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	03/26/2026

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

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide an ongoing activities program to support residents in their choice of activities based on comprehensive assessments, care plans and preferences for 3 (Resident #15, Resident #43, and Resident #70) of 33 sampled residents. This deficient practice has the potential to affect all 83 residents currently residing in the facility. Findings:Review of the facility's undated policy titled, Activities , read in part . The facility will provide an ongoing program of actives that support the interest and enhances the quality of life of each resident. Activities will be individualized based in resident assessments, preferences, and functional abilities. Procedure: 3. Implementations:Activities will be scheduled daily, including afternoon and weekendsPrograms will include group and individual activitiesResidents will be encouraged but not forced to participate Review of the facility's March 2026 activities calendar revealed the following scheduled activities in part . 03/23/2026 - 9:00 a.m. Coffee & Friends03/23/2026 - 9:30 a.m. Music Hour03/23/2026 - 10:00 a.m. Room Visits 03/23/2026 - 2:00 p.m. Hot Dollar/ Pretty Nails03/23/2026 - Serving Chips & Dip - National Chip & Dip Day!03/24/2026 - 9:00 a.m. Coffee & Friends03/24/2026 - 9:20 a.m. Music Hour03/24/2026 - 10:00 a.m. Body in Motion03/24/2026 - 2:00 p.m. Activity with Hospice03/24/2026 - 6:00 p.m. Bingo 03/25/2026 - 9:00 a.m. Coffee & Friends03/25/2026 - 9:30 a.m. Music Hour03/25/2026 - 10:00 a.m. Room Visits03/25/2026 - 2:00 p.m. Coffee & Cards on the Patio Resident #15 Review of Resident #15's medical record revealed an admission date of 04/12/2023 with diagnoses that included Chronic Obstructive Pulmonary Disease, Anemia, Morbid (Severe) Obesity Due To Excess Calories, Pulmonary Hypertension, Heart Failure, and Obstructive Sleep Apnea. Review of Resident #15's 01/21/2026 Quarterly MDS revealed a BIMS score of 15, indicative of intact cognition. Further review of MDS revealed Resident #15's reported Activity Preferences were very important to him. Review of Resident #15's Care plan revealed in part. Cognition: Cognitively intact per BIMS score. Interventions included in part. Encourage to participate in activities. In an interview on 03/23/2026 at 10:38 a.m., Resident #15 stated the activity director was never around. Resident #15 stated he likes to go to bingo but they only have it about once per week and he doesn't attend due to the inconsistent activity schedule In an interview on 03/24/2026 at 9:16 a.m., Resident #15 observed sitting in recliner. Observed March 2026 activities posted on wall in room, Resident stated You may see the activity director for 20 minutes. Resident #15 stated I use to go, but I got tired of sitting and waiting for activities to begin. Resident #43 Review of Resident #43's medical record revealed an admission date of 07/15/2023 with diagnoses that include Type 2 DM, Edema, HTN, Acute Embolism of Deep Veins of LUE, Pain, Primary Insomnia, Unspecified Psychosis, Bipolar disorder, Current Episode Manic Severe with Psychotic Features and Major Depressive Disorder, Recurrent Mild Review of Annual MDS Assessment with ARD 02/19/2026 revealed a BIMS score of 15 indicative of intact cognition. Further review of MDS revealed Resident #43's Activity Preferences were very important. Review of Resident #43's Care plan with a review date of 05/20/2026 revealed in part. Cognition: Cognitively intact per BIMS score with goal resident will follow orders per MD daily. Interventions included in part. Encourage to participate in activities. Focus of Activities: Involved in some activities with goal for Resident will continue to be involved in activities of choice. Interventions include in part. Beanbag (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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	/ring toss board games. (Bingo, pokeno, checkers, etc.), determine feasibility of offering activities of interest to resident that are not currently offered, encourage resident to attend facility activities, post calendar in room and remind resident of activities by announcement prior to beginning. Resident #70 Review of Resident #70's medical record revealed an admission date of 08/04/2025 with diagnosis that include COPD, Chronic Atrial Fibrillation, Hyperlipidemia, MDD, recurrent, severe with psychotic symptoms, Bipolar disorder, HIV, Viral Hepatitis C, Extrapyramidal and movement disorder, Vitamin D deficiency, Thyroid disorder, Pain, Liver transplant status, GERD, Enlarged prostate, Insomnia, Dementia and Hypertensive Heart Disease.Review of Resident #70's Quarterly MDS with ARD revealed a BIMS score of 11 indicating moderate cognitive impairment. Review of Resident #70's admission Comprehensive MDS Assessment with ARD 08/13/2025 revealed a BIMS score of 12, indicative of moderate cognitive impairment. Further review of Resident #70's MDS revealed Resident #70's Activity Preferences were very important. Interview on 03/24/2026 at 3:00 p.m. with Resident #70 revealed no activities for the mornings. Resident #70 revealed we have been waiting for a body building exercise activities in the morning but have not had it yet. Interview on 03/23/2026 at 3:21 p.m. with Resident #43 revealed staff did not have morning activities scheduled. Resident #43 revealed would like to be have more activities offered. Observation on 03/24/2026 at 9:25 a.m. of Resident #43 awake sitting in his recliner in his bedroom. Interview at this time with Resident #43 revealed a volunteer from hospice played bingo yesterday afternoon on the north dining area. Resident #43 revealed he likes playing Bingo but would like to play more often. 