

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2024
NAME OF PROVIDER OR SUPPLIER  Chateau Napoleon Caring		STREET ADDRESS, CITY, STATE, ZIP CODE  252 Hwy. 402 Napoleonville, LA 70390	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48855</p> <p>Based on interviews and record reviews, the facility failed to immediately ensure a resident's physician was notified of a resident's change of condition in a timely manner 1 (Resident #2) of 3 (Resident #1, Resident #2, Resident #3) residents investigated for Quality of Care.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Resident Rights: Notification of Change of Condition and Room Changes, dated 03/2023, revealed, in part, the facility would promptly inform the resident, consult with the resident's physician, and notify the resident representative, consistent with his or her authority, when there was an accident that involved the resident, which resulted in injury, and had the potential for requiring physician interventions.</p> <p>Review of the facility's Incident Audit Report, dated 05/02/2024, revealed, in part, on 04/27/2024, Resident #2's wife reported Resident #2 had a blister to his left hand index finger from a cigarette burn.</p> <p>Review of the facility's electronic facsimile sheet dated 04/27/2024 revealed, in part, a faxed communication was sent to Resident #2's physician on 04/27/2024 that indicated Resident #2 sustained a blister to his left index finger. Resident #2's physician's office was faxed of the above mentioned blister from a cigarette burn on 04/27/2024.</p> <p>There was no documented evidence and the provider did not present any documented evidence to identify the time the faxed communication was sent to Resident #2's physician's office.</p> <p>There was no documented evidence and the provider did not present any documented evidence that Resident #2's physician was at the office when the facsimile was sent and read the above mentioned facsimile, and/or followed-up with Resident #2's physician to see if the facsimile was received and/or if there were any new orders.</p> <p>In an interview on 12/03/2024 at 9:14AM, S5Licensed Practical Nurse (S5LPN) indicated she notified Resident #2's physician by electronic facsimile on 04/27/2024 of Resident #2's above mentioned blister.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/03/2024 at 3:18PM, the medical receptionist at Resident #2's physician's office indicated the above mentioned facsimile sheet was sent to Resident #2's physician on 04/27/2024 at 7:44PM, but she did not have any documented evidence that Resident #2's physician reviewed the above mentioned facsimile sheet.</p> <p>In an interview on 12/03/2024 at 3:25PM, S5LPN indicated she called, texted, and faxed Resident #2's physician on 04/27/2024 indicating Resident #2's blister to his left hand index finger and did not receive any orders before the end of her shift.</p> <p>There was no documented evidence and the facility did not present any documented evidence that S5LPN called and/or texted Resident #2's physician of the blister to his left index finger.</p> <p>In an interview on 12/03/2024 at 3:32PM, S3Staff Development Coordinator indicated she had not received any orders from Resident #2's physician on her shift and did not call Resident #2's physician to follow-up on Resident #2's blister to the left finger.</p> <p>In an interview on 12/03/2024 at 3:53PM S2Director of Nursing (S2DON) indicated nursing staff should have notified and followed-up with Resident #2's physician timely.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46361</p> <p>48855</p> <p>Based on observations and interviews, it was determined the facility failed to ensure shower rooms were maintained in a clean and sanitary manner for 2 (shower room y and shower room z) of 2 shower rooms reviewed for physical environment.</p> <p>Findings included:</p> <p>Observation of shower room y on 12/02/2024 at 8:50 AM revealed, an unknown black/gray substance on the floor and base moldings in all 4 shower stalls. Further observation revealed several cracked tiles had an unknown black/gray substance along the cracked tile on the back wall of shower room y. Further observation revealed and unknown black/gray substance on the tiled floor around the toilet in shower room y. Further observation revealed 4 shower curtains had an unknown black/gray substance on both sides of the bottom of the shower curtains. Further observation of shower room y revealed two areas had missing tile molding which exposed sheet rock. Further observation of shower room y revealed an unknown orange/red substance on the metal ceiling supports.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/2024 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.</p> <p>In an interview on 12/02/2024 at 9:18 AM Resident #1 indicated he refused to use the shower room because it was too gross.</p> <p>Observation of shower room z on 12/02/2024 at 8:20 AM revealed cracked tiles along the left wall of the first stall with a black discoloration noted inside the cracks and around the edges of the tile. Further observation revealed 2 of the 4 shower curtains had smears of a black/gray unknown substance along the bottom of the curtain. Further review of the shower room z revealed in the left corner of the room on the floor and along the baseboard there was black/gray spots of an unknown substance.</p> <p>In an interview on 12/02/2024 at 8:50 AM, S9Certified Nursing Assistant (S9CNA) indicated the facility's housekeeping staff was responsible for cleaning the facility's shower room y and shower room z every day.</p> <p>In an interview on 12/02/2024 at 9:05 AM S1Administrator indicated the shower curtains in the shower room y and shower room z should not have an unknown black/gray substance on them, should be removed by housekeeping staff, and washed and/or disposed.</p> <p>In an interview on 12/02/2024 at 10:12 AM S1Administrator confirmed the above mentioned findings in shower room y and shower room z, and had nothing to present to dispute the above mentioned deficient practice.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on interviews, record reviews, and facility policy review, the facility failed to assist a resident and/or provide transportation for a residents podiatry (physician which treats disorders of the feet) appointment for 1 (Resident #1) of 3 sampled residents reviewed for foot care.