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	01/29/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post daily nursing staffing that included the facility name, date, census, and the total number and actual hours worked by staff responsible for resident care in a prominent place readily accessible to residents and visitors. The facility census was 119.Findings: On 01/27/2026 at 8:39 a.m., an observation was made throughout the entire facility, and there was no evidence that the daily nursing staffing was posted.On 01/27/2026 at 10:30 a.m., a second observation was made throughout the entire facility, and there was no evidence that the daily nursing staffing was posted.On 01/27/2026 at 12:21 p.m., a third observation was made throughout the entire facility, and there was no evidence that the daily nursing staffing was posted.On 01/27/2026 at 12:30 p.m., an interview was conducted with S7BenCoor (Benefits Coordinator). S7BenCoor confirmed she is responsible for the calculation and posting of the nurse staffing hours. She confirmed it had not been done and should be done daily.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents received the proper treatment and assistive devices to maintain hearing abilities by failing to follow up with community resources for 1 (Resident #6) out of 44 sampled residents.Findings:Review of the facility's policy titled Social Services, with a last reviewed date of 04/09/2025, read in part: 4. The social worker/social services staff are responsible for: g. making referrals and obtaining needed services from outside entities.Review of Resident #6's EHR (Electronic Health Record) revealed the resident was admitted to the facility on [DATE] and had diagnoses including, but not limited to, end stage renal disease and type 2 diabetes.Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 13, indicating the resident was cognitively intact. Further review revealed the resident was coded as moderate difficulty for hearing, indicating that the speaker has to increase volume and speak distinctly.Review of Resident #6's plan of care revealed the following: Alteration in communication r/t (related to) HOH (Hard of Hearing) impaction of cerumen reoccurring, does need hearing aids, sent paperwork with family who did not return because of financial issues 01/9/2024.On 01/27/2026 at 10:41 a.m., an interview was conducted with Resident #6. The surveyor had to speak very loudly for the resident to be able to hear the surveyor's questions. The resident stated that she had been waiting for hearing aids for months, and the facility told her that they were waiting on a company to get the hearing aids. On 01/28/2026 at 1:38 p.m., an interview was conducted with S3SSD (Social Services Director). S3SSD stated the resident was seen by an Ears, Nose, Throat (ENT) specialist for her hearing last year, and was recommended for a hearing program that could have provided her assistance with obtaining hearing aids. However, the resident's family had to complete paperwork that included financial information, and the family never returned the paperwork, so she could not participate in the hearing program.On 01/28/2026 at 4:13 p.m., S3SSD provided further information to the surveyor after calling a community provider, and stated that Resident #6 was seen by this community provider on 02/18/2025 to assist the resident with purchasing or obtaining hearing aids. This provider sent out a referral to a second outside provider that was also supposed to provide assistance with obtaining hearing aids for the resident.On 01/29/2026 at 8:30 a.m., a follow up interview was conducted with S3SSD who stated that a representative from the second community provider informed her that Resident #6 was supposed to have an evaluation at their location, but she was never scheduled for that evaluation and the representative was not sure why. She stated it appeared the provider was waiting on communication from another community resource. S3SSD was asked if she followed up with either community provider in February of 2025, and she stated she was not aware that the resident saw the first community provider, or that she was then referred to a second provider. S3SSD was asked who set the appointment up with the first community provider, and she stated that she believed the ENT specialist set that appointment up, but she was not sure. She was then asked how she found out that the resident had an appointment with the first community provider to call them to obtain further information, and she stated that there was another resident who was seen by them who needed hearing aids, so she called out of chance. S3SSD confirmed that after 08/13/2024 when the facility lost communication with the family, she did not try to obtain other assistance or resources for the resident to obtain hearing aids, and did not look into the situation until the surveyor began asking questions on 01/28/2026. On 01/29/2026 at 12:00 p.m., S3SSD provided a progress noted dated 03/05/2024 that was written by herself that read in part: Resident brought information to SSD on . program for hearing aids. SSD reviewed information with resident and informed her that there was a $300 application fee for the hearing aids program. Resident stated I don't have that kind of money!. You can't ask them to waive that fee? SSD spoke to . at [ENT] office and explained that resident stated she did not have the money for the application fee. stated that if resident couldn't pay the fee, (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she would not be able to participate in the program.also stated that resident was referred . for assistance with hearing devices. S3SSD stated that evidently she did know about the referral to the community provider to obtain hearing aids for Resident #6. S3SSD could not explain why she did not follow up with the community provider after not receiving communication from them regarding the resident's hearing aids or for an appointment from February 2025 to now. S3SSD was asked if she was responsible for providing residents with assistance or resources to obtain hearing aids or other assistive devices, and she stated Yea I guess.