STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195184	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Living Center	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47081 Based on record reviews, observation, and interviews the facility failed to ensure a resident was provided privacy during Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted through the skin into the stomach to provide liquid nourishment) feeding care for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for resident rights. Findings: Review of the facility's Enteral Nutrition Therapy (Tube Feeding) policy and procedure dated 01/14/2016 revealed, in part, staff should pull privacy screen and drape the resident during care for privacy. Review of the facility's Residents Rights policy and procedure dated 01/2023 revealed, in part, residents have the right to be treated with respect for their personal privacy. Review of Resident #3's record revealed, in part, Resident #3 had a diagnosis of mild intellectual disability. Observation on 08/28/2024 at 11:57 a.m. revealed S7Licensed Practical Nurse (LPN) entered Resident #3's room to perform PEG tube care without closing the door. Further observation revealed S7LPN raised Resident #3's shirt up to access her PEG tube port and completed PEG tube air bolus placement check, residual check, and free water flush while Resident #3's door remained open. Resident #3's exposed abdomen was visible from the hallway during care. In an interview on 08/28/2024 at 12:14 p.m., S7LPN indicated the door was left open during Resident #3's PEG tube care and should not have been. In an interview on 08/28/2024 at 12:30 p.m., S3Assistant Director of Nursing confirmed Resident #3's door should have been closed during PEG tube care. In an interview on 08/28/2024 at 1:18 p.m., S1Administrator confirmed Resident #3's door should have been closed during PEG tube care to maintain privacy.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47081 Based on record reviews, observations, and interviews, the facility failed to ensure staff wore proper protective equipment for Enhanced Barrier Precautions (EBP) during Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted through the skin into the stomach to provide liquid nourishment) feeding care for 1 (Resident #3) of 1 (Resident #3) sampled residents reviewed for PEG tube feeding care. Findings: Review of the facility's Enhanced Barrier Precautions policy and procedure dated 04/01/2024 revealed, in part, EBP was indicated for residents with indwelling medical devices including feeding tubes. Further review revealed staff should wear a gown when performing high contact activity, such as feeding device care, with residents for whom EBP was indicated. Review of Resident #3's medical record revealed, in part, a diagnosis of age-related cognitive decline, moderate protein-calorie malnutrition, and gastrostomy (a surgical hole made in the skin of the abdomen allowing placement of a PEG tube). Review of Resident #3's physician orders dated 08/2024 revealed, in part, an order for EBP. Further review revealed staff shall utilize gown and gloves during high contact care activities for residents with indwelling medical devices. Observation on 08/28/2024 at 11:55 a.m. revealed an EBP sign above Resident #3's room door indicating staff must wear personal protective equipment during medical device care. Observation on 08/28/2024 at 11:57 a.m. revealed S7Licensed Practical Nurse (LPN) entered Resident #3's room to perform PEG tube care without wearing a gown. Further observation revealed S7LPN completed PEG tube air bolus placement check, residual check, and free water flush without wearing a gown. In an interview on 08/28/2024 at 12:14 p.m., S7LPN indicated she did not wear a gown when performing Resident #3's PEG tube care and should have. In an interview on 08/28/2024 at 12:30 p.m., S3Assistant Director of Nursing confirmed a gown should have been worn during PEG tube care for a resident on EBP. In an interview on 08/28/2024 at 1:18 p.m., S1Administrator confirmed a gown should have been worn during PEG tube care for a resident on EBP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49259 Based on observations and interviews, he facility failed to ensure water from the shower room did not leak into the hallway for 1 (Shower Room A) of 4 (Shower Room A, Shower Room B, Shower Room C, and Shower Room D) shower rooms observed for physical environment. Findings: Observation on 08/27/2024 at 2:44 p.m. revealed a pool of water was present in the hallway outside Shower Room A's doorway. In an interview on 08/27/2024 at 2:45 p.m., S5Staff Developer confirmed there was a pool of water in the hallway outside of Shower Room A's doorway. Observation on 08/27/2024 at 3:45 p.m. revealed a pool of water was present in the hallway outside of Shower Room A's doorway. In an interview on 08/27/2024 at 3:50 p.m., S6Maintenance confirmed there was a pool of water in the hallway outside of Shower Room A's doorway. Observation on 08/27/2024 at 3:51 p.m. revealed, in part, Shower Room A's floor was uneven, and water had pooled into the low areas of the floor and was draining into the hallway. In an interview on 08/27/2024 at 3:52 p.m., S6Maintenance confirmed Shower Room A's floor was uneven, and water had pooled into the low areas of the floor and drained into the hallway. In an interview on 08/27/2024 at 3:53 p.m., S3Assistant Director of Nursing confirmed Shower Room A's floor was uneven, and water had pooled into the low areas of the floor and drained into the hallway. In an interview on 08/27/2024 at 3:54 p.m., S5Staff Developer confirmed Shower Room A's floor was uneven, and water had pooled into the low areas of the floor and drained into the hallway. In an interview on 8/27/2024 at 4:13 p.m., S1Administrator acknowledged he was aware of the above incident.