

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  09/23/2025
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, and record review, the facility failed to provide Activities of Daily Living (ADL) care in a timely manner for 1 (Resident #2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for ADL care. Findings: Review of Resident #2's Electronic Medical Record (EMR) revealed, in part, Resident #2 was admitted to the facility on [DATE]. Further review revealed Resident #2 had diagnoses, in part, of overactive bladder and unspecified urinary incontinence. Review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/2025 revealed, in part, Resident #2 required supervision/touching assistance with toileting hygiene and had occasional bladder incontinence. Review of Resident #2's Care Plan with a goal date of 10/17/2025 revealed, in part, an intervention for staff to assist Resident #2 with perineal cleansing as needed. Further review revealed Resident #2 required assistance with toilet transfers, dressing, and hygiene. Observation on 09/22/2025 at 12:49PM revealed Resident #2 was seated in her wheelchair crying in the hallway outside of her room. Further observation revealed S6Licensed Practical Nurse (LPN) passed by and questioned Resident #2 as to why she was crying. Further observation revealed Resident #2 stated she had an accident on herself and S6LPN stated she would find a certified nursing assistant (CNA) to change her. Observation on 09/22/2025 at 1:18PM revealed Resident #2 wheeled herself down the hallway in her wheelchair crying, looking in rooms, and appeared in distress. Resident #2 approached S7Certified Nursing Assistant Supervisor (CNA Supervisor) in the hall to tell her she couldn't find any clothes and she was soaking wet while gesturing towards her groin area. S7CNA Supervisor stated she would check and see after she finished her current task. Observation on 09/22/2025 at 1:27PM revealed S7CNA Supervisor came back to Resident #2's room and showed Resident #2 she had clothes in her closet and walked out without giving assistance to Resident #2. Observation on 09/22/2025 at 1:30PM revealed Resident #2 wheeled herself back into the hallway in her wheelchair, crying and indicated she did not have any panties. Observation on 09/22/2025 at 1:31PM revealed Resident #2 did not receive incontinence care from the facility's staff until 09/22/2025 at 1:31PM, when S8CNA observed Resident #2 crying in the hallway and brought Resident #2's into her room to provide incontinence care. In an interview on 09/22/2025 at 1:40PM, S8CNA indicated Resident #2 had an episode of urinary incontinence and Resident #2's underwear and pants were wet with urine. In an interview on 09/22/2025 at 2:09PM, S7CNA Supervisor indicated once a resident had an episode of incontinence, they should be changed within 15 to 20 minutes. In an interview on 09/22/2025 at 2:12PM, S2Assistant Director of Nursing (ADON) indicated it was the facility's process for staff to change a resident after a known episode of incontinence within 15 to 20 minutes. In an interview on 09/22/2025 at 03:09PM, S3ADON indicated it was the facility's process for staff to change a resident after a known episode of incontinence within 15 minutes. In an interview on 09/22/2025 at 3:40PM, S7CNA Supervisor indicated she did hear Resident #2 state she was soaking wet but was unaware Resident #2 was incontinent of bladder and required assistance from staff for incontinence care.</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
---	-------	-----------

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  09/23/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's medication was not available for administration for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for medication administration. Findings: Review of Resident #1's August 2025 physician's orders revealed, in part, an order to administer Resident #1 one Hydrocodone-Acetaminophen (a medication used to treat pain) 10-325 milligrams (mg) tablet every eight hours as needed for pain. Review of the Individual Narcotic Record for Resident #1's Hydrocodone-Acetaminophen 10-325 mg tablets revealed, in part, Resident #1's had zero Hydrocodone-Acetaminophen 10-325 mg tablets available after she was administered the last Hydrocodone-Acetaminophen 10-325 mg tablet on 08/29/2025 at 8:43PM. In a telephone interview on 09/19/2025 at 1:14PM, Resident #1 indicated she was in pain related to a previous fall and her chronic pain on the night of 08/29/2025 to the morning of 08/30/2025. Resident #1 further indicated she had requested her pain medication, but the facility's nurse told her the pain medication was not available because the medication had not been reordered. In a telephone interview on 09/22/2025 at 12:40PM, S5 Licensed Practical Nurse (LPN) indicated when she arrived at the facility on the morning of 08/30/2025, Resident #1 had complained of pain. S5 LPN further indicated Resident #1's Hydrocodone-Acetaminophen 10-325 mg tablets were not available. S5 LPN further indicated she was not able to administer Resident #1's Hydrocodone-Acetaminophen 10-325 mg tablet as needed because none were available. In an interview on 09/22/2025 at 1:08PM, S4 Staff Development/Charge Nurse/Infection Preventionist indicated when a resident had an active order for a medication, the medication should have been available for administration. In an interview on 09/22/2025 at 2:08PM, S1 DON indicated a resident's medication should have been ordered from the pharmacy before a resident was out of a medication.</p>		