

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Chateau Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Village Road Kenner, LA 70065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>41461</p> <p>Based on record reviews, observations, and interviews, the facility failed to assess a resident for self-administration of medications for 2 of 53 sampled observed for self-administration of medications (Resident #122 and Resident #189).</p> <p>Findings:</p> <p>Review of the facility's Self-Administration of Medications policy dated 12/05/2014 revealed, in part, each resident would be assessed upon admission, quarterly, annual, for any signs of significant change in condition, and as needed for self-administration of medications, if applicable. Further review revealed a physician order would be written indicating it was safe for the Resident to self-administer medication and the Nursing staff would monitor the resident weekly and as needed. Further review of the policy revealed the care plan would also be updated.</p> <p>Resident #122</p> <p>Review of Resident #122's Minimum Data Set with an Assessment Reference Date of 04/17/2024 revealed, in part, Resident #122 had a Brief Interview for Mental Status score of 8 which indicated Resident #122's cognition was moderately impaired.</p> <p>Observation on 07/22/2024 at 10:59 a.m., revealed one bottle of Nystatin Topical Powder approximately 1/3 full on Resident #122's bedside table.</p> <p>Review of Resident #122's record revealed there was no documented evidence and the facility did not present any documented evidence that Resident #122 was assessed or care planned to self-administer medication.</p> <p>Observation 07/23/2024 at 9:24 a.m., revealed one bottle of Nystatin Topical Powder 1/3 full located on Resident #122's bedside table.</p> <p>In an interview on 07/23/2024 at 11:48 a.m., S26Licensed Practical Nurse (LPN) indicated Resident #122 had 1 bottle of Nystatin topical powder (a powder to treat fungal or yeast infection) approximately one half full on her bedside table and it should not be there.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/23/2024 at 12:05 p.m., S5Assistant Director of Nursing (ADON) indicated Resident #122 was not assessed or care planned to have medications at her bedside to self-administer. S5ADON further indicated Resident #122 should not have had any medications at the bedside.</p> <p>In an interview on 07/24/2024 at 11:15 a.m., S6Director of Nursing (DON) indicated a self-administration of medication assessment was not completed for Resident #122. S6DON further indicated Resident #122 should not have had medications at the bedside.</p> <p>Resident #189</p> <p>Review of Resident #189's Minimum Data Set with as Assessment Reference Date of 07/03/2024 revealed, in part, a Brief Interview for Mental Status score of 12 which indicated Resident #189 was cognition was moderately impaired.</p> <p>Observation on 07/22/2024 at 10:10 a.m. revealed 1 bottle of Nystatin topical powder (a powder to treat fungal or yeast infection) approximately one half full, 1 bottle of Nystatin topical powder approximately two thirds full, and 1 large tube of Ammonium Lactate 12% lotion (a medication used to treat dry, itchy skin) on Resident #189's bedside table.</p> <p>Review of Resident #189's record revealed no documented evidence and the facility was unable to present any documented evidence Resident #189 was assessed or care planned to self-administer medication.</p> <p>Observation 07/23/2024 at 9:24 a.m. revealed 1 bottle of Nystatin topical powder (a powder to treat fungal or yeast infection) approximately one half full, 1 bottle of Nystatin topical powder approximately two thirds full, and 1 large tube of Ammonium Lactate 12% lotion on Resident #189's bedside table</p> <p>In an interview on 07/23/2024 at 11:48 a.m., S26Licensed Practical Nurse (LPN) indicated Resident #189 had 1 bottle of Nystatin topical powder (a powder to treat fungal or yeast infection) approximately one half full, 1 bottle of Nystatin topical powder approximately two thirds full, and 1 large tube of Ammonium Lactate 12% lotion on Resident #189's bedside table. S26LPN further indicated Resident #189 was not assessed or care planned to have medications at the bedside to self-administer.