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record and policy review, the facility failed to maintain an effective infection prevention and control program, by failing to ensure:Staff utilized Enhanced Barrier Precautions (EBP) by wearing a gown when providing wound care to Resident #1;Proper infection control techniques were practiced during perineal care (cleaning of the genitals and anal areas) for Resident #75; andFailing to properly store clean bed pads.The facility census was 119.Findings: 1. On 01/28/2026, a review of the facility's policy titled Enhanced Barrier Precautions with a last revised date of 08/2025 read in part: Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .h. wound care (this generally includes residents with chronic wounds, and not those with only shorter lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers.). Resident #1 was admitted to the facility on [DATE], with diagnoses that included, but were not limited to type 2 diabetes mellitus without complications, unspecified open wound left foot and chronic kidney disease, stage 3 unspecified. Review of Resident #1's 01/2026 active orders revealed in part.01/06/2026 left heel diabetic foot ulcer – cleanse with wc (wound cleanser), pat dry, apply medihoney and calcium alginate, cover with abd (abdominal) pad and wrap with kerlix (gauze) as needed for soilage or removal. Review of wound care progress note by S10WCNP (Wound Care Nurse Practitioner) dated 01/27/2026 revealed in part.L (left) heel wound with moderate serous-sanguineous exudate. On 01/28/2026 at 8:23 a.m., an observation was made of S8TXN (Treatment Nurse) performing Resident #1's wound care. She was assisted by S9CNA (Certified Nursing Assistant). No gowns were utilized throughout the procedure by either employee. During a subsequent interview with S8TXN, she confirmed that no gowns were utilized during the procedure because the resident was not on EBP. She stated S4ADON/IP (Assistant Director of Nursing/Infection Preventionist) gave her a list of residents on EBP and Resident #1 was not on the list. On 01/28/2026 at 9:08 a.m., an interview was conducted with S4ADON/IP. She confirmed Resident #1 had a diabetic foot ulcer with drainage and should have been on EBP precautions but she failed to identify that the resident required such precautions. S4ADON/IP confirmed staff should have been gowning for Resident #1's wound care. 2. Review of a facility policy titled Perineal Care, with a last reviewed date of 04/09/2025, revealed, in part, Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Review of Resident #75's medical record revealed an admit date of 12/04/2023 with diagnoses that included, in part, personal history of urinary tract infections, dysuria, and chronic kidney disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #75's MDS (Minimum Data Set) dated 12/19/2025 revealed, in part, Section H: Urinary continence: 1. Occasionally incontinent (less than 7 episodes of incontinence). Review of Resident #75's Care Plan revealed UTI-hx (history) of UTI with interventions that included, in part, assist with peri (perineal)-care as needed. Further review of Resident #75's Care Plan revealed alteration in elimination r/t (related to) has bladder accidents, wears pull ups with interventions included, in part, assist with personal hygiene/peri-care as needed. On 01/29/2026 at 10:00 a.m., an observation of peri-care was conducted on Resident #75 and a subsequent interview was conducted with S13CNA (Certified Nursing Assistant). S13CNA donned gloves, applied perineal cleanser to a wipe, and wiped Resident #75's perineal area from front to back. S13CNA then wiped Resident #75's perineal area from front to back a second time using the same wipe. An interview was conducted with S13CNA. S13CNA confirmed that she should have thrown away the wipe after wiping Resident #75's perineal area, and obtained a new wipe to wipe Resident #75's perineal area again. On 01/29/2026 at 11:12 a.m., an interview was conducted with S4ADON/IP (Assistant Director of Nursing/Infection Preventionist). S4ADON/IP confirmed the CNA should not have used the same wipe to wipe Resident #75's perineal area from front to back multiple times. She also confirmed that a new wipe should have been used each time her perineal area was wiped from front to back. 3. Review of the facility's policy titled Departmental (Environmental Services) – Laundry and Linen, with a last review date of 04/09/2025, read in part, General Guidelines: Standard Precautions: 1. Separate soiled and clean linens at all times. On 01/29/2026 at 12:10 p.m., an observation was made of the laundry department with S6HskSup (Housekeeping Supervisor). An observation was made of the soiled linen room of