STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195574	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maison Teche Nursing Center	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)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure the most recent survey results of the facility were posted in a place readily accessible to residents, family members, and legal representatives of residents. The facility's census was 87.Findings:Review of the facility's survey history in the state agency's database revealed the following: Revisit Complaint Survey dated 10/30/2024;Complaint Survey dated 11/06/2024;Revisit Complaint Survey dated 11/26/2024;Recertification, Re-Licensure, State Licensure Survey dated 12/04/2024;Revisit Re-Licensure, State Licensure Survey dated 01/13/2025;Complaint Survey dated 01/28/2025;Complaint Survey dated 01/28/2025;Complaint Survey dated 02/25/2025; andComplaint Survey dated 08/26/2025.On 01/11/2026 at 1:30 p.m., an observation and interview was conducted with S1ADM (Administrator). S1ADM stated the survey results were in a binder attached to the bulletin board near the dining room. S1ADM reviewed the binder and confirmed the last survey results in the binder were dated 10/15/2024. S1ADM confirmed the most recent survey results were not in the binder and should have been posted in a place readily accessible to residents, family members and legal representatives.

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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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** Based on observations, record review, and interviews, the facility failed to develop and implement a person-centered care plan for 2 (#41 and #76) of 34 sampled residents by:not monitoring behaviors and side effects of medications for Resident #41, andnot completing skin checks for Resident #76 per the physician's order and care plan.Findings:Resident #41Review of Resident #41's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, major depressive disorder, other specified depressive episodes, and generalized anxiety disorder.A review of Resident #41's physician orders for January 2026 revealed the following orders:-order dated 08/01/2024 for Trazodone (an antidepressant) 50 mg (milligram), give 1 tablet by mouth at bedtime.-order dated 08/02/2024 for Zoloft (an antidepressant) 25 mg, give 1 tablet by mouth one time a day.-order dated 09/04/2025 for Clorazepate Dipotassium (an antianxiety) 3.75 mg, give 1 tablet by mouth two times a day.-order dated 10/31/2025 for Buspirone (an antianxiety) 10 mg, give 1 tablet by mouth three times a day.Further review of Resident #41's physician orders failed to reveal orders to monitor behaviors or side effects of antidepressant and antianxiety medications.A review of Resident #41's care plan revealed the following, in part .At Risk for Increased Complicated from Psych History, Anxiety, Depression, and Insomnia. Interventions included, in part .Assess for changes in mood status.Assess for increased s/sx (signs/symptoms) of Depression.Monitor for side effects and behaviors r/t psych med usage. A review of Resident #41's December 2025 and January 2026 Medication Administration Record (MAR) revealed documentation that the resident received Trazodone 50 mg, give 1 tablet by mouth at bedtime, Zoloft 25 mg, give 1 tablet by mouth one time a day, Clorazepate Dipotassium 3.75 mg, give 1 tablet by mouth two times a day and Buspirone10 mg, give 1 tablet by mouth three times a day, December 1, 2025-January 12, 2026.Further review of the MAR revealed no documentation that the resident was monitored for behaviors or side effects of antidepressant and antianxiety medications.On 01/13/2026 at 2:45 p.m., a record review and interview was conducted with S6LPN (Licensed Practical Nurse). She confirmed the resident had physician orders for Trazodone 50 mg, Zoloft 25 mg, Clorazepate Dipotassium 3.75 mg and Zoloft 25 mg. S6LPN further reviewed Resident #41's December 2025 and January 2026 MAR, and confirmed that there was no documentation that behaviors, or side effects of antidepressant and antianxiety medications were monitored each shift and they should have been.On 01/13/2026 at 2:48 p.m., an interview and record review was conducted with S2DON (Director of Nursing). She stated that residents on antidepressant and antianxiety medications should be monitored for behaviors and side effects of each medication. S2DON reviewed Resident #41's electronic medical record and confirmed that there was no documented evidence that behaviors or side effects of medications were completed every shift per the resident's care plan.Resident #76On 01/13/2026, a review of the facility's policy titled, Skin Assessment, with an unknown last reviewed date or revised date, revealed in part.Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission and weekly.