

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  12/30/2024
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</b></p> <p>Based on record reviews and interviews, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for care planning.</p> <p>Findings:</p> <p>Review of the facility's 2023 policy titled, Clinical Services Policy and Guidelines For Implementation, Quality of Care, Skin Integrity, revealed, in part, a resident identified as having risk for developing pressure ulcers would have individualized interventions implemented to attempt to prevent pressure ulcers from developing, interventions would be monitored for effectiveness, and the resident's care plan would reflect the interventions.</p> <p>Review of Resident #1's Electronic Medical Record (EMR) revealed, in part, Resident #1 was admitted to the facility on [DATE].</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024 revealed, in part, Resident #1 was at risk for developing pressure ulcers.</p> <p>Review of Resident #1's record revealed, in part, Resident #1 did not have a baseline care plan and the facility was unable to present any documented evidence Resident #1 had a baseline care plan developed and implemented.</p> <p>In an interview on 12/30/2024 at 4:40 p.m., S3Minimum Data Set (MDS) nurse indicated Resident #1 did not have a baseline care plan completed.</p> <p>In an interview on 12/30/2024 at 4:52 p.m., S2Director of Nursing confirmed a baseline care plan was not developed for Resident #1 and should have been developed and implemented.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45877</p> <p>46361</p> <p>Based on record review and interview, the facility failed to ensure medications were available for use for 2 (Resident #1 and Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for pharmacy services.</p> <p>Findings:</p> <p>Resident #1</p> <p>Review of Resident #1's clinical record revealed, in part, Resident #1 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, hypertension (high blood pressure), and gout (a condition that causes swelling and tenderness in joints).</p> <p>Review of Resident #1's November 2024 physician's orders revealed, in part, orders for potassium chloride 20 milliequivalent (mEq) (a medication used to treat chronic kidney disease) to be administered twice a day; allopurinol 100 milligram (mg) (a medication used to treat swelling and tenderness in joints) to be administered once a day; and, lisinopril-hydrochlorothiazide 10-12.5 mg (a medication used to treat high blood pressure) to be administered once a day with a start date of 11/16/2024 at 8:00 a.m.</p> <p>Review of Resident #1's November 2024 electronic Medication Administration Record (eMAR) revealed the following was documented, in part:</p> <ul style="list-style-type: none"> <li>- On 11/16/2024 at 8:00 a.m. potassium chloride 20mEq was documented as a 9 (9 indicated other and see progress notes);</li> <li>- On 11/16/2024 at 8:00 a.m. allopurinol 100mg was documented as a 9; and,</li> <li>- On 11/16/2024 at 8:00 a.m. lisinopril-hydrochlorothiazide 10-12.5mg was documented as a 9.</li> </ul> <p>Review of Resident #1's progress notes dated 11/16/2024 revealed, in part, Resident #1's above mentioned medications would be delivered from the pharmacy on the evening of 11/16/2024.</p> <p>In an interview on 12/26/2024 at 11:31 a.m., Resident #1's son indicated Resident #1 did not receive his medications as ordered when he was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/26/2024 at 4:20 p.m., S2Director of Nursing (DON) reviewed Resident #1's November 2024 eMAR and progress notes on 11/16/2024 and indicated the documentation revealed the above mentioned medications were not available to be administered to Resident #1 on 11/16/2024 at 8:00 a.m. because Resident #1's medications had not arrived from the pharmacy. S2DON indicated any medications ordered by the facility after 3:00 p.m. would arrive from the pharmacy the next day. S2DON indicated the facility did not utilize the on-call pharmacist or another local pharmacy to obtain Resident #1's medications.</p> <p>Resident #3</p> <p>Review of Resident #3's clinical record revealed, in part, Resident #3 was admitted to the facility on [DATE].</p> <p>Review of Resident #3's December 2024 physician's orders revealed, in part, an order for ondansetron hydrochloride (a medication used to treat nausea) 4 mg tablet, give 1 tablet by mouth every 6 hours for nausea starting on 10/07/2024.</p> <p>Review of Resident #3's December 2024 eMAR revealed, in part, Resident #3's odansetron hydrochloride was not administered at the following times:</p> <p>-12/09/2024: 12:00 a.m. and 6:00 a.m.;</p> <p>-12/21/2024: 12:00 a.m. and 6:00 a.m.;</p> <p>-12/22/2024: 12:00 a.m. and 6:00 a.m.; and,</p> <p>-12/23/2024: 12:00 a.m.</p> <p>Review of Resident #3's nursing progress notes written by S4Minimum Data Set (MDS) Nurse revealed a note on 12/09/2024 at 6:56 a.m. and another note on 12/21/2024 at 5:57 a.m. which indicated the facility was waiting to receive Resident #3's ondansetron from the pharmacy.</p> <p>In an interview on 12/30/2024 at 11:28 p.m., S4MDS Nurse indicated the facility had issues receiving Resident #3's ondansetron from the pharmacy.</p> <p>In an interview on 12/30/2024 at 12:36 p.m., S2Director of Nursing (DON) indicated the floor nurses and the pharmacist were responsible for ordering medications for residents. S2DON confirmed the above mentioned deficient practice and further indicated Resident #3 should have received his medications as prescribed.</p>		