the laundry department. A clothes line made of metal was attached to two walls and sloped across the soiled linen room. There were blue multi-use and washable bed pads draped on the metal clothesline. S6HskSup stated the blue bed pads hanging on the metal clothes line were resident bed pads, and they had been washed and were hanging on the metal clothes line to dry. An observation of the blue bed pads revealed that the bed pads were hanging next to the washing machines and directly above the mop bucket, which contained dirty water in the soiled linen room. One bed pad was touching the outside of the door and the handle of the washing machine. S6HskSup stated the clean bed pads should probably not be hanging to dry in the soiled linen room. He stated that these items should be hung to dry in the clean linen room. On 01/29/206 at 12:35 p.m., an interview and observation was conducted with S4ADON/IP (Assistant Director of Nursing/ Infection Preventionist). An observation was conducted with S4ADON/IP of the soiled linen room. S4ADON/IP confirmed that the clean bed pads were hanging in the soiled linen laundry room, and they should not be there. S4ADON/IP confirmed that they should be hanging to dry in the clean linen laundry room since they are clean.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse for 2 (Resident #2 and Resident #81) of 2 (Resident #2 and Resident #81) residents investigated for resident to resident abuse. The facility failed to protect:1. Resident #81 from physical abuse by Resident #2; and2. Resident #2 from physical abuse by Resident #81. Findings: Review of the facility's policy titled, Abuse Prevention Program with a last review date of 04/09/2025, read in part. Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents.6. Identify and assess all possible incidents of abuse.8. Protect residents during abuse investigations. Resident #81 Review of Resident #81's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, bipolar disorder and depression with psychotic features. Review of Resident #81's Quarterly Minimum Date Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/29/2025 revealed she had a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact. Review of Resident #81's progress notes revealed the following: On 12/06/2025 at 17:45 (5:45 p.m.), S11LPN (Licensed Practical Nurse) wrote: Resident (#81) was walking in hallway with walker as another resident (Resident #2) passed by this resident said to the other resident you stole my pop, the other resident (Resident #2) then took her w/c (wheelchair) and ran it into this resident's walker. The staff then took resident's (Resident #2) w/c and began to push her to her room and the resident (Resident #2) reached out and hit this resident (#81) on her leg. This resident began yelling and attempted to hit (Resident #2) back without success because staff was between them. Both residents were taken to their rooms. On 12/07/2025 at 9:44 a.m., S11LPN wrote: Resident (#2) was propelling herself in the hallway and as she passed by (Resident #81) this resident came out of her room and kicked the other resident (#2) on her leg. The resident (#2) yelled ouch she kicked me. This nurse asked this resident what happened and she replied yes I kicked her because she hit me yesterday and stole my pop and I'm not sorry. This nurse then assisted resident (#2) to her room and this resident (#81) stayed in her room and finished eating her breakfast. On 01/28/2026 at 3:14 p.m., an interview was conducted with Resident #81. The resident stated that one day she was returning from exercise class and Resident #2 was leaving her (Resident #81's) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with her pop (soda) and Resident #2 ran her wheelchair into her (Resident #81). She stated she kicked Resident #2 and she yelled. She stated that staff came when they heard the yell and she confessed to them that she kicked Resident #2. Resident #2 Review of Resident #2's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, dementia, with other behavioral disturbances, major depressive disorder, and anxiety disorder. Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/22/2025 revealed she had a Brief Interview for Mental Status (BIMS) score of 08, which indicated she was moderately cognitively impaired. A review of the facility's incident titled, Physical Aggression Received, dated 12/06/2025 at 14:35, included a note by S11LPN (Licensed Practical Nurse) that revealed in part. This resident (Resident #2) was propelling down the hallway in her w/c (wheelchair), when another resident (Resident #81) walked up and told this resident you stole my pop (soda). This resident (Resident #2) ran into the other resident's (Resident #81) walker. A CNA (certified nurse assistant) ran over and took this resident (Resident #2) and began pushing her w/c towards her room and this resident hit the other resident (Resident #81) on her leg.No injuries observed at time of incident. A review of the facility's incident titled, Physical Aggression Received, dated 12/07/2025 at 07:50, included a note by S11LPN that revealed in part.Resident (Resident #2) was propelling herself in the hallway and as she passed by, the resident (Resident #81) came out of her room and kicked this resident (Resident #2) on her leg. This resident yelled ouch she kicked me. This nurse asked the resident (Resident #81) what happened, and she replied, Yes, I kicked her because she hit me yesterday