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 01/06/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47487 Based on observations, interviews and record reviews, the facility failed to ensure the resident's environment remained free of accident/hazards, identify and eliminate the risk of accident hazards to keep a resident free from elopement for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) residents investigated for accidents/hazards. This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 12/23/2024 at 8:50 a.m., when Resident #1 who was ordered a WanderGuard transmitter (a personal safety device that will alert facility staff when the resident approaches an exit and/or has left the building) exited the facility through Exit b. On 12/23/2024 at 9:25 a.m., Resident #1 was found 0.4 miles away from the facility with a skin tear to the back of his head. Resident #1 was then transferred via Emergency Medical Services (EMS) to the emergency department (ED) where he was diagnosed with a right temporal bone fracture and a right subdural hematoma (brain bleed). The IJ situation continued on 01/02/2025 at 12:30 p.m. when S10 Assistant Administrator used a secondary reset code that should have only been used by S1Administrator to open exits f and i; when using the secondary reset code, door exits f and i failed to alarm when a WanderGuard transmitter was placed near the door. The IJ situation continued on 01/02/2025 at 1:01 p.m. when S7CNA was observed using the secondary reset code that disabled the alarm. The IJ situation continued on 01/02/2025 at 1:30 p.m. when S3CNA was observed using the secondary reset code to unlock exit d. The IJ situation continued on 01/02/2025 when interviews of S3CNA, S4Maintenance, S5CNA and S6CNA verified they all used the secondary reset code to open exits f and d and that using this code disabled the alarm system. S1Administrator/Regional Administrator was notified of the Immediate Jeopardy on 01/02/2025 at 4:48 p.m. This deficient practice had the likelihood to cause more than minimal harm to the 6 residents identified by the facility as being at risk for elopement. Findings: (continued on next page)

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

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

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 01/06/2025
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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 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Review of the facility's policy effective 07/31/2019 titled, Elopement, Resident Policy and Procedure revealed, in part, the facility would provide at least one of the following safety precautions for residents who are at risk for elopement: door alarms on facility exits, a personal safety device that will alert facility staff when the resident has left the building without supervision, and staff supervision. Further review revealed at no time shall a personal safety alarm or door alarm be turned off without the continual supervision of the exit. Further review revealed all staff shall be trained on preventing and responding to an elopement. Further review revealed staff training would include risk factors and interventions for prevention of elopement.

Review of WanderGuard's (Door GUARDIAN) Installation Manual dated 03/11/2016 revealed, in part, if a nursing staff member was required to escort a resident with a WanderGuard transmitter out of the protected area, an escort code (secondary reset code) can be entered into the door panel/monitor to allow both the transmitter to pass through the perimeter without creating an alarm. Further review revealed the secondary reset code was used to escort a resident with a WanderGuard transmitter through the monitored door.

Resident #1

Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/2024 revealed, in part, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #1 had moderate cognitive impairment.

Review of Resident #1's Elopement Risk Evaluation dated 12/09/2024 revealed in part, Resident #1 wandered aimlessly. Further review revealed Resident #1 had an elopement score of 1, which indicated Resident #1 was at risk for elopement.

Review of Resident #1's nurse's note dated 12/23/2024 revealed, in part, Resident #1 was noted to have been found by staff outside of the facility and lying on the ground. Further review revealed Resident #1 had a small skin tear to his posterior head with minimal bleeding. Resident #1 was sent to the ED.

Review of the facility's incident investigation dated 12/23/2024 revealed, in part, on 12/23/2024 at 8:50 a.m., Resident #1 was observed to unsuccessfully exit through door b. Resident #1 was then observed engaged in conversation with another resident, attempted to open door b again, and successfully opened door b and walked away from the facility. Subsequently, on 12/23/2024 at 9:25 a.m., Resident #1 was found 0.4 miles away from the facility and on the ground. Resident #1 was then transported via EMS to the ED where he was diagnosed with a right temporal bone skull fracture and a right subdural hematoma (a collection of blood outside the brain that are usually caused by severe head injuries).

