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	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Napoleon Caring, LLC	252 Hwy. 402 Napoleonville, LA 70390

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all medical records regarding the resident's code status reflected the resident's wishes for 2 (Resident #10, Resident #106) of 22 (Resident #2, Resident #4, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #12, Resident #15, Resident #16, Resident #19, Resident #23, Resident #25, Resident #29, Resident #37, Resident #50, Resident #54, Resident #60, Resident #99, Resident #103, Resident #106, Resident #105) sampled residents reviewed for Advanced Directives. Findings:Review of the facility's policy, Resident Rights Advanced Directives dated 03/2023, revealed, in part, upon admission, the facility verifies the formulation of an advanced directive or the resident's wishes with regard to formulating an advanced directive. Further review revealed, in part, the facility will place the information about whether or not the resident has an Advanced Directive, and documents reflecting the decision regarding the Resident's Advanced Directive in the medical record, and are easily retrievable by the facility staff. Review of Resident #10's Clinical Record revealed Resident #10 was admitted to the facility on [DATE]. Review of Resident #10's electronic Medical Chart (eChart) profile revealed, in part, Resident #10 did not have an advance directive in Resident #10's eChart profile.Review of Resident #106's Clinical Record revealed Resident #106 was admitted to the facility on [DATE]. Review of Resident #106's electronic Medical Chart (eChart) profile revealed, in part, Resident #106 did not have an advance directive in Resident #10's eChart profile. In an interview on 09/24/2025 at 12:04PM, S12Minimal Data Set Nurse stated indicated if the resident did not elect to have an advanced directive, then the resident was considered a full code. In a telephone interview on 09/22/2025 at 1:55pm, Resident #106's son indicated he and his father were over Resident #106's care, and Resident #106 was a full code.Review of Resident #10's 5 day Minimal Data Set with an Assessment Reference Date of 07/21/2025 revealed, in part, Resident #10 had a Brief Interview for Mental Status score of 15, which indicated Resident #10 was cognitively intact.In an interview on 09/23/2025 8:12AM Resident #10 indicated she would like to be a full code.In an interview on 09/22/2025 at 1:35PM, S2Director of Nursing, indicated all residents' advanced directives are located on the residents' eChart profile. S2Director of Nursing confirmed that Resident #10, and Resident #106 did not have an advanced directive; therefore, Resident #10 and Resident #106's wish to be a full code should have been documented in their eChart profile.

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. Review of Resident #37's electronic health record revealed, in part, Resident #37 had an admission date of 06/07/2024. Review of Resident #37's electronic health record revealed, in part, Resident #37 had a diagnosis of dysphagia, unspecified. Review of Resident #37's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/2024 revealed, in part, Resident #37 had a Brief Interview Mental Score of 03, which indicated Resident #37 was severely cognitively impaired.Review of Resident #37's physician orders revealed, in part, Resident #37 had an order for a dental consult as needed with a start date of 06/10/2024. Observation on 09/23/2025 at 8:25AM revealed Resident #37 had missing and broken teeth on the upper jaw and lower jaw. On 09/23/2025 at 11:49AM S2Director of Nursing (DON) was asked for documentation of dental visits for Resident #37. In an interview on 09/23/2025 at 12:37PM, S2DON indicated she did not find any documentation that Resident #37 had received any dental services since admission. In an interview on 09/23/2025 at 2:23PM, S2DON indicated she called the facility's dental provider and the facility's dental provider indicated they never received a dental service referral from the facility for Resident #37. S2DON further indicated Resident #37 should have been seen by the facility's dental provider as ordered.On 08/01/2025 at 5:30PM during exit conference, S1Administrator was asked if he had any additional documentation to present. S1Administrator had nothing to add and did not provide any documentation as requested to dispute the above mentioned deficient