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	07/23/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure resident equipment and rooms were maintained in a sanitary manner for 2 (Resident #57, Resident #148) of 2 (Resident #57, Resident #148) sampled residents investigated for tube feeding.Findings: Resident #57Review of Resident #57's electronic medical record revealed, in part, Resident #57 was admitted to the facility on [DATE] with diagnoses of encounter for attention to gastrostomy (surgical creation of an opening in the stomach to administer feedings), dysphagia (difficulty swallowing), and cognitive communication deficit. Review of Resident #57's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/11/2025 revealed, in part, Resident #57 was non-interviewable, dependent for all activities of daily living, had a feeding tube, and received enteral feeding.Observation on 07/21/2025 at 11:35AM revealed multiple areas of a reddish/brown substance located on Resident #57's tube feeding pump, on the base of Resident #57's tube feeding pole, and on Resident #57's floor near the tube feeding pole.Observation on 07/22/2025 at 12:49PM revealed multiple areas of a reddish/brown substance located on Resident #57's tube feeding pump, on the base of Resident #57's tube feeding pole, and on Resident #57's floor near the tube feeding pole. Resident #148Review of Resident #148's electronic medical record revealed, in part, Resident #148 was admitted to the facility on [DATE] with a diagnoses of an encounter for attention to gastrostomy and dysphagia following cerebral infarction (death of brain tissue due to insufficient blood flow).Review of Resident #148's Quarterly MDS with an ARD date of 05/07/2025 revealed, in part, Resident #148 was non-interviewable and received enteral feedings through tube feedings. Observation on 07/21/2025 at 10:30AM revealed multiple areas of a reddish/brown substance located on Resident #148's tube feeding pump, on the base of Resident #148's tube feeding pole, and on Resident #148's floor near the tube feeding pole.Observation on 07/22/2025 at 12:20PM revealed multiple areas of a reddish/brown substance located on Resident #148's tube feeding pump, on the base of Resident #148's tube feeding pole, and on Resident #148's floor near the tube feeding pole.In an interview on 07/22/2025 at 1:55PM, S1Administrator indicated the above mentioned findings in Resident #57's and Resident #148's rooms were not maintained in a sanitary manner.In an interview on 07/22/2025 at 3:30PM, S3Director of Nursing indicated the above mentioned findings in Resident #57's and Resident #148's rooms were not maintained in a sanitary manner.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195184	A. Building B. Wing	07/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to ensure an incident of resident to resident physical abuse was reported to the state agency for 1 (Resident #110) of 1 (Resident #110) sampled residents identified to have physically abused residents during a mood and behavior investigation.Findings:Review of the facility's policy and procedure titled, Abuse-Prevention and Prohibition dated 03/25/2023 revealed, in part, the administrator shall immediately initiate a report to the state agency after forming the suspicion the allegation involves abuse of any type. Review of Resident #110's incident report dated 07/02/2025 revealed, in part, Resident #110 hit Resident #62 and punched Resident #180 in the chest. Review of the facility's list of incidents reported to the state agency for the last six months revealed no documented evidence, and the facility presented no documented evidence, the facility had reported incidents involving physical abuse as noted in the above mentioned incident report dated 07/02/2025. In an interview on 07/22/2025 at 3:30PM, S1Administrator indicated he was informed on 07/02/2025 that Resident #110 hit Resident #62 and punched Resident #180. S1Adminstrator further indicated he did not report the incidents of resident to resident physical abuse to the state agency as required.

