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	06/03/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's call light was within reach for 2 (Resident #1, (Resident #3) of 3 residents investigated for call lights. Findings:Resident #1 Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/2026 revealed Resident #1 had a Brief Interview Mental Status (BIMS) Score of 14 which indicated Resident #1 was cognitively intact. Review of Resident #1's Care Plan, dated 05/08/2026, with a goal date of 08/09/2026, revealed, in part, Resident #1's call light was to be placed in Resident #1's reach. Observation on 06/01/2026 at 9:48AM, revealed Resident #1 was lying in his bed, in his room with the call light on the floor out of Resident #1's reach. Observation on 06/01/2026 at 1:42PM revealed S6Receptionist brought Resident #1 to his room in a Geri-chair. Observation further revealed Resident #1's call light was on the floor out of Resident #1's reach. In an interview on 06/01/2026 at 1:45PM, Resident #1 indicated he was able to use the call light and the call light was often out of his reach. Observation on 06/01/2026 at 4:04PM revealed Resident #1 was sitting in his room in a Geri-chair with his call light approximately 4 feet away wrapped around the positioning bar of Resident #1's bed. Observation on 06/01/2026 at 4:18PM with S7Certified Nursing Assistant (CNA) revealed Resident #1 was sitting in his room in a Geri-chair with his call light approximately 4 feet away wrapped around the bed's positioning bar. In an interview on 06/01/2026 at 4:20PM, S7CNA indicated Resident #1 could use the call light and the call light should've been within his reach. Observation on 06/02/2026 at 8:36AM revealed Resident #1 was lying in bed with the call light on the floor out of Resident #1's reach. Observation on 06/02/2026 at 8:48AM revealed S4CNA entered Resident #1's room. Further observation revealed S4CNA exited Resident #1's room without ensuring Resident #1's call light was within reach. Observation on 06/02/2026 at 9:10AM with S4CNA revealed Resident #1 was lying in bed in his room with the call light on the floor out of Resident #1's reach. In an interview on 06/02/2026 at 9:11AM, S4CNA indicated Resident #1's call light should have been placed within Resident #1's reach and not on the floor. Observation on 06/02/2026 at 1:40PM revealed S6Receptionist brought Resident #1 to his room in a Geri-chair and exited Resident #1's room without ensuring Resident #1's call light was within reach. Observation on 06/02/2026 2:07PM with S3CNA Supervisor revealed Resident #1 was sitting in a Geri-chair with his call light approximately 3 feet away wrapped around the bed's positioning bar. In an interview on 06/02/2026 at 2:08PM, S3CNA Supervisor confirmed Resident #1's call light was out of Resident #1's reach and it should not be. Resident #3Review of Resident #3's Care Plan, dated 03/17/2026, with a goal date of 06/18/2026, revealed, in part, Resident #1's call light was to be placed in Resident #1's reach.Observation on 06/01/2026 at 12:35PM revealed S8Licensed Practical Nurse entered Resident #3's room where Resident #3 was lying in bed with the call light located on the floor underneath the bed and was not within Resident #3's reach. Further observation revealed S8LPN exited Resident #3's room without ensuring Resident #3's call light was within reach. Observation on 06/01/2026 at 12:42PM revealed S5CNA entered Resident #3's room where Resident #3 was lying in bed with the call light located on the floor underneath the bed and was not within Resident #3's reach. Further observation revealed S5CNA exited Resident #3's room without ensuring Resident #3's call light was within reach. Observation on 06/01/2026 at 4:36PM revealed, Resident #3's call light was on the floor (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	underneath Resident #3's bed, out of Resident #3's reach. Observation on 06/01/2026 at 4:48PM revealed S9CNA entered Resident #3's room where Resident #3 was lying in bed with the call light located on the floor underneath the bed and was not within Resident #3's reach. Further observation revealed S9CNA exited Resident #3's room without ensuring Resident #3's call light was within reach. In an interview on 06/01/2026 at 4:52PM, S9CNA indicated Resident #3 could use the call light, and Resident #3's call light should have been in the bed within reach. Observation on 06/01/2026 at 4:54 PM with S9CNA revealed Resident #3's call light was on the floor underneath the bed and was not within Resident #3's reach. In an interview on 06/01/2026 at 4:55PM, S9CNA indicated Resident #3's call light was out of Resident #3's reach. In an interview on 06/02/2026 at 2:10PM, S3Director of Nursing indicated a resident's call lights should be within a resident's reach.