STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey # LA00052944. No deficiencies cited as a result of this complaint.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Recertification Survey	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure 1(#74) of 35 sampled residents rights were honored by not providing bath care for	F 561	Resident #74 has expired. All residents have the potential to be	5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/18/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 four days. This deficient practice had the potential to affect any of the facility's total census of 93 residents listed on the Resident Census and Conditions of Residents report identified as dependent or requiring assistance with bathing. Findings: Review of the medical record revealed Resident #74 was admitted to the facility on 10/25/12 with cumulative diagnoses of End Stage Renal Disease, Hemiplegia for unspecified Cerebrovascular Disease. Heart Failure, Essential Primary Hypertension. Further review of the medical records revealed an MDS (Minimum Data Set) dated 02/07/19. Review of Section C4 Cognitive Status of the MDS revealed the resident's BIMS score (Brief Interview of Mental Status) was 15. A BIMS score of 13-15 indicates the resident is cognitively intact. An interview was conducted with Resident #74 on 04/01/19 at 12:37PM. During the interview the resident was asked when she was last bathed. The resident said Thursday, 03/28/19. Resident#74 was also asked when her bath days were. The resident said Tuesdays and Thursdays. The facility's documented scheduled bath days are Tuesdays, Thursdays, and Saturdays. The surveyor asked Resident#74 did she receive baths on the weekends. The resident's response was "sometimes". An interview was conducted with S13Assistant Director of Nursing (ADON) on 04/03/19 at 09:45AM. During the interview, S13ADON was asked the last documented date Resident #74 had been bathed. S13ADONstated she would check the bath book. Review of the bath book revealed the resident had received a bath on	F 561	affected. The bath schedule and the bath team schedule were revised to assure residents are offered a bath a minimum of 3 times per week including weekends. Aides were re educated on the schedule and documenting of baths. DON or designee will monitor bath care by observation of the bath log 5 days per week for 4 weeks including weekends then randomly. Failure to honor wishes for bath care will be investigated and addressed at time of discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 04/01/19 and 04/02/19. S13ADON stated she didn't know why the bath book indicated the resident received baths on 04/01/19 and 04/02/19. S13ADON asked the bathe aides (S15CNA and S16CNA) when did the resident last receive a bath. The bathe aides stated the resident received a shower Tuesday (04/02/19). They also stated the resident shower days are Tuesdays and Thursdays. Surveyor asked S13ADON and bath aides before Tuesday, when was the resident's last shower. S15CNA and S16CNA said they didn't work on weekends. S13ADON said there was someone else giving baths on weekends, and she would call them to find out if the resident had received a bath last weekend. S13ADON stated the bath/shower schedule days are Monday, Wednesday, and Friday or Tuesday, Thursday, and Saturday. An interview was conducted with S2DON on 04/04/19 at 9:58AM. During the interview S2DON stated she spoke with the weekend bath aide via telephone and the aide stated she had not given Resident #74 a bath on neither Saturday nor Sunday. The surveyor asked S2DON did the aide offer a reason for not bathing the resident. S2DON's response to the surveyor was she did not ask the staff member for an explanation.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that each	F 641	Resident #4 was reassessed for skin issues on 4/1/19. All wounds had	5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 3 resident's pressure ulcer was assessed. This deficient practice was identified for 1 (Resident # 4) of 3(Residents #4, #9, #78) residents sampled for pressure ulcers and had the potential to affect any of the 7 residents with pressure ulcers greater than Stage 1 who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form (CMS-672). Findings: Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/2019 revealed the resident was assessed as being at risk for the development of a pressure ulcer. Review of Resident# 4's record revealed a care plan was developed for potential for skin breakdown. One approach included to complete weekly skin assessment and report changes in skin status to the physician and wound care as ordered. An observation was made on 04/01/19 at 1:37pm with surveyor, S3LPN and S7LPN of Resident #4's sacral area. Observation revealed Resident #4 had an unstageable sacral decubitus. Observation further revealed Eschar to the sacral area. In an interview on 04/01/19 at 01:34pm, S3LPN revealed the resident was admitted to the facility from the hospital with a sacral pressure sore but did not know what stage it was. In an interview with S8LPN on 04/01/19 at 01:34pm, S8LPN stated she had been doing wound care for 3 days, was not aware of a sacral pressure wound on Resident #4, and had not been providing wound care to his sacral wound. Interview on 04/03/19 at 1:00pm with S10CNA revealed Resident #4 returned from the hospital with a pressure wound to his sacral region.	F 641	assessment documented and orders for treatment obtained/clarified at that time. Skin assessments were performed for in house census on 4/1/19 and 4/2/19. Any issues noted were clarified at the time. Nurses aides will be reeducated on reporting skin changes to the nurse. Nurses will be re educated on policy for skin assessments DON or designee will monitor wounds weekly through observation rounds and sign off on the weekly documentation notes weekly x 4. Results will be discussed in the morning QA meeting with changes to action plan as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 S10CNA stated she reported this to S11LPN lthe previous week. In an interview on 04/04/19 at 2:45pm with S11LPN, she confirmed she completed Resident #4's head to toe assessment on 03/23/19 upon his return to the facility, and the resident did have a pressure ulcer to the sacrum. Review of Resident #4's head to toe assessment dated 03/23/19 revealed no documentation of a pressure ulcer to the sacral region. Upon review of the assessment with S11LPN, S11LPN confirmed she forgot to document the sacral wound in the note. In an interview with S2DON, on 04/04/19 at 10:10am, S2DON confirmed there was no documentation of a sacral wound on Resident #4's 03/23/19 head to toe assessment. In interview on 04/04/19 at 3:53pm S12Clinical Nurse Consultant stated a Registered Nurse should assess wounds at least weekly, or more often if needed, or if the condition of the wound worsens. There was no documented evidence and the facility presented no documented evidence that Resident #4's sacral wound was assessed and treated in a timely manner.	F 641		
F 644 SS=D	. Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F 644		5/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 5 pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to refer a resident diagnosed with mental disorders for a PASRR (Pre-Admission Screening and Resident Review) Level II review. This deficient practice was identified for 1 (Resident #19) of 2 (Resident #6, Resident #19) residents, in a total investigation stage of 34 residents. There were 93 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form CMS 672. Findings: Review of Resident #19's Diagnosis/History record revealed that he was admitted to the facility on 1/5/2018 with a diagnosis of Schizophrenia, Unspecified and Recurrent Depressive Disorders. Review of Resident #19's Level I PASRR screening dated 1/2/2018 revealed that Resident	F 644	Resident # 19 had the Level II review done during survey In house census will be reviewed to determine if any other residents need Level II review. Any identified resident will be referred for review. Social Services will be re educated on the requirements for Level II review Social Services will maintain a log of residents that require Level II and the status of review. Log will be reviewed with the Administrator weekly. Any identified concerns will be addressed at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 6 #19 was not diagnosed with a serious mental illness. Further review of Resident #19's Psychoactive Medication Gradual Dose Reduction worksheet revealed diagnoses of Schizophrenia and Major Depressive Disorder. Review of Resident #19's March 2019 physician's orders revealed he was on medications for diagnoses of Schizophrenia and Major Depressive Disorder. During an interview on 4/2/2019 at 2:15 PM, S6Regional Director of Quality Measures confirmed Resident #19 was admitted on 1/5/2018, did not have a Level II PASRR completed at that time, and the Level II screening was currently in progress. Review of Resident #19's Office of Behavior Health (OBH) PASRR Level II Request for Resident Review revealed it was dated 4/2/2019, which is almost fifteen (15) months after his admission date of 1/5/2018.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement the person-centered care plan by failing to obtain lab work for 1 (Resident #61) of 34 sampled residents. This had the potential to affect all 93 residents currently residing in the facility according to the Resident Census and Conditions of Residents form provided by the	F 656	The physician for resident # 61 has been contacted to request a BMP. The standing physician orders do not call for a BMP on Bumex. The facility was following the standing orders. Other residents had their care plans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 facility. Findings: Review of the clinical record revealed Resident #61 was admitted to the facility on 09/06/17 with the diagnoses, in part; Hyperlipidemia, Recurrent Depressive Disorder, Generalized Anxiety Disorder, Atherosclerotic Heart Disease, Aortic Aneurysm, Chronic Obstructive Pulmonary Disease, Pneumoconiosis due to asbestos and other mineral fiber, Acute and Chronic Respiratory Failure unspecified with hypoxia or hypercapnia, Muscle Weakness, and Gastro-esophageal Reflux Disease. Review of Resident #61's care plan revealed the care plan was developed for a diuretic (Bumex) and approaches were to obtain lab work as ordered and monitor potassium levels. Review of David's Drug Guide Assessment for lab test considerations for the medication Bumetanidine (Bumex) revealed to monitor electrolytes (especially potassium), blood glucose, BUN (Blood Urea, Nitrogen), Serum Uric Acid before and periodically throughout the course of therapy. Review of the facility's standing orders revealed Lasix: BMP (Basic Metabolic Panel) every three (3) months. Review of Resident #61's March 2019 and April 2019 Physician's Orders revealed Bumetanidine (Bumex) 0.5mg tablet administer one by mouth every Monday, Wednesday and Friday. Review of Resident #61's March 2019 Medication Administration Record (MAR) revealed	F 656	audited through chart review to assure all care planned labs were done if there was an existing physician order or had the physician contacted to request the lab if not ordered. Care plans were updated accordingly. Nurses will be re educated on following the care plan and obtaining labs as ordered Labs will monitored by DON or designee using a QA tool weekly x 3 months. Results will be discussed in the QA meeting. Changes will be made to the action plan as indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 Bumetanide 0.5mg was given on 03/01/19, 03/04/19, 03/06/19, 03/08/19, 03/11/19, 03/13/19, 03/15/19, 03/18/19, 03/20/19, 03/22/19, 03/25/19, 03/27/19, and 03/29/19. Review of Resident #61's April 2019 Medication Administration Record (MAR) revealed Bumetanide 0.5mg was given on 04/01/19 and 04/03/19. Review of Resident #61's clinical record revealed the last documented BMP results were dated 02/22/18 which included a potassium level 4.2 (reference range 3.5-5.5 mmol/L). Further review of Resident #61's record revealed no documented evidence of a BMP having been completed since 02/22/18. In an interview on 04/04/19 at 12:45pm, S3LPN (Licensed Practical Nurse) acknowledged the last BMP test found in Resident #61's clinical record was dated 02/22/18 and could not provide documented evidence of a current BMP test. In an interview on 04/04/19 at 1:15pm, S2DON (Director of Nursing) after reviewing Resident #61's clinical record and calling the lab acknowledged the last BMP test done was dated 02/22/18. S2DON stated she could not provide documented evidence of a current BMP test.