

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 03/13/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>44336</p> <p>Based on observations and interviews, the facility failed to ensure</p> <ol style="list-style-type: none"> 1. facility's halls were free of strong unpleasant odors for Hall A and Hall B; and, 2. debris and trash were removed from Resident #1's floor; and 3. a damaged wedge pillow used to reposition Resident #1 was replaced. <p>This deficient practice was identified for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for environment.</p> <p>Findings:</p> <p>Observation on 03/11/2025 at 5:09AM, revealed Hall A had very strong unpleasant odor of urine throughout.</p> <p>Observation on 03/11/2025 at 5:12AM, Hall B had a strong unpleasant odor of trash and urine.</p> <p>Observation on 03/11/2025 at 5:20AM, of Resident #1's room revealed a container, napkins, mints, two plastic bags and chipped paint, wall debris on the floor near Resident #1's bed.</p> <p>Observation on 03/11/2025 at 5:33AM, revealed Resident #1's wedge pillow had pieces of foam missing from it.</p> <p>In an interview on 03/13/2025 at 2:05PM, S1Administrator indicated that Resident #1 floor had trash on it. S1Administrator further indicated Resident #1's room should not have that on the floor.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336</p> <p>Based on observation, interviews, and record reviews, the facility failed to provide good personal hygiene for 1 (Resident #2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for Activities of Daily Living (ADL) care.</p> <p>Findings:</p> <p>Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, in part, dementia, neuroleptic-induced parkinsonism, and hypertension.</p> <p>Review of Resident #2's 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/2025, revealed Resident #2 had Brief Interview for Mental Status (BIMS) Score of 10 which indicated moderate cognitive impairment; required substantial/maximal assistance with shower/bathing and personal hygiene; and was incontinent of bladder and bowel.</p> <p>Observation on 03/11/2025 at 9:11AM, revealed S7Certified Nursing Assistant (CNA) transferred Resident #2 to the shower chair, and rinsed the front of Resident #2's body. S7CNA then gave Resident #2 a soapy rag to wash his own genital area, and S7CNA proceeded to wash his legs. S7CNA then told Resident #2 to close his eyes and S7CNA washed his hair. S7CNA continued the bath by standing Resident #2 up and proceeded to encouraged him to was his own genitals. Resident #2 washed his genitals but did not wash his buttocks. S7CNA rinsed Resident #2 off with the shower head, and proceeded to dry the front of Resident #2's body with a towel. S7CNA placed pants on Resident #2, stood Resident #2 up with his pants partially pulled up. Further observation revealed Resident #2's buttocks were dry, and Resident #2 buttocks were not washed during this bathing process.</p> <p>In an interview on 03/11/2025 at 9:25AM, the surveyor noted Resident #2's buttocks had not been washed, S7CNA acknowledged she had not washed Resident #2's buttocks.</p> <p>In an interview on 03/11/2025 at 10:37AM, S1Administrator indicated that Resident #2's buttocks should have been washed during his bath.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336</p> <p>Based on observation, interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) notified the nurse that wound dressings were removed from Resident #1's sacral wound; right gluteal wound; and right ischium ; and, a Licensed Practical Nurse (LPN) ensured Resident #1's heel protector was applied to her left heel.</p> <p>The deficient practice was identified for 1 (Resident #1) of 2 (Resident #1, Resident #3) residents observed for wound care.</p> <p>Findings:</p> <p>Review of the facility's Wound Care policy and procedure, dated 11/26/2024, revealed in part; after observation of the affected skin area, implement standing orders. Further review revealed, in part, Nursing Interventions: Cleansing and dressing as ordered and appropriate; and heel protectors.</p> <p>Review of Resident #1's Electronic Medical Record (EMR) revealed, in part, Resident #1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Further review revealed Resident #1 had diagnoses, in part, morbid obesity, muscle weakness, other lack of coordination, other reduced mobility, muscle wasting atrophy, right ankle stage 3 pressure injury, right gluteal stage 3 pressure injury , right ischium stage 3 pressure injury, and sacrum stage 3 pressure injury.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed, in part, Resident #1 had (4) stage three pressure injuries and was at risk for developing pressure ulcers/injuries. Further review revealed Resident #1 had functional limitations in range of motion in the lower extremity on the right and left sides.