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	07/23/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to ensure an incident of resident to resident physical abuse was thoroughly investigated for 1 (Resident #110) of 1 (Resident #110) sampled residents identified to have physically abused residents during a mood and behavior investigation.Findings:Review of the facility's policy and procedure titled, Abuse-Prevention and Prohibition dated 03/25/2023 revealed, in part, the administrator should complete a thorough investigation of allegations of abuse to include interviews with employees and the administrator should obtain signed statements from the employees. Further review revealed the investigator should interview cognitive residents involved or the roommate if the resident was cognitively impaired. Review of Resident #110's incident report dated 07/02/2025 revealed, in part, Resident #110 hit Resident #62 and punched Resident #180 in the chest.In an interview on 07/23/2025 at 8:50AM, Resident #62 indicated Resident #110 entered her room and hit her legs several times with a closed fist. Resident #62 further indicated Resident #110 punched her roommate, Resident #180. There was no documented evidence, and the provider could not present any documented evidence, a thorough investigation, that included witness statements from nurses and cognitive residents, was completed for the above mentioned resident to resident physical abuse incident. In an interview on 07/23/2025 at 10:25AM, S15Corporate Administrator indicated the facility did not have witness statements for the incident of resident to resident physical abuse which occurred on 07/02/2025. In an interview on 07/23/2025 at 10:25AM, S2Corporate Nurse indicated the facility did not have witness statements for the incident of resident to resident physical abuse which occurred on 07/02/2025. In an interview on 07/23/2025 at 11:15AM, S2Corporate Nurse confirmed the above mentioned resident to resident physical abuse incident was not thoroughly investigated.

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	07/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to:1. Ensure staff used soap and water to perform hand hygiene for a resident on physician ordered contact precautions for Clostridium Difficile (a highly contagious encapsulated bacteria that causes severe abdominal pain and diarrhea and is resistant to alcohol based hand sanitizer [ABHS])(C. Difficile) (Resident #75);2. Ensure staff wore proper personnel protective equipment (PPE) while caring for a resident on C. Difficile contact isolation precautions (Resident #75); and,3. Ensure housekeeping used the proper cleaning agent to clean and disinfect a room on contact isolation precautions for C. Difficile (Resident #75). This deficient practice was identified for 1 (Resident #75) of 1 (Resident #75) sampled residents investigated for infection control surveillance. Findings:1.Review of the facility's Hand Hygiene policy and procedure, dated 07/01/2020, revealed, in part, after contact with a resident with infectious diarrhea, including C. difficile, hands shall be washed with soap and water. Review of the facility's Isolation policy and procedure, dated 11/30/2020, revealed, in part, alcohol rub is not effective in eradicating C. Difficile spores, therefore handwashing with soap and water was required prior to exiting room. Further review revealed if gloves were to become exposed to the pathogen while in the resident's room, staff should discard gloves, wash hands, and reapply gloves. Further review revealed after cleaning room, wash hands thoroughly with soap and water prior to exiting room. Review of Resident #75's July 2025 physician's orders revealed, in part, an order for contact precautions with strict isolation related to an active infection of C. Difficile. Observation on 07/21/2025 at 10:30AM revealed no signage on the outside or inside of Resident #75's room door indicating staff members should use soap and water to clean their hands. Further observation revealed, a contact isolation sign with a picture of ABHS being used to clean hands. Observation on 07/22/2025 at 1:25PM revealed S11Certified Nursing Assistant (CNA) entered Resident #75's room to perform catheter care and incontinence care. S11CNA cleaned Resident #75's catheter tubing, then changed gloves using ABHS without washing her hands with soap and water. S11CNA then removed Resident #75's urine and feces soiled brief, cleaned Resident #75's buttock area of feces, and placed a clean brief on Resident #75 without washing her hands with soap and water in between glove changes. In an interview on 07/22/2025 at 2:15PM, S11CNA indicated she did not use soap and water to wash her hands in between glove changes and should have. In an interview on 07/23/2025 at 9:12AM, S12Housekeeper confirmed she was assigned to clean Resident #75's room. S12Housekeeper further indicated she had just completed cleaning Resident #75's room and used ABHS to clean her hands upon completion. S12Housekeeper further indicated she did not use soap and water to wash her hands prior to exiting Resident #75's room. In an interview on 07/22/2025 at 3:10PM, S3Director of Nursing confirmed the contact precautions sign on Resident #75's door was the only visual sign posted for notifying staff of Resident #75's precautions. S3DON could not provide any further explanation as to why there was no signage requiring staff to wash their hands with soap and water. In an interview on 07/23/2025 at 11:16AM, S7Infection Control Nurse (ICN) confirmed there was no signage on the outside or inside of Resident #75's room which indicated staff members should use soap and water to wash their hands before leaving the room and should have been. S7ICN further confirmed the facility's policy indicated ABHS was not effective against C. Difficile and S11CNA and S12Housekeeper should have washed their hands with soap and water. 2.Review of the facility's Isolation policy and procedure, dated 11/30/2020, revealed, in part, contact isolation infections such as C. Diff, are transmitted via contact or indirect contact with the resident or the resident's environment; therefore, gown and gloves are to be utilized for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Further review revealed gloves are to be utilized at all times. If gloves become exposed to the pathogen while in the resident's room, discard gloves, wash hands, and reapply gloves. Observation on 07/22/2025 at 1:25PM revealed S11CNA entered Resident #75's room to perform catheter care and incontinence care. Upon completing care, S11CNA removed her soiled (continued on next page)