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: Kelly-Armont, Lisa Based on record review and interview the facility failed to revise the care plan for 2 (Resident#3 and #79) of 34 sampled residents. This deficient practice had the potential to affect any of the facility's total census of 93 residents listed on the Resident Census and Conditions of Residents report. Findings: Resident#3 Record review of the clinical record revealed Resident#3 was diagnosed with a urinary tract infection on 02/06/19 and was treated with a	F 657	Residents # 3 and # 79 have had care plan revised to reflect current status Residents with orders for antibiotics since 4/4/19 and with falls since 4/4/19 have been identified through chart review. These residents have had the care plan revised to include these areas. MDS nurses have been re educated on the requirement for revising and updating care plans MDS will keep a monitoring tool of care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 seven day course of antibiotics. Further review of the clinical record revealed the resident was diagnosed with a repeat urinary tract infection on 03/14/19, and the physician ordered a seven day course of antibiotic therapy. Record review of Resident#3's care plan revealed a nursing diagnosis was developed to address the urinary infection dated 02/06/19, but the care plan lacked any documented evidence of revisions of the interventions when the resident was treated for a repeat urinary tract infection on 03/14/19. An interview was conducted with S14Care Plan Nurse, S2Director of Nursing (DON) and S12 Corporate Registered Nurse on 04/03/19 at 12:30PM in which they confirmed the care plan had not been revised to address the repeat urinary tract infection. Resident #79 Review of the medical record revealed Resident#79 was admitted to the facility on 10/29/18. Further review of the medical record revealed an MDS (Minimum Data Set) dated 02/07/19. Review of Section C4 Cognitive Status of the MDS revealed the resident's BIMS score (Brief Interview of Mental Status) was 15. A BIMS score of 13-15 indicates the resident cognitively intact. Record review of Nurses Notes dated 03/02/19 indicated Resident#79 sustained a fall while attempting to transfer himself from his wheelchair to his bed. The resident sustained a laceration to the forehead. Resident#79 was sent to the local hospital where he received four sutures to the forehead and was released.	F 657	plans that have been revised each week. This list will be compared to the physician orders for antibiotics and the falls list with the DON or designee weekly at the high risk meeting x 6 weeks. Discrepancies will be addressed as they are identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 Review of Resident#79's care plan which addressed falls failed to reveal a revision to the interventions. An interview was conducted with S14Care Plan Nurse on 04/03/19 at 2:30PM. During the interview S14 was shown the care plan and asked about the additions of new interventions after the resident's fall. S14 reviewed the care plan and found the resident's fall was not addressed on the fall section of the care plan but on the decreased vision/blind section of the care plan. The intervention added reads as follows: "Sent to Hosp/Remove sutures X 7 days". On 4/04/19 at 2:45PM an interview was conducted with S2DON, S12 Corporate Nurse, and S14 Care Plan Nurse. During the interview S12 agreed, "send to the hospital and remove the sutures" was not a nursing intervention, but was the doctor's orders.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to provide activities of daily living care for 1(#62) of 35 sampled residents. This deficient practice had the potential to affect any of the facility's total census of 93 residents listed on the Resident Census and Conditions of Residents as being dependent or	F 677	Resident # 62 had her hair detangled and combed on 4/2/19. Other residents with unmet ADL needs were identified through observation rounds. Any residents identified had those needs met at that time.	5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 requiring staff assistance for care. Findings: Review of the medical record revealed Resident # 62 was admitted to the facility on 05/05/17. Further review of the medical records revealed an MDS (Minimum Data Set) dated 05/05/19. Review of Section C4 Cognitive Status of the MDS revealed the resident's BIMS score (Brief Interview of Mental Status) was 15. A BIMS score of 13-15 indicates cognitively intact. An observation was made of Resident #62 on 04/01/19 at 9:50AM. During the observation Resident #62 was noted lying in the bed. The resident's hair was extremely matted and tangled. The resident was asked by the surveyor, when her hair was last combed. The resident stated her hair was combed last week by one of the facility's evening nurses. Another observation was made of Resident#62 on 04/02/19 at 10:30AM. The observation revealed the resident's hair was still very matted and tangled. An interview was conducted with S2Director of Nursing (DON) on 04/01/19 at10:45AM. S2DON was asked to accompany the surveyor to Resident #62's room. Before entering the resident's room, S2DON was asked to look at the resident's hair. S2DON acknowledged the resident's matted and tangled hair. S2DON asked the resident when her hair was last combed. Resident#62 said it had been about a week ago. An interview was conducted with S15CNA and S16Certified Nursing Assistant (CNA)shower aides on 04/03/19 at 11:00AM. During the interview S15CNA stated she combed the	F 677	C.N.A. staff and floor nurses were educated on the requirements for ADL care and personal grooming for residents. Observation rounds will be made by department heads 5 x week x 2 weeks then 3 x week x 2 weeks then by DON/designee randomly using a monitoring tool. Results of rounds will be discussed in the morning meeting with changes to action plan ass needed. Identified issues will be corrected at time identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 resident's hair yesterday and put it in two braids. The surveyor informed S15CNA she saw the resident yesterday morning, and the resident's hair was not combed. S15CNA said she combed the resident's hair early yesterday morning and the resident must have taken it loose. S15CNA and S16CNA were asked to accompany the surveyor to the resident's room. The resident was asked to look at S15CNA and she was asked did S15CNA comb her hair yesterday. The resident responded no. Resident#62 said her hair was combed last week by another staff member. The surveyor asked the two CNAs to look at the resident's hair. They looked at the resident's hair and said they understood what the surveyor was talking about. They acknowledged that the resident's hair was matted and tangled. An interview was conducted with S13Assistant Director of Nursing (ADON) on 04/03/19 at 11:15AM. During the interview the surveyor asked S13ADON to accompany her to the resident's room. S13ADON looked at the resident's hair and stated it would take a while for the resident's hair to become as matted and tangled as it was. During the interview, Resident#62 asked about a hair dresser and said she did not want her hair cut. S13ADON said she was going to see about getting a hairdresser appointment, but informed the resident her hair may have to be cut because of the matted and tangled condition it was in.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of Manufacturers pharmaceutical instructions, and interview the facility failed to ensure medications were stored in accordance with the manufacturer's directives and labeled upon removal from packaging. This failed practice had the potential to affect any resident who takes medication. Findings: Observation conducted on 4/4/2019 at 12:27 PM of medication cart 1, accompanied by S5 Licensed Practical Nurse (LPN), revealed an Advair Diskus was out of it's packing without a date to show when it opened. Instructions on the side of the box stated to discard 30 days after opening. In addition, One (1) bottle containing	F 761	The Advair discus was removed from the cart and a replacement ordered at time of identification. The Lorazepam was removed from the cart and replacement ordered. All med carts were audited for undated items and items that needed to be refrigerated. None were found. Medication nurses have been re educated on requirements for dating and refrigerating medications that require same. DON/designee will do weekly med cart	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 Lorazepam 2mg/ml oral solution had a label on the front of the bottle which read in part: "refrigerated". The bottle was stored in the locked narcotic box contained in a non-refrigerated medication cart. Review of Manufacturers pharmaceutical instructions for Lorazepam oral solution is to be stored in the refrigerator. Review of Medscape administration for Advair Diskus Oral Inhalation Preparation: Open from foil pouch before first time use; indicate date opened on diskus. An interview was conducted with S5 LPN on 4/4/2019 at 01:48PM during the medication cart observation, in which S5 LPN acknowledged the identified medication labeled "refrigerated". An interview was conducted with S2 DON on 04/4/2019 at 02:35 PM in which she acknowledged the findings.	