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, Parkinson's disease, dementia, cerebral infarction, moderate protein calorie malnutrition and pressure ulcer of left buttock, stage 3.A review of Resident #76's physician orders for January 2026 revealed the following order dated 01/31/2025 for head to toe skin assessment every night shift every Tuesday.A review of Resident #76's care plan revealed the following, in part .Skin Integrity aging process, decreased ROM (range of motion), joint pain or stiffness, contractures, edema, and impaired mobility. Interventions included, in part .Head to toe assessment weekly . Review of Resident #76's weekly head to toe skin checks revealed the last assessment was dated 12/30/2025. There was no documented skin check completed for the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following date: 01/06/2026.On 01/13/2026 at 2:58 p.m., an interview and record review was conducted with S2DON (Director of Nursing). She stated that head to toe skin checks should be completed on all residents every week. S2DON reviewed Resident #76's electronic medical record and confirmed that there was no documented evidence that a head to toe skin check had been completed on 01/06/2026.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the provider failed to revise a resident's care plan for 1 (Resident #42) out of 34 sampled residents as evidenced by the care plan failing to reflect the resident's plans for discharge out of the facility.Findings Review of Resident #42's medical record revealed he was admitted to the facility on [DATE].Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was able to participate in the Brief Interview for Mental Status (BIMS) with a score of 15 indicating the resident was cognitively intact.On 01/11/2026 at 9:34 a.m., an initial interview was conducted with Resident #42. Resident #42 stated he really wanted to get out of the nursing facility and move into his own place. Review of Resident #42's care plan meeting dated 03/19/2025 revealed: Resident hopeful waiver will find housing soon with S3MDS/LPN (MDS Licensed Practical Nurse) and S5SSD (Social Services Director) were present.Review of Resident #42's care plan meeting dated 06/18/2025 revealed Resident wants to discharge with waiver as soon as housing is available with S3MDS/LPN and S5SSD were present.Review of Resident #42's current care plan revealed in part, No plans for discharge: plans to remain in facility long term with interventions to hold care plan meeting quarterly and no active discharge planning at this time. On 01/13/2026 at 2:55 p.m., an interview was conducted with S5SSD who stated she was familiar with Resident #42 and verified the resident was on a waiting list for waiver services to assist him with housing. S5SSD confirmed Resident #42's current care plan had not been revised to reflect the resident's plan to discharge out of the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to maintain an effective infection prevention and control program by failing to ensure staff utilized appropriate personal protective equipment (PPE) for a resident on Enhanced Barrier Precautions (EBP) while administering a water flush via feeding tube for 1(Resident #5) sampled resident was reviewed for tube feeding. Findings:A review of the facility's policy titled, Enhanced Barrier Precautions, with a last reviewed date of 04/01/2024, read in part, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions refer to an infection control interventions designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. High-contact resident care activities include: . g. device care or use central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes.A review of Resident #5's record revealed he was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction and gastrostomy status. A review of Section K: Swallowing/Nutritional Status of Resident #5's Quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed that the resident was assessed as having a feeding tube.A review of Resident #5's physician orders revealed an order written on 11/25/2025 that read, every 4 hours enteral: flush feeding tube with 1100 cc (cubic centimeters) of water q 4 hours (every 4 hours).Further review of Resident #5's physician orders revealed an order dated 05/31/2024 that read, enhanced barrier precautions with direct care r/t (related to) feeding tube every day and night shift.On 01/12/2026 at 12:07 p.m., an observation was conducted of S4LPN (Licensed Practical Nurse), who administered Resident #5's water flush via feeding tube. S4LPN entered Resident #5's room, but did not wear a gown while administering Resident #5's water flush via feeding tube. An EBP precaution sign was observed in Resident #5's room, which read, wear gloves and gown for the following high-contact resident care activities: . Device care of use: central line, urinary catheter, feeding tube, tracheostomy . On 01/12/2026 at 1:20 p.m., an interview was conducted with S4LPN. She stated Resident #5 was on EBP, and she confirmed she did not wear a gown while administering Resident #5's water flush via feeding tube, but should have.On 01/12/2026 at 2:07 p.m., an interview with S2DON (Director of Nursing), she confirmed that Resident #5 was on EBP, and S4LPN should have worn a gown while administering his water flushes via feeding tube.