STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195476	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol House Nursing and Rehab Center	11546 Florida Blvd Baton Rouge, LA 70815

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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 record reviews and interviews, the facility failed to notify the State's Long-Term Care Ombudsman of discharges in writing for 1 (Resident #97) of 1 (Resident #97) sampled residents reviewed for transfer and discharge requirements. Findings: Review of the facility's policy titled Transfer and Discharge (including AMA) revealed in part: Policy: It is the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited circumstances. This policy applies to all residents regardless of their payment source. Definitions: Transfer and Discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. 5. The facility will maintain evidence that the notice was sent to the Ombudsman. Review of Resident #97's Electronic Medical Record (EMR) revealed, in part, Resident #97 was admitted to the facility on [DATE] and was transferred from the facility to the local hospital on [DATE]. Review of the facility's Emergency Transfer Log dated 05/01/2025-05/30/2025 revealed no documentation of Resident #97's transferred to the hospital on [DATE]. Review of Resident #97's Nurse's note dated 05/07/2025 at 6:06 p.m. revealed, in part, Resident #97 was transferred on 05/07/2025 at 3:48 p.m. to a local hospital for treatment. On 06/11/25 at 2:26 p.m., an interview was conducted with S1ADM. S1ADM confirmed the facility had not issued a written notice to the facility's assigned Ombudsman when Resident #97 transferred to a local hospital as required.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan which met the needs of 2 (#26 and #84) of 24 residents reviewed in the final sample. The facility failed to: 1. Ensure Resident #26 was care planned for his preference of a daily bath; and 2. Ensure Resident #84's soft mitt or splint was in place on right hand at all times This deficient practice had the potential to affect a current census of 97 residents. Findings: Review of the facility's policy titled Care Planning Special Needs, with a revision date of 09/2020 revealed the following: Policy: To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This policy pertains to the following needs: .respiratory care, prostheses . Policy Explanation and Compliance Guidelines: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 6. The person-centered care plan will be developed, based on specific factors identified in assessments and physician orders, and in accordance with the resident's goals and preferences. 7. Medical conditions will be monitored and managed to prevent complications. b. RNs and LPNs will participate in the management of medical conditions by following physician orders . 1. Review of Resident #26's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #26's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2025, revealed a Brief Interview of Mental Status (BIMS) of 13, which indicated he was cognitively intact. Further review revealed he was dependent on staff assistance for bathing. Review of Resident #26's ADL (Activities of Daily Living) Flowsheet, dated June 2025, revealed Resident #26 should receive a bath on Mondays, Wednesdays, and Fridays. Further review revealed no evidence of his preference for a daily bath. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the C.N.A. (Certified Nursing Assistant) Assignment Sheet, dated June 2025, revealed no documentation of Resident #26's preference for a daily bath. Review of Resident #26's current Care Plan revealed the following: Problem: Date initiated 05/12/2025- The resident has an ADL self-care performance deficit related to Cerebrovascular Accident with Residual Effects. Interventions: Bathing/Showering: The resident is totally dependent on staff to provide as scheduled and as necessary. Further review revealed no documentation of the resident's preference for daily baths. On 06/09/2025 at 10:15 a.m., an interview was conducted with Resident #26. He stated he preferred daily bed baths, and he confirmed he informed staff of him wanting daily baths. On 06/10/2025 at 12:25 p.m., an interview was conducted with S15CNA. She stated Resident #26 preferred a daily bath. She stated his bath days on the ADL Flowsheet were scheduled for Monday, Wednesday, and Friday. She stated it was not documented anywhere Resident #26 preferred a daily bath. She stated staff who did not usually work with Resident #26, like agency staff, would not know he preferred a daily bed bath as it was not documented anywhere. On 06/10/2025 at 1:02 p.m., an interview was conducted with S14CNA. She stated Resident #26 preferred a daily bath. She stated his bath days on the ADL Flowsheet were scheduled for Monday, Wednesday, and Friday. She stated she knew Resident #26 was a daily bed bath because the resident and the staff who trained her informed her of this. She confirmed there was no documentation of the resident's preference for daily baths. On 06/10/2025 at 3:32 p.m., an interview was conducted with S16CNA. She stated she was assigned to Resident #26 on 06/08/2025, but was not normally assigned to him. She stated she was