</p> <p>Review of Resident #1's March 2025 physician orders revealed, in part, an order dated 08/01/2024 for heel protectors, to protect the left lateral ankle while in bed and to monitor every shift. Further review revealed an order dated 02/24/2025 for sacrum; cleanse with vashe, pat dry, apply silver alginate to wound bed, cover with clean, dry dressing every 1 hour as needed for soilage and dislodgement. Further review revealed an order dated 02/24/2025 for stage 3 right gluteus; cleanse with vashe, pat dry, apply silver alginate to wound bed, cover with dry dressing every 1 hour as needed for soilage and dislodgement. Further review revealed an order dated 02/24/2025 for stage 3 right ischium (is a bone that is a part of the hip bone located in the lower back part of the pelvis; cleanse with vashe, pat dry, apply silver alginate to wound bed, cover with dry dressing every 1 hour as needed for soilage and dislodgement.</p> <p>Observation on 03/11/2025 at 5:33AM, revealed S5CNA removed Resident #1's wound dressings to the sacrum, right gluteus and right ischium, during incontinence care.</p> <p>Observation on 03/11/2025 at 5:41AM, revealed there was no heel protector on Resident #1's left heel noted.</p> <p>In an interview on 03/11/2025 at 5:48AM, S5CNA indicated she did not inform Resident #1's nurse that she removed Resident #1's wound dressings.</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 03/12/2025 at 7:58AM, S13Treatment Nurse indicated she was not notified by S5CNA that Resident #1's wound dressings were removed 03/11/2025 at 5:33AM. S13Treatment Nurse further indicated Resident #1 did not have a wound dressings on her pressure ulcers when she assessed her on 03/11/2025 at approximately 9:15AM.</p> <p>In an interview on 03/12/2025 at 8:26AM, S8CNA indicated on 3/11/2025 at approximately 9AM, Resident #1 did not have wound dressings on her wounds. SCNA8 indicated Resident #1's diaper was soiled with feces which was noted in the wounds.</p> <p>Observation on 03/12/2025 at 8:35AM, Resident #1's heel protector was on the right heel.</p> <p>In an interview on 03/12/2025 at 9:23AM, S9LPN stated Resident #1 is ordered to have a heel protector on the left heel. S9LPN further indicated that Resident #1 had the heel proctor on the right heel and it should have been on her left heel.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident diagnosed with peripheral vascular disease had an appointment for toenail trimming for 1 (Resident #3) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for foot care.</p> <p>Findings:</p> <p>Review of Resident #3's clinical record revealed, in part, Resident #3 was admitted to the facility on [DATE] with diagnoses , in part, of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Observation on 03/12/2025 at 9:42 AM, revealed Resident #3's left Great toe toenail was unusually long, thick, and curled backwards away from the nail bed.</p> <p>In an interview on 03/12/2025 at 9:42 AM, Resident #3 stated she requested toenail care when she was admitted to the facility.</p> <p>In an interview on 03/12/2025 at 11:56 AM, S11Assistant Director of Nursing (ADON) stated both of Resident #3's great toes toenails were long and thick and needed to be trimmed.</p> <p>In an interview on 03/12/2025 at 12:40 PM, S11ADON stated Resident #3 was not scheduled to have a Podiatry appointment/consult.</p> <p>In an interview on 03/13/2025 at 8:33 AM, S12LPN stated Resident #3's toenails needed to be trimmed.</p> <p>Further review revealed no documented evidence, and the facility did not present any documented evidence, Resident #3 had a podiatry consult or had seen a podiatrist prior to the survey entrance date of 03/11/2025.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336</p> <p>Based on observation, record reviews, and interviews, the facility failed to ensure Certified Nursing Assistants (CNAs) demonstrated competencies for hand hygiene; use of Enhanced Barrier Precautions; proper showering; and and, a Licensed Practical Nurse (LPN) demonstrated competency applying a heel protector when providing care to residents.</p> <p>This deficient practice was identified for 2 (Resident #1, Resident#2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated.</p> <p>Findings:</p> <p>Resident #1</p> <p>Review of Resident #1's record revealed, in part, an initial admitted [DATE] with a readmitted [DATE].</p> <p>Review of Resident #1's March 2025 physician orders revealed, in part, an order dated 08/01/2024, for heel protectors to protect left lateral ankle while in bed, monitor every shift.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed, in part, Resident #1 had four stage three pressure injuries and an indwelling urinary catheter. Further review revealed Resident #1 was always incontinent of bowel and bladder. Further review also revealed Resident #1 was dependent on staff for toileting hygiene.