

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  06/04/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on interviews and record reviews, the facility failed to ensure a Quarterly Minimum Data Set (MDS) accurately reflected medication orders for 1 (Resident #74) of 5 (Resident #11, Resident #53, Resident #55, Resident #74, Resident #102) residents reviewed for medications.</p> <p>Findings:</p> <p>Review of Resident #74's electronic medication administration record (eMAR) for April 2025 revealed, in part, an order for Lasix 20 milligrams (mg) by mouth one time a day (a diuretic medication used to reduce swelling and fluid retention) and Trazodone Hydrochloride 50 mg by mouth one time a day (an antidepressant medication used to treat depression) were administered during the lookback period (the period required to review information to complete the MDS), 04/24/2025 through 04/30/2025.</p> <p>Review of Resident #74's Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 04/30/2025 revealed, in part, Sections C: antidepressant was not checked, Section G: diuretic was not checked, and Section Z: none of the above was checked.</p> <p>In an interview on 06/04/2025 at 12:24PM, S3Clinical Care Coordinator (CCC) indicated Resident #74's Quarterly MDS, with an ARD of 04/30/2025, was not accurate and Section-C: antidepressant and Section G diuretic should have been checked. S3CCC further indicated Section-Z none of the above should not have been checked.</p> <p>In an interview on 06/04/2025 at 1:45PM, S2Director Of Nursing, indicated Resident #74's Quarterly MDS was not accurate and should have been as required.</p> <p>In an interview on 06/04/2025 at 1:45PM S1Administrator indicated Resident #74's Quarterly MDS section was not accurate and should have been as required.</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure an enteral feeding bag (bag that contains a formula for the purpose of supplying nutrients directly into the stomach) and the free water flush bag was properly labeled to include the rate of the infusion for 1 (Resident #130) of 1 (Resident #130) sampled residents reviewed for enteral feeding.</p> <p>Findings:</p> <p>Review of the Resident #130's electronic medical record revealed, in part, Resident #130 was admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing food and/or liquids) and gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach to provide nutritional support).</p> <p>Review of the facility's Enteral Tube Feeding via Continuous Pump policy and procedure, undated, revealed, in part, to check the enteral nutrition label against the order before administration. Further review revealed to check the resident's name and room number, type of formula, date and time formula was prepared, route of delivery, access site, method (pump, gravity, syringe); and the rate of administration in milliliters (ml) and hours (hrs).</p> <p>Review of Resident #130's May 2025 physician's order revealed, in part, continuous Isosource 1.5 (brand of enteral feeding formula) with an infusion rate of 45 ml/hr and free water flush with an infusion rate of 120 ml every four hours.</p> <p>Review of Resident #130's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/20/2025 revealed, in part, Resident #130 received enteral feedings.</p> <p>Observation on 06/02/2025 at 10:21AM revealed Resident #130's enteral feeding bag and free water flush bag was not labeled with the infusion rate.</p> <p>Observation on 06/03/2025 at 10:56AM revealed Resident #130's enteral feeding bag and free water flush was not labeled with the infusion rate.</p> <p>Observation on 06/03/2025 at 3:00PM revealed Resident #130's enteral feeding bag and free water flush was not labeled with the infusion rate.</p> <p>Observation on 06/04/2025 at 8:48AM revealed Resident #130's enteral feeding bag and free water flush was not labeled with the infusion rate.</p> <p>In an interview on 06/04/2025 at 8:51AM, S2Director of Nursing indicated Resident #130's enteral feeding bag and free water flush should have been labeled with the infusion rate.</p> <p>In an interview on 06/04/2025 at 10:05AM, S1Administrator indicated Resident #130's enteral feeding bag and free water flush should have been labeled with the infusion rate as required.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, interviews, and record reviews, the facility failed to follow a physician's order for oxygen administration for 1 (Resident #52) of 1 (Resident #52) sampled residents reviewed for respiratory care.