</p> <p>In an interview on 07/23/2024 at 12:05 p.m., S5Assistant Director of Nursing (ADON) indicated Resident #189 was not assessed or care planned to have medications at the bedside to self-administer. S5ADON further indicated Resident #189 should not have had any medication at the bedside.</p> <p>In an interview on 07/24/2024 at 11:15 a.m., S6Director of Nursing indicated a self-administration of medication assessment was not completed for Resident #189. He further indicated Resident #189 should not have had medications at the bedside.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>22609</p> <p>Based on observations and interviews the facility failed to ensure a resident's wheelchair was in good repair and maintained in a sanitary manner for 1 resident (Resident #77) of 3 Residents (Resident #4, Resident #77, and Resident #168) sampled residents reviewed for environment.</p> <p>Findings:</p> <p>Observation on 07/22/2024 at 9:51 a.m., revealed Resident #77's wheelchair had an unknown blackish brownish substance was covering both brake levers. Further observation revealed the arm pad for the right arm of the wheelchair was missing.</p> <p>Observation on 07/23/2024 11:41 a.m. revealed Resident # 77 was rolling himself down the hall and the wheelchair's right arm pad was missing and the left arm pad was torn, which displayed exposed foam.</p> <p>Observation on 07/24/2024 at 10:10 a.m., revealed Resident #77 was in his wheelchair and the right arm pad was missing and the left arm pad was torn, which displaced exposed foam.</p> <p>In an interview on 07/24/2024 at 10:14 a.m., S22Licensed Practical Nurse confirmed Resident #77's wheelchair's right arm pad was missing, the left side arm pad was torn, and it was dirty.</p> <p>In an interview on 07/24/2024 at 10:29 a.m., S6Director of Nursing indicated Resident #77's wheelchair should be replaced.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>22609</p> <p>34608</p> <p>Based on record reviews and interviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the facility's policy was followed by failing to complete a Braden skin risk assessment upon re-admission as required for 1 (Resident #62) of 2 (Resident #62 and Resident #29) sampled residents investigated for pressure ulcer; 2. Ensure a resident's pressure ulcer status was accurately documented for 1 (Resident #62) of 2 (Resident #62 and Resident #29) sampled residents investigated for pressure ulcers, and; 3. Ensure Resident #29's pressure ulcer prevention/treatment interventions were implemented for 1 (Resident #29) of 2 (Resident #29 and Resident #62) sampled residents investigated for pressure ulcers. <p>Findings:</p> <p>Review of the facility's Skin Care policy and procedure, with an effective date of 11/25/2014 revealed, in part, all residents will have a Braden skin assessment completed upon admission, re-admission, quarterly, annual, with significant changes and as needed.</p> <p>1.</p> <p>Review of Resident #62's Minimum Data Set tracker revealed, in part, Resident #62 had hospital stays from 06/02/2024 to 06/10/2024 and from 06/22/2024 to 06/26/2024.</p> <p>In an interview on 07/24/2024 at 9:40 a.m., S4Assistant Director of Nursing confirmed a Braden skin assessment was not completed on 06/10/2024 and 06/26/2024 for Resident #62 as required.</p> <p>In an interview on 07/24/2024 at 10:30 a.m., S2Corporate Nurse confirmed a Braden skin assessment should have been completed on Resident #62 upon re-admission. S2Corporate Nurse further confirmed Resident #62 did not have a Braden skin assessment upon re-admission on 06/10/2024 and 06/26/2024.</p> <p>2.</p> <p>Review of the facility's Skin Care policy and procedure, with an effective date of 11/25/2014 revealed, in part, the purpose of the policy is to maintain and prevent further skin breakdown through prevention, assessment, and treatment. Further review of the policy revealed an individual wound documentation will be completed for each individual wound.</p> <p>In an interview on 07/22/2024 at 9:00 a.m., S25Treatment Nurse indicated Resident #62 had a stage III pressure ulcer to the sacral area as of 07/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 07/23/2024 at 12:56 p.m., S17Treatment Nurse indicated Resident #62 had a stage III pressure ulcer to the sacral area. S17Treatment Nurse further indicated Resident #62's sacral wound was staged as a stage III pressure ulcer as of 07/23/2024.