

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER Chateau St. James Rehab and Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 1980 Jefferson Hwy Lutcher, LA 70071	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure a resident's care plan was revised to reflect a resident's individualized needs following a significant change in condition.</p> <p>This deficient practice was identified for 1 (Resident #2) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5) sampled residents reviewed for quality of care.</p> <p>Findings:</p> <p>Review of Resident #2's Quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 03/20/2025 revealed, in part, Resident #2 no wandering behaviors noted and required a walker or wheelchair for locomotion. Further review revealed Resident #2 required supervision or touching assistance with eating, performing oral hygiene, personal hygiene, bathing or showering, and partial and moderate assistance with toileting hygiene.</p> <p>Review of Resident #2's Significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/02/2025 revealed, in part, Resident #2 had no wandering behaviors noted and required substantial or maximal assistance performing personal hygiene, bathing or showering, chair to bed transfers, toileting transfers, and toileting hygiene.</p> <p>Review of Resident #2's Physician's Orders revealed, in part, on 01/02/2025 Resident #2 had an order to place a wander guard to Resident #2's right ankle due to wandering and exit seeking. Further review revealed on 04/24/2025 Resident #2 had an order to remove his wander guard due to Resident #2's status changed to being bedbound.</p> <p>Resident #2 was at risk for falls which included interventions for a fall mat at bedside, encourage Resident #2 to utilize walker while ambulating, ensure resident has on proper footwear when up out of bed, and ensure the call light was within reach.</p> <p>Review of Resident #2's Care Plan header revealed, in part, a special instructions warning which indicated Resident #2 was a fall risk and required rounding every hour, a fall mat at the bedside while Resident #2 was in bed, and that Resident #2 was a wanderer and had a wander guard on Resident #2's right ankle. Further review revealed, this care plan header was also visible to nursing staff on Resident #2's profile in his electronic record.</p> <p>(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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/27/2025 at 3:23PM, Resident was noted lying in bed and had no fall mat at bedside and call light/button was on the floor behind Resident #2's bed on the floor out of reach. Resident #2 was unable to state if he had any falls recently or how to call for staff when he needs assistance, Resident #2 could not say where his call light/button was.</p> <p>In an interview on 05/27/2025 at 3:25PM, S6Certified Nursing Assistant (CNA) indicated Resident #2 did not remember to ask for assistance, she stated he use to have a fall mat but was unsure if he still required one.</p> <p>In an interview on 05/27/2025 at 4:05PM, S2Assistant Director of Nursing (ADON) indicated Resident #2's order for a fall mat by bedside while Resident #2 was in bed should have been discontinued because Resident #2 was now bed bound and was no longer mobile.</p> <p>In an interview on 05/28/2025 at 2:55PM, S4Licensed Practical Nurse indicated that Resident #2 was unable to use the call bell to call for assistance, and will call out for assistance and was bedbound now.</p> <p>In an interview on 05/28/2025 at 3:51PM, S5Licensed Practical Nurse indicated Resident #2's care plan should be updated and revised with all significant changes and quarterly assessments. S5 Licensed Practical Nurse further indicated Resident #2's care plan should have been updated and revised with individual interventions.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, interviews, and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1) obtain settings for Continuous Positive Airway Pressure (CPAP) administration (Resident #1); and, 2) follow a physician's order for oxygen administration (Resident #2). <p>This deficient practice was identified for 2 (Resident #1, Resident #2) of 3 (Resident #1, Resident #2, Resident #5) sampled residents reviewed for respiratory care in a total sample of 5.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> Review of the facility's CPAP/bi-level positive airway pressure (BPAP) Support policy and procedure revised on 03/2015 revealed, in part, the purpose was to improve oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or obstructive lung disease. Further review revealed staff was to review the physician's order to determine the oxygen concentration and flow, and the positive end-expiratory pressure (PEEP). Further review revealed staff was to set mode for CPAP settings on the machine as prescribed. Review of Resident #1's Minimum Data Set with an assessment reference date of 03/09/2025 revealed, in part, Resident #1 had a medical history of chronic respiratory failure, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and received oxygen therapy. Review of Resident #1's May 2025 Physician's Orders revealed, in part, staff were to check and fill Resident #1's CPAP canister with distilled water at bedtime. Further review revealed no documented evidence, and the facility was unable to present any evidence Resident #1 had a physician order which included settings for oxygen concentration, flow, and pressure for the CPAP to be administered. In an interview on 05/28/2025 at 1:19PM, S1Quality Improvement (QI) Nurse confirmed Resident #1 did not have a physician order which included settings for oxygen concentration, flow, and pressure for CPAP administration as required. 2. <ul style="list-style-type: none"> Review of facility's Oxygen Administration policy and procedure with a revision date of February 2025, revealed, in part, staff was to review physician's orders to determine the proper flow of oxygen to be administered for safe oxygen administration, and infection prevention associated with respiratory therapy tasks. Review of Resident #2's Physician's Orders dated 05/15/2025 revealed, in part, Resident #2's oxygen was to be administered at 2 Liters per minute (LPM) via nasal cannula (a device that gives you additional oxygen through your nose). <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/27/2025 at 3:23PM revealed, Resident #2 was lying in bed with oxygen set to be administered at 3LPM via nasal cannula.</p> <p>Observation on 05/27/2025 at 4:02PM revealed, Resident #2 was lying in bed with oxygen set to be administered at 3LPM via nasal cannula. Further observation revealed Resident #2's nasal cannula was not positioned correctly over both nares.</p> <p>In an interview on 05/27/2025 at 4:05PM, S2Assistant Director of Nursing (ADON) verified that Resident #2's oxygen was not set at 2LPM via nasal cannula.</p> <p>In an interview on 05/27/2025 at 4:07PM, S3Licensed Practical Nurse confirmed Resident #2's oxygen was to be administered at 2LPM via nasal cannula, and was not.</p>		