STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195602	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Terrebonne Health Care Center	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 - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to assess a resident for self-administration of medications for 1 (Resident #143) of 1 (Resident #143) sampled residents reviewed for accident hazards. Findings: Review of the facility's Self-Administration of Medications policy and procedure revised on 12/2016 revealed, in part, the interdisciplinary team would assess each resident's cognitive and physical abilities to determine whether self-administration of medications was safe and clinically appropriate for the resident. Further review revealed any medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party. Review of Resident #143's clinical record revealed Resident #143 was admitted to the facility on [DATE]. Review of Resident #143's Quarterly Minimum Data Set with an Assessment Reference Date of 03/18/2025 revealed, in part, Resident #143 had a Brief Interview of Mental Status score of 6, which indicated Resident #143 had severe cognitive impairment. Review of Resident #143's May 2025 Physician's Orders revealed, in part, no documented evidence of an order for Resident #143 to self-administer medications. Observation on 05/18/2025 at 10:25AM revealed a bottle of Polyvinyl Alcohol 1.4% Lubricating Eye Drops and Systane Lubricant Eye Drops (medicated eye drops used to relieve dry eyes) were on Resident #143's bedside table. Further observation revealed the bottle of Polyvinyl Alcohol 1.4% Lubricating Eye Drops had an expiration date of 07/2024. In an interview on 05/18/2025 at 10:25AM, Resident #143 indicated she self-administered the above mentioned eye drops once or twice a day. Review of Resident #143's clinical record revealed no documented evidence, and the facility did not present any documented evidence Resident #143 was assessed and/or authorized to self-administer medications. In an interview on 05/19/2025 at 10:12AM, S6Licensed Practical Nurse (LPN) indicated the above mentioned medications should not have been at Resident #143's bedside and available for self-administration. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 05/19/2025 at 10:42AM, Resident #143's son indicated his mother had eye drops at her bedside since she was admitted to the facility. In an interview 05/20/2025 at 2:10PM, S1Assistant Administrator indicated Resident #143 should not have had the above mentioned medications at her bedsides and available for self-administration.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide the resident or responsible party (RP) with written notice which specified the duration of the bed-hold policy at the time of transfer to the hospital for 2 (Resident #16, Resident #86) of 2 (Resident #16, Resident #86) sampled residents investigated for hospitalizations. Findings: Review of the facility's Bed Hold and Returns policy, revised on 04/16/2024, revealed, in part, when a resident was transferred to the hospital, or goes out on therapeutic leave, a copy of this form (Notice of Hospital Transfer/Therapeutic Leave) was sent with the resident, and the resident representative will be notified specifying the duration of the bed-hold according to state plan, and the facilities policy regarding bed-hold periods. In cases of emergency transfer, notice at the time of transfer means that the family or resident representative are provided with written notification within 24 hours of the transfer. Resident #16 Review of Resident #16's record revealed no documented evidence, and the facility was unable to present any documentation showing that Resident #16 and Resident #16's responsible party had received written notification of the bed hold policy when admitted to the hospital on [DATE]. In an interview on 05/20/2025 at 9:45AM, S1Assistant Administrator indicated the facility did not provide residents with the Notice of Hospital Transfer/Therapeutic Leave policy upon hospital admissions. S1Assistant Administrator confirmed Resident #16 was not provided a copy of the Notice of Hospital Transfer/Therapeutic Leave when Resident #16 was admitted to the hospital on [DATE]. Resident #86 Review of Resident #86's record revealed no documented evidence, and the facility was unable to present any documentation showing that Resident #86 and Resident #86's responsible party had received written notification of the bed hold policy when admitted to the hospital on [DATE]. In an interview on 05/20/2025 at 2:05PM, S1Assistant Administrator indicated Resident #86 was not provided a copy of the Notice of Hospital Transfer/Therapeutic Leave when Resident #86 was admitted to the hospital on [DATE].

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, the facility failed to complete a care plan conference for 1 (Resident #119) of 1 (Resident #119) sampled residents investigated for care planning. Findings: Review of the facility's Resident Participation in Assessment and Care Plan policy, revised December 2016, revealed, in part, a comprehensive care plan was developed within 7 days of completion of the resident assessment and a 7 day advance notice of the care planning conference was provided to the resident and his or her representative. Review of Resident #119's record revealed no documented evidence, and the facility did not present any documented evidence, evidence a care plan conference had been completed after the completion of the MDS on 04/04/2025. In an interview on 05/18/2025 at 11:59AM, Resident #119 indicated he had not participated in a care plan conference. In an interview on 05/19/2025 at 11:29AM, S8Minimum Data Set Nurse (MDS Nurse) indicated Resident #119 had a MDS assessment completed on 04/04/2025 and should have had a care plan conference. S8MDS nurse indicated Resident #119's last scheduled care plan conference was on 10/03/2025. In an interview on 05/20/2025 at 12:19AM, S2Quality Improvement (QI) Nurse indicated Resident #119 should have had a care plan conference after the Minimum Data Set (MDS) Assessment on 04/04/2025. S2QI Nurse confirmed Resident #119 did not have a scheduled care plan conference in April 2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews, and record reviews, the facility failed to complete quarterly safe smoking assessments for 1 (Resident #11) of 1 (Resident #11) sampled residents investigated for smoking. Findings: Review of the facility's policy and procedure titled, Smoking Policy-Resident, dated 2001 and revised on 03/08/2023, revealed once the resident was determined to be a smoker, his/her ability to smoke safely would be evaluated upon admission, with subsequent Minimum Data Set (MDS) assessment and as needed. Review of Resident #11's annual MDS with an assessment reference date (ARD) of 09/16/2024 revealed Resident #11 used tobacco. Review of the facility's list of smoker's documentation revealed, in part, Resident #11 was determined to be a smoker. Review of Resident #11's medical record revealed the last Safe Smoking Assessment document was completed on 09/16/2024 with Resident #11's Annual MDS. Further review revealed a Quarterly MDS with an ARD of 12/15/2024 and a Quarterly MDS with an ARD of 03/13/2025 was completed. In an interview on 05/19/2025 at 10:36AM, S7 MDS Coordinator indicated the Safe Smoking Assessment document was completed on admit, quarterly with MDS assessment, and as needed. S7MDS Coordinator confirmed the last Safe Smoking Assessment completed in Resident #11's medical record was on 09/16/2024, and Resident #11 should have had a Safe Smoking Assessment completed with the 12/15/2024 MDS and the 03/13/2025 MDS. In an interview on 05/19/2025 at 11:05AM, S3Director of Nursing (DON) indicated Safe Smoking Assessments were completed quarterly with MDS assessments. S3DON further indicated Resident #11 should have had quarterly Safe Smoking Assessments completed since 09/16/2025. There was no documented evidence and the facility failed to present documented evidence a Safe Smoking Assessment document was completed for Resident #11 for December 2024 and March 2025.