STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195304	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau St. James Rehab and Retirement	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)
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. Based on observations, interviews, and record reviews, the facility failed to:1. Ensure weighted sandbag (weighted base to prevent something from tipping over) located on a resident's intravenous pole (pole to hold fluids or equipment), and enteral feeding pump (equipment used to deliver liquid nutrition) was maintained in a sanitary manner (Resident #12); and,2. Ensure a resident's wheelchair was maintained in a sanitary manner (Resident #43). This deficient practice was identified for 2 (Resident #12, Resident #43) of 61 sampled resident rooms observed for environmental requirements. Findings:1.Review of Resident #12's quarterly Minimum Data Set with an Assessment Reference Date of 09/24/2025 revealed, in part, Resident #12 received enteral nutrition (liquid/formula going directly into the stomach) through an enteral feeding pump. Observation on 12/08/2025 at 9:53AM revealed several areas of a dried tan colored unknown substance which covered 25% of Resident #12's enteral feeding pump handle and several areas of a dried tan colored unknown substance which covered 25% of Resident #12's left side of the enteral feeding pump. Further observation revealed several areas of a dried tan colored unknown substance which covered 80% of Resident #12's weighted sandbag located on Resident #12's intravenous pole. Observation on 12/09/2025 at 9:05AM revealed several areas of a dried tan colored unknown substance which covered 25% of Resident #12's enteral feeding pump handle and several areas of a dried tan colored unknown substance which covered 25% of Resident #12's left side of the enteral feeding pump. Further observation revealed several areas of a dried tan colored unknown substance which covered 80% of Resident #12's weighted sandbag located on Resident #12's intravenous pole. Observation on 12/09/2025 at 9:29AM revealed several areas of a dried tan colored unknown substance which covered 25% of Resident #12's enteral feeding pump handle and several areas of a dried tan colored unknown substance which covered 25% of Resident #12's left side of the enteral feeding pump. Further observation revealed several areas of a dried tan colored unknown substance which covered 80% of Resident #12's weighted sandbag located on Resident #12's intravenous pole. In an interview on 12/09/2025 at 9:32AM, S4Licensed Practical Nurse further indicated she did not noticed the condition of Resident #12's enteral feeding pump and Resident #12's weighted sandbag located on Resident #12's intravenous pole. S4Licensed Practical Nurse further indicated Resident #12's enteral feeding pump and Resident #12's weighted sandbag located on Resident #12's intravenous pole should have been maintained in a sanitary manner. In an interview on 12/09/2025 at 9:35AM, S2Director of Nursing indicated Resident #12's enteral feeding pump and Resident #12's weighted sandbag located on Resident #12's intravenous pole was not maintained in a sanitary manner, and should have. In an interview on 12/09/2025 at 9:50AM, S1Administrator indicated Resident #12's enteral feeding pump and Resident #12's weighted sandbag located on Resident #12's intravenous pole was not maintained in a sanitary manner, and should have. 2. Review of Resident #43's quarterly Minimum Data Set with and Assessment Reference Date of 10/15/2025 revealed, in part, Resident #43 used a wheelchair for mobility. Review of the facility's Wheelchair Cleaning Assignment Log for the time period of 11/09/2025 to 11/15/2025 revealed, in part, Resident #43's wheelchair was last cleaned on Tuesday during the week of 11/09/2025 to 11/15/2025. Observation on 12/08/2025 at 9:39AM revealed Resident #43's wheelchair had multiple (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	areas of a dried white colored unknown substance which covered 25% on the left side Resident #43's wheelchair seat and multiple areas of a dried white colored unknown substance which covered 25% of the left side of Resident #43's wheelchair leg. Observation on 12/09/2025 at 11:47AM revealed Resident #43's wheelchair had multiple areas of a dried white colored unknown substance which covered 25% on the left side Resident #43's wheelchair seat and multiple areas of a dried white colored unknown substance which covered 25% of the left side of Resident #43's wheelchair leg Observation on 12/10/2025 at 8:55AM revealed Resident #43's wheelchair had multiple areas of a dried white colored unknown substance which covered 25% on the left side Resident #43's wheelchair seat and multiple areas of a dried white colored unknown substance which covered 25% of the left side of Resident #43's wheelchair leg In an interview on 12/09/2025 at 11:47AM Resident #43 indicated her wheelchair was dirty and had not been cleaned. In an interview on 12/10/2025 at 10:52AM, S3Assistant Director of Nursing indicated Resident #43's wheelchair was not cleaned as scheduled, was not maintained in a sanitary manner, and should have been. In an interview on 12/10/2025 at 11:30PM, S1Director of Nursing indicated Resident #43's wheelchair was not maintained in a sanitary manner, and should have.