and stole my pop and I'm not sorry. This nurse then assisted this resident (Resident #2) to her room, and the other resident (Resident #81) stayed in her room and finished eating her breakfast.No injuries observed at time of incident. On 01/28/2026 at 2:14 p.m., a phone interview was conducted with S11LPN regarding the incidents on 12/06/2025 and 12/07/2025 between Resident #2 and Resident #81. S11LPN stated on 12/06/2025, Resident #2 was in the hall, and Resident #81 was walking out of her room, and saw Resident #2 in the hall. Resident #81 stated to Resident #2 something about she had stolen her pop. Resident #2 then approached Resident #81's walker with her wheelchair, and S12CNA separated the residents. When S12CNA was moving Resident #2, she hit Resident #81's leg with her hand. S11LPN stated on 12/07/2025, Resident #2 was propelling herself down the hall, and she passed by Resident #81's room. Resident #81 was coming out of her room when S11LPN stated she heard Resident #2 state, ouch, she kicked me. S11LPN stated she asked Resident #2 what had happened, and she stated that Resident #81 had kicked her in the leg. Resident #81 told S11LPN that she had kicked Resident #2 because she had hit her leg yesterday, and had stolen her pop. S11LPN stated she informed S1ADM (Administrator) of the incidents on 12/06/2025 and 12/07/2025 at the times that they occurred. On 01/28/2026 at 2:31 p.m., a phone interview was conducted with S12CNA (Certified Nursing Assistant) regarding the incident on 12/06/2025 between Resident #2 and Resident #81. S12CNA stated on 12/06/2025, Resident #2 was wheeling herself down the hall, Resident #81 walked out of her room, and both residents were in the hall at the same time. Resident #81 stated something about (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 stealing her pop. S12CNA stated that when she was separating the residents and wheeling Resident #2 back to her room, she hit Resident #81 on her leg. On 01/28/2026 at 3:53 p.m., an interview and record review were conducted with S1ADM. S1ADM confirmed he was notified by S3SSD (Social Service Director) and S11LPN of the physical altercations between Resident #2 and Resident #81 at the times they occurred on 12/06/2025 and 12/07/2025. S1ADM stated the incidents resulted in no injury to both residents.

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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** Based on record reviews, interviews, and facility policy review, the facility failed to ensure an allegation of physical abuse was reported immediately, but not later than two (2) hours after the allegation was made to the State Survey Agency for 2 (Resident #2 and Resident #81) of 2 (Resident #2 and Resident #81) residents investigated for resident to resident abuse. Findings: Review of the facility's policy titled, Abuse Investigation and Reporting with a last reviewed date of 04/09/2025, 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. An 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 #2 Review of Resident #2's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, dementia, with other behavioral disturbances, major depressive disorder, and anxiety disorder. Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/22/2025 revealed she had a Brief Interview for Mental Status (BIMS) score of 08, which indicated she was moderately cognitively impaired. Resident #81 Review of Resident #81's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, bipolar disorder and depression with psychotic features. Review of Resident #81's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/29/2025 revealed she had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. A review of the facility's incident report titled, Physical Aggression Received, dated 12/06/2025 at 14:35, included a note by S11LPN (Licensed Practical Nurse) that revealed in part. This resident (Resident #2) was propelling down the hallway in her w/c (wheelchair), when another resident (Resident #81) walked up and told this resident you stole my pop (soda). This resident (Resident #2) ran into the other resident's (Resident #81) walker. A CNA (Certified Nurse Assistant) ran over and took this resident (Resident #2) and began pushing her w/c towards her room and this resident hit the other resident (Resident #81) on her leg. A review of the facility's incident report titled, Physical Aggression Received, dated 12/07/2025 at 07:50, included a note by S11LPN that revealed in part. Resident (Resident #2) was propelling herself in the hallway and as she passed by, the resident (Resident #81) came out of her room and kicked this resident (Resident #2) on her leg. This resident yelled ouch she kicked me. This nurse asked the resident (Resident #81) what happened, and she replied, Yes, I kicked her because she hit me yesterday and stole my pop and I'm not sorry. This nurse then assisted this resident (Resident #2) to her room, and the other resident (Resident #81) stayed in her room and finished eating her breakfast. On 01/28/2026 at 2:14 p.m., a phone interview was conducted with S11LPN regarding the incidents on 12/06/2025 and 12/07/2025 between Resident #2 and Resident #81. S11LPN stated on 12/06/2025, Resident #2 was in the hall, and Resident #81 was walking out of her room, and saw Resident #2 in the hall. Resident #81 stated to Resident #2 something about she had stolen her pop. Resident #2 then approached Resident #81's walker with her wheelchair, and S12CNA separated the residents. When S12CNA was moving Resident #2, she hit Resident #81's leg with her hand. S11LPN stated on 12/07/2025, Resident #2 was propelling herself down the hall, and she passed by Resident #81's room. Resident #81 was coming out of her room when S11LPN stated she heard Resident #2 state ouch, she kicked me. S11LPN stated she asked Resident #2 what had happened, and she stated that Resident #81 had (continued on next page)