Review of Resident #1's hospital record dated 12/23/2024, revealed, in part, Resident #1 reportedly absconded (escaped) from his nursing home and was found after a ground level fall several blocks away. Review further revealed a Computed Tomography Scan (CT) (a type of scan that shows detailed images of the body) of Resident #1's head revealed a Non-displaced right temporal bone skull fracture and a right subdural hematoma.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 01/03/2025 11:41 a.m., a 3rd party WanderGuard vendor staff member indicated the facility's original WanderGuard transmitters had a sleep mode function that would activate if a resident remained motionless for 20 to 30 seconds. Review of the facility's Elopement Binder located at Nursing Station j revealed a list dated 12/30/2024 of the following residents who required a WanderGuard transmitter and were considered at risk for elopement: Resident #2, #3, #R4, #R5, #R6, and #R7. Review of the facility's schedule dated 01/02/2025 revealed S7CNA provided direct care to #R4 and #R7. In an interview on 01/02/2025 at 1:01 p.m., S7CNA indicated Resident #R7 was the only resident at risk for elopement in her room assignment. S7CNA failed to identify Resident #R4 as a resident at risk for elopement. In a telephone interview on 01/02/2025 at 3:25 p.m., S7CNA indicated she used the secondary reset door code to open exit f. In an interview on 01/02/2025 at 1:15 p.m., S1Administrator/Regional Administrator indicated that he was the only person who used the secondary reset door code because it bypassed the WanderGuard panel/monitor security alert; if an elopement risk resident were to attempt to exit the facility the door would not alarm. S1Administrator/Regional Administrator confirmed the secondary reset door code should not be used by staff to open the facility's exit doors. Observation on 01/02/2025 at 1:30 p.m. revealed S3CNA used the secondary reset door code to unlock exit d. In an interview on 01/02/2025 at 1:32 p.m., S3CNA confirmed she used the secondary reset door code to unlock exits d and f. In an interview on 01/02/2025 at 1:40 p.m., S4Maintenance indicated the secondary reset door code was the code used to unlock both exits d and f. In an interview on 01/02/2025 at 1:41 p.m., S5CNA indicated the secondary reset door code was used to unlock both exits d and f. In an interview on 01/02/2025 at 1:45 p.m., S6CNA indicated the secondary reset door code was used to unlock both exits d and f. In an interview on 01/02/2025 at 2:27 p.m., S2Director of Nursing (DON) indicated Resident #1 obtained the right temporal bone (a bone in the skull) fracture and a right subdural hematoma after he eloped from the facility. S2DON further indicated Resident #1 should not have been able to get out the facility. The Immediate Jeopardy was removed on 01/03/2025 at 11:55 a.m., after it was verified through observations, interviews, and record reviews that the provider implemented an acceptable Plan of Removal prior to the survey exit. A Plan of Removal was accepted on 01/03/2025 at 11:55 a.m. which included the following actions to correct the deficient practice: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately after the elopement on 12/23/2024 at approximately 10:00 a.m., S2Director of Nursing and designees performed a census check to ensure all residents with WanderGuard transmitters were accounted for and that the WanderGuard transmitters were functioning properly. All residents were accounted for and all WanderGuard transmitters were checked by 10:20 a.m. On 12/13/2024 S1Administrator/Regional Administrator contacted a 3rd party WanderGuard vendor to inspect the facility's WanderGuard system. The inspection was completed on 12/23/2024 with no issues. S1Administrator/Regional Administrator discovered on 12/23/2024 at 10:00 a.m. that some WanderGuard transmitters have a sleep mode feature. S1Administrator/Regional Administrator immediately verified that the WanderGuard transmitters actively used by the facility's residents did not have the sensor with the sleep mode function. S1Administrator/Regional Administrator also ordered additional WanderGuard transmitters without a sleep mode on 12/23/2024 and received the new WanderGuard transmitters on 12/26/2024 at 9:00 a.m. S1Administrator/Regional Administrator immediately locked all entrances on 12/23/2024 at approximately 10:00 a.m. and they will remain locked indefinitely. Immediately after the elopement on 12/23/2024, S2DON and designees began in-servicing all staff on the WanderGuard system and appropriate monitoring for WanderGuard transmitter residents. S2DON also