</p> <p>Review of Resident #1's Care Plan with a target date of 05/03/2025 revealed, in part, Resident #1 had a clinical condition (i.e. chronic wound, etc.) and or medical device (i.e. urinary catheter etc.) that warrants enhanced barrier precautions (EBP) with a goal to prevent Resident #1's potential Multi Drug Resistant Organism (MDRO) infection will not spread through the facility. Further review revealed, in part, interventions to perform hand hygiene prior to providing high contact resident care activity and after providing the high contact resident care activity included the following interventions: utilize gloves and gown when performing high-contact resident care activities (i.e. providing hygiene, changing briefs, and assisting with toileting) and utilize glove and gown when providing care to medical devices (i.e. urinary catheter).</p> <p>Observation on 03/11/2025 at 5:23AM, revealed Resident #1 had signage on the door which indicated Resident #1 was on EBP (gown and gloves). Further observation revealed, upon entering Resident #1's room for incontinence care, S5CNA and S6CNA did not place a gown on prior to performing incontinence care on Resident #1. Further observation revealed S6CNA failed to perform hand hygiene prior to placing gloves to assist with incontinence care for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/11/2025 at 5:33AM, revealed S5CNA removed Resident #1's urine and feces soiled brief and cleaned Resident #1's buttock area. Further observation revealed S5CNA disposed of Resident #1's soiled brief and touched Resident #1's pillow and bed linens with the same gloves used to perform incontinence care. Further observation revealed S6CNA touched Resident #1's face, pillow, bedside table and bed linens with the same gloves used to perform incontinence care on Resident # 1.</p> <p>Observation on 03/12/2025 at 8:35AM, Resident #1's left heel protector was applied to Resident #1's right heel.</p> <p>In an interview on 03/12/2025 at 9:23AM, S9LPN indicated Resident #1 had an order for a heel protector for the left heel. S9LPN further indicated Resident #1's heel protector was on the right heel and it should have been applied to her left heel.</p> <p>Resident #2</p> <p>Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, in part, dementia, neuroleptic-induced parkinsonism, and hypertension.</p> <p>Review of the 5-Day MDS (minimum data set) with ARD of 03/04/2025 revealed, in part, Resident had the following: moderately impaired cognition; required substantial/maximal assistance with shower/bathing and personal hygiene; and was incontinent of bladder and bowel.</p> <p>Review of Resident #2's baseline care plan, with a target date of 06/03/2025, revealed, in part, Resident #2 required assistance from staff with Activities of Daily Living (ADL).</p> <p>Observation on 03/11/2025 at 9:11AM, S7Certified Nursing Assistant showered Resident #2 and did not wash his buttocks.</p> <p>In an interview on 03/11/2025 at 9:25AM, the surveyor noted Resident #2's buttocks had not been washed, S7CNA acknowledged she had not washed Resident #2's buttocks.</p> <p>In an interview on 03/11/2025 at 10:37AM, S1Administrator indicated that Resident #2's buttocks should have been washed during his bath.</p> <p>Observation on 03/13/2025 at 9:36AM, revealed S14Certified Nursing Assistant entered Resident #2's room to perform incontinence care, applied gloves and did not perform hand hygiene. S14CNA removed Resident #2's urine soiled brief, cleaned Resident #2's perineal area and buttock's, and placed a clean brief on Resident #2 without changing her gloves or performing hand hygiene.</p> <p>In an interview on 03/13/2025 at 9:40AM, S14CNA confirmed she did not perform hand hygiene before performing incontinence care for Resident #2. S14CNA further indicated she did not change her gloves or perform hand hygiene after removing Resident #2's urine soaked brief and should have.</p> <p>In an interview on 03/13/2025 at 2:05PM, S1Administrator indicated that staff should be performing hand hygiene when performing incontinence care. S1Administrator further indicated staff should have wear gowns for residents that require Enhanced Barrier Precautions.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44336</p> <p>Based on observations, interviews, and record reviews facility failed to maintain an infection prevention and control program for 2 (Resident #1, Resident #2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents.</p> <p>Findings:</p> <p>Resident #1</p> <p>Review of Resident #1's physician orders dated March 2024 revealed, in part, Oxygen-Clean Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BIPAP/CPAP) mask (respiratory face mask used for machines that treat sleep apnea) and tubing change every week and in the evening every 24 hours as needed.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed, in part, Resident #1 had four stage three pressure injuries and an indwelling urinary catheter. Further review revealed Resident #1 was always incontinent of bowel and bladder. Further review revealed Resident #1 was dependent on staff for toileting hygiene.