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	195567	A. Building B. Wing	01/29/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kicked her in the leg. Resident #81 told S11LPN that she had kicked Resident #2 because she had hit her leg yesterday, and had stolen her pop. S11LPN stated she informed S1ADM (Administrator) of the incidents on 12/06/2025 and 12/07/2025 at the times that they occurred. On 01/28/2026 at 2:31 p.m., a phone interview was conducted with S12CNA (Certified Nursing Assistant) regarding the incident on 12/06/2025 between Resident #2 and Resident #81. S12CNA stated on 12/06/2025, Resident #2 was wheeling herself down the hall when Resident #81 walked out of her room, and both residents were in the hall at the same time. Resident #81 stated something about Resident #2 stealing her pop. S12CNA stated that when she was separating the residents, and wheeling Resident #2 back to her room, she hit Resident #81 on her leg with her hand. On 01/28/2026 at 3:53 p.m., an interview and record review were conducted with S1ADM. S1ADM confirmed he was notified by S3SSD (Social Service Director) and S11LPN of the physical altercations between Resident #2 and Resident #81 at the times they occurred on 12/06/2025 and 12/07/2025. S1ADM stated the incidents were not reported to the state agency.

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	01/29/2026

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a discharge summary for 1 (Resident #123) of 3 closed records reviewed.Findings:A review of the facility's policy titled, Discharge Summary and Plan, with a last reviewed date of 04/09/2025, read in part, When the facility anticipates a resident's discharge to private residence, another nursing care facility, a discharge summary and post discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: c. discharge summary.A review of Resident #123's record revealed she was admitted to the facility on [DATE] and discharged from the facility on 11/07/2025. Further review of the record revealed no documentation of a discharge summary completed for Resident #123.On 01/28/2026 at 2:06 p.m., a record review and interview was conducted with S3SSD (Social Services Director). S3SSD confirmed Resident #123 was discharged from the facility on 11/07/2025. S3SSD further confirmed that a discharge summary was not completed for Resident #123.

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	01/29/2026

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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(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 observation, interview and record review, the facility failed to ensure that residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 1 (#9) of 2 (#9, #124) residents investigated for ADLs.Findings:On 01/28/2026, a review of the facility's policy titled Activities of Daily living (ADLs), Supporting, with a last reviewed date of 04/09/2025, read in part: Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation .4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. Resident #9 was admitted to the facility on [DATE], with diagnoses that included, but were not limited to unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety; encounter for attention to gastrostomy and anxiety disorder.Review of Resident #9's quarterly Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of 01/14/2026, revealed in Section E0800 under Rejection of Care that the behavior was not exhibited. Further review revealed a code of 01 in Section GG0130 Self-Care I. Personal hygiene indicating the resident was dependent - helper does ALL of the effort. Resident does none of the effort to complete the activity.Review of Resident #9's current care plan revealed a focus area dated 06/11/2025 self-care deficit r/t (related to) needs assistance with ADLs, decreased mobility, dx (diagnosis) dementia, refuses to get up. Interventions in part: assist with ADLs as needed and Personal Hygiene (totally dependent).On 01/27/2026 at 9:23 a.m., an observation was made of Resident #9. The resident was in bed with her left hand exposed. Her fingernails of her left hand were observed to be long and dirty with a thick layer of brown substance underneath her left middle fingernail.On 01/28/2026 at 2:34 p.m., a second observation was made of Resident #9. The resident was in her bed and her left hand fingernails were still long and dirty with a thick brown substance underneath her left middle fingernail.On 01/28/2026 at 2:40 p.m., an observation of Resident #9 was conducted with S4ADON/IP (Assistant Director of Nursing/Infection Preventionist). She confirmed the above findings, and stated the CNA (Certified Nursing Assistant) should have cleaned the resident's nails. She further stated that if she was unable to do so she should have notified the treatment nurse. S8TXN (Treatment Nurse) was standing outside Resident #9's room door and stated that she was not notified by the CNA that the resident refused nail care.