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	07/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves and used ABHS to perform hand hygiene. S11CNA then used her ungloved hands to cover Resident #75 with his used linen. Further observation revealed, S9Wound Care Nurse entered Resident #75's room to perform a sacral wound dressing change. Upon completion of the dressing change, S11CNA recovered Resident #75 with his used linens using her ungloved hands. In an interview on 07/22/2025 at 2:15PM, S11CNA indicated she could not provide any explanation as to why she did not put on new gloves before handling Resident #75's used linen. In an interview on 07/23/2025 at 11:16AM, S7ICN indicated all of the surfaces in Resident #75's room are potentially contaminated with C Difficile spores; therefore, staff members should wear gloves at all times while inside Resident #75's room. 3.Review of the facility's Isolation policy and procedure, dated 11/30/2020, revealed, in part, cleaning of an isolation room should be with bleach wipes with a 1:10 bleach solution or bleach wipes that kill C. Difficile spores. Observation on 07/23/2025 at 9:00AM revealed S12Housekeeper exiting Resident #75's room carrying a bottle of Micro-kill Q3 general disinfectant. In an interview on 07/23/2025 at 9:12AM, S12Housekeeper indicated she used MicroKill Q3 general disinfectant and Multisurface peroxide to clean Resident #75's room. S12Housekeeper indicated she did not know if the general cleaner was effective against C. Difficile. Review of the Environmental Protection Agency's (EPA) Registered Antimicrobial Products Effective against Clostridium Difficile Spores list, updated 02/2025, revealed, in part, the above mentioned general disinfectants were not on the list of effective agents against C. Difficile. In an interview on 07/23/2025 at 10:55AM, S6Housekeeping Supervisor (HS) indicated S12Housekeeper should have used Micro-kill bleach wipes to clean Resident #75's room. S6HS further indicated the above mentioned general cleaning solution used to clean Resident #75's room was not effective against C. Difficile and should not have been used in Resident #75's room. In an interview on 07/23/2025 at 11:16AM, S7ICN confirmed the Micro-kill Q3 general cleaner was not effective against C-Difficile spores. S7ICN further confirmed S12Housekeeper should have used the Micro-kill bleach wipes and/or a bleach solution to clean Resident #75's room. In an interview on 07/23/2025 at 1:30PM, S1Administrator was presented with the above mentioned findings and offered no further explanation for the deficient practice.

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	07/23/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations and interviews the facility failed to maintain an effective pest control management program for 7 (Resident #16, Resident #24, Resident #67, Resident #72, Resident #95, Resident #139, Resident #148) of 7 (Resident #16, Resident #24, Resident #67, Resident #72, Resident #95, Resident #139, Resident #148) sampled resident rooms observed for pests, 1 (Hall C) of 3 (Hall C, Hall D, Hall E) sampled halls reviewed for environment, and for 2 (Dining Room A, Dining Room B) of 2 (Dining Room A, Dining Room B) sampled dining rooms observed during dining observations. Findings:Observation on 07/21/2025 at 10:30AM revealed a brown flying insect in Resident #148's room.In an interview on 07/21/2025 at 10:47AM, Resident #24 indicated it bothered her that there were flying insects in her room. Observation on 07/21/2025 at 10:48AM revealed brown flying insects in Resident #24's room. Observation on 07/21/2025 at 11:14AM revealed a brown flying insect in Resident #95's room. Observation on 07/21/2025 at 11:26AM revealed two brown flying insects on Resident #67's blanket while she was in bed. Observation on 07/21/2025 at 11:27AM revealed two brown flying insects on Resident #72's blanket while she was in bed. Observation on 07/21/2025 at 11:35AM revealed a brown flying insect on Resident #16's food on her breakfast tray in her room. Observation on 07/21/2025 11:43AM revealed a brown flying insect landed on the surveyor's arm in Dining Room A. Observation on 07/21/2025 at 12:30PM revealed two brown flying insects were present in Dining Room B. Observation on 07/21/2025 at 3:43PM revealed a brown flying insect were present on Hall C.Observation on 07/22/2025 at 11:30AM revealed brown flying insects were present in Dining Room A. Observation on 07/22/2025 at 3:40PM revealed a brown unknown flying insect was present in Dining Room A. In an interview on 07/22/2025 at 12:38PM, Resident #139 indicated a brown flying insect landed on her bread this morning at breakfast. In an interview on 07/22/2025 at 1:34PM the facility's contracted pest management company's administrator indicated they had not received any reports from the facility regarding brown flying insects. In an interview on 07/22/2025 at 1:55PM, S1Administrator indicated he was not aware of the presence of brown flying insects in the above mentioned areas of the facility.