</p> <p>Findings:</p> <p>Review of Resident #52's Minimum Data Set with an Assessment Reference Date of 04/16/2025 revealed, in part, Resident #52 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #52's cognition was intact. Further review revealed Resident #52 had a medical history of chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe) and lung cancer.</p> <p>Review of Resident #52's June 2025 Physician's Orders revealed, in part, Resident #52's oxygen was to be administered at 4 liters per minute (lpm) via nasal cannula (a device that gives you additional oxygen through your nose) every shift related to COPD, which may be removed for bathing and daily care.</p> <p>Review of Resident #52's care plan revealed, in part, Resident #52 was at risk for altered breathing related to the diagnosis of COPD and lung cancer.</p> <p>Observation on 06/02/2025 at 10:05AM revealed, Resident #52 was lying in bed with oxygen administered at 3.4lpm via nasal cannula.</p> <p>Observation on 06/03/2025 at 2:35PM revealed, Resident #52 was lying in bed with oxygen set to be administered at 3lpm via nasal cannula.</p> <p>In an interview on 06/03/2025 at 2:35PM, S3Clinical Care Coordinator/Licensed Practical Nurse (CCC/LPN) confirmed Resident #52's oxygen was administered at 3lpm via nasal cannula. S3CCC/LPN indicated Resident #52's oxygen should have been administered at 4lpm via nasal cannula.</p> <p>In an interview on 06/03/2025 at 3:20PM, S2Director of Nursing confirmed Resident #52's oxygen should have been administered at 4lpm via nasal cannula per physician orders.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on interviews and record reviews, the facility failed to develop resident-specific approaches and implement a plan of care for a resident with post-traumatic stress disorder (PTSD) for 1 (Resident #52) of 1 (Resident #52) sampled residents reviewed for behavioral/emotional services.</p> <p>Findings:</p> <p>Review of Resident #52's Minimum Data Set with an Assessment Reference Date of 04/16/2025 revealed, in part, Resident #52 had a Brief Interview of Mental Status score of 15, which indicated Resident #52's cognition was intact. Further review revealed Resident #52 had a medical history of PTSD, anxiety, and depression.</p> <p>Review of Resident #52's June 2025 Physician's Orders revealed, in part, no documented evidence, and the facility did not present any documented evidence an order was implemented to monitor for signs and symptoms of PTSD and/or triggers associated with Resident #52's PTSD.</p> <p>Review of Resident #52's Psychiatric Progress Notes dated 03/28/2025 and 04/28/2025 revealed, in part, Resident #52's active medical problems were PTSD and depression. Further review revealed no documented evidence Resident #52's PTSD was assessed to include the source of his trauma, monitoring for signs and symptoms of PTSD, identification of triggers, and/or interventions implemented to avoid further trauma.</p> <p>Review of Resident #52's Office of Behavioral Health-Preadmission Screening and Resident Review (PASRR) Level II Summary &amp; Determination Notice (a federal requirement for Medicaid-certified nursing facilities that ensures residents with serious mental illness are not inappropriately placed in nursing homes) dated 04/29/2025 revealed Resident #52 had a serious mental illness. Further review revealed a recommendation for Resident #52 to have a crisis/safety intervention plan.</p> <p>Review of Resident #52's care plan revealed, in part, no documented evidence, and the facility did not present any documented evidence Resident #52's plan of care included documentation regarding Resident #52's diagnosis of PTSD to include the source of his trauma, monitoring for signs and symptoms of PTSD, identification of triggers, and/or interventions implemented to avoid further trauma.</p> <p>In an interview on 06/04/2025 at 10:45AM, S3Clinical Care Coordinator/Licensed Practical Nurse (CCC/LPN) confirmed Resident #52's clinical record and plan of care did not address his diagnosis of PTSD, to include the source of his trauma, monitoring for signs and symptoms of PTSD, identification of triggers, and/or interventions implemented to avoid further trauma, and should have.</p> <p>In an interview on 06/04/2025 at 11:02AM, S2Director of Nursing (DON) confirmed Resident #52's clinical record and/or plan of care should have addressed his diagnosis of PTSD to include the source of his trauma, monitoring for signs and symptoms of PTSD, identification of triggers, and/or interventions implemented to avoid further trauma.</p>		