</p> <p>Review of Resident #1's Care Plan with a target date of 05/03/2025 revealed, in part, Resident #1 had a clinical condition (i.e. chronic wound, etc.) and or medical device (i.e. urinary catheter etc.) that warrants Enhanced Barrier Precautions (EBP) with a goal to prevent Resident #1's potential Multi Drug Resistant Organism (MDRO) infection to not spread through the facility. Further review revealed, in part, interventions to perform hand hygiene prior to providing high contact resident care activity and after providing high contact resident care activity. The following interventions: utilize gloves and gown when performing high-contact resident care activities (i.e. providing hygiene, changing briefs, assisting with toileting) and utilize gloves and gown when providing care to medical devices (i.e. urinary catheter).</p> <p>Observation on 03/11/2025 at 5:23AM, revealed a sign on Resident #1's door indicating EBP prior to entering Resident #1's room. Further observation revealed S5Certified Nursing Assistant (S5CNA) and S6Certified Nursing Assistant (S6CNA) did not put on a gown before performing incontinence care for Resident #1 and prior to entering Resident #1's room.</p> <p>Observation on 03/11/2025 at 5:24AM, revealed S5CNA entered Resident #1's room to perform incontinence care on Resident #1 with gloves on, but no gown. S6CNA entered Resident #1's room to assist S5CNA in performing incontinence care and did not perform hand hygiene before applying gloves and with no gown on. S5CNA and S6CNA then removed Resident #1's urine and feces soiled brief, cleaned Resident #1's buttock's area of feces, and placed a clean brief on Resident #1 without changing gloves or performing hand hygiene. S5CNA then disposed of Resident #1's soiled brief into the trash, and touched Resident #1's pillow and bed linens with the same gloves she used to perform incontinence care. S6CNA touched Resident #1's face, pillow, bedside table, and bed linens with the same gloves she used to perform incontinence care on Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/11/2025 at 5:25AM, revealed Resident #1's BIPAP/CPAP mask was uncovered, in an opened drawer, next to her bed.</p> <p>Observation on 03/11/2025 at 5:44AM, revealed S5CNA placed a lid on the garbage can and removed her gloves. S5CNA proceeded to go into Resident #1's room and opened Resident #1's refrigerator, touched the water pitcher, and gave Resident #1 a soft drink, without performing hand hygiene.</p> <p>In an interview on 03/11/2025 at 5:48AM, S5CNA confirmed she did not wear a gown, change her gloves or perform hand hygiene prior to placing a clean adult brief on Resident #1 or touching food items, and should have.</p> <p>In an interview on 03/11/2025 at 5:57AM, S6CNA confirmed she did not wear a gown, change gloves or perform hand hygiene prior to placing a clean adult brief on Resident #1, and should have.</p> <p>Observation on 03/12/2025 at 8:37AM, revealed Resident #1's BIPAP/CPAP was uncovered, in an opened drawer, next to her bed.</p> <p>In an interview on 03/11/2025 at 10:37AM, S1Administrator indicated S5CNA and S6CNA should have performed hand hygiene while performing incontinence and Activities of Daily Living (ADL) care. S1Administrator further indicated staff should wear a gown when performing incontinence care on residents on EBP.</p> <p>In an interview on 03/13/2025 at 2:05PM, S3Director of Nursing (DON) indicated S5CNA and S6CNA should have performed hand hygiene and incontinence care according to the facility's policy and procedure. S3DON further indicated that both of the CNA's that performed incontinence care for Resident #1 should have worn gowns for a Resident on EBP. S3DON also indicated Resident #1's CPAP/BIPAP mask was not properly stored and should have been.</p> <p>Resident #2</p> <p>Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, in part, dementia, neuroleptic-induced parkinsonism, and hypertension.</p> <p>Review of Resident #2's 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/2025, revealed Resident #2 had Brief Interview for Mental Status (BIMS) Score of 10 which indicated moderate cognitive impairment; required substantial/maximal assistance with shower/bathing and personal hygiene; and was incontinent of bladder and bowel.</p> <p>Review of Resident #2's baseline care plan with a target date of 06/03/2025 revealed, in part, Resident #2 was incontinent of bladder/ bowel and required assistance from staff.</p> <p>Observation on 03/13/2025 at 9:36AM, revealed S14Certified Nursing Assistant (S14CNA) entered Resident #2's room to perform incontinence care and applied gloves without performing hand hygiene. Further observation revealed S14CNA removed Resident #2's urine soiled brief, cleaned Resident #2's perineal area and buttock's, and placed a clean brief on Resident #2 without changing gloves or performing hand hygiene.</p> <p>(continued on next page)</p>

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