</p> <p>Findings included:</p> <p>Review of the facility's undated Resident [NAME] of Rights Louisiana, revealed, in part, residents have the right to receive adequate and appropriate health care and support services consistent with rules promulgated by the Louisiana Department of Health.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/2024 revealed, in part, Resident #1 admitted to the facility on [DATE] and had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Further review revealed Resident #1 had diagnoses of, in part, chronic osteomyelitis (bone infection) to right ankle/foot and diabetes mellitus with polyneuropathy (high blood sugar levels that can cause nerve damage to feet and toes).</p> <p>Review of Resident #1's After Visit Summary, dated 08/29/2024 revealed, in part, Resident #1 had a scheduled podiatry appointment for 09/04/2024 at 9:00AM.</p> <p>Review of Resident #1's nursing Progress Note, dated 08/29/2024 revealed, in part, Resident #1 returned from a physician visit with a podiatry appointment scheduled for 09/04/2024, and the appointment was made with the ward clerk.</p> <p>Review of the facility's appointment book/calendar for appointments scheduled on 09/04/2024 revealed, in part, no documented evidence Resident #1 had attended the podiatry appointment on 09/04/2024 at 9:00AM.</p> <p>Review of Resident #1's IDT (interdisciplinary team) Care Plan Conference/Welcome Meeting, dated 11/06/2024 revealed, in part, Resident #1 would attend all scheduled appointments and would be put on the podiatry list.</p> <p>In an interview on 12/02/2024 at 9:18AM, Resident #1 indicated he had a podiatry appointment scheduled for 09/04/2024 which he did not attend. Resident #1 further indicated he had notified the facility staff that he wanted to be assessed by the podiatrist, but had not been seen by a podiatrist since admission.</p> <p>In an interview on 12/03/2024 at 11:34AM, S8Social Service Worker (SSW) indicated Resident #1 was not on the podiatry list to be seen when the podiatrist made rounds in the facility on 10/02/2024.</p> <p>In an interview on 12/03/2024 at 11:36AM, S7Ward Clerk indicated she was responsible for placing appointments for residents in the appointment book/calendar after being reviewed by the nurse. S7Ward Clerk further indicated she had no knowledge of having received Resident #1's After Visit Summary, dated 08/29/2024 and had not documented the appointment in the facility's appointment book/calendar.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/03/2024 at 1:50PM, S2Director of Nursing (DON) confirmed Resident #1's podiatry appointment scheduled for 09/04/2024 was missed. S2DON indicated after Resident #1 did not attend his scheduled podiatry appointment on 09/04/2024, staff should have rescheduled the appointment and/or had Resident #1 seen by the in house podiatrist who made rounds in the facility on 10/02/2024. S2DON confirmed the facility had not assisted Resident #1 with his foot care as required.</p>

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on interviews, facility policy, and record reviews, it was determined facility failed to ensure a resident was seen by a physician in a timely manner for 1 (Resident #1) of 3 sampled residents reviewed for physician visits.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Physician Services Physician Visits and Physician Delegation of Visits, dated 03/2023 revealed, in part, a physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Further review revealed the requirement for physician visits can be satisfied in accordance with stated law by a Non Physician Practitioner (NPP).</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/2024 revealed, in part, Resident #1 admitted to the facility on [DATE] and had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.</p> <p>Review of Resident #1's medical record revealed, in part, Resident #1 was seen by the physician on 08/21/2024, 08/27/2024, 10/08/2024, and 11/05/2024. Further review revealed Resident #1 was seen by the physician on 08/27/2024 and not seen again until 10/08/2024 which was greater than 10 days from the required date.</p> <p>In an interview on 12/02/2024 at 9:18AM, Resident #1 indicated he was not being seen by his primary physician on a regular basis.</p> <p>In an interview on 12/03/2024 at 3:55PM, S2Director of Nursing (DON) confirmed the facility had no documented evidence Resident #1 was seen by the physician or NPP no later than 10 days after the date the visit was required (09/26/2024).</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46361</p> <p>Based on record reviews and interviews, it was determined the facility failed to obtain laboratory services per physician's order for 1 (Resident #1) of 3 sampled resident's records reviewed for pharmaceutical services.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/2024 revealed, in part, Resident #1 was admitted to the facility on [DATE] and had diagnoses of, in part, chronic myeloid leukemia not having achieved remission (blood cancer), chronic osteomyelitis (bone infection) to the right ankle/foot, diabetes mellitus with polyneuropathy (high blood sugar levels that can cause nerve damage to feet and toes), hypertension (high blood pressure), and hyperlipidemia (high cholesterol).</p> <p>Review of Resident #1's Physician Orders, for the month of 12/2024 revealed, in part, an order dated 09/23/2024, for Complete Blood Count (CBC) (a blood test which measures the number and size of the different cells in your blood) and Comprehensive Metabolic Panel (CMP) (a blood test which gives information on the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are functioning) to be drawn weekly on Mondays.</p> <p>Review of Resident #1's medical record revealed the facility had no documented evidence and the facility did not present any documented evidence Resident #1's CBC and CMP were drawn on the following dates: 09/23/2024, 09/30/2024, 10/14/2024, 10/21/2024, 11/04/2024, 11/18/2024, and 11/25/2024.</p> <p>In an interview on 12/03/2024 at 3:55PM, S2Director of Nursing (DON) indicated routine laboratory test were drawn on Monday, Wednesday, and Fridays by a laboratory testing company, but the company did not draw the laboratory tests as scheduled. S2DON confirmed the facility's nursing staff should have drawn the laboratory tests when the laboratory testing company did not draw laboratory tests as scheduled. S2DON confirmed the facility had no evidence Resident #1 had a CBC and/or a CMP test drawn on the following Mondays 09/23/2024, 09/30/2024, 10/14/2024, 10/21/2024, 11/04/2024, 11/18/2024, and 11/25/2024 per physician orders.</p>