practice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to:1. Implement the facility's Enhanced Barrier Precautions (EBP) policy and procedure for a resident with a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the abdominal wall and into the stomach) for 1 (Resident #6) of 1 (Resident #6) sampled residents observed for EBP in a total sample of 3 residents investigated for activities of daily living;2. Ensure reusable medical equipment was maintained in a sanitary manner for 2 (Resident #62, Resident #85) of 8 (Resident #6, Resident #24, Resident #31, Resident #42, Resident #62, Resident #80, Resident #81, Resident #85) sampled residents investigated for infection control; and,3. Ensure a laundry staff member properly sorted and washed dirty laundry on the proper wash cycles for 1 (S11Laundry Aide) of 1 (S11Laundry Aide) laundry staff observed for handling and processing dirty laundry. Findings:Review of the facility's Infection Prevention and Control Program: Enhanced Barrier Precautions Policy and Procedure dated 03/10/2025 revealed, in part, enhanced barrier precautions must be observed when providing direct care for residents with high-risk conditions, including indwelling medical devices such as feeding tubes. Further review revealed gowns and gloves should be worn for the following high-contact resident care area activities: maintenance or manipulation of devices (feeding tubes) and providing hygiene assistance (bathing and toileting). Signage will be placed outside the room. 1. Review of Resident #6's physician's orders, in part, revealed an order dated 02/21/2025 for enhanced barrier precautions. Further review revealed providers should put on a gown and gloves during high contact care activities which included providing hygiene such as changing bed linens, changing briefs or assisting with toileting. Review of Resident #6's Care plan dated 03/12/2025, in part, revealed Resident #6 had enhanced barrier precautions. Further review revealed gown and gloves were required for high-contact resident care such as bathing, incontinence care, toileting care, or devices. Observation on 09/23/2025 at 4:45PM, revealed a sign on Resident #6's door which read Enhanced Barrier Precautions. Observation further revealed gloves, gowns, and masks were available on the door. Review of the Enhanced Barrier Precautions sign on the outside of Resident #6's door revealed the following: Everyone must: clean their hands, including before entering and when leaving the room. Provider's and staff must also: wear gloves and a gown for the following high-contact resident care activities – dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Devices care or use: feeding tube. Observation on 09/23/2025 at 4:55PM revealed Resident #6 had a PEG tube. Further observation evealed S9Certified Nursing Assistant (CNA) and S10CNA provided Resident #6 incontinence care without using a gown. In an interview on 09/23/2025 at 5:21PM, S10CNA indicated she should have put on a gown when she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided incontinence care to Resident #6, and she confirmed she did not. In an interview on 09/23/2025 at 5:24PM, S9CNA indicated she should have put on a gown when she provided incontinence care to Resident #6, and she confirmed she did not. In an interview on 09/24/2025 at 9:19AM, S3Infection Preventionist indicated staff should put on a gown and gloves when changing a resident or providing any direct resident care when a resident was on enhanced barrier precautions. S3Infection Preventionist confirmed S9CNA and S10CNA should have put on gown when they performed incontinence care to Resident #6. In an interview on 09/24/2025 at 9:24AM, S2Director of Nursing (DON) confirmed a gown and gloves should have been worn when providing incontinence care to a resident on enhanced barrier precautions. Observation on 09/24/2025 at 10:00AM revealed, S8Licensed Practical Nurse (LPN) removed the enteral feeding tubing from Resident #6's PEG tube without putting on a gown. In an interview on 09/24/2025 at 10:02AM, S8LPN indicated she was unaware that she needed to put on a gown when she removed the enteral feeding tubing from Resident #6's PEG tube. In an interview on 09/24/2025 at 10:16AM, S12Unit Manager indicated a gown and gloves should have been worn when disconnecting enteral feeding tubes. In an interview on 09/24/2025 at 10:23AM, S2DON confirmed a gown should have been worn when disconnecting enteral feeding tubes. 