

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Chateau DE Notre Dame Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2832 Burdette Street New Orleans, LA 70125	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30587</p> <p>47487</p> <p>Based on interviews, record reviews, and observations, the facility:</p> <ol style="list-style-type: none"> Failed to ensure a resident (Resident #1), who was assessed as being at risk for wandering/elopement, was supervised and unable to elope off of the facility's grounds; Failed to ensure staff tested the WanderGuard system to ensure the transmitters were properly functioning at ankle level to alert staff and prevent residents from being able to exit the facility unsupervised for 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of 5 residents. <p>This deficient practice was identified for 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) sampled residents reviewed for wandering/elopement and accident/hazards.</p> <p>The deficient practice resulted in an Immediate Jeopardy situation on 05/07/2024 at 6:30 p.m. when Resident #1, a resident who was assessed as being at high risk for wandering and elopement, and who had a WanderGuard transmitter placed on his right ankle was allowed to exit the facility through Door a. Resident #1 left the supervision of the facility's staff for approximately 13.45 hours. Resident #1 was located by S4Licensed Practical Nurse (LPN) on 05/08/2024 when she observed him walking on a street near the facility. S4LPN returned Resident #1 to the facility on [DATE] at 8:12 a.m.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 05/17/2024 at 4:52 p.m.</p> <p>The Immediate Jeopardy was removed on 05/20/2024 at 2:10 p.m., after it was verified through observations, interviews, and record review the facility implemented an acceptable Plan of Removal, prior to the survey exit.</p> <p>This deficient practice had the likelihood to cause more than minimum harm to the remaining 19 residents were identified as being at risk for wandering and elopement.</p> <p>Findings:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #1</p> <p>Review of Resident #1's Risk of Elopement/Wandering Review dated 05/06/2024 revealed, in part, Resident #1 was assessed as being at risk for wandering with a score of 11 (a score of 11 or above indicated Resident #1 was at high risk for wandering).</p> <p>Review of Resident #1's May 2024 Physician's Orders revealed, in part, an order dated 05/07/2024 and discontinued on 05/08/2024 for Resident #1 to have a WanderGuard bracelet in place to his right ankle. Further review revealed, an order dated 05/08/2024 for Resident #1 to have a WanderGuard bracelet in place to his left ankle.</p> <p>Review of Resident #1's Nurse's Note dated 05/07/2024 at 12:51 p.m. revealed, in part, a call was placed to Resident #1's responsible party regarding Resident #1 wandering in and out of other residents' rooms.</p> <p>Review of Resident #1's late entry Nurse's Note dated 05/07/2024 at 3:03 p.m. revealed, in part, Resident #1 would pace in and out of his room and stated, I need to get to work.</p> <p>Review of Resident #1's Nurse's Note dated 05/07/2024 at 6:45 p.m. revealed, in part, a Certified Nursing Assistant (CNA) went into Resident #1's room and he was not present. Further review revealed S4Licensed Practical Nurse (LPN) and a CNA (S5CNA) went to each room on Floor b to look for Resident #1. Further review revealed, after the search for Resident #1 was unsuccessful on Floor b, S4LPN continued to search for Resident #1 on Floor c. Review revealed a staff nurse (S6LPN) informed S4LPN that a person who matched Resident #1's description had inquired about a streetcar or cab and the staff nurse (S6LPN) had directed him to the lobby. Further review revealed, a receptionist (S7Receptionist) informed S4LPN she let out a group of visitors, and hadn't heard any WanderGuard system alarms. Further review revealed, S4LPN and a CNA (S5CNA) continued to search throughout the building, but Resident #1 was still missing. Further review revealed S4LPN went to the facility's parking lot and searched surrounding the area, but Resident #1 remained missing.</p> <p>In a telephone interview on 05/17/2024 at 11:14 p.m., S5CNA indicated on 05/07/2024 she was unable to locate Resident #1. S5CNA further indicated she looked for Resident #1, but was unable to locate him in the facility or the surrounding area.</p> <p>In a telephone interview on 05/20/2024 at 2:29 p.m., S4LPN indicated on 05/07/2024, S5CNA had gone into Resident #1's room and Resident #1 was not there. S4LPN further indicated she and S5CNA attempted to look for Resident #1 on Floor b, Floor c, the facility's common areas, and the facility's parking lot, but were unable to locate Resident #1. S4LPN further indicated she observed Resident #1 walking on a street near the facility on 05/08/2024 and brought him back to the facility around 8:10 a.m.</p> <p>Review of the facility's surveillance footage on 05/20/2024 at 10:32 a.m. revealed, in part, Resident #1 exited the facility through Door a, walked through Parking Lot e, and was last within view of the surveillance cameras at 6:30 p.m. on 05/07/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of S4LPN's written statement dated 05/08/2024 revealed, in part, S4LPN while driving observed Resident #1 walking on a street near the facility and offered him a ride home. Further review revealed S4LPN noted Resident #1 still had a WanderGuard bracelet on his right ankle. Further review revealed S4LPN returned Resident #1 to the facility at 8:12 a.m.</p> <p>Resident #2</p> <p>Review of Resident #2's Risk of Elopement/Wandering Review dated 05/08/2024 revealed, in part, Resident #2 was assessed as being at high risk for wandering with a score of 16 (score of 11 or above indicated Resident #2 was at high risk for wandering).