STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195546	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Chateau Nursing Ctr	16232 Hwy. 1 Simmesport, LA 71369

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview the facility failed to ensure drugs and biologicals were labeled and stored appropriately based on current acceptable professional principles. The Facility failed to ensure: 1. Expired medications were not available for administration to residents for 1 (med cart A) of 3 (med cart A, med cart B, and med cart C) medication carts observed. 2. Medications and wound care products were labeled with the date it was opened for 1 (med cart B) of 3 (med cart A, med cart B, and med cart C) medication carts observed. 3. Medications were stored in a locked compartment and not available to unauthorized staff to access for 1 (med cart B) of 3 (med cart A, med cart B, and med cart C) medication carts observed.This deficient practice had the potential to affect any of the 52 residents who resided in the facility.Findings: Review of the facility's policy titled Labeling of Medications and Biologicals with a revised date of 07/21/2021 revealed, in part. Labels for multi-use vials must include:a) The date the vial was initially opened or accessed;b) All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different date for that opened vial. Review of the facility's policy titled Medication Storage with a revised date of 05/14/2025 revealed, in part . a) All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b) Only authorized personnel will have access to the keys to locked compartments. #1Observation on 09/16/2025 at 08:55 a.m. of Med Cart A accompanied by S8 LPN revealed a vial of insulin with an open date of 07/25/2025 and a discard date of 08/21/2025. S8 LPN confirmed insulin vial should have been discarded after 08/21/2025 and was not. Interview on 09/16/2025 at 9:56 a.m. with S2 DON confirmed insulin vial was opened on 07/25/2025 and should have been discarded after 08/21/2025 and was not. #2Observation on 09/17/2025 at 11:00 a.m. of Med Cart B revealed multiple open items that were undated, including: (1) bottle of 100ml Normal Saline, (1) tube of Calmosepetine cream, (1) bottle of Gentian Violet, and (1) tube of Silver Antimicrobial Wound Gel. S5 LPN confirmed items in Med Cart B should have been dated upon opening and were not. Interview on 09/16/2025 at 11:33 a.m. with S2 DON confirmed items in Med Cart B should have been dated upon opening and were not. #3Observation on 09/17/2025 at 11:00 a.m. revealed the keys to Med Cart B hanging on a hook attached to the outside of the cart, making them accessible to unauthorized personnel. Interview with S5 LPN confirmed that staff hang Med Cart B's keys on the hook located on the outside of the cart. Interview on 09/17/2025 at 11:33 a.m. with S2 DON confirmed that keys to Med Cart B should not have been left unattended or accessible on the outside of the cart.

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 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 observation, record review, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections by: 1. Failed to ensure staff sanitized hands between residents, while providing assistance during mealtime. This deficient practice had the potential to affect 12 residents that are fed by staff in the facility, and; 2.Failed to ensure Enhanced Barrier Precautions were followed for Resident #5 and Resident #33. This deficient practice had the potential to affect all 12 residents that are on EBP. The total sample size was 20. 1. Review of the facility's undated policy titled Dining Room/Meal Time Procedure read in part.Purpose: To ensure residents are provided meals in a timely, organized manner that preserves dignity, promotes adequate nutritional intake while ensuring safety. 3. General Procedure. A. All employee serving meals will wear hair protections and exercise appropriate infection control measures. An observation on 09/15/2025 at 11:22 a.m., while in the dining room, S3 CNA was observed sitting at a table assisting 2 residents with lunch service. S3 CNA was observed going back and forth feeding the 2 residents without sanitizing her hands between residents. An interview on 09/15/2025 at 12:00 p.m., S3 CNA confirmed that she did not sanitize her hands between feeding more than one resident at a time during lunch service. 2. Review of facility policy titled, Enhanced Barrier Precautions, revised 04/15/2025, revealed in part. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. 2b. Enhanced Barrier Precautions will be implemented for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, etc.) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, hemodialysis catheters, PICC lines, midline catheters). Resident #33 Review of Resident #33's electronic medical record (EMR) revealed a facility admission date of 06/06/2012, with diagnoses that included in part, Pressure Ulcer of Right Buttock, Stage 2, Extended Spectrum Beta Lactamase (ESBL) Resistance, Retention of Urine, and Resistance to Multiple Antimicrobial Drugs. Special Instructions: Transmission-Based Precautions: Enhanced Precautions (Indwelling urinary catheter). Review of Resident #33's Annual MDS with an ARD of 09/03/2025 revealed the resident had a BIMS score of 15, indicating intact cognition. Review of Resident #33's care plan initiated on 02/27/2025, revealed Resident #33 had an indwelling urinary catheter and a stage 2 pressure area to right buttock with interventions that included in part. Enhanced Barrier Precautions per protocol. On 09/16/2025 at 09:40 a.m. observation of EBP signage on Resident #33's door read . Stop Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activities Dressing Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs, or assisting with toileting, Device care or use: Central Line, Urinary Catheter, Feeding tube, Tracheostomy. Wound Care: any skin opening requiring a dressing. On 09/16/2025 at 9:50 a.m., observation revealed S5LPN entered Resident #33's room, performed direct patient care, including wound care to Resident #33's right buttock stage 2 pressure ulcer and right leg skin tear, and flushed Resident #33's urinary catheter. S5LPN did not apply a gown prior to or during the course of the direct patient care. In an interview on 09/16/2025 at 09:58 a.m. S5LPN revealed she was aware Resident #33 required Enhanced Barrier Precautions (EBP). S5LPN confirmed she did not wear a disposable gown while performing direct patient care for Resident #33, and should have. In an interview on 09/16/2025 at 10:20 a.m., the above findings were discussed with S2DON. S2DON confirmed the nurse should have applied a disposable gown prior to performing wound and catheter care for a resident on enhanced barrier precautions, and did not. Findings: Review of Resident #5's medical record revealed an admission date of 04/06/2025 with an admitting diagnosis of Hypertensive Chronic Kidney Disease with Stage 5 CKD or End Stage Renal Disease, Kidney Transplant Failure, Type 1 Diabetes Mellitus, Anemia in Chronic Kidney Disease, and Dependence on Renal Dialysis. Review of Resident #5's Quarterly MDS (Minimum Data Set) dated 07/16/2025 revealed in part. Resident#5 required substantial/maximal assistance with personal hygiene and Resident #5 had a BIMS (Brief Interview Mental Status) score of 5 indicating cognition was severely impaired. Review of Resident #5's Care Plan on 09/16/2025 at 1:34 p.m. initiated on 04/25/2025 with revision date of 04/25/2025 revealed in part, Focus: I have the potential for alteration in health maintenance related to my diagnosis: End Stage Renal Disease (ESRD) on hemodialysis status post renal transplant in 2012 .Intervention/tasks: Enhanced barrier precautions as per protocol when providing care related to implanted dialysis access, PEG tube. On 09/16/2025 at 8:32 a.m., an interview with S7 CNA revealed she had just performed a bath, oral care, and peri care on Resident #5. When surveyor asked S7 CNA what personal protective equipment she wore while performing the care to Resident #5, she stated, just gloves. She stated she did not wear a gown. When asked what the Enhanced Barrier Precaution sign meant, she stated, It means precautions, wear gloves and gown if necessary. On 09/17/2025 at 11:54 a.m. an interview was conducted with S2 DON who confirmed S7 CNA should have worn a gown and gloves while providing Resident #5's bath and did not.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure the resident's right to formulate an advanced directive was properly reflected in the resident's medical record for 1 (Resident #30) of 1 resident reviewed for advanced directives. The facility failed to ensure all medical records regarding advanced directive/code status consistently reflected Resident #30's wishes to be a DNR (Do Not Resuscitate).Review of the facility undated policy titled Advanced Directives read in part. Advanced directives will be respected in accordance with state law and facility policy. 4. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. Review of Resident #30's electronic medical record (EMR) revealed an initial admission date of 08/09/2024 with diagnoses that included in part, Hypertensive Heart Disease without Heart Failure, Major Depressive Disorder, Essential (Primary) Hypertension, Type 2 Diabetes Mellitus without Complications, and Unspecified Dementia, Mild, with Anxiety.Review of Resident #30's Significant Change MDS with ARD of 06/11/2025 revealed in part. Resident #30 had a BIMS score of 09, indicating moderate cognitive impairment. Resident #30 received hospice care.Review of Resident #30's current care plan read in part. Focus: Advanced Directive: I have an Advanced Directive. Interventions included in part. I am not to receive cardio-pulmonary resuscitation. A do not resuscitate (DNR) request was completed by me/my responsible party/representative, communicated and submitted to my physician, and communicated to staff. A STOP sign has been placed in my visual cue in my room.Review of Resident #30's September 2025 active orders in the electronic medical record revealed in part. 06/09/2025- Admit to All Saints Hospice with terminal diagnosis of Alzheimer Disease. Resident #30 did not have any active orders reflecting advanced directive/code status information.In an interview on 09/16/2025 at 12:29 p.m. S8LPN revealed Resident #30's code status information can be found in multiple places such as on QCARD above the resident bed, the binder spine on the resident hard chart, special instruction tab in EMR, physician orders, and if the resident had a documented advanced directive such as a LAPOST (Louisiana Physician Orders for Scope of Treatment), it would be located in hard chart behind the face sheet. S8LPN revealed a picture of a red stop sign present on QCARD above the resident's bed and on the spine of the hard chart, indicated DNR status. A picture of a green go sign present on QCARD above the resident bed and on spine of hard chart, indicated Full Code status. On 09/16/2025 12:35 p.m., observation of QCARD above Resident #30's bed revealed a red Stop sign, indicating Resident #30 code status was DNR. In an interview on 09/16/2025 at 12:45 p.m., S2DON revealed if a resident did not have an advanced directive on file, the resident was presumed full code. After review of Resident #30's EMR with S2DON during interview, S2DON stated Resident #30 did not have advanced directive/code status documentation present in active orders or the code status section of EMR; therefore, Resident #30 was presumed a full code. Further into the interview, S2DON learned from another facility staff member, Resident #30 did have an advanced directive, and the information was documented in profile tab of EMR. Review of this section of Resident #30's EMR with S2DON revealed Resident #30 was documented as a full code status. S2DON stated, Resident #30 was a full code.On 09/16/2025 at 12:50 p.m., review of Resident #30's hard chart with S2DON revealed Resident #30 had a green go sign on spine of hard chart. S2DON stated the green Go sign indicated Resident #30 was a full code. Further review of Resident #30's facility hard paper chart with S2DON revealed Resident #30 had two LAPOST documents signed and dated. One LAPOST document signed and dated 08/09/2024, reflecting Resident #30's code status was full code, and the most up-to-date LAPOST signed and dated 06/09/2025, reflecting Resident #30's code status was DNR. S2DON confirmed Resident #30 was not a full code, Resident #30's code status was DNR. S2DON confirmed there was conflicting advanced directive/code status information within Resident #30's medical record, and should not have been.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents identified with Mental Disorder and/or Intellectual Disability had an accurately completed PASARR (Pre-admission Screening and Resident Review) Level I and/or Level II for 1(#8) of 1 resident reviewed for PASARR screening. Findings: Review of the facility's undated policy titled, Resident Assessment-Coordination with PASARR Program read in part .8. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Review of Resident #8's medical record revealed an admit date on 08/23/2005 with the following diagnoses: Vascular Dementia with Agitation, Major Depression Disorder with Severe with Psychotic Symptoms, Generalized Anxiety Disorder, and Schizoaffective Disorder (12/10/2018). Review of Resident #8's medical record revealed a Level 1 pre-screening was provided for Resident #8 prior to admission on [DATE], which indicated diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder. No Level II screening was completed at time of or since admission. Review of Resident #8's electronic record revealed a diagnosis of Schizoaffective Disorder with a start date of 12/10/2018. An interview on 09/16/2025 at 10:47 a.m., S4 SSD revealed that Resident #8 had not had a Level II screening completed since admit in 08/17/2005. S4 SSD stated that Resident #8 had a new diagnosis of Schizoaffective Disorder on 12/10/2018 and the facility failed to submit a new level 2 screening at that time, but should have. An Interview on 09/16/2025 at 10:54 a.m., S2 DON confirmed that Resident #8 had a pre admission Level 1 screening on admit and the facility failed to provide a Level II screening after Resident #8 was diagnosed with Schizoaffective Disorder in 2018, but should had.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to dispose of garbage and refuse properly. This deficient practice had to the potential to affect all 52 residents who resided in the facility according to the Resident Census and Conditions of Residents Form dated 09/15/2025.Findings: Review of the facility policy titled (Facility Name) Disposal of Garbage and Refuse on 09/15/2025 at 1:30 p.m. revealed in part.the facility shall properly dispose of kitchen garbage, and other garbage. Policy Explanation and Compliance Guidelines: (7) Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. Observation of the facility dumpster area on 09/15/2025 at 8:57 a.m. accompanied by S6 Dietary Manager revealed there were 3 shopping carts, a broken chair, and 3 open trash cans with trash and debris not contained. Interview with S6 Dietary Manager at that time confirmed the findings and stated the items should be thrown away.