

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 04/01/2026
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the medication error rate was not greater than 5% for 2 (Resident #R5 and Resident #R6) of 4 residents observed during medication administration. Findings: Review of the facility's Medication Administration and Storage Policy, Med Pass Guidelines dated 12/04/2017 revealed, in part, staff was to check directions (for medication administration) against a resident's medication administration record. Further review revealed, in part, staff must check the medication cart for out-of-date medications. Further review revealed staff were to make sure that drugs matched the medication administration record.</p> <p>Resident #R5</p> <p>Review of Resident #R5's electronic medical record revealed, in part, Resident #R5 was admitted on [DATE] and had diagnoses, which included, Alzheimer's disease, vascular dementia, generalized anxiety disorder, and hemiplegia.</p> <p>Review of Resident #R5's physician's orders revealed, in part, an order dated 03/06/2026 to administer Resident #R5 one oral tablet of Risperidone (an antipsychotic medication) 0.25 milligrams (MG) one time a day.</p> <p>Review of Resident #R5's March 2026's electronic medication administration record revealed, in part, Resident #R5 was administered one Risperidone 0.5MG tablet once per day from 03/01/2026 through 03/05/2026. Further review revealed Resident #R5's Risperidone 0.5MG dosage was discontinued on 03/05/2026. Further review revealed an order to administer one Risperidone 0.25MG tablet with a start date of 03/06/2026.</p> <p>Observation on 03/31/2026 at 9:03AM revealed S5Licensed Practical Nurse administered one Risperidone 0.5MG tablet by mouth to Resident #R5.</p> <p>In an interview on 03/31/2026 at 10:40AM, S5Licensed Practical Nurse confirmed she had administered 0.5MG tablet by mouth of Risperidone and she should have administered 0.25MG of Risperidone by mouth as per Resident #R5's physician's orders.</p> <p>Resident #R6</p> <p>Review of Resident #R6's electronic medical record revealed, in part, Resident #R6 was admitted on [DATE] and had diagnoses, which included, unspecified sequelae of cerebral infarction and adjustment disorder with depressed mood.</p> <p>Review of Resident #R6's quarterly Minimum Data Set with an Assessment Reference Date of (continued on next page)</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/11/2026 revealed, in part, Resident #R6 was cognitively intact with a Brief Interview for Mental Status score of 15.</p> <p>Review of Resident #R6's physician's orders revealed, in part, an order dated 03/03/2026 to administer Resident #R6 2.5 oral tablets of Fluoxetine HCl (an antidepressant medication) 20 milligrams (MG) by mouth one time a day.</p> <p>Observation on 03/31/2026 at 9:08AM revealed S4Licensed Practical Nurse administered one Fluoxetine HCl 40MG tablet by mouth to Resident #R6.</p> <p>In an interview on 03/31/2026 at 10:42AM, S4Licensed Practical Nurse confirmed she had administered 40MG tablet by mouth of Fluoxetine HCL and she should have administered 50MG by mouth as per Resident #R6's physician's order.</p> <p>In an interview on 03/31/2026 at 11:10AM, S6Corporate Nurse confirmed S4Licensed Practical Nurse had administered Resident #R6 40MG by mouth of Fluoxetine HCL, and S4Licensed Practical Nurse should have administered Fluoxetine HCl 50MG by mouth as per Resident #R6's physician's order. S6Corporate Nurse further confirmed S5Licensed Practical Nurse had administered Resident #R5 0.5MG by mouth of Risperidone and S5Licensed Practical Nurse should have administered 0.25MG by mouth as per Resident #R5's physician's order.</p> <p>In an interview on 03/31/2026 at 12:50PM, S3Director of Nursing confirmed S4Licensed Practical Nurse had administered Resident #R6 40MG by mouth of Fluoxetine HCL, and S4Licensed Practical Nurse should have administered 50MG by mouth as per Resident #R6's physician's order. S3Director of Nursing further confirmed S5Licensed Practical Nurse had administered Resident #R5 0.5MG by mouth of Risperidone and S5Licensed Practical Nurse should have administered 0.25MG by mouth as per Resident #R5's physician's order.</p> <p>In an interview on 03/31/2026 at 12:58PM, S2Assistant Administrator confirmed S4Licensed Practical Nurse had administered Resident #R6 40MG by mouth of Fluoxetine HCL, and S4Licensed Practical Nurse should have administered Fluoxetine HCl 50MG by mouth as per Resident #R6's physician's order. S2Assistant Administrator further confirmed S5Licensed Practical Nurse had administered Resident #R5 0.5MG by mouth of Risperidone and S5Licensed Practical Nurse should have administered 0.25MG by mouth as per Resident #R5's physician's order.</p> <p>In an interview on 04/01/2026 at 9:33AM, S1Administrator confirmed the above-mentioned medications were administered incorrectly, and should have been administered according to the physician's orders for Resident #R5 and Resident #R6.</p>		