03/24/2026 09:30 am Observation of North dining area where activities are held revealed no activities occurring, no residents or staff noted in area Interview on 03/24/2026 at 9:50 a.m. with S15 CNA revealed she used to be the Activity Director. S15 CNA stated she now usually works as CNA on the North hall on the 2-10 p.m. shift but filling in today for S9 Activity Director. S15 CNA revealed S9 Activity Director left early yesterday and out again today. S15 CNA revealed she had not received any instructions and did not know about the activity 'body in motion' on the activity schedule. Interview on 03/24/2026 at 9:55 a.m. with S16 CNA Transportation revealed she recalls the last outing was around Christmas for lights in Church Point and ice cream at Wendy's. S16 CNA Transportation revealed S9 Activity Director does meal of the month. S16 CNA Transportation revealed that sometimes S9 Activity Director does bingo but it is mostly led by volunteer hospice staff. Telephone interview on 03/24/2026 at 10:06 a.m. with S9 Activity Director accompanied by S15 CNA's cell phone revealed the 'body in motion' activity had not been done yet. S9 Activity Director hung up abruptly and ended the telephone call. Interview on 03/24/2026 at 10:08 a.m. with S15 CNA revealed she did not do activity, 'music hour' this am at 9:30 a.m. because she was doing pretty nails on north hall. She stated she did 5 resident's nails this morning. Observation on 03/24/2026 at 10:15 a.m. of utility cart in the activity room revealed with 6 bags of chips and 4 jars of assorted dips unopened. Interview at this time with S16 CNA Transportation revealed she shares the activity office with S9 Activity Director. S16 CNA Transportation revealed the chips and dips were supposed to be served yesterday for the residents for the activity Chips and Dips as noted on the activity schedule, but was not done. Interview on 03/24/2026 at 10:20 a.m. with S14 CNA Supervisor revealed she was not aware of an activity called 'body in motion' and had not seen the activity provided for the residents. S14 CNA Supervisor further revealed the volunteers of hospice usually do the Bingo activities. Interview on 03/24/2026 at 11:15 a.m. with S8 Administrator revealed she is aware of the ongoing issues with S9 Activity Director and the residents' complaints in reference to activities. S8 Administrator revealed she had initiated a Plan of Improvement for S9 Activity Director who had to leave early yesterday and was not here today to review it with her. S8 Administrator reported S9 Activity Director had to leave yesterday due to a family emergency. S8 Administrator revealed the activities posted on the board and schedule state that activities are subject to change. In an interview on 03/25/2026 at 8:53 a.m., S14 CNA Supervisor stated, That's not my job; She was not here, she is never here, she is the DON's daughter referring to S9 Activity Director; That is her sister (S15 CNA walking down the hall), she is a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	night CNA but they have her filling in because S9 Activity Director is not here. Observation on 03/25/2026 at 9:28 a.m. of residents in the south dining area drinking coffee and listening to music. Interview at this time with S15 CNA revealed she was filling in for and working as the Resident Activity Director again today due to S9 Activity Director called in again today. S15 CNA revealed this is the first time doing this activity 'Coffee & friends' and confirmed it was not done yesterday, but should have been. Interview on 03/26/2026 at 11:30 a.m. with S8 Administrator revealed S9 Activity Director had not been here this week, called in again this morning, and she was unable to counsel her in regard to her Improvement Plan. S8 Administrator revealed that S9 Activity Director would be terminated. S8 Administrator confirmed that activities should have been provided for the residents, but was not.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record review, the facility failed to ensure a resident's medical record was complete and accurate by failing to ensure administration of narcotics were properly documented on the narcotic record for 2 (Cart A & Cart B) of 2 medication carts reviewed during the medication storage facility task. Findings:Review of the Controlled Substances facility policy dated 01/15/2026 revealed the following in part: Policy Statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Scheduled II and other controlled substances. 