2. Review of the Infection Prevention and Control Program policy, revision date 04/28/2025, revealed, in part, the facility has established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Resident #62 Observation on 09/23/2025 at 11:03AM revealed an unidentifiable and uncontained toilet seat riser lying directly on Resident #62's bathroom floor. Observation on 09/24/2025 at 10:10AM with S13Certified Nursing Assistant (CNA) Supervisor present, revealed a toilet seat riser was unidentifiable uncontained, and lying directly on Resident #62's bathroom floor. In an interview on 09/24/2025 at 10:10AM, S13CNA Supervisor indicated the toilet seat riser had been used by Resident #62 and should not have been placed directly on the bathroom floor. S13Certified Nursing Assistant Supervisor further indicated the toilet seat riser should have been labeled and placed inside a bag for storage. In an interview on 09/24/2025 at 1:15PM, S2DON indicated the toilet seat riser for Resident #62 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should not have been placed directly on the bathroom floor. S2DON further indicated the toilet seat riser should have been labeled and placed inside a bag for storage. Resident #85 Observation on 09/22/2025 at 9:22AM revealed an unidentifiable and uncontained bed pan was lying on Resident #85's bathroom floor. Observation on 09/23/2025 at 11:10AM revealed an unidentifiable and uncontained bed pan was lying directly on Resident #85's bathroom floor. Further observation revealed the bed pan had a brown unknown substance along the inside surface of the bed pan. Observation on 09/23/2025 at 3:53PM, with S13CNA Supervisor present, revealed an unidentifiable and uncontained bed pan was lying directly on Resident #85's bathroom floor. Further observation revealed the bed pan had a brown unknown substance along the surface of the bed pan. In an interview on 09/23/2025 at 3:54PM, S13CNA Supervisor confirmed there was an unidentifiable and uncontained bed pan lying directly on Resident #85's bathroom floor. S13CNA Supervisor indicated the bed pan had been used by a resident. S13CNA Supervisor further indicated the used bed pan was not stored in a sanitary manner, and should have been labeled and placed inside of a bag for storage. In an interview on 09/23/2025 at 3:57PM, S2DON confirmed the used bed pan observed in Resident #85's bathroom should not have been placed directly on the floor. S2DON further indicated the used bed pan was not stored in a sanitary manner, and should have been labeled and placed inside of a bag for storage. In an interview on 09/24/2025 at 10:20PM, S3Infection Preventionist confirmed a used bed pan should not have been place directly on Resident #85's bathroom floor. S3Infection Preventionist indicated the used bed pan was not stored in a sanitary manner, and should have been labeled and placed inside of bag for storage. 3. Review of the Clinical Services Policy and Guidelines of Linen, dated 04/28/2025, revealed in part, laundry and direct care staff should handle, and process linens to prevent the spread of infections. Review of the facility's laundry service agreement dated 01/28/2025, revealed in part, the provider would receive a wall chart as training for product/equipment use to be posted at the provider location. In an interview on 09/22/2025 at 8:56AM, S6Laundry/Housekeeping Supervisor indicated laundry staff was responsible for sorting dirty laundry and washing the dirty laundry on the wash cycle according to the wall chart instructions provided by the laundry service company. Observation on 09/22/2025 at 8:57AM revealed the provider's washers contained a mixture of dirty laundry including sheets, towels, bed pads, and resident clothing that were not sorted and separated before washing. In an interview on 09/22/2025 at 8:59AM, S11Laundry Aide confirmed she did not sort the dirty (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laundry before washing, and indicated she did not wash the dirty laundry on the correct wash cycle as required according to the chart provided by the laundry service company. Observation on 09/22/2025 at 9:00AM of the Linen Handling procedures chart posted on the wall in the laundry room revealed, in part, soiled linen was to be sorted before loading in the washer and the proper wash formula should be selected for each load. Observation on 09/22/2025 at 9:00AM of the Laundry System Processing Information chart posted on the wall in the laundry room revealed, in part, sheets should be washed on Wash Cycle 1, towels should be washed on Wash