</p> <p>Review of Resident #62's Wound Assessment Reports revealed, in part;</p> <p>06/14/2024-Resident #62 had a new wound to the sacral area and the wound type was listed as an irritation/excoriation.</p> <p>06/21/2024-Resident #62 sacral wound status was unchanged. Wound type was listed as irritation/excoriation.</p> <p>07/02/2024-Resident #62 sacral wound status was improved. Wound type was listed as irritation/excoriation. Further review revealed Resident #62's sacral wound changed to a stage III and vitamin therapy and Pro-stat (a nutritional supplement) was to be started to promote wound healing.</p> <p>07/08/2024-Resident #62 sacral wound status was improved. Wound type was listed as irritation/excoriation. Further review revealed Resident #62 has a stage III sacral ulcer and treatment plan included Pro-stat to promote wound healing.</p> <p>07/15/2024-Resident #62 sacral wound status was improved. Wound type was listed as irritation/excoriation. Further review revealed Resident #62 has a stage III sacral ulcer and treatment plan included Pro-stat to promote wound healing.</p> <p>07/23/2024-Resident #62 had a new wound in the same area of irritation/excoriation to Resident #62's sacral area. Wound type was listed as pressure ulcer. Further review revealed, in part, Resident #62's sacral wound has declined from irritation to a stage III sacral pressure wound.</p> <p>In an interview on 7/24/2024 at 10:30 a.m., S2Corporate Nurse acknowledged Resident #62's wound care assessment and treatment documentation was inconsistent and incorrect which could affect treatment provided to Resident #62. S2Corporate Nurse confirmed Resident #62's wound status changed from irritation/excoriation to a stage III pressure ulcer on 07/02/2024. S2Corporate Nurse further confirmed Resident #62's wound should have been documented as a new pressure ulcer as of 07/02/2024.</p> <p>3.</p> <p>In an interview on 07/22/2024 10:10 a.m., Resident # 29 indicated staff were not turning her.</p> <p>Review of Resident # 29's Minimum Data Assessment with an assessment reference date of 06/25/2024 revealed, in part, a brief interview mental status of 12 which indicated Resident 29's cognition was moderately impaired. Review of Resident #29's skin assessment form revealed Resident # 29 was at risk for pressure ulcer developing/injuries, had one plus unhealed pressure ulcer/injuries and had two Stage 4 pressure ulcers and number present was 2.</p> <p>Review of Resident #29's plan of care with a start date of 04/01/2024 and an active review date of 09/19/2024 revealed, in part, to turn Resident #29 every two hours and float heels off of the bed while in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/23/24 08:17 a.m., revealed Resident #29 was positioned on her right side in the bed and had no heel protectors on with her feet touching the bed.</p> <p>In an interview on 07/23/2024 at 8:28 a.m., S7Treatment Nurse asked Resident #29 if she could turn herself in the bed and Resident #29 demonstrated she could move herself a little but was unable to turn herself independently.</p> <p>In an interview on 07/23/2024 at 8:37 a.m., S7Treatment Nurse indicated Resident #29 had a stage 4 pressure ulcer to the right buttocks and a stage 4 pressure ulcer to the sacrum. S7Treatment Nurse further indicated the plan of care was to turn Resident #29 every 2 hours and ensure heel protectors where on while in bed.</p> <p>Observation on 07/23/2024 at 9:04 a.m., revealed Resident #29 remained on her right side in bed with no heal protectors on.</p> <p>In an interview on 07/23/2024 at 9:24 a.m. Resident #29 stated there were no heel protectors in her room.</p> <p>Observation on 07/23/2024 at 9:59 a.m. revealed S19Certified Nursing Assistant (CNA) came into Resident #29's room and asked if Resident #29 if she was all right. Observation revealed S19CNA did not turn, did not offer to turn, and did not put heel protectors on Resident #29 prior to leaving the room.</p> <p>Observation on 07/23/2024 at 10:03 a.m., revealed S20Licensed Practical Nurse (LPN) came into Resident #29's room and gave her morning medications. Observation revealed Resident # 29 feet were exposed and no heel protectors were observed. Further observation revealed S20LPN did not turn, did not offer to turn, and did not put heel protectors on Resident #29 prior to leaving the room.</p> <p>Observation on 07/23/2024 at 10:27 a.m., revealed S12LPN came into Resident #29's room followed by S19CNA. Observation revealed neither of the above staff offered Resident # 29 to be turned.