7. The charge nurse who administers the prescribed narcotic will immediately document it on the medication administration record and the controlled drug administration record.Medication Carts A and B were observed and narcotics were counted and compared to narcotic records for both carts with S5 LPN present on 03/25/2026 at 2:15 p.m. The following discrepancies were found:Record Review revealed Medication Administration Record (MAR) for March 2026 for Resident #36 dated March 25, 2026 revealed in part-----Hydrocodone/APAP 10-325 mg given at 08:48 a.m. by S5LPN. Medication administration was not signed by nurse on the narcotic record when reviewed at 02:20 p.m. on 03/25/2026. Review of Resident #36 Hydrocodone/APAP 10-325 mg tab 1 PO q 4 hours prn pain breakthrough Narcotic records revealed in part . amount received/remaining 19, but there were 18 tablets remaining on the medication card.2. Review of Resident #67 Gabapentin 600 mg tab 1 PO TID Narcotic records on 03/25/2026 at 2:21 p.m. revealed in part . amount received/remaining 38, but there were 39 tablets remaining on the medication card.3. Review of Resident #79 Lorazepam 1 mg 1 PO q 6 hours. Narcotic records revealed in part . amount received/remaining 30, but there were 29 tablets remaining on the medication card (S5 LPN documented on the narcotic record at 2:25 p.m., given at 11 a.m.)4. Review of Resident #30 Gabapentin 300 mg cap 1 PO TID Narcotic records revealed in part . amount received/remaining 30, but there were 29 capsules remaining on the medication card.5. Record Review revealed Medication Administration Record (MAR) for March 2026 for Resident #4 dated March 25, 2026 revealed in part Oxycodone w/ Acetaminophen Tab 10-325 MG Give 1 tablet by mouth four times a day related to pain, unspecified given at 11:00 a.m. by S5 LPN. Medication was not signed out by nurse at narcotic record review at 02:20 p.m. Resident #4 Oxycodone APAP 10/325 mg 1 PO every 6 hours Narcotic records revealed in part . amount received/remaining 21, but there were 20 tablets remaining on the medication card.6. Resident #25 Gabapentin 800 mg take 1 tab PO TID Narcotic records revealed in part . amount received/remaining 7, but there were 6 tablets remaining on the medication card.7. Resident #46 Lacosamide 100 mg take 1 tab PO BID Narcotic records revealed in part . amount received/remaining 17, but there were 16 tablets remaining on the medication card.8. Resident #56 Clonazepam 0.5 mg tab 1 per tube TID Narcotic records revealed in part . amount received/remaining 12, but there were 11 tablets remaining on the medication card.In an interview on 03/25/2026 at 2:15 p.m., S5 LPN stated she gave the medications, but did not document it on the Narcotic Record.In an interview on 03/25/2026 at 2:24 p.m., S1 DON confirmed nurses should document narcotics on the Narcotic record at the time they are administered.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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: Resident #60 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. 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. 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. 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. 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. Resident #59 Review of Resident #59's medical record revealed an admit date of 12/12/2024 with diagnoses that included in part: Vascular Dementia, Entercolitis due to Clostridium Difficile, Hyperlipidemia, Heart Failure, and Depression. 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. Review of a Physician Order for single room isolation with contact precautions was discontinued on 02/17/2026. 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. 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.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 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 each of the resident.Review of Resident #3's medical record revealed an admission date of 12/07/2023, with diagnoses that included, in part, Moneural 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure the person-centered care plan was implemented for 1 (Resident #84) of 33 sampled residents. Findings:Review of Resident #84's electronic health record revealed an admission date of 10/06/2023 with diagnoses which included: Dementia, Depressive Disorder, Anxiety, Polyneuropathy, Peripheral Vascular Disease, Repeated Falls, and Mild Cognitive Impairment. Review of Resident #84's Quarterly MDS with an ARD of 12/25/2025 revealed a BIMS score of 6, indicating moderate cognitive impairment. Resident #84 required substantial to maximal assistance with transfers. Review of a task in Resident #84's electronic medical record, initiated on 02/15/2026, revealed Resident #84 required transfer using a Hoyer lift with two-person assist. Review of Resident #84's comprehensive care plan dated 02/04/2026 revealed Resident #84 required transfer using a Hoyer lift with two-person assist. On 03/23/2026 at 1:35 p.m., observation of S12CNA and S13CNA revealed staff exited Resident #84's room without a Hoyer lift. Interview with S12CNA confirmed that staff were providing incontinent care and did not utilize a lift for the transfer. S12CNA confirmed Resident #84 should have been transferred utilizing a Hoyer lift, but was not. On 03/23/2026 at 1:52 p.m., interview with S13CNA confirmed she assisted S12CNA in providing incontinent care to Resident #84. S13CNA confirmed Resident #84 should have been transferred back to bed utilizing a Hoyer lift, but was not. On 03/25/26 at 1:54 PM, interview with S1DON confirmed Resident #84's care plan read in part. Resident #84 required transfers utilizing a Hoyer lift with a two-person assist. S1DON acknowledged that S12CNA and S13CNA did not utilize a Hoyer lift when transferring Resident #84, but should have.