F 761	audit x 4 weeks for non-dated discus and items that require refrigeration using a monitoring tool. Any discrepancies noted will be corrected at the time of discovery. Results will be discussed in the QA meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an effective Infection Control Program to ensure that appropriate hand hygiene is performed after incontinent bowel care and before assisting with wound care. This deficient practice had the ability to affect 1(Resident #4) of 3 (#9, #78) sampled residents out of a total of 7 residents who received wound care as per the facility's Resident Census and Conditions of Residents Form (CMS-Form 672). Findings: An observation was made of wound care on 04/03/19 at 9:25am. Observation revealed S9CNA assisting LPN (Licensed Practical Nurse) with wound care. Further observation revealed Resident #4 had a bowel movement during wound care. S9CNA cleaned the resident and then continued to assist with wound care without removing her gloves or performing any kind of hand hygiene between cleaning the resident and assisting with wound care. S9CNA was observed touching the wound area and the wound as the nurse cleansed and redressed the wound. In an interview during wound care with S9CNA, on 04/03/19 at 9:35am, S9CNA acknowledged	F 880	Resident #4 suffered no documented negative outcome for the occurrence All residents who are incontinent with wounds have the potential to be affected Nurses and C.N.A. were reeducated on hand hygiene per policy DON/designee will monitor hand hygiene during wound care per direct observation 3x week x 4 weeks. Any issues identified during the observations will be addressed at that time. Results will be discussed in the QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 she should have removed her gloves and performed hand hygiene before assisting with wound care. In an interview during wound care with S8LPN, on 04/03/19 at 9:37am, S8LPN acknowledged S9CNA should have removed her gloves and performed hand hygiene before assisting with the resident's wound care. In an interview on 04/03/19 at 11:19am, S2DON acknowledged the nursing assistant should have removed her gloves and used hand sanitizer before touching the resident's dressing and assisting S8LPN with wound care.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents who were capable of using call bells were equipped with a functioning call system that allowed communication between the residents room/bathroom and the nurses' station for 3 (a, b, and c) of 49 rooms checked during the initial screening phase of the survey. This deficient practice had the potential to affect any of the 93 residents who reside in the facility who may use the call bell as documented on the facility's list on the Resident Census and Conditions of Residents Form.	F 919	Residents in room a, b, c were provided with hand bells until the call system was functioning again. Other residents had the potential to be affected. All call bells were checked at that time and no others were identified as nonfunctioning. Staff has been re educated on reporting non functioning call lights. Maintenance has been reeducated on monitoring and	5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 20 Findings: An observation on 04/01/19 at 10:30am and on 04/02/19 at 11:55am of room (c) revealed the call bell did not light up in the hallway or make an alarm sound when pressed. Further observation revealed resident #71 who resides in this room is capable of using the call bell. An observation on 04/01/19 at 11:15am and on 04/02/19 at 10:15am of room (a, b) with adjourning bathrooms revealed the bathroom was not equipped with a call bell. Further observation revealed call bells for residents #13 and 53 who reside in room (a) and resident #250 who reside in room (b) call bells did not light up in the hallway or make an alarm sound when pressed. All residents who reside in those rooms are capable of using the call bells. In an interview on 04/04/19 at 10:10am S4Maintenance Supervisor stated he made rounds every week to check call bells but did not keep a log. S4Maintenance Supervisor could not provide documented evidence that call bells were being checked weekly. During an environmental tour on 04/04/19 at 8:18am S2Director of Nursing (DON) acknowledged call bells in room (a, b, and c) did not light up in the hallway or make an alarm sound when pressed and the adjourning bathroom for rooms (a and b) were not equipped with a call bell.	F 919	documenting call light check weekly. Administrator or designee will check call lights on 1 hall per day x 5 days for functioning using a monitoring tool then 1 hall per week x 4 weeks. Any issues will be corrected at the time identified. Administrator will review call light logs with maintenance and sign off on logs weekly x 3 months. Results will be discussed on the QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Maison De'ville Nursing Home of Harvey is not in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The findings that follow in this CMS 2567 demonstrate the non-compliance. The facility is sprinklered, licensed for 100 beds and a census of 96 at time of survey.	K 000		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to provide the continuation of the exit discharge to include access to the public way from all required exits. The access provides an easier transition for occupants to evacuate from all exits in the building. It was observed the corridors ceiling were not the required 7 ft. in height along the entire designated means of egress. The deficient practice had the potential to affect 96 of 96 residents. The exit discharge was deficient for 4 of 4 exits. Findings: During the facility tour, between the hours of 9:00am to 2:00p.m. the corridors were observed	K 271	Waiver approved through 05/04/2019	5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/23/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 1 not to meet the means of egress path minimum headroom requirement of 7 ft. along the entire designated means of egress path. Interview with the administrator revealed the facility was aware that the means of egress path is required, minimum headroom shall be 7 ft. along the entire designated means of egress path but a waiver was approved until 5/4/2021, this was also confirmed by the administrator during the exit meeting.	K 271		
K 521 SS=C	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the heating, ventilation and air conditioning system was installed in accordance with NFPA 90A. The system could re-circulate smoke originating from one part of the building into other parts of the building otherwise unaffected. The deficient practice had the potential to affect 96 of 96 residents. 4 of 4 corridors are deficient in being used as a return air plenum. Findings:	K 521	Waiver approved through 05/04/2021	5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 2 During the facility tour, between the hours of 9:00am to 1:00pm the corridors were observed being used as the return air plenum for the facility HVAC system. Interview with the administrator revealed the facility was aware the HVAC system was using the corridors as a return air plenum and requested the waiver granted by CMS to be approved until 5/4/ 2021; this was also confirmed by the Administrator during the exit meeting.	K 521		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 3 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the generator sets were exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources are in accordance with NFPA 110. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. In cases of a power outage the emergency generator powers essential life safety equipment for the facility. The deficient practice had the potential to affect 96 of 96 residents. 12 of 12 months were deficient. Findings: Review of the generator logs between 9:00 am and 2:00 pm revealed the facility was not	K 918	1. Generator was exercised underload for 30 minutes on 04/03/2019. 2. The Maintenance Director was educated on exercising generator underload for 30 minutes 12 times a year in a 20 - 40 day intervals. 3. A new generator exercise log was implemented including monitoring of underload for 30 minutes 12 times a year in 20 - 40 day intervals. 4. Administrator/Designee will monitor compliance through record review at monthly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 4 maintaining and testing the generator under load for 30 minutes 12 times a year in accordance with NFPA 110. Interview with administrator revealed the facility was not aware that all documentation was not complete regarding the inspection/testing of the emergency generator.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey #LA00052432, #LA00052506, and #LA00052535 Complaint Survey #LA00052432. Tag # F580 and F684 cited as result of Complaint #LA00052432. Complaint Survey #LA00052506. No deficiencies cited as a result of this complaint. Complaint Survey #LA00052535. Tag # F580, F609, and F684 cited as result of Complaint #LA00052535.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		9/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/10/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the physician was notified after: 1) a resident sustained an injury requiring wound treatment (Resident #1); and 2) a resident sustained an unwitnessed fall (Resident #3); This deficient practice was evidenced in 2 (Resident #1 and Resident #3) of 5 sampled resident and had the potential to affect any of the 95 residents as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents. Findings:	F 580	1. Corrective action was obtained or residents #1 and #3 identified to have been affected by the alleged deficient practice by: a. Resident #1 was discharged from the facility on 07/27/2019 no further corrective action available at this time. b. Resident #3-notifying the physician of unwitnessed fall. 2. Other residents that have the potential to e affected by the alleged deficient were identified and corrective actions were obtained for them by conducting an audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 Resident #1 Resident #1 was admitted to the facility on 10/01/14 with diagnoses of, in part, Chronic Kidney Disease and Alzheimer's Disease. Review of Resident #1's Care Plan revealed, in part, a potential for skin breakdown related to disease process with a documented intervention to report any red or open areas to skin. Review of Resident #1's Accident / Incident Report dated 06/29/19 at 12:18pm revealed, in part, the nurse was notified by the Certified Nursing Assistant (CNA) and wound care nurse that Resident #1 was bleeding from the left foot. Assessment revealed a skin tear / open sore was observed to the left leg /4th toe. Further review revealed Resident #1's Physician was notified at 1:00pm. The Accident / Incident report was completed by S4LPN (Licensed Practical Nurse). Further review of Resident #1's Accident / Incident Report dated 06/29/19 revealed no documented evidence the physician responded to the notification at 1:00pm. Review of Resident #1's clinical record revealed no documented evidence a treatment order was obtained for Resident #1's skin tear / open sore to the left leg / 4th toe. In a telephone interview on 07/31/19 at 12:20pm, S4LPN stated she was the nurse assigned to care for Resident #1 on 06/29/19. S4LPN further stated she and the wound care nurse assessed Resident #1's left leg / 4th toe wound and provided basic first aid to the wound. S4LPN stated she called the physician and had to leave a voicemail message. S4LPN stated she did not get a response from the physician and a treatment order for the wound was not obtained.	F 580	of the last 30 days of Incident/Accident Reports for notification of physician and notifying the physician as necessary. 3. The measure put in place to ensure the alleged deficient practice does not recur is an in-service with the nurses on physician notification. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. The DON/Designee will conduct audits of Incident/Accident Reports for physician notification. b. Audits will be conducted 3 times weekly for 4 weeks, then weekly for 4 weeks, and then as deemed necessary by the QAPI team. c. Effectiveness of the plan and results of audits will be reported in weekly QA meetings and any issues discovered will be addressed with revision, reeducation, and progressive discipline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