placed binders at each nurses' station identifying WanderGuard residents so that staff would be aware. Staff were in-serviced on the binders. S1Administrator/Regional Administrator, S2DON, S8Assistant DON and S9Assistant DON randomly completed follow up interviews with staff to ensure they had understanding of the WanderGuard system and appropriate monitoring of residents. On 12/23/2024 S2DON, S8Assistant DON and S9Assistant DON placed every 1 hour monitoring to WanderGuard transmitter residents' electronic Medication Administration Record for increased supervision. S2DON and designees also began hourly visual checks on WanderGuard residents. Starting on 12/23/2024, S10Assistant Administrator and designee began performing daily WanderGuard system checks to ensure proper functioning. On 12/23/2024 S1Administrator/Regional Administrator sent a letter to resident family members educating them on not opening entries for residents allowing them to leave the facility. On 01/02/2025 at approximately 2:00 p.m. S1Administrator/Regional Administrator reset all primary and secondary door codes that will remain confidential. All staff have access to the primary code and department head staff have access to the secondary code. On 01/02/2025 at approximately 5:00 p.m. S1Administrator/Regional Administrator and designees began in-servicing staff on how to identify WanderGuard transmitter residents and ensuring WanderGuard transmitter residents were not allowed to exit the facility. All staff would be in-serviced via phone or in person upon arriving for their shift. The in-servicing of all staff would be completed by 01/03/2025. The likelihood of serious harm to any resident related to elopement no longer existed as of 01/03/2025.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47487 Based on interviews and record reviews, the facility failed to ensure a Certified Nursing Assistant (CNA) was competent in the facility's procedure for elopement risk residents for 1 (S7CNA) of 21 (S3CNA, S6CNA, S7CNA, S11Ward Clerk, S12CNA, S13Licensed Practical Nurse [LPN], S14CNA, S15LPN, S16Restorative Aide, S17CNA, S18CNA, S19LPN, S20LPN, S21LPN, S22CNA, S23LPN, S24CNA, S25CNA, S26CNA, S27LPN, and S28CNA facility employees interviewed for competency as it related to residents at risk for elopement. Findings: Review of the facility's policy with an effective date of 07/31/2019 and titled, Elopement, Resident Policy and Procedure revealed, in part, all staff shall be trained on preventing an elopement. Further review revealed staff training would include risk factors and interventions for prevention of resident elopement. Review of the facility's Elopement Binder located at Nursing Station j revealed a list dated 12/30/2024 of the following residents who required a WanderGuard transmitter and were considered at risk for elopement: Resident #R4 and #R7. Review of the above mentioned list revealed, in part, Resident #R4 and #R7 were residents that had a WanderGuard transmitter in place and were identified by the facility as being at risk for elopement. Review of the facility's CNA staffing schedule for 01/02/2025 revealed S7CNA was assigned to Room Assignment k. Review of the facility's census revealed Resident #R4 and Resident #R7 both resided in rooms that were located in Room Assignment k. Review of the facility's in-service dated 12/26/2024 revealed, in part, S7CNA acknowledged with her signature that she was trained on the facility's policy and procedure regarding the elopement of residents. In an interview on 01/02/2025 at 1:01 p.m., S7CNA denied she received training on residents at risk for elopement since 12/23/2024. S7CNA further indicated Resident #R7 was the only resident at risk for elopement in her room assignment, Room Assignment k. S7CNA did not identify Resident #R4 as a resident at risk for elopement. S7CNA further indicated there was not a list or a binder located at the nursing station for her to use as a reference to identify residents at risk for elopement. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/02/2025 at 2:27 p.m., S2Director of Nursing (DON) indicated the nursing staff should have had knowledge of which residents assigned to their care were at risk for elopement. S2DON further indicated the facility's process for staff members to confirm if a resident was an elopement risk was for staff to check the binders located at the nursing stations. These binders included a list of residents at risk for elopement. S2DON further acknowledged S7CNA should have known there was an elopement binder at the nursing station to use as a resource to identify residents at risk for elopement.