

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Maison Teche Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7307 Old Spanish Trail Jeanerette, LA 70544	

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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>41419</p> <p>Based on record review and interviews, the facility failed to ensure residents received mail on Saturdays. This had the potential to affect 90 residents residing in the facility.</p> <p>Findings:</p> <p>On 12/03/2024 at 2:49 p.m., during the resident council meeting, Resident #51 stated residents did not receive mail on Saturdays.</p> <p>On 12/04/2024 at 9:15 a.m., an interview was conducted with S12CNASUP (Certified Nursing Assistant Supervisor) and S11HR (Human Resources). S12CNASUP stated the mail was delivered to the residents on Monday through Friday, but not on Saturdays. She stated the office was closed on weekends, and staff were not available to distribute mail on Saturdays. S11HR confirmed the residents received mail Monday through Friday but the mail carrier holds the mail on the weekend until the following Monday. S11HR stated that the facility does not have staff in the office to deliver the mail to the residents on the weekends. S11HR stated that she was not aware that it was regulatory for the residents to receive mail on the weekend. S12CNASUP confirmed she was aware residents were supposed to receive mail on the weekend, and they had not received mail on the weekend for some time now.</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419</p> <p>Based on record review, interviews, and observations, the facility failed to ensure a resident's rights to personal privacy for 2 (#2, #39) of 2 (#2, #39) residents out of a total sample of 36 residents investigated for Activities of Daily Living by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident #2 had privacy while in the bathroom; and 2. Resident #39 had the room door and bathroom door closed prior to staff providing personal care. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Resident #2</p> <p>Review of Resident #2's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of Dementia, Paranoid Schizophrenia, and Anxiety.</p> <p>Review of Resident #2's Brief Interview for Mental Status (BIMS) revealed a score of 15, which indicated normal cognition.</p> <p>On 12/02/2024 at 9:15 a.m., Resident #2 stated Resident #54, who resided in the next room, made comments to her when she was in the bathroom. She stated if she passed gas in the bathroom, Resident #54 would state he heard that and laugh at her. She added that Resident #54 also would say he heard her diarrhea, or stated she was constipated. She stated she told S8LPN (Licensed Practical Nurse) about what Resident #54 was doing when she used the bathroom, but nothing was done about it. She stated it made her feel bad, but she had to learn to ignore Resident #54.</p> <p>On 12/02/2024 at 9:25 a.m., an interview was conducted with S8LPN. S8LPN stated she did not recall Resident #2 complaining about Resident #54 making comments about her while she was in the bathroom.</p> <p>On 12/02/2024 at 9:43 a.m., an interview was conducted with Resident #54 who stated he hears Resident #2 while she is in the bathroom farting and it's pretty funny. He stated it's funny to hear someone farting in the bathroom. He confirmed that he did make comments to Resident #2 while she used the bathroom. He added that Resident #2 did not say anything to him, but it's pretty funny to him.</p> <ol style="list-style-type: none"> 2. <p>Resident #39</p> <p>Review of Resident #39's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Heart Failure, and Overactive Bladder.</p> <p>Review of Resident #39's Brief Interview Mental Status revealed a score of 12, indicating moderate cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/02/2024 at 10:00 a.m., upon entrance to Resident #39's room, it was observed the room door was opened and the bathroom door was opened. When the surveyor knocked on the room door prior to entrance, S9CNA (Certified Nursing Assistant) stated patient care. S9CNA was observed standing in the bathroom, and Resident #39 was observed pulling up her pants. Further observation revealed Resident #39's roommate who was seated in her wheelchair was in line of site of the bathroom.</p> <p>On 12/02/2024 at 10:03 a.m., an interview was conducted with S9CNA confirmed she should have closed the room door and bathroom door prior to assisting Resident #39 with personal care.</p> <p>On 12/03/2024 at 9:14 a.m., a follow up observation was conducted which revealed the resident's door was closed. Upon knocking prior to entering, the bathroom door was opened, the resident's roommate was seated in her wheelchair in the line of site of the bathroom. S10CNA was observed standing in the bathroom with Resident #39 who was observed pulling up her adult brief and pants.</p> <p>On 12/03/2024 at 9:17 a.m., an interview was conducted with S10CNA who confirmed she was supposed to protect the resident's privacy at all times and she should have closed the bathroom door prior to assisting Resident #39 with personal care.