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	07/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record reviews, the facility failed to protect the residents' right to be free from physical abuse by a resident for 1 (Resident #110) of 1 (Resident #110) sampled residents identified to have physically abused residents during a mood and behavior investigation. Findings: Review of the facility's policy and procedure titled, Abuse - Prevention and Prohibition, and dated 03/25/2023 revealed in part, physical abuse included hitting, slapping, pinching, biting, shoving, and kicking. Further review revealed each resident has the right to be free from abuse. Review of Resident #110's incident report dated 07/02/2025 revealed, in part, Resident #110 hit Resident #62 and punched Resident #180 in the chest. Review of S1Administrator's documentation dated 07/02/2025 revealed, in part, Resident #110 slapped Resident #62 on the foot and punched Resident #180 in the upper chest. In an interview on 07/23/2025 at 8:50AM, Resident #62 indicated Resident #110 entered her room and hit her legs several times with a closed fist. Resident #62 further indicated Resident #110 punched her roommate, Resident #180. Resident #180 was unable to be interviewed due to her cognitive status. In an interview on 07/23/2025 at 3:23PM, S16Licensed Practical Nurse (LPN) indicated she witnessed Resident #110 hit Resident #62. S16LPN further indicated she then attempted to remove Resident #110 from Resident #180's bed and Resident #110 became upset and punched Resident #180 in the chest with a closed fist. In an interview on 07/22/2025 at 3:30PM, S1Administrator acknowledged Resident #110 hit Resident #62 and Resident #180.

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	07/23/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interviews and record reviews, the facility failed to ensure:1. The skilled nurse documented adequate indication for use of an anti-psychotic (medication used to treat psychosis) medication used on an as needed (PRN) basis (Resident #3); and,2. The physician re-evaluated the use of an anti-psychotic used on a PRN basis and documented the rational and duration for an as needed (PRN) anti-psychotic drug (Resident #3). This deficient practice was identified for 1 (Resident #3) of 5 (Resident #3, Resident #16, Resident #98, Resident #110 Resident #119) sampled residents investigated for unnecessary medications. Findings:Review of Resident #3's record revealed diagnoses of, in part, unspecified dementia (condition which caused atrophy of the brain with loss of cognitive function), delusional disorder (condition which caused altered reality), major depressive disorder (condition which caused prolonged episodes of sadness), and psychosis (condition which caused altered reality). Review of Resident #3's July 2025 Physician Order revealed, in part, Haldol 1mg give one tablet by mouth every 24 hours as needed for agitation with an order date of 05/15/2025. 1.Review of Resident #3's July 2025 electronic Medication Administration Record (eMAR) revealed, in part, 1mg of Haldol was administered to Resident #3 on 07/05/2025 at 6:42PM. Further review of Resident #3's July 2025 eMAR revealed on 07/05/2025 on the evening and night shifts Resident #3 was documented as monitored for behaviors of agitation with no behaviors present. Review of Resident #3's Nurses Notes dated 07/05/2025 revealed Haldol was administered and was effective. There was no documented evidence, and the facility did not present any documented evidence, of the behaviors which were the indication for the administration of Haldol 1mg PRN, nor the non-pharmacological interventions attempted prior to having administered the PRN Haldol 1mg. In an interview on 07/23/2025 at 4:40PM, S2Corporate Nurse indicated the facility did not have any documentation of the reason for the administration of the as needed Haldol other than agitation, or the documentation of any non-pharmacological interventions attempted for Resident #3's agitation prior to the administration of the as needed Haldol. 2.Review of Resident #3's Pharmaceutical Consultant Report dated 05/20/2025 revealed, in part, the consultant pharmacist made a recommendation to limit the use of as needed antipsychotics to 14 days, and to provide a diagnosis code for Haldol. There was no documented evidence, and the facility did not present any documented evidence, Resident #3's physician evaluated Resident #3 for the continued use of Haldol or documented: If Resident #3 still required Haldol 1 mg on a PRN basis;The benefits Haldol 1 mg provided to Resident #3; and/or,If Resident #3's expressions or indications of distress improved because of the PRN medication. In an interview on 07/23/2025 at 4:40PM, S2Corporate Nurse indicated the facility did not have documented evidence Resident #3's physician evaluated Resident #3 for the continued use of Haldol 1mg after it was ordered on 05/15/2025, or the duration of the order.