In an interview on 07/30/19 at 11:59am, S2DON (Director of Nursing) stated she did not know if an order was obtained for Resident #1's wound that was identified on 06/29/19. S2DON confirmed there were no documented evidence Resident #1's physician responded to the 06/29/19 notification of a wound to the left leg / 4th toe.

Resident #3
Review of the facility's policy on Assessing Falls and Their Causes revealed in part, the following:
-Notify the resident's attending physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, notify the practitioner routinely (e.g. by fax or by phone the next office day).

Review of Resident #3's medical record revealed an admit date of 03/14/19 with a diagnosis of Dementia without behavioral disturbances, Hypertension, and Type 2 Diabetes Mellitus.

Review of Resident #3's accident/incident report dated 07/23/19 revealed, in part, Resident #3 sustained an unwitnessed fall on 07/23/19 at 7:30pm. Further review revealed Resident #3 was observed in a sitting position on the floor. Further review revealed no documentation of Resident #3's Physician being notified of the unwitnessed fall.

Review of Resident #3's nurse's note dated 07/23/19 revealed, in part, while making rounds, patient was on the floor in a sitting position. Further review of the nurse's note dated 07/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 revealed no documentation of the physician being notified of Resident #3's unwitnessed fall. In an interview on 07/31/19 at 12:00pm S5Licensed Practical Nurse (LPN) stated she was working when Resident #3 had an unwitnessed fall on 07/23/19. S5LPN stated when a Resident has a Fall, if they have a head injury, she takes vital signs; if their vital signs are stable, and the resident says they are okay, then she would put them back into bed. S5LPN stated she would retake vital signs and contact the physician and the residents' family. S5LPN confirmed there was no documentation Resident #3's physician was notified after the unwitnessed fall on 07/23/19. In an interview on 07/31/19 at 2:05pm S2Director of Nursing (DON) reviewed Resident #3's record and accident/incident report and confirmed there was no documentation of the physician being notified after Resident #3's unwitnessed fall on 07/23/19. There was no documented evidence, and the facility did not present any documented evidence, that Resident #3's Physician was notified of the above-mentioned unwitnessed fall.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		9/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 5 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to report an injury of unknown source to the State Survey Agency in a timely manner for 1 (Resident #1) of 5 records reviewed. This deficient practice had the potential to affect any of the 95 residents as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents. Findings: Review of the facility's Abuse Prevention Program Policy revealed, in part, our abuse prevention program provides policies and procedures that govern, as a minimum, timely and thorough investigations of all reports and allegations of abuse and the reporting and filing of accurate	F 609	1. Corrective action was obtained for resident #1 identified to have been affected by the alleged deficient practice by reporting injury via SIMS #3116. Date reported could not be corrected but investigation was completed timely. 2. Other residents that have the potential to be affected by the alleged deficient were identified and corrective actions were obtained by conducting an audit of Incident/Accident Reports for the last 30 days for reporting of any injuries of unknown origin. Any identified will be reported.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 6 documents relative to incidents of abuse. Recognizing signs and symptoms of Abuse / Neglect: Signs of/ Actual physical abuse: fractures, dislocations or sprains of questionable origin. Reporting abuse to facility management. The following definitions of abuse are provided. Injury of unknown source is defined as an injury that meets both of the following conditions: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of the extent of the injury. Reporting Abuse to State Agencies and Other Entities / Individuals: Should a suspected violation or injury of unknown source be reported, the facility Administrator, or his / her designee, will promptly notify the following persons or agencies of such incident. 1. The state licensing / certification agency responsible for surveying / licensing the facility. Verbal / written notices to agencies will be made within 24 hours of the occurrence of such incident. Resident #1 was admitted to the facility on 10/01/14 with diagnoses of, in part, Chronic Kidney Disease and Alzheimer's Disease. Review of Resident #1's Nurse's Notes dated 07/04/19 revealed, in part, resident up in gerichair. Left leg observed per nurses with swelling and bruising noted and dried blood noted to left 1st and 2nd digit. Upon inspection Left tibia and fibula (the two bones in the lower leg) appear dislocated. Resident yells out "that hurts." Resident #1's Nurse Practitioner gave verbal order to send to the hospital for evaluation and treatment. S2DON (Director of Nursing) notified. Resident #1 transported out of building via stretcher.	F 609	3. The measures put in place to ensure the alleged deficient practice does not recur are: a. An in-service with nurses on reporting injuries of unknown origins immediately to the DON and Administrator. b. An in-service with Administrator on reporting injuries of unknown origin to the State Survey Agency in a timely manner. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. The Administrator/Designee will conduct audits of Incident/Accident Reports for timely reporting of injuries of unknown origin. b. Audits will be conducted 3 times weekly for 4 weeks, then weekly for 4 weeks, and then as deemed necessary by the QAPI team. c. Effectiveness of the plan and results of audits will be reported in weekly QA meetings and any issues discovered will be addressed with revision, reeducation, and progressive discipline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7	F 609		

In an interview on 07/30/19 at 2:10pm, S15CNA (Certified Nursing Assistant) stated on 07/04/19 she assisted S16CNA to transfer Resident #1 from the bed to the gerichair. S15CNA stated Resident #1 would always cry out so it was hard to tell when she hurt. S15CNA stated later in the day on 07/04/19 she and S16CNA noticed Resident #1's leg was swollen and she was not moving it like she normally did. S15CNA stated they reported the findings to S8LPN.

In an interview on 07/30/19 at 2:20pm, S16CNA stated that on 07/04/19 she and S15CNA transferred Resident #1 from the bed to the gerichair with no issues. S16CNA stated later in the day she and S15CNA came out of the dining room and observed Resident #1's left leg looked bent and they informed S8LPN.

In an interview on 07/30/19 at 2:35pm, S8LPN stated on 07/04/19 she was notified by S15CNA and S16CNA that Resident #1's left leg "wasn't working right." S8LPN stated upon assessment the left leg was bruised and swollen with a small bump, S8LPN stated she attempted passive range of motion (PROM) on the leg and Resident #1 screamed in pain. S8LPN stated she obtained an order to send Resident #1 to the hospital for an evaluation, called S2DON to inform her of the injury and transfer to the hospital. S8LPN stated upon return from the hospital Resident #1 had a diagnosis of a fracture.

In an interview on 07/30/19 at 1:10pm, S2DON stated on the evening of 07/04/19 she received a telephone call from S8LPN who informed her she was concerned the residents leg may be broken and she had received an order to send her to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 8	F 609		

hospital. S2DON stated she asked S8LPN what happened and the nurse told her nothing had happened on 07/04/19. S2DON stated she does not have access to Louisiana Department of Health Statewide Incident Management Systems (SIMS). S2DON stated at some point over the weekend of 07/06/19 and 07/07/19 she informed S1Administrator of the injury of unknown source.