</p> <p>Review of Resident #2's May 2024 Physician's Orders revealed, in part, an order dated 05/08/2024 for Resident #2 to have a WanderGuard bracelet placed on his right ankle.</p> <p>Resident #3</p> <p>Review of Resident #3's Risk of Elopement/Wandering Review dated 05/08/2024 revealed, in part, Resident #3 was assessed as being at risk for wandering with a score of 16 (a score of 11 or above indicated Resident #3 was at high risk for wandering).</p> <p>Review of Resident #3's May 2024 Physician's Orders revealed, in part, an order dated 05/09/2024 for Resident #3 to have a WanderGuard bracelet placed on her right ankle.</p> <p>Resident #4</p> <p>Review of Resident #4's Risk of Elopement/Wandering Review dated 05/08/2024 revealed, in part, Resident #4 was assessed as being at high risk for wandering with a score of 16 (score of 11 or above indicated Resident #4 was at high risk for wandering).</p> <p>Review of Resident #4's May 2024 Physician's Orders revealed, in part, an order dated 05/08/2024 for Resident #4 to have a WanderGuard bracelet placed on her left ankle.</p> <p>Resident #5</p> <p>Review of Resident #5's Risk of Elopement/Wandering Review dated 05/08/2024 revealed, in part, Resident #5 was assessed as being at high risk for wandering with a score of 19 (score of 11 or above indicated Resident #5 was at risk for wandering).</p> <p>Review of Resident #5's May 2024 Physician's Orders revealed, in part, an order dated 05/08/2024 for Resident #5 to have a WanderGuard bracelet placed on her left wrist.</p> <p>Observation on 05/17/2024 at 12:37 p.m., revealed S2Corporate Administrator placed a WanderGuard transmitter bracelet to the surveyor's left ankle. Further observation revealed the surveyor was able to exit the automatic doors of Door a without the automatic doors locking or the WanderGuard system alarm sounding for two attempts.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 05/17/2024 at 12:42 p.m., revealed the surveyor with the WanderGuard transmitter bracelet placed to her left ankle, was able to exit the automatic door of Door a without the automatic doors locking when surveyor approached from the left side of Door a.</p> <p>Observation on 05/17/2024 at 12:50 p.m. revealed the surveyor with the WanderGuard transmitter bracelet placed to her left ankle, was able to exit the automatic doors of Door a without the automatic doors locking or the WanderGuard system alarm sounding when approached from the left side of Door a.</p> <p>In an interview on 05/17/2024 at 12:55 p.m., S3Plant Manager indicated when he tested the WanderGuard system on Door a weekly, he placed the WanderGuard transmitter in a cup at waist level.</p> <p>In an interview on 05/17/2024 at 1:20 p.m., S2Corporate Administrator indicated the range of the WanderGuard system on Door a was not set as wide as it could have been in order to allow residents with WanderGuard transmitters to use the facility's elevator. S2Corporate Administrator further confirmed the facility was not testing the WanderGuard system on Door a from multiple angles.</p> <p>There was no documented evidence, and the facility did not present any documented evidence, the WanderGuard system on Door a was tested with a WanderGuard transmitter bracelet entering Door a at ankle height or with a WanderGuard transmitter bracelet entering Door a at different angles.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30587</p> <p>47487</p> <p>Based on interviews, record reviews, and observations, the facility:</p> <ol style="list-style-type: none"> Failed to ensure a resident (Resident #1), who was assessed as being at risk for wandering/elopement, was supervised and unable to elope off of the facility's grounds; Failed to ensure staff tested the WanderGuard system to ensure the transmitters were properly functioning at ankle level to alert staff and prevent residents from being able to exit the facility unsupervised for 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of 5 residents. <p>This deficient practice was identified for 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) sampled residents reviewed for wandering/elopement and accident/hazards.</p> <p>The deficient practice resulted in an Immediate Jeopardy situation on 05/07/2024 at 6:30 p.m. when Resident #1, a resident who was assessed as being at high risk for wandering and elopement, and who had a WanderGuard transmitter placed on his right ankle was allowed to exit the facility through Door a. Resident #1 left the supervision of the facility's staff for approximately 13.45 hours. Resident #1 was located by S4Licensed Practical Nurse (LPN) on 05/08/2024 when she observed him walking on a street near the facility. S4LPN returned Resident #1 to the facility on [DATE] at 8:12 a.m.</p> <p>S1Administrator was notified of the Immediate Jeopardy on 05/17/2024 at 4:52 p.m.</p> <p>The Immediate Jeopardy was removed on 05/20/2024 at 2:10 p.m., after it was verified through observations, interviews, and record review the facility implemented an acceptable Plan of Removal, prior to the survey exit. Findings:</p> <p>Cross Reference F689</p> <p>In an interview on 05/17/2024 at 12:55 p.m., S3Plant Manager indicated when he tested the WanderGuard system on Door a weekly, he placed the WanderGuard transmitter in a cup at waist level.</p> <p>In an interview on 05/17/2024 at 1:20 p.m., S2Corporate Administrator indicated the range of the WanderGuard system on Door a was not set as wide as it could have been in order to allow residents with WanderGuard transmitters to use the facility's elevator. S2Corporate Administrator further confirmed the facility was not testing the WanderGuard system on Door a from multiple angles.</p> <p>There was no documented evidence, and the facility did not present any documented evidence, the WanderGuard system on Door a was tested with a WanderGuard transmitter bracelet entering Door a at ankle height or with a WanderGuard transmitter bracelet entering Door a at different angles.</p>		