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	07/23/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's fingernails were maintained for 1 (Resident #174) of 2 (Resident #119, Resident #174) sampled residents investigated for activities of daily living (ADL). Findings:Review of Resident #174's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 5/21/2025, revealed Resident #174 required substantial/maximal assistance with personal hygiene.Review of Resident #174's Care Plan revealed Resident #174 required staff assistance with ADL care with an initiation date of 10/11/2024. Observation on 07/21/2025 at 10:29AM revealed the fingernails on Resident #174's right and left hands extended past the end of the tip of Resident #174's fingers. Further observation revealed the fingernails on Resident #174's right 3rd finger (middle finger) and 5th finger (the smallest finger or the finger furthest from the thumb) were approximately one-fourth of an inch past Resident #174's fingertips. Observation on 07/22/2025 at 8:24AM revealed the fingernails on Resident #174 right and left hands extended past the end of the tip of Resident #174's fingers. Further observation revealed the fingernails on Resident #174's right 3rd finger and 5th finger were approximately one-fourth of an inch past Resident #174's fingertips. In an interview on 07/22/2025 at 4:17PM, S5Assistant Director of Nursing (ADON) indicated a resident's fingernails were to be trimmed as needed by the Certified Nursing Assistants (CNA) during showers and by activities personnel during scheduled rounding. Observation on 07/22/2025 at 4:51PM conducted with S4ADON revealed, in part, S4ADON was at Resident #174's bedside. Further observation revealed the fingernails on Resident #174's right and left hands extended past the end of the tip of Resident #174's fingers. Further observation revealed the fingernails on Resident #174's right 3rd finger and 5th finger were approximately one-fourth inch past Resident #174's fingertips and Resident #174's right 5th fingernail was jagged.In an interview on 07/22/2025 at 4:51PM, S4ADON confirmed the fingernail growth to Resident #174's right and left hands were long and extended past his fingernails and should not have. S4ADON further acknowledged the fingernail's on Resident #174's right hand were long and the length on the right 3rd finger and right 5th finger were excessive. S4ADON indicated Resident #174's nails appeared to not have been trimmed in a couple of weeks. S4ADON confirmed Resident #174's fingernails should have been trimmed prior to this observation.In an interview on 07/23/2025 at 10:46AM, S18ACT stated nails should not be long. S18ACT indicated fingernails should be trimmed if they extend past the tip of the finger. In an interview on 07/23/2025 at 2:10PM, S4ADON indicated, in part, she would expect a resident's fingernails to be trimmed if they extended past the tip of the finger.

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	07/23/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record reviews, the facility failed to ensure chemicals in the beauty shop room were secured and not accessible to wandering residents. Findings:Review of the facility's Wandering Residents List revealed, in part, 11 residents were identified by the facility as at risk for wandering. Observation on 07/21/2025 at 1:05PM revealed the facility's beauty shop room was unlocked, open, and unmonitored. Further observation revealed a container of blue solution labeled Barbicide on the counter not secured. Review of the Barbicide Safety Data Sheet provided by the facility, dated 06/14/2018, revealed, in part, the chemical was irritating to skin and eyes and harmful if swallowed and poison control should be called immediately if ingested. Further review revealed safety glasses and googles should be worn when handling the chemical. In an interview on 07/23/2025 at 12:00PM, S6Housekeeping Supervisor (HS) confirmed the beauty room should be closed and locked when unmonitored or unsupervised. S6HS further confirmed the Barbicide chemical was in the beauty room, unsecured on the counter, and should not have been accessible to residents. In an interview on 07/23/2025 at 1:30PM, S1Administrator was presented with the above mentioned findings and offered no further explanation for the deficient practice.

