STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195498	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Napoleon Caring, LLC	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)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident with a mental disorder received appropriate behavioral health treatment for 1 (Resident #2) of 7 sampled residents reviewed for behavioral health services. Findings:Review of Resident #2's clinical record revealed, in part, Resident #2 was admitted to the facility on [DATE]. Review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/05/2026 revealed, in part, Resident #2 had diagnoses which included, in part, bipolar disorder (mental health disorder characterized by extreme mood swings), depression (mental health disorder characterized by sadness, anxiety, and irritable mood), anxiety (a mental health disorder characterized by excessive worry that causes behavioral changes), and unspecified mood disorder (a psychiatric diagnosis characterized by significant distress from mood symptoms that does not meet the criteria for a specific mood disorder). Review of Resident #2's care plan dated 03/26/2026 revealed, in part, Resident #2 had a mood problem related to bipolar disorder, and antipsychotic medications were to be administered as ordered. Review of Resident #2's clinical record revealed, in part, Resident #2 was transferred to a behavioral health hospital on [DATE], following a behavior incident. Review of Resident #2's Behavioral Health Hospital Discharge Orders dated 03/24/2026 revealed, in part, Resident #2 had discharge diagnoses which included reoccurring major depressive disorder with psychosis and impulse control disorder. Further review revealed Resident #2's had an order for Aripiprazole (an antipsychotic medication used to treat mental health disorders including bipolar disorder) 7.5 milligram (mg) at bedtime for treatment of bipolar disorder. Review of Resident #2's April 2026 Physician Orders revealed, in part, an active order for Aripiprazole 5 mg give one time a day related to bipolar dated 03/25/2026. Further review revealed there was no active order for Resident #2 to receive Aripiprazole 7.5 mg daily at bedtime as ordered on 03/24/2026. Review of Resident #2's March and April 2026 Electronic Medication Administration Records (EMAR) revealed, in part, Resident #2 received Aripiprazole 5 mg once daily on 03/26/2026, 03/28/2026, 03/29/2026, 03/31/2026, 04/01/2026, 04/02/2026, 04/03/2026, 04/05/2026, 04/06/2026, 04/07/2026, 04/08/2026, and 04/09/2026. Further review revealed an order for Aripiprazole 7.5 mg at bedtime for treatment of bipolar disorder with a start date of 03/24/2026 and a discontinue date of 03/25/2026. Further review revealed no documented evidence Resident #2 received Aripiprazole 7.5 mg daily at bedtime as ordered by the physician on 03/24/2025. In an interview on 04/09/2026 2:37PM, S9Unit Manager indicated she was responsible to review residents' medications on admission and/or following hospitalizations. S9Unit Manager confirmed Resident #2's Behavioral Health Hospital Discharge Orders indicated Resident #2 was to receive Aripiprazole 7.5 mg daily at bedtime. S9Unit Manager indicated Resident #2's order for Aripiprazole 7.5 mg one time daily was discontinued in error on 03/25/2026 and Resident #2's previous order for Aripiprazole 5 mg daily was reactivated, and should not have been. In an interview on 04/09/2026 at 3:33PM, S2Director of Nursing (DON) confirmed Resident #2's Behavioral Health Hospital Discharge Orders indicated Resident #2 was to receive Aripiprazole 7.5 mg daily at bedtime. S2DON confirmed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195498	A. Building B. Wing	04/09/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's March and April 2026 EMAR revealed no documented evidence Resident #2 received Aripiprazole 7.5 mg daily at bedtime as ordered by the physician, and Resident #2 should have.