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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Terrebonne Health Care	1386 West Tunnel Blvd. Houma, LA 70360

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17453 Based on record reviews, observations, and interviews, the facility failed to assess residents for self-administration of drugs for 2 (Resident #9 and Resident #61) of 29 (Resident #2, Resident #9, Resident #22, Resident #25, Resident #26, Resident #29, Resident #30, Resident #36, Resident #43, Resident #54, Resident #55, Resident #61, Resident #73, Resident #77, Resident #84, Resident #90, Resident #96, Resident #109, Resident #113, Resident #121, Resident #122, Resident #127, Resident #135, Resident #138, Resident #139, Resident #140, Resident #197, Resident #297, and Resident #397) sampled residents. Findings: Review of the facility's Self-Administration of Medications policy, revised December 2016, revealed, in part, residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. Resident #9 Review of Resident #9's record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses of, in part, Osteoarthritis, Dysphagia and Hypertension. Review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/01/2024 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #9 had moderately impaired cognition. Observation on 05/06/2024 at 10:55 a.m. revealed a disposable medicine cup which contained 7 pills was on Resident #9's overbed table. In an interview on 05/06/2024 at 10:55 a.m., Resident #9's family member stated Resident #9's medications are often left at the bedside. Observation on 05/07/2024 at 9:56 a.m. revealed a disposable medicine cup which contained 8 pills was on Resident #9's overbed table. Observation on 05/07/2024 at 12:02 p.m. revealed a disposable medicine cup which contained 8 pills was on Resident #9's overbed table. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Chateau Terrebonne Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1386 West Tunnel Blvd. Houma, LA 70360	

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/07/2024 at 12:21 p.m. revealed Resident #9 self-administered 6 of the 8 medicines in the disposable medicine cup. In an interview on 05/07/2024 at 12:21 p.m., Resident #9 stated she did not take 2 of the medicines because they give her heartache. In an interview on 05/07/2024 at 12:29 p.m., S5Certified Nursing Assistant (CNA) stated he had observed medications in Resident #9's room, and Resident #9 chose the medications she wanted to take. In an interview on 05/07/2024 at 12:51 p.m., S6Licensed Practical Nurse (LPN) confirmed there were 2 pills in Resident #9's room in a disposable medicine cup. S6LPN identified the pills as a garlic pill and Zoloft 25milligram (a medication used for depression). S6LPN stated Resident #9's medications should not be left at the bedside. In an interview on 05/08/2024 at 12:01 p.m., S1Director of Nursing (DON) stated Resident #9's medications should not have been left at the bedside. Resident #61 Resident #61 was admitted to the facility on [DATE] with diagnoses of, in part, Diabetes, End Stage Renal Disease, Chronic Kidney Disease, and Hypertension. Review of Resident #61's May 2024 electronic Medication Administration Record (eMAR) revealed an order for 4 Sevelamer (a phosphate binder) 800mg tablet to be administered at 5:00 a.m., 1:00 p.m., and 5:00 p.m. Review of Resident #61's MDS with an ARD of 04/13/2023 revealed, in part, a BIMS score of 15, which indicated Resident #61 had intact cognition. Observation on 05/07/2024 at 12:06 p.m. revealed a disposable medicine cup which contained 2 pills was on Resident #61's overbed table. In an interview on 05/07/2024 at 12:06 p.m., Resident #61 stated the pills in the disposable medicine cup were phosphate binders (a medicine used to lower high blood phosphorus levels in patients who are on dialysis due to severe kidney disease). Resident #61 stated the nurse left the phosphate binders at his bedside for Resident #61 to self-administer the medications with his lunch. In an interview on 05/07/2024 at 1:06 p.m., S6LPN stated Resident #61 had a physician's order for 4 tablets of Sevelamer 800mg. S6LPN indicated she had administered 2 of the 4 tablets to Resident #61 and left the remaining 2 tablets with Resident #61 to self-administer with his lunch. In an interview on 05/08/2024 at 12:01 p.m., S1DON indicated medications should not be left at the bedside for Resident #61. In an interview on 05/08/2024 at 12:47 p.m., S2Quality Improvement Nurse indicated Resident #9 and Resident #61 were not assessed for self-administration of medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41876 Based on record reviews, observation, and interviews, the facility failed to ensure a resident's tracheostomy care was completed in a sanitary manner for 1 (Resident #90) of 1 (Resident #90) sampled residents investigated for mechanical ventilation and tracheostomy care. Findings: Review of Resident #90's Minimum Data Set with an Assessment Reference Date of 04/21/2024 revealed, in part, Resident #90 had diagnoses of cardiorespiratory conditions and chronic respiratory failure with hypoxia. Further review revealed Resident #90 received tracheostomy care and invasive mechanical ventilation. Review of Resident #90's May 2024 physician's orders revealed, in part, an order for Resident #90 to receive tracheostomy care twice per day. Further review revealed an order to change Resident #90's disposable inner cannula once per day. Review of Resident #90's care plan for ventilator dependence revealed, in part, interventions for Resident #90 to receive tracheostomy care twice in a 24-hour period and Resident #90's inner cannula to be changed once in a 24-hour period or more as necessary. Observation of Resident #90's tracheostomy care on 05/08/2024 at 9:04 a.m. revealed S3RespiratoryTherapist (RT) opened the inner cannula package, and the inner cannula fell out of the package onto Resident #90's bed linen. S3RT then removed Resident #90's existing disposable inner cannula. Further observation revealed S3RT picked up the new inner cannula off Resident #90's bed linen and inserted the inner cannula into Resident #90's tracheostomy stoma. In an interview on 05/08/2024 at 9:51 a.m., S3RT confirmed Resident #90's inner cannula had fallen out of the package prior to the insertion of the inner cannula into Resident #90's tracheostomy stoma. S3RT confirmed she should have obtained a new inner cannula to insert into Resident #90's tracheostomy stoma. In an interview on 05/08/2024 at 9:53 a.m., S4RespiratoryDirector confirmed S3RT should not have placed Resident #90's inner cannula into her tracheostomy stoma after it had fallen on Resident #90's bed. S4Respiratory Director confirmed S3RT should have obtained a new inner cannula.