STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195619	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy Care Center	906 Cherry Street Mamou, LA 70554

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195619	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy Care Center	906 Cherry Street Mamou, LA 70554

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure services were provided to meet professional standards of practice for 2 (Resident #1 and Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The facility failed to ensure:1. A fall mat was in place as ordered and care planned for Resident #1, and2. Physician's orders for increasing water flush for Resident #3, who received feeding and hydration via PEG (Percutaneous Endoscopic Gastrostomy), was followed. Findings:Resident #1Review of Resident #1's electronic medical record revealed an admit date of 06/06/2025 with diagnoses that included in part: Encephalopathy, Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Generalized Anxiety Disorder, Alcohol Abuse Uncomplicated, and Major Depressive Disorder Recurrent with Psychotic Symptoms. Review of Resident #1's admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/18/2025 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3, which indicated Severe Cognitive Impairment. Resident #1 was dependent on staff for all self-care and transfers. Review of Resident #1's Active Physician Orders revealed an order initiated 07/22/2025 for Fall Mat every shift. Review of Resident #1's Care Plan revealed the resident was at risk for falls related to impaired mobility with an intervention that read in part. 07/18/2025 resident found on floor by bed. Fall Mat initiated. On 07/28/2025 at 11:25 a.m., observation revealed that a fall mat was not in place in Resident #1's room.On 07/28/2025 at 11:45 a.m., S3ADON acknowledged Resident #1 did not have a fall mat at his bedside and confirmed he should have. Resident #3Record Review revealed Resident #3 was admitted to the facility on [DATE], and had the following diagnoses in part. Aphasia following Cerebral Infarction, Unspecified Protein-Calorie Malnutrition, and Encounter for Attention to Gastrostomy.Record Review of Resident #3's annual MDS with ARD of 07/16/2025 BIMS score was not assessed due to resident condition. Resident #3 was dependent on staff for Eating, and all ADL (Activities for Daily Living) care. Resident #3 had a feeding tube. Record Review of Resident #3's Departmental Progress Notes read in part. 07/29/2025 1:36 p.m. S1DON documented: RD (Registered Dietician) seen Resident #3 yesterday (07/28/2025) and made recommendations for increasing free water flush to 40ml/hr.07/29/2025 11:00 p.m. S4LPN documented: Peg tube placement verified, patent and intact. No residual noted. Has formula isosource at 35ml/hour and Water at 30ml/hour in progress to peg per pump.Record Review of Resident #3's 07/2025 active physician orders read in part.Enteral Feed every shift isosource at 35ml/hr with 40ml/hr water flushes per e-pump. Start date: 07/29/2025Observation on 07/30/2025 at 8:35 a.m. of Resident #3 revealed she received feeding and hydration per PEG tube via pump. The tube feeding bag was labeled isosource and was programmed at 35ml/hr. The water flush was programmed at 30ml/hr. Observation on 07/30/2025 at 11:11 a.m. Resident #3 revealed she received feeding and hydration per PEG tube via pump. The tube feeding bag was labeled isosource programmed at 35ml/hr. The water flush was programmed at 30ml/hr. Observation on 07/30/2025 at 12:25 p.m. of Resident #3 and Interview with S2LPN confirmed Resident #3's water flush should be set at 40ml/hr, but was set at 30ml/hr. S2LPN stated the RD recommended an increase for Resident #3's water flush and confirmed the settings should have been changed when the order was put in on 07/29/2025, but had not. Interview on 07/30/2025 at 12:30 p.m. with S1DON revealed the facility had a standing order from the Medical Director to follow RD recommendations for all Residents who receive tube feedings. S1DON stated on 07/29/2025 the RD increased Resident #3's water flush to 40ml/hr from 30/hr, and confirmed that when the order was put in, nursing staff should have increased the water flush settings. S1DON confirmed nursing staff should have checked pump settings on 07/29/2025 night shift, and 07/30/2025 morning shift to ensure Resident #3 received the correct feeding and water flushes, but had not.