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to ensure the comprehensive plan of care was reviewed and revised to include nursing interventions implemented for a client with behaviors that required increased supervision and monitoring of behaviors for 1 resident (Resident #61) of 33 sampled residents. Findings:Review of the facility's revised policy dated March 2022 titled, Care Plans, Comprehensive Person-Centered read in part. Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of Resident #61's medical record revealed an admission date of 01/15/2025 with diagnoses that include Unspecified Dementia, Unspecified Severity with other Behavioral Disturbances, Insomnia, Depression, Alcohol Abuse, in Remission, General Anxiety Disorder and Schizophrenia. Review of Resident #61's Annual MDS with an ARD of 01/14/2026 revealed a BIMS score of 00, indicating severe cognitive impairment. Further review of Resident #61's MDS Behaviors section revealed Resident #61 did not exhibit behaviors in reference to pacing and wandering. Review of Care plan with review date of 04/15/2026 in part .I have cognitive impairment: Diagnosis of Dementia with other behavioral disturbances, Impaired ability to understand others; episodes of disorganized thinking, episodes of inattention impaired judgement/ Impaired Safety awareness. Goal for Resident's needs will be anticipated/met by staff and dignity maintained. Interventions included in part. Assess cognitive deficits or behaviors that interfere with forming relationships with others, avoid an over-stimulating environment, and redirect the resident when behaviors become socially unacceptable. Further review of Resident #61's Care plan revealed no documentation of interventions initiated on 02/14/2026 that included to increase supervision to 1:1 related to resident's behaviors and required close monitoring. Review of Resident #61's Incident Report dated 2/14/2026 at 5 p.m. by S2ADON read in part. Noticed resident wandering into other resident's room down hallway. Redirected twice. Notified DON. Initiated q1hour checks on resident. Daughter aware. Redirection frequently needed. Review of Resident #61's Close Monitoring: Every 15 Minutes documentation dated 02/14/2026 at 5:00 p.m. and Close Monitoring: Every 1 Hour dated 02/17/2025 at 5:00 p.m. through current date and ongoing. Observation on 03/24/2026 at 8:50 a.m. of Resident #61 lying in bed with eyes closed and S11CNA sitting at bedside table in bedroom. Interview at this time with S11CNA revealed she is expected to monitor and document on Resident #61 every hour because started combative behaviors and going into other resident's rooms. Interview on 03/25/2026 at 8:55 a.m. with S10MDS revealed Resident #61 had an incident where he was wandering in other residents' rooms on Valentine's Day. S10MDS revealed she was out on vacation during this time. S10MDS revealed Resident #61 was then placed on 1:1 supervision/ Q1Hour Checks as a nursing intervention. S10MDS confirmed she had not updated or revised his care plan because the order for Resident #61 to place on 1:1 supervision/ Q1Hour Checks was not a physician's order. Interview on 03/25/2026 at 2:30 PM with S1DON revealed she and the MDS nurse were responsible for updating or revising residents' care plans. S1DON revealed Resident #61 did not have a physician's order for increasing monitoring to 1:1 supervision/ Q1Hour Checks after the incident that occurred on 02/14/2026. S1DON revealed it was initiated as a nursing intervention for his behaviors and safety and did not have a physician's order. S1DON confirmed she did not update Resident #61's care plan to include interventions of resident being placed on 1:1 supervision due to his behaviors and wandering in other resident's rooms.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to obtain laboratory services as ordered by a physician to meet the needs of its residents for 1 (#2) of 5 (#1, #2, #7,#10, and #11) residents reviewed for unnecessary medications.Findings: Review of the Facility's undated policy titled Lab and Diagnostic Test Results- Clinical Protocol read in part.1. Thy physician will identify and order diagnostic and lab testing based on the residents diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for the test. Review of Resident #2's medical record revealed an admission to the facility on [DATE] with the following Diagnoses: Cerebral infarction, Dysarthria, Type 2 Diabetes, Congestive Heart Failure, Hypothyroidism, Hypertensive Heart Disease, and Cirrhosis of Liver. Review of Resident #2's medical record revealed a TSH lab completed 01/22/2026 with a hand written order at the bottom of the page that read in part . repeat TSH in 4 weeks. Review of Resident #'2 03/2026 Physician Orders revealed in part.01/26/2026-Repeat TSH (Thyroid Stimulating Hormone) level in 4 weeks. Review of Resident #2's medical record revealed no TSH lab draw was collected since 01/21/2026. An interview on 03/26/2026 at 9:15 a.m., S17 Unit Secretary stated that she manages most of the labs not given an order for Resident # 2's TSH to be drawn in 02/2026 and confirmed with the lab that the TSH was not drawn or collected in 02/2026. An interview on 03/26/2026 at 9:28 a.m., S1 DON confirmed that Resident #2's TSH lab had been overlooked and had not been collected in 02/2026, but should have been.

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	03/26/2026

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.