was conducted while she prepared puree bread. After placing several slices of bread into the blender, she added 8 ounces of whole milk. Observations of the pureed bread after S5Cook completed the process revealed the puree bread was thin liquid. Further observations of pureed beans that were prepared by S5Cook revealed the beans were thin consistency. S5Cook was asked about the consistency of the pureed bread and pureed beans. She stated she thought puree meant not too thick and not too thin. On 12/16/2024 at 11:15 a.m., an interview was conducted with S4Cook who confirmed the consistency of S5Cook's pureed bread and pureed red beans were not consistent for a puree diet, they were thinned liquid. S4Cook stated the consistency should have been smooth and blended. On 12/16/2024 at 2:45 p.m., an interview was conducted with S6DS (Dietary Staff), S8Cook, and S9DS. S6DS stated she was not trained on how to puree using a recipe. S8Cook stated that she was not trained on puree recipes, S9DS stated she was not trained on puree recipes, but was shown how to puree foods from other staff. S6DS confirmed the puree recipe liquid addition - quick guide did not help her puree meals. She stated there were no measurements for puree desserts. On 12/17/2024 at 2:37 p.m., an interview was conducted with S7RD (Registered Dietician). She confirmed puree recipes were not located in the main kitchen, and were not available for the cooks to use while preparing puree meals.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record reviews and interviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices by failing to ensure the comprehensive care plan was accurately documented for 1 (#53) resident. The deficient practice has the potential to affect a census of 112. On 12/19/2024, a review of the facility's policy titled, Charting and Documentation with a last review date of 10/09/2024, read in part, All services provided to the resident, progress toward the care plan goals, or any change in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The policy also indicated that the following information is to be documented in the resident medical record: Progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Resident #53 Review of Resident #53's record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, paraplegia, spinal stenosis, muscle wasting and atrophy, and ileus. Review of Resident #53's progress notes revealed a note dated 11/11/2024 by S7RD (Registered Dietician) that read in part, Current weight is 121.2 from 11/11/2024. Resident is 68 tall with BMI (body mass index) = 18.4 (underweight). Weight loss triggers: -5.0% change [Comparison Weight 10/16/2024, 137.0 Lbs (pounds), -11.5%, -15.8 Lbs], -7.5% change [Comparison Weight 9/10/2024, 141.4 Lbs, -14.3%, -20.2 Lbs], and -10.0% change [Comparison Weight 6/5/2024, 140.2 Lbs, -13.6%, -19.0 Lbs]. Weekly weights until stable . Review of Resident #53's Comprehensive Care Plan revealed the resident had an alteration in nutrition r/t (related to) refuses meals at times and 11/12/2024 weight loss. Interventions included weigh monthly. On 12/18/2024 at 9:50 a.m., a record review and interview was conducted with S10MDS/LPN (Minimum Data Set Coordinator/Licensed Practical Nurse). S10MDS/LPN reviewed Resident #53's progress notes and comprehensive care plan. She confirmed Resident #53 was to be weighed weekly and this was not accurately documented in the comprehensive care plan.

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	195567	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on interviews and record reviews, the facility failed to provide services that met professional standards for 2(#17 and #21) of 2 (#17 and #21) residents investigated for hospice services, by failing to: 1. Collaborate with the hospice agency to ensure the hospice nurse's visit notes and certification were up-to-date in Resident #21's hospice binder; and 2. Communicate with the hospice agency of Resident #17's high blood sugars. Findings: 1. A review of a document titled Nursing Facility Agreement indicated This Agreement is made and entered into this 23rd day of April 2018 by and between the facility and hospice .4.1 Compilation of Records. Nursing facility and hospice shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving nursing facility services and hospice services under this agreement in accordance with prudent record keeping procedures and as required by applicable Federal and state law and regulations and applicable Medicare and/or Medicaid program guidelines. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning each resident hospice patient including evaluations, treatments, program notes, authorizations for admissions to hospice and/or nursing facility . Each such record shall be readily accessible and systematically organized to facilitate retrieval by either party. A review of Resident #21's electronic health record (EHR) revealed an admitted [DATE], with diagnoses which included, but were not limited to heart failure and age related Osteoporosis. A review of Resident #21's physician orders revealed an order written on 03/20/2024 to admit to hospice. A review of resident #21's hospice binder revealed the last certification period was 03/20/2024 to 06/17/2024. Further review revealed the last hospice nurse visit notes were on 11/21/2024. During an interview and review of Resident #21's hospice binder with S11LPNDA (Licensed Practical Nurse/Data analyst) on 12/17/2024 at 1:35 p.m., she confirmed the last certification period was 03/20/2024 to 6/17/2024 and the last hospice nurse visit notes were dated 11/21/2024. During an interview with S2DON (Director of Nursing) on 12/17/24 at 3:25 p.m., she stated she did not know who was responsible for ensuring the hospice agency updated the resident's binder, and would find out. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview with S2DON at 3:35 p.m., she stated that she called her corporate office and it was the hospice agency's responsibility to ensure the hospice binder at the facility was updated with the current certification and visit notes. She stated hospice was responsible and the facility was not responsible for ensuring hospice update the binder. 49784 2. A review of a document titled Hospice and Facility Agreement indicated This Hospice and nursing facility residential agreement is made and entered into this 21st day of January, 2015, by and between Hospice Agency and Facility .4.4 Coordination with Hospice Regarding Plan of Care, c. Monitoring of Residential Hospice Patient. Nursing Facility shall immediately inform Hospice of any change in the condition of a Residential Hospice Patient. A review of Resident #17's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, end stage heart failure, unspecified dementia, and type 2 diabetes mellitus. A review of Resident #17's Order Summary Report, for the month of 02/2024, revealed an order dated 02/12/2024, admit to hospice agency effective 02/12/2024 with a diagnosis of end stage heart failure. A review of Resident #17's Order Summary Report, for the month of 08/2024, revealed an order, dated 08/01/2024, Novolin R Injection Solution (Insulin Regular (Human)) Inject as per sliding scale: if 0-150=0 units if <50, administer orange juice; 151-200=2 units; 201-250=4 units; 251-300 = 6 units; 301-350= 8 units; 351-400=10 units; 401-999= 10 units and call MD (Medical Doctor), subcutaneously before meals and at bedtime for DM (Diabetes Mellitus). Review of Resident #17's MAR (Medication Administration Record), for the month of 09/2024, 10/2024, 11/2024, and 12/2025, revealed abnormal CBG levels above 401 for the following dates: this format is not easy to follow. spell out months and list. a. September 2024: 09/06/2024 at 2000 = 505, 09/21/2024 at 2000 = 467, 09/22/2024 at 2000 = 457, 09/25/2024 at 2000 = 472, 09/27/2024 at 1600 = 439; b. October 2024: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/06/2024 at 1100 = 448, 10/09/2024 at 2000 = 579, 10/12/2024 at 1100 = 403, 10/14/2024 at 2000 = 541, 10/22/2024 at 1600 = 474, 10/23/2024 at 2000 = 459, 10/24/2024 at 2000 = 527, c. November 2024: 11/03/2024 at 2000=558, 11/06/2024 at 2000= 512, 11/12/2024 at 2000 = 426, 11/29/2024 at 2000 = 421, 11/30/2024 at 2000 = 472; d. December 2024: 12/03/2024 at 2000 = 419 12/15/2024 at 2000 = 521. On 12/18/2024 at 4:40 p.m., an interview and record review was conducted with S16CN (Corporate Nurse). A review of Resident #17's Order Summary Report and MARs for the month of 09/2024, 10/2024, 11/2024, and 12/2024 revealed a total of 19 occurrences where Resident #17's CBG levels were greater than 401. She confirmed that there was no documentation in Resident #17's Hospice Binder or the resident's medical record that revealed the Hospice agency was notified of the abnormal CBG levels. On 12/18/2024 at 4:52 p.m., a phone interview was conducted with S17HADON (Hospice Agency Director of Nursing). She stated that the Hospice agency should be notified of significantly high CBG levels for Resident #17 as collaboration between the facility and the Hospice agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41419 Based on observations, record review and interviews, the facility failed to maintain an effective infection control and prevention program by failing to ensure staff used personal protective equipment according to accepted standards of practice during biohazard trash removal. Findings: Review of a facility policy and procedure titled Personal Protective Equipment - Using Gloves, with revised date of 10/09/2024, read in part, .purpose to guide the use of gloves. Objectives - 1. To prevent the spread of infection. 3. To protect hand from potentially infectious material. When to use gloves: 4. When cleaning potentially contaminated items; and 5. Whenever in doubt. On 12/17/2024 at 10:58 a.m., an observation of Hall A revealed a treatment cart positioned against the wall. The treatment cart had a trash can attached with the lid of the trash can opened. A red biohazard trash bag was observed lining the trash can. A partially discarded blue glove was observed hanging half way outside of the red trash bag along with other discarded materials. On 12/17/2024 at 10:59 a.m., an observation and interview was conducted with S3TXN (Treatment Nurse) who stated she had completed her treatments for the day. S3TXN stated that she should have emptied her trash when she completed her treatments. Further observation revealed S3TXN removed the partially discarded blue glove from the trash can, and placed it inside the biohazard trash bag without gloves. She then proceeded to remove the biohazard trash bag from the trash can, and placed the biohazard bag on top of the treatment cart. S3TXN confirmed she should have donned gloves prior to touching the soiled blue glove, and removing the biohazard trash bag. She also confiirmed she should not have placed the biohazard bag on top of her treatment cart. On 12/17/2024 at 4:07 p.m., an interview was conducted with S2DON (Director of Nursing) who was also the facility's Infection Preventionist. She confirmed S3TXN should have put on personal protective equipment before she handled soiled and biohazard materials. She also confirmed the nurse should not have placed the biohazard bag on top of her treatment cart.