In an interview on 07/31/19 at 9:15am, S1Administrator stated he was informed of Resident #1's broken leg on Monday 07/08/19 by S2DON. S1Administrator confirmed he is the only person in the facility who had access to enter incidents into the SIMS system. S1Administrator further stated the DON and floor nurses have the ability to contact him at any time to notify him of any incident or accidents.

Review of Resident #1's Louisiana Department of Health Statewide Incident Management Systems (SIMS) with an entry date 07/08/19 at 11:53am revealed, in part, an incident occurred on 07/08/19 at 9:00am and was discovered 07/08/19 at 9:00am. Review of Resident #1's SIMS report revealed, in part, a description which included: Today when S1Administrator walked into work at 9:00am on 07/08/19, S2DON (Director of Nursing) informed S1Administrator of Resident #1 going to the hospital due to a broken toe. Further review revealed an investigation was opened when S1Administrator was informed of the injury of unknown source. Resident #1's SIMS report was completed by S1Administrator on 07/15/19.

S1Administrator presented the survey team with 5 statements from staff members from the investigation for Resident #1's incident of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 9 unknown source. Review of the 5 statements revealed, in part, 3 of the statements were note dated and one was dated 07/08/19 and one was dated 07/09/19.	F 609		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice as evidenced by: 1.) failing to ensure a resident with an identified skin issue was treated and assessed (Resident #1); 2.) failing to ensure a fall risk assessment was completed after falls (Resident #3); 3.) failing to ensure neurochecks were completed as ordered after falls (Resident #3); 4.) failing to ensure an assessment was completed within 48 hours after falls (Resident #3); 5.) failing to ensure a therapy screen was conducted after falls (Resident #3); and 6.) failing to ensure a care plan was revised after unwitnessed falls (Resident #3) This deficient practice was evidenced in 2 (Resident #1 and Resident #3) of 5 sampled	F 684	1. Corrective actions were obtained for the residents #1 and #3 identified as being affected by the alleged deficient practice by: a. Resident #1- Discharged from facility on 0727/2019. No further corrective action available at this time. b. Resident #3- Completing a Fall Risk Assessment, obtaining a therapy screen, completing a nursing assessment, revising the care plan related to the unwitnessed fall and obtaining an order clarification for the neurochecks. 2. Other residents that had the potential to be affected by the alleged deficient practice were identified and corrective action obtained for them by conducting an audit of the last 30 days of Incident/Accident Reports to ensure	9/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 resident and had the potential to affect any of the 95 residents as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents. Findings: Resident #1 Resident #1 was admitted to the facility on 10/01/14 with diagnoses of, in part, Chronic Kidney Disease and Alzheimer's Disease. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/19 revealed a Brief Interview for Mental Status (BIMS) score of 0. A score of 0 indicated severe cognitive impairment. Review of Resident #1's Care Plan revealed, in part, a potential for skin breakdown related to disease process with a documented approach to report any red or open areas to skin. Review of Resident #1's Accident / Incident Report dated 06/29/19 at 12:18pm revealed, in part, the nurse was notified by the Certified Nursing Assistant (CNA) and wound care nurse that Resident #1 was bleeding from the left foot. Assessment revealed a skin tear / open sore was observed to the left leg /4th toe. Further review revealed Resident #1's Physician was notified at 1:00pm. The Accident / Incident report was completed by S4LPN (Licensed Practical Nurse). Further review of Resident #1's Accident / Incident Report dated 06/29/19 revealed no documented evidence the physician responded to the notification at 1:00pm. Review of Resident #1's clinical record revealed no documented evidence a treatment order was obtained for Resident #1's skin tear / open sore to the left leg / 4th toe.	F 684	resident received treatment and care in accordance with the facilities policy "Assessing Falls and Their Causes" and that identified skin tears were treated and assessed. Any identified issues will be corrected according to the policy. 3. The measures put in place to ensure the alleged deficient practice does not recur are: a. The policy "Assessing Falls and Their Causes" was updated. b. An in-service was conducted with Nursing on policy "Assessing Falls and Their Causes" and on assessing and obtaining treatments for skin tears. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. The DON/Designee will monitor Incident/Accident Reports to ensure the updated "Assessing Falls and Their Causes" police is followed and that skin tears are assessed and treatments obtained. b. Monitoring will occur 3 times weekly for 4 weeks, then weekly for 4 weeks and the as deemed necessary by the QAPI team. c. Effectiveness of the plan and results of the audits will be reported weekly in QA meeting. Any issues discovered will be addressed with revision, reeducation, and progressive discipline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11	F 684		

In an interview on 07/30/19 at 12:13pm, S7CNA stated she was assigned to pass hall lunch trays on 06/29/19 and waited for the trays in the dining room. S7CNA stated she observed blood on the floor and determined Resident #1 had blood on her left sock and reported the finding to S4LPN.

In a telephone interview on 07/31/19 at 12:20pm, S4LPN stated she was the nurse assigned to care for Resident #1 on 06/29/19. S4LPN further stated she and the wound care nurse assessed Resident #1's left leg / 4th toe wound and provided basic first aid to the wound. S4LPN stated she called the physician and had to leave a voicemail message. S4LPN stated she did not get a response from the physician and a treatment order for the wound was not obtained.

In an interview on 07/30/19 at 11:59am, S2DON (Director of Nursing) stated on 06/29/19 S7CNA noticed blood on the floor in the dining room and determined the blood was from Resident #1's left toe. S2DON stated S7CNA reported the findings to S4LPN. S2DON stated she did not know if an order was obtained for wound care. S2DON stated there was no standard protocol for monitoring wounds. S4DON confirmed there were no documented nurse's notes or assessments for Resident #1 from 06/29/19 through 07/04/19 at 6:15pm.

In an interview on 07/30/19 at 2:35pm S8LPN stated she worked with Resident #1 on 07/01/19, 07/02/19, 07/03/19 and 07/04/19. The surveyor asked S8LPN if she was aware of a wound on Resident #1's toe which occurred on 06/29/19 and she stated she had not been made aware of the toe injury and did not assess the left foot while

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12	F 684		

on duty on 07/01/19, 07/02/19, 07/03/19 and 07/04/19.

In an interview on 07/31/19 at 9:20am, S1Administrator stated incident / accident reports were discussed in the morning meeting that was held on Monday through Friday mornings. S1Administrator stated a written summary of the morning meetings were maintained. S1Administrator reviewed the morning meeting notes from Monday 07/01/19 and stated the incident / accident report of 06/29/19 was not reviewed nor discussed in the morning meeting of 07/01/19.

In a telephone interview on 07/31/19 at 10:45am, S9DataEntryCorporateConsultant stated all physician orders were efaxed (electronically faxed) to her for entry into the computer system. S9DataEntryCorporateConsultant confirmed there were no physician orders for Resident #1 efaxed from 06/29/19 through 07/03/19.

In an interview on 07/31/19 at 11:59am, S10LPNChargeNurse stated that on 07/03/19 and 07/04/19 she worked in the capacity of treatment nurse and she did not provide any treatments for Resident #1. S10LPNChargeNurse further stated when she worked as the treatment nurse she determined work load by reviewing each residents Treatment Administration Record (TAR). S10LPNCharge Nurse stated Resident #1 did not have any treatment orders documented on the July 2019 TAR.

Review of Resident #1's June 2019 and July 2019 Medication Administration Record (MAR) and TAR revealed no documentation of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13	F 684		

treatment for the left leg / 4th toe wound identified on 06/29/19.

Review of Resident #1's clinical record revealed, in part, no nursing note documentation from 6/29/19 until 07/04/19 at 6:15pm. The facility was unable to provide documentation that Resident #1's left leg / 4th toe injury identified on 06/29/19 was treated and assessed, after the initial discovery, from 06/29/19 through 07/04/19.

Resident #3
Review of Resident #3's record revealed an admit date of 03/14/19 with a diagnosis of Dementia without behavioral disturbances, Hypertension, and Type 2 Diabetes Mellitus.

Review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date of 07/06/19 revealed a Brief Interview for Mental Status score of 15, (score of 13-15 was cognitively intact) with no falls since previous assessment.