</p> <p>On 12/03/2024 at 12:50 p.m., an interview was conducted with Resident #39 who stated she was not comfortable when staff left the bathroom door opened while she was using the bathroom.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observation and interview, the facility failed to provide a homelike environment for 1 (#35) out of 5 (#18, #35, #36, #46 and #60) residents investigated for environment, out of a total sample of 36 residents.</p> <p>Findings:</p> <p>Review of a facility policy titled, Safe and Homelike Environment, reviewed 01/2024, indicated Policy: In accordance with the residents' rights, the facility will provide a safe, clean, comfortable and homelike environment .Policy Explanation and Compliance Guidelines: 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.</p> <p>Resident #35 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinsonism and End Stage Renal Disease.</p> <p>Review of Resident #35's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 09/17/2024 revealed he had a BIMS (Brief Interview for Mental Status) of 15, indicating his cognition was intact.</p> <p>During an observation and interview on 12/02/2024 at 9:36 a.m., a hole the size of the door knob was observed in the sheetrock on the right wall immediately after entering Resident #35's room. The resident stated it had been there about a month and the nurses and maintenance had been notified. Further observation revealed there was no door stopper to prevent the door knob from slamming into the wall.</p> <p>During an interview on 12/03/2024 at 12:54 p.m., S4Maint (Maintenance Director) stated that he was not aware of the hole in Resident #35's wall.</p> <p>During an interview on 12/03/2024 at 2:25 p.m., S1ADM (Administrator) stated that all staff members were responsible for checking the residents' rooms and notifying maintenance of identified problems so they can be addressed.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176</p> <p>Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental disorder to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 1 (#31) of 3 (#3, #31, #54) residents investigated for PASARR in a final sample of 36 residents.</p> <p>Findings:</p> <p>A review of Resident #31's medical record revealed she was admitted to the facility on [DATE]. Further review revealed she was diagnosed with Schizoaffective Disorder on 12/14/2022.</p> <p>A review of the Resident #31's physician's orders for December 2024 revealed resident had been prescribed the antipsychotic medication Aripiprazole 2mg (milligrams) related to the diagnosis of Schizoaffective Disorder.</p> <p>Further review of Resident #31's record revealed a Level 1 PASARR (Preadmission Screening and Resident Review) dated 07/21/2022. There was no evidence that a new review or a Level II PASARR had been submitted to the appropriate state-designated authority after the new diagnosis of Schizoaffective Disorder on 12/14/2022.</p> <p>On 12/04/2024 at 4:13 p.m., an interview and review of Resident #31's diagnosis list was conducted with S2SSD (Social Service Director). She confirmed that Resident #31 received a new diagnosis of Schizoaffective Disorder on 12/14/2022 and that a Level II PASARR had not been submitted for this new diagnosis and should have been.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on interview, and record review, the facility failed to develop and implement a comprehensive plan of care for 3 (#15, #39, #76) residents out of a total sample of 36 residents as evidenced by failing to:</p> <ol style="list-style-type: none"> Administer Resident #15's medications before meals; apply compression stockings daily for Resident #39; and monitor behaviors and side effects of anticoagulant, antidepressant and antipsychotic medications for Resident #76. <p>Findings:</p> <p>Resident #15</p> <p>On 12/04/2024, a review of the facility's policy titled Medication Administration with a revision date of 06/01/2024, read in part, Medications are administered by licensed nurses, or other staff .Policy Explanation and Compliance Guidelines: 12. Compare medication source (bubble pack, vial etc.) with MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time .Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .</p> <p>A review of Resident #15's EHR (Electronic Health Record) revealed an admitted [DATE] and Diagnoses which included, but were not limited to Gastro-Esophageal Reflux Disease without Esophagitis and Iron Deficiency Anemia.</p> <p>Further review of Resident #15's EHR revealed Physician Orders, for the month of December 2024, which included the following orders dated 11/19/2024:</p> <ol style="list-style-type: none"> Carafate Oral Tablet 1 GM (gram) (Sucralfate). Give 1 tablet by mouth before meals . Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (milligram) (Ferrous Sulfate) Give 1 tablet by mouth before meals . <p>During an observation of morning medication pass on 12/03/2024 at 7:50 a.m., S6LPN (Licensed Practical Nurse) administered medications to Resident #15 after the resident returned from having breakfast in the dining room. S6LPN scanned the single dose medication blister packets which included the medications above, and administered them to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/03/2024 at 9:03 a.m., S6LPN stated that the resident had eaten breakfast in the dining room then came back to Hall W for medications. S6LPN checked the orders for Ferrous Sulfate and Sucralfate and confirmed that the orders were written to be given before meals for GERD and were not offered before the resident ate breakfast. S6LPN stated the blister packets should have been compared with the physician orders and were not.</p> <p>41419</p> <p>Resident #39</p> <p>Review of Resident #39's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Heart Failure, Peripheral Vascular Disease, and Overactive Bladder.</p> <p>Review of Resident #39's Brief Interview Mental Status revealed a score of 12, indicating moderately intact cognition.</p> <p>Review of Physician Orders dated 08/01/2024, read in part .compression stocking on daily, remove at night.</p> <p>On 12/02/2024 at 10:12 a.m., an observation of Resident #39 was conducted. The resident was observed sitting in her wheelchair with Christmas socks on bilateral feet, no compression stockings were noted.</p> <p>On 12/02/2024 at 3:00 p.m., a follow up observation and interview was conducted with Resident #39 who stated that staff had not applied her compression stockings that morning.</p> <p>On 12/03/2024 at 1:00 p.m., another observation and interview was conducted with Resident #39 who was observed without compression stockings on. The resident stated that staff had not applied her compression stockings, and she had not refused to have them applied.</p> <p>On 12/04/2024 at 1:00 p.m., an interview was conducted with S10CNA (Certified Nursing Assistant) who stated she was not aware Resident #39 was to have compression stockings applied daily.</p> <p>On 12/04/2024 at 1:05 p.m., an interview was conducted with S9CNA who confirmed the resident was to have compression stockings applied daily by staff. She stated they should have been applied.</p> <p>49176</p> <p>Resident #76</p> <p>Review of Resident #76's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Atrial Fibrillation, Dementia, Psychotic Disturbance and Anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #76's physician orders for December 2024 revealed the following orders dated 08/26/2024: Eliquis (an anticoagulant) 2.5 mg (milligram), give 1 tablet by mouth two times a day; Trazodone (an antidepressant) 50 mg, give 1 tablet by mouth at bedtime; and Zyprexa (an antipsychotic) 2.5 mg, give 1 tablet by mouth one time a day. A further review of Resident #76's physician orders failed to reveal orders to monitor behaviors or side effects of anticoagulant, antidepressant and antipsychotic medications.</p> <p>A review of Resident #76's care plan revealed the following, in part .Potential for Bruising and Bleeding r/t (related to) Anticoagulant Use. Interventions included, in part .Monitor for bleeding/DVT (Deep Vein Thrombosis) Blood Clot q (every) shift .Report any increased s/sx (sign and symptom) of bleeding: Bruising, Hematuria, Melana, Coughing or Spitting up blood, Coffee ground emesis, Headache, Pale appearance. Further review of the care plan revealed the following, in part .At Risk for Increased Complications from Psych History, Anxiety, and Insomnia. Interventions included, in part .Assess for changes in mood status . Assess for increased s/sx of Depression .Monitor for side effects and behaviors r/t psych med usage.</p> <p>A review of Resident #76's November 2024 and December 2024 Medication Administration Record (MAR) revealed documentation that the resident received Eliquis 2.5 mg (milligram), give 1 tablet by mouth two times a day, Trazodone 50 mg, give 1 tablet by mouth at bedtime, and Zyprexa 2.5 mg, give 1 tablet by mouth one time a day, November 1, 2024-December 3, 2024. Further review of the MAR revealed no documentation that the resident was monitored for behaviors or side effects of anticoagulant, antidepressant and antipsychotic medications.</p> <p>On 12/04/2024 at 2:22 p.m., a record review and interview was conducted with S14LPN (Licensed Practical Nurse). She confirmed the resident had physician orders dated 08/26/2024 for Eliquis 2.5 mg, Trazodone 50 mg, and Zyprexa 2.5 mg. S14LPN further reviewed Resident #76's November 2024 and December 2024 MAR and confirmed that there was no documentation that behaviors, or side effects of anticoagulant, antidepressant and antipsychotic medications were monitored each shift and they should have been.</p> <p>On 12/04/2024 at 2:28 p.m., an interview and record review was conducted with S3DON (Director of Nursing). She stated that residents on anticoagulant, antidepressant and antipsychotic medications are monitored for behaviors and side effects of each medication. S3DON reviewed Resident #76's electronic medical record and confirmed that there was no documented evidence that behaviors or side effects of medications were monitored every shift.