

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Savoy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation and interview the facility failed to ensure that each resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 (Resident #59 & Resident #60) of 33 sampled residents, by failing to:1. Promote resident dignity by providing a bedpan per the resident request for Resident #60.2. Promote resident dignity by providing disposable dishware for Resident #59 in the dining room. Findings:</p> <p>Resident #60</p> <p>Record review of facility policy Resident Rights reads in part . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence.</p> <p>On 03/25/2026 at 8:59 a.m. observation revealed Resident #60 lying in bed requesting bed pan. Surveyor assisted resident with pressing call light, per resident request. S6 CNA entered room shortly and stated resident has on a diaper and is not able to get up at this time due to left side weakness due to stroke; S6 CNA said she can go in her diaper.</p> <p>On 03/25/2026 at 10:48 a.m. an interview with S7 COTA revealed on 03/24/2026 therapy recommended Resident #60 use a bedpan and removed the bedside commode from her room.</p> <p>S7 COTA stated Resident #60's left arm is flaccid and requires maximum assistance of 2 people. S7 COTA stated Resident #60 does not want to use a diaper and I don't blame her. S7 COTA stated she told the wound care nurse on 03/24/2026 the resident was able to use bedpan.</p> <p>An interview on 03/25/2026 at 11:02 a.m. with S1 DON, S2 ADON, and S8 Administrator confirmed the CNA should have offered Resident #60 the bedpan. S2 ADON stated, We will in-service staff.</p> <p>Resident #59</p> <p>Review of Resident #59's medical record revealed an admit date of 12/12/2024 with diagnoses that included in part: Vascular Dementia, Enterocolitis due to Clostridium Difficile, Hyperlipidemia, Heart Failure, and Depression.</p> <p>Review of Resident #59's quarterly MDS with an ARD of 02/19/2026 revealed Resident #59 had a BIMS score of 9, indicating moderately impaired cognition.</p> <p>Review of a Physician Order for single room isolation with contact precautions was discontinued on 02/17/2026. (continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/23/2026 at 11:20 a.m., Observation revealed Resident #59 received her lunch meal tray on disposable dishware while seated in the dining room.</p> <p>On 03/23/2026 at 11:22 a.m., interview with S2ADON revealed Resident #59 had previously been placed on contact & isolation precautions and received meals on disposable dishware. S2ADON confirmed Resident #59 was no longer on contact precautions and should not have received meals on disposable dishware.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received a reasonable accommodation of their needs by failing to ensure the call light was accessible to a resident for 1 (Resident #3) of 33 sampled residents. Review of a facility policy dated 01/16/2026, titled Answering the Call Light revealed in part. The purpose of this procedure is to respond to the residents needs and request. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Review of Resident #3's medical record revealed an admission date of 12/07/2023, with diagnoses that included, in part, Mononeurial Disorder, Paraplegia, Epilepsy, and Peripheral Vascular Disease. Review of Resident #3's Quarterly MDS with an ARD 03/03/2026 revealed Resident #3 had a BIMS of 6, indicating severe cognitive impairment. Resident required set up assistance with eating, dependent for toileting hygiene and personal hygiene, and required substantial/maximal assistance to roll left to right. An observation on 03/24/2026 at 10:12 a.m. revealed Resident #3 lying in his bed, resting with his eyes closed. Resident #3's call bell was observed on the floor on the right side of the bed, not within reach of the resident. An observation/interview on 03/24/2026 at 12:24 p.m. revealed that Resident #3 was sitting up in bed, awake and alert. Resident #3's call bell was observed on the floor on the right side of the bed and not within reach of the resident. Resident #3 revealed he could not reach his call bell. An interview on 03/24/2026 at 12:45 p.m. with S4CNA revealed she was familiar with Resident #3 and the care he required. S4CNA stated Resident #3 can express his wants and needs with short responses and utilizes his call bell. On 03/24/2026 at 12:48 p.m., an observation was made of Resident #3 in his room with S4CNA. Observation revealed Resident #3's call bell was on the floor on the right side of the bed and not within reach of the resident. S4CNA confirmed Resident #3's call bell was not within reach for the resident and should have been. An observation on 03/24/2026 at 1:41 p.m. revealed that Resident #3 was in his room, awake and alert, in a reclined position in his Geri chair. Resident #3's call bell was observed hanging on the side of the bed, out of reach for the resident. An observation on 03/24/2026 at 3:00 p.m. revealed Resident #3 in his room, awake and alert, in a reclined position in his Geri chair. Resident #3's call bell was observed hanging on the side of the bed, not within reach for the resident. S1DON present in Resident #3's room at this time. S1DON confirmed the call bell was not within reach for Resident #3, and should have been.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>Based on observation, interview, and record, the facility failed to ensure that the mattress was compatible with the bedframe for 1 (Resident #3) of 33 sampled residents. Review of Resident #3's medical record revealed an admission date of 12/07/2023, with diagnoses that included, in part, Myoneural Disorder, Paraplegia, Epilepsy, and Peripheral Vascular Disease. Review of Resident #3's Quarterly MDS with ARD 03/03/2026 revealed Resident #3 had a BIMS of 6, indicating severe cognitive impairment. On 03/23/2026 at 11:39 a.m., observation revealed Resident #3 lying in bed with his feet hanging off of his mattress. Resident #3's mattress appeared to be too small for the bed frame. On 03/24/2026 at 10:12 a.m., an observation revealed Resident #3 lying in bed, positioned on his back with his head elevated. The resident's air mattress was observed not to fit the bed frame properly. There was approximately a 1-foot gap between the top of the bedframe and the head of Resident #3's mattress. Resident #3's head was partially above the mattress. On 03/24/2026 at 12:48 p.m., S4CNA was present at Resident #3's bedside. S4CNA confirmed that Resident #3's air mattress in place did not fit the bed frame properly. There was approximately a 1-foot gap between the top of the bedframe and the head of Resident #3's mattress. Resident #3's head was partially above the mattress. S4CNA revealed that if she pulled the resident and the mattress up in the bed, there would be a gap at the foot of the resident's bed between the air mattress and the footboard. On 03/24/2026 at 1:00 p.m., S2ADON was present at Resident #3's bedside. S2ADON confirmed Resident #3's mattress was not accommodating to Resident #3's height and should be. On 03/24/2026 at 3:00 p.m., observation of Resident #3 at this time with S1DON revealed Resident #3 in his room, reclined in a Geri chair. Observation of the resident's bed with S1DON at this time revealed that the air mattress on the bed was approximately 1 foot smaller than the bedframe. S1DON confirmed the resident's bed is not accommodating the resident and should be. S1DON confirmed that Resident #3's mattress does not fit the bedframe properly, but should.</p>		