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	04/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47487 Based on observation and interviews, the facility failed to provide a privacy cover for a urinary catheter drainage bag for 1 (Resident #R9) of 1 (Resident #R9) residents reviewed for catheters. Findings: Observation on 04/07/2025 at 8:02AM revealed Resident #R9 was ambulating in her wheelchair on Hall c. Further observation revealed Resident #R9's catheter drainage bag was attached under her wheelchair seat and her yellow urine was visible in the catheter drainage bag. Further observation revealed Resident #R9 called out to S4LPN, and asked for a privacy cover for her catheter drainage bag. Further observation revealed S4LPN responded back to Resident #R9 that she would get her a privacy cover for her catheter drainage bag. S4LPN further indicated to Resident #R9 that she was aware Resident #R9 had requested the privacy cover last week. In an interview on 04/07/2025 at 8:03AM, Resident #R9 indicated she had asked for a privacy cover for her catheter drainage bag last week but had not received one. In an interview on 04/07/2025 at 9:25AM, S4LPN confirmed Resident #R9 had asked for a privacy cover for her catheter drainage bag last week. S4LPN confirmed Resident #R9 should have a privacy cover over her catheter drainage bag. In an interview on 04/07/2025 at 9:32AM, S2Assistant Director of Nursing indicated Resident #R9 should have a privacy cover for her catheter drainage bag.

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on observation, interview, and record review, the facility failed to ensure expired medications were not available for resident use for 2 (Medication Cart a, Medication Cart b) of 2 (Medication Cart a, Medication Cart b) medication carts reviewed for medication storage. Findings: Review of the United States Food and Drug Administration's Information Regarding Insulin Storage and Switching Between Products in an Emergency, located on the website https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency, and current as of 09/19/2017 revealed, in part, open and unopened insulin products contained in vials or cartridges may be left unrefrigerated up to 28 days and continue to work. Review of the Lantus SoloStar Step-by-Step Guide dated 2022, revealed, in part, an opened Lantus pen should be discarded after 28 days. Observation of Medication Cart b on 04/07/2025 at 6:11AM revealed Resident #R11's Insulin Lispro (a medication used to lower blood glucose levels) 100 units (u) /milliliter(ml) pen was in Medication Cart b and available for use. Further observation revealed the above mentioned insulin pen had an opened date of 02/27/2025. In an interview on 04/07/2025 at 6:11AM, S3LPN confirmed Resident #R11's above mentioned insulin pen was expired. Observation of Medication Cart a on 04/07/2025 at 9:15AM revealed Resident #R10's Lantus (a medication used to lower blood glucose levels) 100 u/ml pen was in Medication Cart a and available for resident use. Further observation revealed the above mentioned pen was not labeled with the opened date. In an interview on 04/07/2025 at 9:15AM, S4LPN indicated without the opened date on Resident #R10's Lantus 100u/ml pen, she could not know when the medication was opened or if the medication was expired. S4LPN further indicated Resident #10's [NAME] 100u/ml pen should have been discarded.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47487 Based on observation, interviews, and record reviews, the facility failed to ensure medications were not left unattended at a resident's bedside for 1 (Resident #2) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #12) sampled residents investigated for medication storage. Findings: Review of the facility's Medication Pass Guidelines policy and procedure dated 12/04/2017 revealed, in part, nurses should not leave residents with medications in a medication cup. Observation on 04/07/2025 at 2:25AM revealed a medication cup containing 2 unidentified white/round pills were present on Resident #2's bedside table. In an interview on 04/07/2025 at 2:25AM, Resident #2 indicated the two pills on her bedside table were her sleeping pills that were given to her by the nurse last night; however, she did not want the medication at the time so she left them on the side. In an interview on 04/07/2025 at 9:32AM, S2Assistant Director of Nursing (ADON) indicated Resident #2's medication should not have been left in a medication cup on Resident #2's bedside table.