Cycle 2, blankets and residents' personal clothing should be washed on Wash Cycle 3, and bed pads should be washed on Wash Cycle 5. In an interview on 09/22/2025 at 9:01AM, S6Laundry/Housekeeping Supervisor confirmed the clothes in the washers were not sorted as required. S6Laundry/Housekeeping Supervisor indicated S11Laundry Aide should have sorted and washed the dirty laundry according to the Linen Handling procedure chart and Laundry System Processing Information chart provided by the laundry service company. In an interview on 09/23/2025 at 10:27AM, S1Administrator acknowledged S11Laundry Aide should have followed the wall charts provided by the laundry service company for sorting and washing dirty laundry.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interviews, and record reviews the facility failed to provide toenail care for 1 (Resident #99) of 3 (Resident #6, Resident #7, Resident #99) sampled residents investigated for activities of daily living. Findings:Review of Resident #99's electronic health record revealed, in part, Resident #99 had a diagnosis of diabetes mellitus due to underlying conditions with hyperglycemia and morbid (severe) obesity due to excessive calories. Review of Resident #99's quarterly Minimum Data Set with an Assessment Reference Date of 08/12/2025 revealed, in part, Resident #99 had a Brief Interview for Mental Status score of 15, which revealed Resident #99 was cognitively intact. Observation on 09/22/2025 at 8:51AM revealed Resident #99's toenails on his right foot extended one inch to one and a half inches past the toes. In an interview on 09/23/2025 at 9:09AM Resident #99 indicated his toenails had not been clipped by facility staff, and he wanted them clipped. In an interview on 09/24/2025 at 9:59AM Resident #99 indicated he did not have his toenails clipped since April of 2025. In an interview on 09/24/2025 at 1:15PM, S15Licensed Practical Nurse/Wound Care indicated she was responsible for providing toenail care of diabetic residents and she had not checked to see if Resident #99's toenails needed to be trimmed because he sometimes refused wound care. S15Licensed Practical Nurse/Wound Care further indicated Resident #99's toenails should have been clipped.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record reviews, the facility failed to ensure a urinary catheter drainage bag (a medical device that collects urine from the bladder) was not placed directly on the floor for 1 (Resident #23) of 2 (Resident #9, Resident #23) sampled residents investigated for urinary catheter requirements. Findings:Review of Resident #23's electronic health record revealed, in part, Resident #23 had a diagnosis of chronic kidney failure stage 3 and acute kidney failure, unspecified. Review of the facility's contracted hospice nurse's progress note dated 09/16/2025 revealed, in part, Resident #23 had an indwelling catheter (a medical device inserted into the bladder that drains urine to a urinary catheter drainage bag). Observation on 09/22/2025 at 8:50AM revealed Resident #23 was lying in bed. Further observation revealed her urinary catheter drainage bag was lying on the floor with part of the urinary catheter tubing touching the floor. Observation on 09/22/2025 at 9:18AM revealed Resident #23 was lying in bed. Further observation revealed her urinary catheter drainage bag was lying on the floor with part of the urinary catheter tubing touching the floor. In an interview on 09/23/2025 at 1:34PM, Resident #23's contracted hospice nurse indicated a urinary catheter drainage bag and tubing should not have been on or touching the floor. In an interview on 09/23/2025 1:23PM, S16Certified Nursing Assistant indicated Resident #23's urinary catheter drainage bag and tubing should not have been on or touching the floor. In an interview on 09/24/2025 at 8:32AM, S17Certified Nursing Assistant indicated urinary catheter drainage bag and tubing should not have been be on or touching the floor. In an interview on 09/24/2025 at 9:21AM, S3Infection Preventionist indicated a urinary drainage bag and tubing should not have been on or touching the floor. S3Infection Preventionist further indicated it is standard infection control practice to ensure a resident's urinary catheter drainage bag and tubing should not be on or touching the floor. In an interview on 09/28/2025 at 9:27AM, S13Certified Nursing Assistant Supervisor indicated Resident #23's urinary catheter drainage bag and tubing should not have been on or touching the floor. In an interview on 09/24/2025 at 12:17PM, S1Administrator indicated a urinary catheter drainage bag and tubing should not have been on or touching the floor.