Review of the facility's policy on Assessing Falls and Their Causes revealed, in part, the following:
-Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall, and will document findings in the medical record.
-Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings.
-Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14	F 684		

history, known functional impairments, etc.
-When a resident falls, the following information should be recorded in the resident's medical record:
1. The condition in which the resident was found;
2. Assessment data, including vital signs and any obvious injuries;
3. Interventions, first aid, or treatment administered;
4. Notification of the physician and family, as indicated;
5. Completion of a falls risk assessment; and
6. Appropriate interventions taken to prevent future falls

Review of Resident #3's accident/incident report dated 07/04/19 revealed, in part, Resident #3 fell (slipped) from her wheelchair on her buttocks.
Review of Resident #3's accident/incident report dated 07/16/19 revealed, in part, Resident #3 was found on the floor lying on her left side and confirmed she hit her head.
Review of Resident #3's accident/incident report dated 07/23/19 revealed, in part, Resident #3 was observed in a sitting position on the floor.

Review of Resident #3's Assessment of Risk for Falls form dated 03/26/19 revealed a score of 6 (0-6 low, resident is low risk). Further review of Resident #3's Assessment of Risk for Falls form dated 07/01/19 revealed a score of 6. Further review of Resident #3's medical record revealed no documentation of a fall risk assessment after Resident #3's unwitnessed falls on 07/04/19, 07/16/19, and 07/23/19.

Review of Resident #3's care plan dated 03/26/19 revealed a problem for at risk for falls secondary to the need for assistance with transfer, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

unsteady gait. Further review of Resident #3's care plan revealed no documentation of a new measurable intervention with time tables after Resident #3's unwitnessed falls on 07/16/19 and 07/23/19.

Review of Resident #3's record revealed a verbal order dated 07/16/19 at 8:00pm for neurochecks every 15 minutes, every 30 minutes, 1 hour, every 4 hours and then every 8 hours for fall.

Review of Resident #3's nurses' notes for the month of July 2019 revealed no documentation of an assessment for 48 hours after Resident #3's fall on 07/04/19.
Review of Resident #3's nurses' notes dated 07/16/19 revealed no documentation for the day shift (6:00am to 2:00pm) and no documentation for the night shift (10:00pm to 6:00am).
Review of Resident #3's nurses' notes dated 07/17/19 revealed no documentation for the night shift.
Review of Resident #3's nurses' notes dated 07/18/19 revealed no documentation for the day shift and the night shift.
Further review of Resident #3's nurses' notes revealed the last documented nurse's note was on 07/23/19 with no time documented.

Review of Resident #3's record revealed no documentation of neurochecks performed after a physician's order on 07/16/19, after Resident #3 had head involvement from an unwitnessed fall.

Review of Resident #3's record revealed no documentation of a therapy screen completed after Resident #3's unwitnessed fall on 07/04/19, 07/16/19 and 07/23/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

In an interview on 7/31/19 at 9:35am, S6LPN stated she completed an incident report on 07/4/19 after Resident #3 had an unwitnessed fall. S6LPN stated Resident #3's fall was an unwitnessed fall, but she did not remember if she started neurochecks. S6LPN stated she would do neuro checks for an unwitnessed fall.

In a joint interview on 07/31/19 at 11:30am, S11Licensed Practical Nurse (LPN)/Care Planner and S12LPN/MDS stated they find out about incidents/accidents at the morning meeting. When questioned if the care plan in the chart was the current care plan they both stated yes. S11LPN/Care Planner and S12LPN/MDS both confirmed they were unaware of Resident #3's falls on 07/16/19 and 07/23/19. They confirmed the care plan was not revised after Resident #3's falls on 07/16/19 and 07/23/19.

In an interview on 07/31/19 at 11:35am, S2DON stated a fall risk assessment should be done on admit, quarterly and after every fall per their policy.
In an interview on 07/31/19 at 2:05pm S2DON confirmed there were no fall risk assessments completed after Resident #3's falls on 07/04/19, 07/16/19 and 07/23/19.

In an interview on 07/31/19 at 11:40am, S1Administrator stated all incidents and accidents, including falls, are discussed at the daily morning meeting the day following a fall. S1Administrator reviewed the facility's team communication meeting minutes dated 07/17/19 and confirmed there was no discussion of Resident #3's fall that occurred on 07/16/19. The meeting minutes dated 07/17/19 revealed no new falls in the past 24 hrs. Further review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

facility's team communication meeting minutes dated 07/24/19 revealed no discussion of Resident #3's fall that occurred on 07/23/19.

In an interview on 07/31/19 at 12:00pm, S5Licensed Practical Nurse (LPN) stated she was working when Resident #3 had an unwitnessed fall on 07/16/19 and 07/23/19. S5LPN stated when a Resident had a Fall, if they have a head injury, she takes vital signs; if their vital signs are stable, and the resident says they are okay, then she would put them back into bed. S5LPN stated she would retake vital signs and contact the physician and the residents' family. S5LPN stated if the physician ordered neurochecks then she would start them and hand off to the night nurse. S5LPN stated she would only do neurochecks if they were ordered by the physician. S5LPN reviewed the accident/incident report dated 07/16/19 and confirmed Resident #3 stated she hit her head, and there was no documentation of neurochecks in the medical record, and there was a physician's order for neurochecks. S5LPN stated she was unable to determine if a Resident hit their head for an unwitnessed fall, and the nurses take the Residents' word, whether they did or did not hit their head, if the resident was cognitive. S5LPN stated there should be an assessment every shift for 72 hours after a fall. S5LPN reviewed Resident #3's nurses' notes after the 07/16/19 and 07/23/19 falls and confirmed there was blank nurses' notes on the above mentioned dates and there was not a nurse's note every shift for 72 hours. S5LPN confirmed the last nurse's note documented in the record was on 07/23/19 and there was no time documented on the nurse's note.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

In an interview on 07/31/19 at 12:38pm, S3Regional Director of QM confirmed there was a physician's order dated 07/16/19 for neurochecks and she could not locate documentation of the neurochecks after Resident #3's 07/16/19 fall. S3Regional Director of QM was questioned by the surveyor if neurochecks should be done for all unwitnessed falls and S3Regional Director of QM stated yes I would agree.

In an interview on 8/01/19 at 10:45am, S13Physical Therapist (PT) stated a therapy screen was done after every resident fall, to determine if the fall was the resident's fault, a fault with equipment or an isolated incident. S13PT stated he was unaware of Resident #3's recent falls on 07/04/19, 07/16/19 and 07/23/19. S13PT stated if a Resident was on therapy caseload and they had a fall, the screen would not be done, but they would tweak the current goals or interventions. S13PT confirmed Resident #3 was on the therapy caseload from 07/01/19 through 07/12/19. S13PT stated the therapy department did not receive a screening form from the Nursing department after Resident #3's falls on 07/04/19, 07/16/19 and 07/23/19.
In an interview on 08/01/19 at 10:55am, S14Therapy Tech stated she attended the facility morning meetings and falls are discussed at the morning meetings. S14Therapy Tech stated if a resident had a fall, nursing would give her the therapy screening form, or she would fill out a screening form. S14Therapy Tech stated if she filled out a screening form, she would put fall screen at the top of the page so the therapist would know it was a screen. S14Therapy Tech stated she did not recall any discussion at the morning meeting involving Resident #3's falls on 07/16/19 and 07/23/19. S14Therapy Tech

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19	F 684		

reviewed Resident #3's therapy file and there was no documentation of a therapy screen after Resident #3's falls on 07/04/19, 07/16/19 and 07/23/19.

In an interview on 07/31/19 at 11:30am, S3Regional Director of Quality Measures (QM) stated there was no documentation of neurochecks and no documentation of an assessment for 48 hours after Resident #3's falls on 07/04/19, 07/16/19, and 07/23/19. S3Regional Director of QM confirmed there was no revision to Resident #3's care plan after Resident #3's falls on 07/16/19 and 07/23/19.