</p> <p>Observation on 07/23/2024 at 10:41 a.m., revealed S19CNA was looking around Resident #29's room but did not offer Resident #29 to be turned.</p> <p>Observation on 07/23/2024 at 10:45 a.m. revealed Resident #29 remained on her right side and staff did not turn, did not offer to turn, and did not put heel protectors on Resident #29 since wound care was observed completed on 07/23/2024 at 8:37 a.m. by the surveyor.</p> <p>Observation on 07/23/2024 at 10:54 a.m. revealed S19CNA checked on Resident #29, but did not turn, did not offer to turn, and did not put heel protectors on Resident #29 prior to leaving the room.</p> <p>In an interview on 07/23/2024 at 11:00 a.m., S19C.N.A. Indicated she was never told by S17Treatment Nurse when Resident # 29 was lasted turned after the completion of wound care for Resident #29. S19C.N.A indicated Resident #29 should be turned every 2 hours, and she never offered to turn Resident #29. S19C.N.A indicated she was not aware if Resident #29 needed to wear heel protectors S19C.N.A further indicated they do not have a turn schedule as we just automatically turn residents every 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 07 /23/2024 at 11:09 a.m., S21LPN indicated Resident #29 should be turned every 2 hours, and Resident # 29 should have had a heel protector on her right ankle.</p> <p>Observation on 07/23/2024 at 11:10 a.m., revealed S21LPN looked around Resident #29's room for the right heel protector and could not find the heel protector in her room.</p> <p>In an interview on 07/24/2024 at 10:35 a.m., S6Director of Nursing indicated staff should turn Resident #29 every 2 hours and/or offer her to be turned every 2 hours.</p> <p>In an interview on 07/24/2024 at 12:20 p.m., S22LPN indicated Resident # 29 had a nursing intervention for a heel protector to her right lateral ankle while in bed.</p> <p>Review of Resident #29's nursing intervention revealed, in part, a start date of 02/01/2023 and apply heel protector to protect right lateral ankle while in bed.</p> <p>Observation on 07/24/2024 at 12:26 p.m. revealed Resident #29 had no heel protector on her right ankle and was touching the mattress.</p> <p>In an interview on 07/24/2024 at 12:40 p.m., S6Director of Nursing indicated the right heel protector should be placed on Resident #29 while she was in bed.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41461</p> <p>Based on record reviews and interviews the facility failed to ensure site care was provided to a peripherally inserted central catheter (PICC) as per professional standards of practice for 1 (Resident #596) of 2 (Resident #177 and Resident #596) sampled residents investigated for PICC site care.</p> <p>Findings:</p> <p>Review of Resident #596's Minimum Data Set with an Assessment Reference Date of 04/11/2024 revealed Resident #596 was receiving intravenous medications.</p> <p>Review of Resident #596's record revealed no documented evidence and the facility was unable to produce documented evidence that PICC site care was provided for the time period of 04/04/2024 through 05/05/2024.</p> <p>In a telephone interview on 07/23/2024 at 9:36 a.m., Resident #596, indicated he was admitted to facility for rehabilitation for knee surgery and antibiotics through a PICC line 04/04/2024 and left the facility on [DATE]. He further indicated the PICC site was never cleaned or the bandage changed from 04/04/2024 through 05/05/2024.</p> <p>In an interview on 07/23/2024 at 12:45 p.m., S6Director of Nursing (DON) indicated PICC site care was completed on Sundays by the treatment/wound care nurse and should be documented on the wound care management report.</p> <p>In an interview on 07/23/2024 at 1:00 p.m., S17Treatment Nurse indicated she could not remember if she performed PICC site care for Resident #596. S17Treatment Nurse further indicated she could not provide documentation of PICC site care.</p> <p>In a telephone interview on 07/23/2024 at 3:59 p.m., S18Treatment Nurse indicated she could not remember if she provided PICC site care for Resident #596.</p> <p>In an interview on 07/24/2024 at 2:15 p.m., S1Administrator indicated there was no documentation and he could not present documentation that PICC site care was performed on Resident #596 during the resident stay at the facility.</p>		