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>44269</p> <p>Based on interview, observation and record review, the facility failed to provide treatment/services to prevent further avoidable reduction of Range of Motion (ROM) and mobility as evidenced by a resident being unable to use his left leg prosthetic limiting his ability to walk for 1 (Resident #60) of 2 (#36 and #60) residents investigated for positioning and mobility in a final sample of 36 residents.</p> <p>Findings:</p> <p>Review of Resident #60's Admission Record indicated the facility admitted the resident on 02/16/2023 with diagnoses that included acquired absence of left leg below the knee with an onset date of 07/23/2019, other specified Depressive episodes and Generalized Anxiety disorder.</p> <p>Review of the list of residents with current wounds in the facility provided by S3DON (Director of Nursing) on 12/02/2024 at approximately 10:00 a.m. indicated Resident #60 had a facility acquired non pressure ulcer to his left stump that was acquired on 05/14/2024.</p> <p>Review of Resident #60's current physician's orders as of 05/31/2024 revealed the following orders dated:</p> <p>11/20/2023 FYI (For Your Information) steps to put prosthetic leg on: 1st tangel (rubber) on skin, 2nd 3 ply or 5 ply sock, 3rd prosthetic leg and roll brown sleeve all the way up onto thigh;</p> <p>05/23/2024 for open area to left stump: cleanse with wc (wound cleanser), apply ca (Calcium) alg (Alginate), cover with clean/dry dressing daily and PRN (as needed) soiling/peeling.</p> <p>On 12/04/2024 at 8:12 a.m., an interview was conducted with S13TxRN (Treatment Registered Nurse) who explained that Resident #60 had a wound to his left BKA that started out as an intact blister on 05/14/2024 which has deteriorated to 100% slough with bone exposure that was last assessed on 11/28/2024. S13TxRN further explained the facility participated in a special event offsite and Resident #60 was a participant in a dance contest. One of the therapy aides had assisted Resident #60 in the bathroom and noticed that the resident's left leg prosthetic sleeve/stocking was applied in the wrong order causing friction during the time that the resident was wearing his prosthesis. S13TxRN stated Resident #60 had not been able to wear his prosthetic leg currently due to the presence of an unhealed wound that subsequently developed.</p> <p>Review of Physical Therapy (PT) Discharge Summary dated 07/31/2023 revealed the resident was seen for 2 days during the 07/25/2023- 07/27/2023 progress period. PT's discharge recommendations included an exercise program and prosthesis. PT established an ambulation program and evaluated the resident as currently able to walk to the dining room, walk in corridor and negotiate steps and balance is steady.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of PT Evaluation and Plan of Treatment dated 06/03/2024 revealed reason for therapy indicated recurrent falls with pressure ulcer noted to L (left) residual limb with L BK (below knee) prosthesis not being worn, negatively impacting functional mobility tasks as he is requiring increased assistance. Resident presents with generalized weakness/fatigue, decreased balance, decreased standing tolerance and decreased endurance/activity tolerance.</p> <p>Review of Resident #60's quarterly MDS (Minimum Data Set), with an ARD (Assessment Reference Date), of 03/26/2024 revealed the resident's functional abilities and goals were assessed as the resident requiring max assistance putting on/taking off footwear and getting in and out of a tub/shower. The resident required partial/moderate assistance to shower/bathe self and with upper body dressing. The resident required supervision or touching assistance with toileting hygiene, lower body dressing and transferring to and from a bed to a chair (or wheelchair).The resident required set up assistance when transferring from sitting to standing and maintaining his personal hygiene The resident was able to independently roll from left and right, sit to lying, lying to sitting on side of bed, and get on and off a toilet or commode.</p> <p>Review of Resident #60's quarterly MDS, with an ARD of 06/18/2024, revealed the resident's Brief Interview for Mental Status (BIMS) score was 15 indicating intact cognition. The resident's functional abilities and goals revealed the resident now required partial/moderate assistance with showering/bathing self, upper and lower body dressing, personal hygiene, putting on/taking off footwear. The resident was also coded as needing partial/moderate assistance for mobility moving from sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer.</p> <p>On 12/04/2024 at 2:10 p.m., an interview was conducted with S5PT (Physical Therapist). S5PT explained Resident #60 was present at the offsite special event and recalled the resident was complaining of pain during his dancing contest. One of the former therapy aides assisted the resident in the bathroom and observed the resident's prosthetic leg was incorrectly applied and observed he had breakdown on his left knee stump. S5PT evaluated Resident #60 on 06/03/2024 because the resident was experiencing a functional decline since he could no longer wear his leg prosthetic. S5PT explained the resident was mobile, able to walk without assistance using is prosthesis, and did not use his wheelchair prior to 05/14/2024.</p> <p>On 12/04/2024 at 2:45 p.m., an interview was conducted with Resident #60 who was observed in his bed, and stated he was able to put on and wear his leg prosthetic prior to the event on 05/14/2024. Resident #60 was unable to recall which therapy staff assisted him the morning of 05/14/2024 with putting on his prosthetic leg. Resident #60 confirmed he went to the event offsite and participated in a dancing contest. He stated while he was at the event, he began to feel pain to his in his left leg. One of the therapy aides helped him get out of his costume which is when the therapy aide saw that his left thigh stocking and sleeve were put on incorrectly. Resident #60 expressed feeling sad about not being able to walk anymore and could not wear his leg prosthesis until the wound healed.</p>

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NAME OF PROVIDER OR SUPPLIER Maison Teche Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7307 Old Spanish Trail Jeanerette, LA 70544	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on observations, interviews, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 (#42) out of 2 (#8 and #42) residents investigated for respiratory care, by failing to label and properly store Oxygen tubing, and safely store Oxygen tanks. The total sample size was 36 residents.</p> <p>Findings:</p> <p>On 12/04/2024, a review of the facility's policy titled Oxygen Administration with a revision date of 06/01/2024, indicated Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice .5. e. Keep delivery devices covered in a black IFP (infection prevention) bag when not in use.</p> <p>On 12/04/2024, a review of the facility's policy titled Oxygen Safety with a revision date of 06/01/2024, indicated Policy: It is the policy of this facility to provide a safe environment for residents, staff, and the public .Policy Explanation and Compliance guidelines: 4. Oxygen storage - a. Oxygen storage locations shall be in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors or gates that can be secured against unauthorized entry.</p> <p>Resident #42 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.</p> <p>During an observation on 12/02/2024 at 10:44 a.m., Two Oxygen tanks were observed on a rack by the door in Resident #42's room. Another Oxygen tank was in a hanger on the back of the resident's wheelchair with a nasal cannula tubing attached and wrapped around the back of the wheelchair. The tubing was not dated and/or stored in a bag.</p> <p>During an interview on 12/02/2024 at 10:52 a.m., S7LPN (Licensed Practical Nurse) stated that as long as the oxygen tanks are on a rack they can be stored in the resident's room. S7LPN confirmed the O2 tubing was undated and opened to air on the back of the resident's chair and stated it should have been labeled and in a bag.</p> <p>During an interview on 12/03/2024 at 10:51 a.m., S3DON (Director of Nursing) stated that the Oxygen tanks should not have been stored in the resident's room. She stated that they should have been placed on a rack in a separate room.</p>		

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NAME OF PROVIDER OR SUPPLIER Maison Teche Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7307 Old Spanish Trail Jeanerette, LA 70544	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>47965</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure their medication error rate was less than five percent.</p> <p>Findings:</p> <p>Observations of morning med pass were conducted on 12/03/2024. S6LPN (Licensed Practical Nurse) administered Carafate Oral Tablet 1 GM (gram) and Ferrous Sulfate Oral Tablet 325 MG (milligram) to Resident #15 after the resident ate breakfast.</p> <p>Review of Resident #15's EHR (Electronic Health Record) revealed Physician Orders, for the month of December 2024, including the following orders dated 11/19/2024:</p> <ol style="list-style-type: none"> 1. Carafate Oral Tablet 1 GM (gram) (Sucralfate). Give 1 tablet by mouth before meals . 2. Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (milligram) (Ferrous Sulfate) Give 1 tablet by mouth before meals . <p>During an interview on 12/03/2024 at 9:03 a.m., S6LPN stated that the resident had eaten breakfast in the dining room then came back to Hall W for medication administration. S6LPN checked the orders for Ferrous Sulfate and Sucralfate in the resident's EHR and confirmed that the orders were written to be given before meals and were not administered before the resident ate breakfast.</p> <p>A total of 30 opportunities for medication pass were conducted during the survey with two errors observed. The facility's calculated medication error rate was 6.67%.</p>