

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Bayou Chateau Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16232 Hwy. 1 Simmesport, LA 71369	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure direct care staff consulted with the Physician or Nurse Practitioner for 1 (Resident #2) of 3 (Resident #1, Resident #2 and Resident #3) sampled residents reviewed. The facility failed to notify the Physician or Nurse Practitioner when Resident #2 refused medications for the months of May, June, and July 2026. Findings: Review of the Clinical Record for Resident #2 revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, which included Paranoid Schizophrenia, Bipolar Disorder, Current Episode Mixed, Severe with Psychotic Features. Review of July 2026 Physician Orders revealed in part. (1) Trileptal 300mg 1 tablet by mouth twice a day with a start date of 04/29/2026. (2) Zyprexa 15mg 1 tablet by mouth at bedtime with a start date of 04/29/2026. On 07/20/2026 at 1:58 p.m., review of the Quarterly MDS with an Assessment Reference Date of 05/13/2026 for Resident #2 revealed she had a BIMS (Brief Interview for Mental Status) of 15, which indicated the resident was cognitively intact. Review also revealed Resident #2 was receiving antipsychotics on a routine basis only. In an interview on 07/21/2026 at 4:04 p.m., with S3 NP revealed she was not aware of Resident #2 refusing her medications of Trileptal and Zyprexa for the months of May, June, and July 2026. She stated she should have been notified of Resident #2 refusing her medications but was not. Review of Resident #2's May EMAR (electronic medication administration record) revealed Resident #2 refused Trileptal 300mg for the entire month of May. EMAR also revealed Resident #2 refused Zyprexa 15mg for the dates of July 2, 3, 5-11, 13-19, 21-28, and 30. Review of Resident #2's June EMAR revealed Resident #2 refused Trileptal 300mg for the entire month of June. EMAR also revealed Resident #2 refused Zyprexa 15mg for the dates of July 1-4, 6, 7, 9-11, 13, 14, and 16-30. Review of Resident #2's July EMAR revealed Resident #2 refused Trileptal 300mg for dates of July 1-4, July 5-8, and July 10-21, 2026. EMAR also revealed Resident #2 refused Zyprexa 15mg for the dates of July 1-4, July 6, 7, 10-11, 14-17, and 19. In an interview on 07/21/2026 at 4:10 p.m., S2 DON stated, if a resident refuses a medication more than once, they are to notify the MD/NP. In an interview on 07/21/2026 at 4:47 p.m., S4 LPN stated, if a resident refuses a medication more than once, nurses are to notify the MD/NP by the end of the day and not wait until multiple doses had been refused by the resident. When the 1st dose is refused, I call the NP to make them aware by the end of my shift. In an interview on 07/21/2026 at 5:07 p.m., S2 DON confirmed Res #2 had been refusing her medications for the months of May, June, and July and the nurses did not notify the MD/NP but should have.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices. The facility failed to ensure documentation on the EMAR Electronic Medication Administration Record was accurate for Resident #2. The facility had a census of 75. Findings: Review of the undated facility's policy titled Medication Administration Policy and Procedure revealed in part. Procedure: (35) Each dose of medication administered shall be properly recorded in the resident's medical record. On 07/20/2026 at 1:58 p.m., review of the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/13/2026 for Resident #2 revealed she had a BIMS (Brief Interview for Mental Status) of 15, which indicated the resident was cognitively intact. Review also revealed Resident #2 was receiving antipsychotics on a routine basis only. Review of Resident #2's May 2026 EMAR revealed Resident #2 did not receive her medication of Paliperidone Palmitate ER Intramuscular Suspension Prefilled Syringe 234mg/1.5ml one time a day monthly on the 28th. Review of Resident #2's June E[DATE] revealed Resident #2 did not receive her medication of Paliperidone Palmitate ER Intramuscular Suspension Prefilled Syringe 234mg/1.5ml one time a day monthly on the 28th. On 07/21/2026 at 4:04 p.m., review of nurses' progress notes for 05/28/2026 at 2:24 p.m. revealed the Paliperidone Palmitate ER Intramuscular Suspension 234mg was not administered with the reason of awaiting arrival from pharmacy okay to admin upon arrival by [NAME] Lee, LPN. Review of review of nurses' progress notes for 06/28/2026 at 11:47 a.m. revealed the Paliperidone Palmitate ER Intramuscular Suspension 234mg was not administered with the reason of waiting on Rx by [NAME] Laprarie, LPN. In an interview on 07/21/2026 at 4:47 p.m., S4 LPN stated she had ordered Resident #2's medication (Paliperidone Palmitate ER Intramuscular Suspension 234mg) from the pharmacy and that S6 ADON must administer it to Resident #2. S4 LPN stated Resident #2 will not allow anyone else to administer her injections but S6 ADON. S4 LPN stated she was off for a couple days after ordering the medication, so when she returned, she asked S6 ADON did she got Resident 2's medication and gave it to her. She stated S6 ADON told her she had given Resident #2 her injection. Observation of the medication room with S4 LPN revealed Resident #2's injection was not available, therefore S4 LPN stated, she must have given it. S4 LPN stated they must wait and order the medication when it is almost due to be administered, so in a couple days they will order the July dose. In an interview on 07/21/2026 at 5:00 p.m., S5 Pharmacist revealed the Paliperidone Palmitate ER Intramuscular Suspension 234mg had been ordered and delivered on 05/29/2026 and 06/29/2026. In an interview on 07/21/2026 at 5:07 p.m., S2 DON stated, any medication that is given to a resident should be documented. S2 DON stated S6 ADON is the only nurse who can administer Resident #2's injections because she will not allow anyone else to give it to her. S2 DON stated S6 ADON probably gave Resident #2 her monthly injections for May and June 2026 and did not document it but should have. In an interview on 07/21/2026 at 6:02 p.m., S2 DON confirmed the medical record for Resident #2 was not accurate but should have been.		