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interviews and record reviews, the facility failed to ensure staff had ongoing communication and collaboration with the resident's dialysis provider regarding the resident's dialysis care and services for 1 (Resident #7) of 1 sampled resident investigated for dialysis requirements. Findings:Review of the facility's End-Stage Renal Disease, Care of a Resident, undated, policy revealed, in part, that agreements between the facility and the end stage renal disease facility should include all aspects of how the resident's care would be managed, including how information would be exchanged between the facility and dialysis center facility's. Review of Resident #7's electronic medical record revealed, in part, Resident #7 had an admission date of 11/18/2025 and a diagnosis of end stage renal disease (loss of kidney function). Review of Resident #7's electronic medical record revealed, in part, an order for Resident #7 to receive dialysis every Monday, Wednesday, and Friday, for the facility staff to review the facility's dialysis communication sheet/form every Monday, Wednesday, and Friday, and for the facility staff to review the dialysis communication sheet/form for any records and/or orders every Monday, Wednesday, and Friday after dialysis care and services. Review of Resident #7's admission Minimum Data Set with an Assessment Reference Date of 11/24/2025 revealed, in part, Resident #7 received dialysis services. Review of provider's dialysis communication binder for Resident #7 revealed, in part, no dialysis communication sheet/forms had been completed since 11/25/2025. In an interview on 12/09/2025 at 9:32AM, S4Licensed Practical Nurse indicated she had not received Resident #7's dialysis communication sheet/form for Monday 12/08/2025 when Resident #7 returned from her scheduled dialysis treatment. S4Licensed Practical Nurse further indicated she had not called the dialysis provider for Resident #7's dialysis communication sheet/form, and should have. In a telephone interview on 12/09/2025 at 11:39AM, Resident #7's dialysis provider's administrator indicated he had not received a dialysis communication sheet/form from the facility to complete for Resident #7 after Resident #7 received dialysis on Monday, 12/08/2025. In an interview on 12/09/2025 at 12:54PM, S2Direcctor of Nursing indicated the facility's nursing staff were responsible to ensure a dialysis communication sheet/form was completed prior to the resident's scheduled dialysis service and when a resident returned from their scheduled dialysis service. S2Director of Nursing further indicated Resident #7 should have had a dialysis communication sheet/form for Sunday 11/23/2025, Wednesday 11/26/2025, Friday 11/28/2025, Friday 12/05/2025, and Monday 12/08/2025 when Resident #7 received dialysis services. In an interview on 12/10/2025 at 8:34AM, S7Licensed Practical Nurse indicated it was the nursing staff's responsibility to call the dialysis provider if a resident did not have a dialysis communication sheet/form when the resident returned to the facility after receiving dialysis treatment. In an interview on 12/10/2025 at 8:48AM, S6Ward Clerk indicated it was the nursing staff's responsibility to ensure the dialysis communication sheet/form was received from the dialysis provider after their scheduled dialysis treatment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and records review, the facility failed to administer a resident's enteral feeding (intake of food through a tube placed in the stomach) as ordered by the physician for 1 (Resident #25) of 1 sampled resident investigated for enteral nutritional requirements. Findings:Review of the facility's Enteral Tube Feeding via Continuous Pump policy with a revision date of 08/04/2019, revealed, in part, the enteral nutritional label and rate of administration (milliliters per hour) should be checked against the order before administration.Review of Resident #25's Quarterly Minimum Data Set with an Assessment Reference Date of 11/02/2025 revealed, in part, Resident #25 had a feeding tube placed directly into his stomach.Review of Resident #25's December 2025 order listing report revealed, in part, an order with a start date of 11/28/2025 for Isosource 1.5 at 50 milliliters per hour via feeding tube continuously.Observation on 12/08/2025 at 1:17PM revealed Resident #25's continuous tube feeding was infusing at 53 milliliters per hour via pump.Observation on 12/09/2025 at 8:55AM revealed Resident #25's continuous tube feeding was infusing 53 milliliters per hour via pump.In an interview on 12/09/2025 at 9:00AM, S5Licensed Practical Nurse indicated Resident #25's tube feeding should not have been infusing at 53 milliliters per hour and should have been infusing at 50 milliliters per hour as ordered.In an interview on 12/09/2025 at 9:14AM, S2Director of Nursing indicated Resident #25's tube feeding should not have been infusing at 53 milliliters/hour and should have been infusing at 50 milliliters per hour as ordered.