In an interview on 08/01/19 at 9:50am S3Regional Director of QM confirmed there was no documentation of a therapy screen after Resident #3's falls on 07/16/19 and 07/23/19. S3Regional Director of QM stated Resident #3 was already on the therapy caseload with her 07/04/19 fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey #LA00052732	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		9/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 1 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain Nurse's Notes in a resident's clinical record. This deficient practice was identified for 1 of 5 sampled residents (Resident #3), but had the potential to affect any of the 93 residents as documented on the facility's census.	F 842	1. Corrective action was obtained for Resident #3 identified as being affected by the alleged deficient practice by locating the nurse's notes for the described incident and placing them in Resident #3's clinical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 2 Findings: In interview on 08/28/19 at 11:41am, S4Licensed Practical Nurse (LPN) indicated she was Resident #3's nurse when he hit Resident #4 on 08/03/19. S4LPN indicated on 08/03/19 at around 7:00am, she was at the nurse's station and heard a slap coming from the dining room, so she ran to the dining room and saw Resident #3 yelling at Resident #4, other residents and staff. S4LPN further indicated he had slapped a female resident (Resident #4) in the face, was not able to be controlled, and was angry and belligerent. S4LPN indicated staff got the residents out of the way, and put Resident #3 alone in his room. The police were called, as well as Resident #3's doctor, who gave a Physician's Emergency Certificate (PEC) order. Resident #3 went to the hospital emergency room, and from there was sent to a behavioral unit. S4LPN indicated she documented the incident in the Nurse's Notes. There was no documented evidence in Resident #3's chart of having August 2019 Nurse's Notes or any documentation of the above mentioned incident in Resident #3's clinical record. In interview on 08/26/19 at 11:11am, S2Licensed Practical Nurse (LPN), staff member in charge of medical records, was informed that the surveyor could not locate Resident #3's August 2019 Nurse's Notes. S2LPN indicated she looked all over, but was unable to locate the above mentioned missing records for Resident #3. In interview on 08/26/19 at 1:57pm, S1Director of Nursing (DON) was informed of the above and indicated that staff had looked all over for Resident #3's August 2019's Nurse's Notes, but	F 842	2. Other residents that have the potential to be affected by the alleged deficient practice were identified and corrective action obtained for them by conducting an audit of the last 30 days of Incident/Accident reports to ensure the corresponding nurse note was present in the clinical record. 3. The measure put in place to ensure the alleged deficient practice does not recur is an in-service with the DON and ADON on maintaining nurses notes related to Incident/Accidents in the resident's clinical record. 4. The facility plans to monitor its performance to make sure solutions are sustained by: a. The DON/Designee will conduct audits of Incident/Accident reports to ensure corresponding nurse's note is present in resident's clinical record. b. Audits will be conducted 3 times weekly for 4 weeks then weekly for 4 weeks. c. Effectiveness of plan and results of audits will be reported weekly in QA meeting and any issues discovered will be addressed with revision, reeducation, and progressive discipline.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 3 were unable to find them. In interview on 08/27/19 at 9:41am, S1DON indicated that they (facility staff) were still unable to locate Resident #3's missing August 2019's Nurse's Notes. In interview on 08/28/19 at 11:44am, S3Corporate Nurse indicated she was unable to locate Resident #3's August 2019 Nurse's Notes and documentation about Resident #3 hitting Resident #4.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey #LA00053785	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents received medications while out of the facility for 2 (Resident #3 and Resident #5) of 5 sampled residents. This deficient practice was identified for 2 (Resident #3, and Resident #5) of 5 sampled residents but could affect any resident who left the facility on pass. The total census was 97 according to the facility's CMS Form-672 Resident Census and Conditions of Residents form. Findings: Record review of facility's policy on Signing Residents Out revealed in part, Policy Statement All residents leaving the premises must be signed out. 3) Unless otherwise prohibited by law, medications that must be administered while the resident is out will be given to the resident/person signing the resident out;	F 684	1. Resident #3 and #5 had the physician notified of the missed medications. 2.All residents who go on pass have the potential to be affected 3.Ward clerks who sign residents out were re educated on the policy for signing residents out. Also included in the training was reporting to nurse if resident has not returned by the stated time as well as asking the resident how long they are going to be gone. A special Resident Council meeting was held to re educate residents on the signing out process. Nurses were re educated on the procedure for signing out medications for residents on pass. 4. DON or designee will monitor the sign out log and will be medication released on pass authorization daily x 5 days then 3 x	1/27/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/29/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 Resident #3 Record review revealed Resident #3 was admitted on 8/16/19 to the facility for diagnoses in part: Peripheral vascular disease, Rhabdomyolysis, Essential hypertension, Type 2 diabetes mellitus, Hemiplegia following cerebral infarction, Hyperlipidemia, and Traumatic ischemia of muscle. Review of Resident #3's admit Minimum Data Set (MDS) with Assessment Reference Date (ARD) 8/23/19 revealed Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #3 was cognitively intact. Medications - Resident #3 received antipsychotics 2 days during 7 day look back. Record review of Resident #3's Physician Orders November 2019 Orders with original order date of 8/16/19 read in part, Spironolactone 25 (milligrams) mg tablet administer 1 by mouth every day (check edema), Benztropine MESYLATE 2 mg tablet administer 1 by mouth twice daily for Essential hypertension, Coreg 25mg tablet administer 1 by mouth twice daily, Crestor 10mg tablet administer (1) by mouth every night for hyperlipidemia, Norvasc 10mg tablet administer (1) by mouth every day for essential hypertension, Aspirin 81mg chewable tablet administer (1) by mouth every day, Plavix 75mg tablet administer (1) by mouth every day, Depakote delayed release (DR) 500mg tablet administer (1) by mouth every day, Losartan potassium 100mg tablet administer (1) by mouth every day for essential hypertension, Risperdal 1 mg tablet administer (1) by mouth every evening, Zyprexa 20mg tablet administer (1) by mouth every day, Januvia 100mg tablet administer (1) by mouth every day for Type 2 diabetes mellitus with	F 684	week x 4 weeks. Non compliance will be discussed in the morning meeting to determine course of action based on individual resident situations. Results of monitoring will be discussed in QA meeting with changes to the action plan as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2	F 684		

hyperglycemia, Glucophage extended release (XR) 500mg tablet administer (2=1000mg) by mouth every day and Accu-checks before meals (AC) and at hour of sleep (HS) to sliding scale of Novolog Insulin. Addition doctor order dated 12/10/19 at 1:45pm written as verbal order written by S6Licensed Practical Nurse (LPN) from Resident #3's physician ok to send to Resident #3.

Medication Administration Record (MAR) for December 2019 revealed Resident #3 did not receive any medications on December 12/08/19 on the day he showed up at this family home but received medication every day prior to leaving the facility. There was no documentation indicating that any medications were sent with Resident #3.

Record review of Resident #3's nurses noted revealed documentation on 12/08/19 at 8:00pm noted by S5Director of Nursing (DON) which read as follows: I was informed by a 2-10pm shift Certified Nursing Assistant (CNA) and ward clerk that they received a phone call stating that Resident #3 was home with his sister. A second entry on the same nurse's note sheet for 12/10/19 at 4:00pm noted by S5DON read as followed, "Resident returned to the facility with a social worker from Assertive Community Treatment (ACT). Resident out of facility for three days without medications. Resident was confused not making sense when speaking. Call placed to Resident #3's physician for the confusion, and order was given to send him to the hospital at this time for an evaluation." On a separate nurse's note page with notes beginning on 11/23/19 an entry was made on 12/10/19 at 1:45pm written by S6Licensed Practical Nurse (LPN) and it read in part, as follows, Resident #3 returned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

facility after leaving a few days. Resident #3 was escorted by ACT team. Resident #3 noted to be babbling and rambling continuously. Disorganized thinking. Resident #3 stated he did have something to drink. Resident #3 denies use of drugs. Notified Resident #3's physician, who gave orders to send Resident #3 to local hospital for evaluation. Notified Resident #3's responsible party sister. Local EMS called per staff and arrived at 2:00pm. Resident #3 transported via stretcher to local hospital.

Record review of Resident #3's Social Service Progress Notes dated 120/9/19 by S12Social Worker (SW) note revealing Resident #3's sister called S12SW about Resident #3 not wanting to return to facility and how can Resident #3 get his medicine. S12SW stated to Resident #3's sister that if Resident #3 doesn't return Resident #3 will be Against Medical Advice (AMA) but if Resident #3 returns, S12SW will get an order from the doctor to be discharged with his medications. Another note on 12/10/19 by S12SW revealed Resident #3 returned today with someone from the ACT team. Resident #3 was cussing and fussing and talking out of his head. The lady from the ACT team stated, she never seen Resident #3 act like that before. The nurse S6LPN was called in room to observe him.

Record review of local hospital records revealed in part, Resident #3 arrived to hospital 12/10/19 at 2:20pm via Ambulance for chief complaint Other: confused with abnormal tangential thought process with initial vital signs of blood pressure 186/91, pulse 80, temperature 99.8 degrees Fahrenheit, respiratory rate 22 and pulse oximetry 97%. Physician was unable to perform review of system due to mental status change and noted in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

physical exam under comments, Patient is alert and oriented to person however Resident #3 provides bizarre tangential responses to questions. Review of documentation from the ED provider revealed in part, this is an emergent evaluation of a critically ill patient. Differential diagnosis includes: psychiatric illness, stroke, hyponatremia, Urinary tract infection (UTI). Negative drug screen. Alcohol level is 0. This is likely an acute exacerbation of the patient's chronic underlying schizophrenia. I will place the patient under Physician's Emergency Certificate (PEC) and transfer for psychiatric evaluation.