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47487 Based on observations and interviews, the facility failed to serve residents' food at an acceptable temperature as required. Findings: In an interview on 04/08/2025 at 8:40AM, Resident #3 indicated the facility's food was always cold. In an interview on 04/08/2025 at 10:14AM, Resident #2 indicated the facility's food was cold when it was served to her in her room. In an interview on 04/08/2025 at 10:17AM, Resident #1 indicated the facility served cold food. Observation on 04/08/2025 at 12:11PM revealed Resident #R14's lunch tray was placed on top of an insulated tray cart (a cart used to help food retain it's temperature as it is transported,) instead of inside the insulated tray cart, as S5Certified Nursing Assistant (CNA) pulled the insulated tray cart down Hall c. On 04/08/2025 at 12:15PM, surveyor collected Resident #R14's tray to be used as a test tray. Upon sampling the food on Resident #14's tray, the chicken, rice, and peas were found to be lukewarm/room temperature. In an interview on 04/08/2025 at 12:20PM, Resident #4 indicated the food at the facility was always cold. Observation on 04/09/2205 at 12:45PM revealed Resident #3's lunch tray arrived to Hall c. Further observation revealed Resident #3's lunch tray was placed on top of an insulated tray cart as it was transported down Hall c instead of inside the insulated tray cart. On 04/09/2025 at 1:00PM, surveyor collected Resident #3's lunch tray from the top of the insulated tray cart to be used as a test tray. Surveyor left Resident #3's plate covered and brought Resident #3's lunch tray directly to the kitchen to have the temperatures checked. Observation on 04/09/2025 at 1:02PM revealed the cover was removed from the plate on Resident #3's lunch tray and S7Dietary Technician checked the temperature of the food on Resident #3's lunch tray. Further observation revealed the pork was 78 degrees Fahrenheit (F), the lima beans were 81 degrees F, and the cabbage was 91 degrees F. On 04/09/2025 at 1:04PM both the surveyor and S7Dietary Technician sampled the food from Resident #3's lunch tray. Surveyor found the food to room temperature. In an interview on 04/09/2025 at 1:04PM, S7Dietary Technician indicated the food she had sampled was cold. S7Dietary Technician further indicated based on the food temperatures she had obtained she knew the food would be cold.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47487 Based on observation and interview, the facility failed to ensure a functional call bell was available for 2 (Resident #2, Resident #R6) of 15 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #R5, Resident #R6, Resident #R7, Resident #R8, Resident #R9, Resident #R10, Resident #R11, Resident #12, Resident #R13, Resident #R14, Resident #R15) residents investigated for functional call bells. Findings: Observation on 04/07/2025 at 2:20AM revealed the door/call light was illuminated above the door to Resident #2 and Resident #R6's room. In an interview on 04/07/2025 at 2:20AM, S5Certified Nursing Assistant (CNA) indicated Resident #2 and Resident #R6's call bell was illuminated above their door because it was broken. In an interview on 04/07/2025 at 2:25AM, Resident #2 indicated her call bell had been broken since Friday, 04/04/2025. Observation on 04/07/2025 at 5:21AM revealed the door/call light was illuminated above the door to Resident #2 and Resident #R6's room. In an interview on 04/08/2025 at 10:11AM, Resident #R6 indicated the call bell had been broken since Friday, 04/04/2025. Resident #R6 further indicated she had no way to call for assistance over the weekend while the call bell was not functioning; therefore, Resident #R6 had to wait for staff to round if she needed assistance. In an interview on 04/08/2025 at 10:14AM, Resident #2 indicated when her roommate (Resident #R6) would activate the call bell over the weekend, staff would not come due to the call bell not working. Resident #2 indicated Resident #R6 just had to wait for staff to come in the room if she needed something. In an interview on 04/07/2025 at 9:45AM, S1Administrator indicated he would have liked for staff to have notified him Resident #2 and Resident #R6's call bell was broken over the weekend. S1Administrator did not present any further evidence that disputed deficient practice.