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to have evidence a resident's oxygen tubing was changed weekly for 1 (Resident #74) of 2 (Resident #74, Resident #187) residents reviewed for respiratory care. Findings: Review of the facility's Oxygen Administration Policy and Procedure dated 11/16/2014 revealed, in part, at regular intervals, the facility staff were responsible to check and clean oxygen equipment, masks, tubing and cannula. Review of Resident #74's electronic health record revealed diagnoses of chronic obstructive pulmonary disease with an acute exacerbation (lung disease that blocks air flow) and acute chronic respiratory failure with hypoxia (absence of oxygen in body tissue).Review of Resident #74's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/28/2025 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 15 (score of 08-15) which indicated Resident #74 was cognitively intact. Further review revealed Resident #74 required oxygen. Review of Resident #74's physician orders dated 08/13/2024 revealed, in part, an active order to change Resident #74's oxygen tubing every week and as needed. Observation on 07/22/2025 at 10:14 AM revealed Resident #74's oxygen tubing was not dated. Observation on 07/22/2025 at 8:50AM revealed Resident #74's oxygen tubing was not dated. Observation on 07/23/2025 at 8:34AM revealed Resident #74's oxygen tubing was not dated.In an interview on 07/23/2025 at 8:35AM, Resident #74 indicated the facility staff did not change her oxygen tubing weekly as required.In an interview on 07/23/2025 at 8:43AM, S24Clinical Care Specialist indicated oxygen tubing should be changed as required per physician orders. In an interview on 07/23/2025 at 10:03AM, S3Director of Nursing indicated Resident #74's oxygen tubing should be changed as required per physician orders.

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	07/23/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure food was stored in a sanitary manner. Findings:Observation on 07/21/2025 at 8:45AM revealed an employee's frozen drink was present in the facility's freezer. In an interview on 07/21/2025 at 8:46AM, S8Dietary Manager indicated the employee's frozen drink should not have been stored in the facility's freezer. In an interview on 07/21/2025 at 1:20PM, S1Administrator confirmed the employee should not have stored her frozen drink in the facility's freezer. Observation on 07/22/2025 at 12:21PM revealed a bottle of clear liquid labeled with S21Dietary Aide's name and date stored in the facility's freezer. In an interview on 07/22/2025 at 12:22PM, S21Dietary Aide confirmed she had placed her water bottle in the facility's freezer. S21Dietary Aide further indicated she should not have put her bottle of water in the facility's freezer. In an interview on 07/22/2025 at 12:23PM, S8Dietary Manager confirmed S21Dietary Aide should not have put her water in the facility's freezer.

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	07/23/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interview, the facility failed to post the required nurse staffing information at the beginning of each shift daily for 3 (07/21/2025, 07/22/2025, 07/23/2025) of 3 (07/21/2025, 07/22/2025, 07/23/2025) days observed for nurse staffing information. Findings:Observation on 07/21/2025 at 10:07AM revealed the facility's posted nurse staffing information dated 07/21/2025 did not include the facility's daily census. Observation on 07/22/2025 at 10:15AM revealed the facility's posted nurse staffing information dated 07/22/2025 did not include the facility's daily census. In an interview on 07/22/2025 at 3:05PM, S3Director of Nursing indicated he did not know what information was required to be on the facility's posted nurse staffing information. Observation on 07/23/2025 at 12:30PM revealed the facility's posted nurse staffing information dated 07/23/2025 did not include the facility's daily census. In an interview on 07/23/2025 at 1:00PM, S2Corporate Nurse confirmed the facility's daily staffing report form should be posted every morning and include the facility's current daily census. In an interview on 07/23/2025 at 1:30PM, S1Administrator was presented with the above mentioned findings and offered no further explanation for the deficient practice.