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interviews, and record reviews, the facility failed to ensure the medication error was not greater than 5% for 1 (Resident #28) of 7 (Resident #15, Resident #16, Resident #28, Resident #42, Resident #59, Resident #72, Resident #79) sampled residents observed during the medication administration task. Findings:Review of the facility's undated Medication Pass Administration Policy and Procedure, last revised 12/01/2021, revealed, in part, medications shall be administered within 60 minutes prior to or after the scheduled time. Review of the facility's Nursing Recommendations/Manager Report dated 09/14/2025 revealed, in part, medications were not being administered as ordered (different time, etc. [other similar things]). Review of Resident #28's September 2025 physician's orders revealed, in part, Resident #16 had the following orders:Gabapentin (a medication used to treat seizures and neuropathy) 300 milligram (mg) oral capsule every morning scheduled at 8:00AM;Lyrica (a medication used to treat seizures and nerve pain) 75 mg oral capsule scheduled daily at 8:00AM;Culturelle capsule (a probiotic medication) scheduled daily at 8:00AM;Guaifenesin Extended-Release (ER) (a medication used to thin mucus) 600 mg tablet scheduled every 12 hours at 8:00AM and 8:00PM;B-12 (a vitamin) 500 mg tablet scheduled daily at 8:00AM;Plavix (an antiplatelet medication uses to prevent blood clots) 75 mg tablet scheduled daily at 8:00AM;Sertraline Hydrochloric acid (HCL) (a medication used to treat depression) 100 mg tablet every morning scheduled at 8:00AM; and,2 Acetaminophen 325 mg tablets scheduled daily at 8:00AM. There were 26 medication administration opportunities for error, with 8 observed errors for a medication administration error rate of 30.77%. Observation on 09/23/2025 at 9:17AM revealed S18Licensed Practical Nurse (LPN) administered the following medications by mouth to Resident #28: Gabapentin 300 mg oral capsule, Lyrica 75 mg oral capsule, Culturelle capsule, Guaifenesin ER 600 mg tablet, B-12 500 mg tablet, Plavix 75 mg tablet, Sertraline HCL 100 mg tablet, and 2 Acetaminophen 325mg tablets. In an interview on 09/23/2025 at 9:12AM, S18LPN indicated Resident #28's medications were given late this particular morning because of the care that her residents required. S18LPN further indicated the medications were scheduled for 8AM so they should have been given between 7:00AM and 9:00AM. In an interview on 09/23/2025 at 11:54AM, S2Director of Nursing indicated when medications are scheduled for 8:00AM they should be given an hour before an hour after the scheduled time, so between 7AM and 9AM. S2DON further indicated the facility's medication error rate should not be greater than 5%. In an interview on 09/23/2025 at 12:00 PM, S19Regional Director of Clinical Services confirmed if a medication was given more than 1 hour after the scheduled time it was considered a medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record reviews, the facility failed to ensure a medication were stored at the appropriate temperature for 1 (Medication Cart A) of 3 (Medication Cart A, Medication Cart B, Medication Cart C) medication carts observed for medication storage requirements. Findings:Review of the facility's Labeling and Storage of Drugs and Biologicals Policy and Procedure, last revised 03/2023, revealed drugs and biologicals were to be stored under proper temperature controls. Review of an email from the facility's pharmacy dated 09/24/2025 at 2:13PM revealed prior to initial use, Ozempic (medication used to treat diabetes) should be stored between 36 degrees Fahrenheit to 46 degrees Fahrenheit and should not be stored directly adjacent to the refrigerators cooling element. Observation of Medication Cart A on 09/24/2025 at 2:06PM, revealed an unopened Ozempic, a medication used to treat diabetes, stored on an unrefrigerated drawer on Medication Cart A. Observation further revealed the unopened Ozempic medication had a label which read to refrigerate until opened. In an interview on 09/24/2025 at 2:08PM, S12Unit Manager indicated the above mentioned Ozempic medication should have been refrigerated until opened. In an interview on 09/24/2025 at 2:10PM, S2Director of Nursing confirmed the above mentioned Ozempic medication should have been refrigerated until opened.