In an interview on 12/12/19 at 11:44am with S1Administrator acknowledged the procedure for family pass is to have the resident sign out in a book and sign where they are going. If leaving with family the medications are given to family for the amount of day's resident on pass.

In an interview 12/12/19 at 11:52am S5Director of Nursing (DON) verbalized being told by an aide Resident #3's sister called Sunday 12/8/19 and stated Resident #3 would be brought back on Monday. S5DON verbalized when resident returned she assessed Resident #3 and had S6LPN call Resident #3's physician due to Resident #3 being confused and wobbly. S5DON described Resident #3 as being happy and a cooperative person on 12/8/19 prior to leaving the facility and on 12/10/19 upon return described Resident #3 as confused and talking out his head.

In an interview 12/12/19 at 12:03pm S6LPN verbalized Resident #3 as being very compliant and nice but a very talkative person. S6LPN revealed Resident #3 routine was from getting out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

of his bed and walking to the patio to smoke and then back to his room unless it was meal time. S6LPN verbalized being present on 12/10/19 when Resident #3 returned with someone from the ACT team. S6LPN verbalized assessing Resident #3 upon his return and asked him questions to see if he had consumed drugs or alcohol while out of the facility due to Resident #3 not acting himself. S6LPN revealed she realized Resident #3 was not being himself due to babbling, unorganized thoughts, and continuous rambling therefore she spoke with S5DON, and Resident #3's physician was notified and gave order to send Resident #3 to the local hospital.

In a telephone interview 12/12/19 at 12:25pm Resident #3's sister verbalized being on the phone with the ACT team on 12/10/19 when they were bringing Resident #3 back to the facility and heard Resident #3 cursing the ACT team member out and Resident #3's sister attempted to calm him down. Resident #3's sister acknowledged facility nurse calling her when Resident #3 returned to facility and was informed he was being sent to a local hospital. Resident #3's sister further verbalized after being transferred to the hospital she was later informed by the hospital that Resident #3 was being transferred to a local psychiatric hospital.

In an interview 12/12/19 at 2:32pm S5DON denied returning family member phone call on 12/8/19 to verify that Resident #3 was indeed with them and to investigate to see how long Resident #3 would be with family so that the facilities policy of signing out medications could be followed to ensure Resident #3 medications could be given to the family.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

In an interview 12/13/19 at 0800am S7Receptionist revealed a part of the process for a resident going out on pass is to notify the resident's nurse of the length of the pass in order to get the correct amount of medications for the resident to take with them on pass. The nurse would then have the family sign out for the medications for the days the resident would be out of the facility. If the family was signing the resident out but not present they would have family come in and sign out meds.

In a telephone interview on 12/13/19 at 9:45am Resident #3's brother verbalized on 12/08/19 at approximately 5:30pm Resident #3 showing up to his home. Resident #3's brother verbalized on 12/08/19 at 7:38pm he called the facility and was told by the Receptionist that the facility that the nurse was busy and would call him back. Resident #3's brother denied ever receiving a call back from the nurse.

In an interview 12/13/19 at 11:45am, S5DON acknowledged being notified of Resident #3 being by his sister's house and acknowledged she never called back to speak with family regarding Resident #3's leave during and/or having his medications picked up. During this interview, S2Corporate Nurse Consultant acknowledged Resident #3's family should have been called to verify whereabouts and length of stay with family so his medications could be given to family according to the facility sign out policy. S2Corporate Nurse Consultant further acknowledged that Resident #3 went from 12/08/19 through 12/10/19 without any of his medications and they couldn't provide a medication release/receipt form with medications sent home due to resident not being signed out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7	F 684		

properly.

Resident #5
Record review of Resident #5 revealed the resident was admitted to the facility 03/22/19 with diagnoses in part; Hyperlipidemia, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Essential Hypertension, Coronary Artery Disease, End Stage Renal Disease on Hemodialysis, Hepatitis C, and Chronic Obstructive Pulmonary Disease.

Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/08/19 has a Brief Interview for Mental Status Score (BIMS) of 15 which indicated he was cognitively intact.

Review of December 2019 MD orders revealed Lasix 80 milligram (mg) one tablet by mouth daily, Aspirin 81mg one tablet by mouth, Symbiocort 160-4.5 micrograms (mcg) inhaler 2 puff twice daily, Bupropion Hydrogen Chloride (HCL) 150mg one tablet by mouth twice daily, calcitriol 0.25mcq one capsule every day, coreg 25mg one tablet by mouth twice daily, clonidine HCL 0.1mg one tablet by mouth three times a day, ferrous gluconate 324mg one tablet by mouth with breakfast, Losartan Potassium 50mg by mouth twice a day, renvela 800mg 3 tablets (2,400)mg by mouth with meals, Spiriva 18mcg inhaler daily, tradjenta 5mg by mouth daily, tudorza pressair 400mcg inhaler 2 puff every daily, and albuterol sulfate 2.5mg/0.5 milliter (ml) nebulizer administer nebulizer 4 times a day while awake.

Review of admit/discharge log revealed Resident #5 signed out on home pass on 11/29/19 at 4:00pm and returned to the facility on 11/30/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

11:00pm. Further review revealed Resident #5 signed out on a home pass on 12/01/19 at 9:30am and returned to the facility on 12/02/19 at 1:12pm.

Review of Resident #5's clinical record revealed no documentation of medication release/receipts noted in Resident #5's record for the following dates from 11/29/19 through 11/30/19, and 12/01/19 through 12/02/19.

In interview on 12/13/19 at 9:25am with Resident #5 stated when he went home on pass on 11/29/19 and again on 12/01/19, the facility never gave him medication to take home.

In an interview on 12/13/19 at 11:42am with S2Corporate Nurse Consultant stated the protocol when a resident goes home on a pass is if a resident goes out on a pass and will miss scheduled medications, the facility should provide the resident with the prescribed doses of medications to take home with them. She further stated if a resident does not return to the facility then the facility should follow up with the resident.

In an interview on 12/13/19 at 1:13pm with S6LPN stated when a resident goes out on a home pass a medication release form is filled out and medications is sent home with the resident. She further stated if the resident is not cognitive then the nurse will explain to the person who picks up the resident and have that person sign the medication release form.

In an interview on 12/13/19 at 1:30pm, S5DON acknowledged there were no medication release/receipts in Resident #5's chart for dates 11/29/19 through 11/30/19 and 12/01/19 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 12/02/19. There was no documented evidence and the provider presented no documented evidence of medication release/receipts for Resident #5.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. This deficient practice was identified for 1 (Resident #5) of 5 sampled residents The facility had 3 residents who received dialysis, and a total census of 97 residents who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form (CMS-672). Findings: Record review of Resident #5 revealed the resident was admitted to the facility 03/22/19 with diagnoses in part, End Stage Renal Disease on Hemodialysis, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, and Essential Hypertension. Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/08/19 had Brief Interview for Mental	F 698	1. Resident # 5 has had a communication sheet sent to dialysis and it was returned 12/13/19. 2. A chart review was conducted of other dialysis residents. Identified residents were audited for communications with dialysis. Binders were set up and communications were started with dialysis for any resident missing communication forms. 3.Nurses were re educated on communicating with dialysis. Ward clerks were educated to check for dialysis communication on residents return and if not present to notify DON or designee. 4.DON or designee will monitor dialysis communication sheets 3 x week x 4 weeks. Non compliance will be addressed as indicated. Results will be discussed in QA meeting with changes to the action plan as needed.	1/27/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 10	F 698		

Status Score (BIMS) of 15 which indicated he was cognitively intact. Further review revealed Resident #5 received dialysis services outside of the facility.

Review of Physician's orders dated 12/07/19 revealed Resident #5 received dialysis three times per week.

Review of Resident #5's complete clinical record revealed no documentation of communication between the facility and the dialysis center.

In an interview on 12/12/19 at 11:42am, Resident #5 stated he went to an outside dialysis center on Monday, Wednesday, and Fridays for dialysis treatments.

In an interview on 12/12/19 at 3:40pm with S11Licensed Practical Nurse (LPN), surveyor asked for the communication sheets/binder for Resident #5 and after S11LPN looked for the communication sheets/binder, she stated she could not find communication sheets/binder for Resident #5.

In an interview on 12/13/19 at 9:25am, Resident #5 stated he was never given a binder or paperwork by the facility to bring to the dialysis center.

In an interview on 12/13/19 at 11:37am, S5Director of Nursing (DON) acknowledged there was no communication sheets/binder for Resident #5.

There was no documented evidence and the provider presented no documented evidence that the facility and the dialysis center had ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	C 12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET HARVEY, LA 70058**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 11 communication for coordination and continuity of care regarding Resident #5.	F 698		