unaware of Resident #26's preference for a daily bath as it was not documented on the C.N.A. Assignment Sheet or the ADL Flowsheet. On 06/11/2025 at 12:00 p.m., an interview was conducted with S3ADON. She stated Resident #26 was to receive a daily bed bath per his preference. She confirmed Resident #26's preference for a daily bath was not documented on his care plan, the C.N.A. Assignment Sheet, or ADL Flowsheet and should have been. On 06/11/2025 at 12:22 p.m., an interview was conducted with S10MDS. She stated she was responsible for resident care plans. She stated she would care plan a resident's ADL preferences. She stated she would be notified of a resident's preferences during care plan meetings. She stated she was not aware Resident #26 preferred daily baths. She reviewed Resident #26's current care plan and confirmed Resident #26's care plan did not reflect his preference of a daily bed bath and should have. On 06/11/2025 at 1:06 p.m., an interview was conducted with S2DON. She stated Resident #26 preferred a daily bed bath. She stated he should be care planned for his preference of a daily bath. She reviewed Resident #26's care plan, C.N.A. Assignment Sheet, and ADL Flowsheet and confirmed he was not care planned for his preference of daily baths and should have been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #84's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction, Gastrostomy Status, and Tracheostomy Status. Review of Resident #84's quarterly MDS with an ARD of 05/15/2025, revealed a BIMS was not conducted due to resident being rarely or never understood, indicating severe cognitive impairment. Further review revealed the resident was totally dependent on staff for all self-care activities. Review of Resident #84's current Physician's Orders revealed the following: Start date: 01/09/2025 - Soft mitt to right hand with every 30 minute checks due to pulling tubing. Review of Resident #84's current Care Plan revealed the following: Problem: Date initiated 04/02/2025-Resident has an alteration in musculoskeletal status related to right hand contracture. Resident wears right hand splint usually during the day. Resident wears right hand soft mitt when splint not in use. Interventions Problem: Date initiated 01/08/2025-Resident uses physical restraints (Right hand soft mitt/guard) related to pulling of tubing. On 06/10/2025 at 8:38 a.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 11:39 a.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 1:50 p.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 3:24 p.m., an interview was conducted with S8LPN. She reviewed Resident #84's current Physician's Orders, and stated Resident #84 should always have either a soft mitt or a splint on her right hand due to the possibility of the resident pulling on her tubes. S8LPN observed and confirmed Resident #84 did not have a mitt or splint in place on her right hand and should have. On 06/10/2025 at 3:35 p.m., an interview was conducted with S3ADON. She reviewed Resident #84's Physician's Orders and confirmed Resident #84 should have a soft mitt or splint on her right hand at all times.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident with a Pressure Ulcer and at high risk for Pressure Ulcer development received care consistent with professional standards of practice and based on the comprehensive assessment by failing to ensure an air mattress was properly implemented for 1 (#54) of 3 (#45, #54, #150) residents reviewed with Pressure Ulcers. Findings: Review of the facility's policy titled, Pressure Injury Prevention and Management with a revision date of 07/2024 revealed the following, in part: Policy: This facility is committed to the prevention of avoidable pressure injuries, to provide treatment and services to heal the pressure ulcer/injury, and the development of additional pressure ulcers/injuries. Policy Explanation and Compliance Guidelines: Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Provide appropriate, pressure-distributing support surfaces. Review of Resident #54's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Chronic Respiratory Failure, Anoxic Brain Damage, Muscle Wasting and Atrophy, and History of Pressure Ulcers. Review of Resident #54's Quarterly MDS with an ARD of 04/15/2025 revealed a Brief Interview for Mental Status (BIMS) was unable to be conducted, which revealed she was severely cognitively impaired. Further review revealed Resident #54 was at risk for Pressure Ulcer development and was dependent on staff for turning and repositioning. Review of Resident #54's Braden Scale for Predicting Pressure Ulcer Risk dated 04/15/2025 revealed a score of 11, which indicated she was at high risk for Pressure Ulcer development. Review of Resident #54's current Physician Orders revealed, in part: A Low Air Loss Mattress on her bed. Review of Resident #54's current Care Plan revealed the following, in part: History of Pressure Ulcers Problem: 06/04/2025 Stage 1 Pressure Ulcer to Right Hip. Interventions: Low Air Loss Mattress on bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made of Resident #54 on 06/09/2025 at 8:36 a.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/09/2025 at 12:40 p.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/09/2025 at 1:40 p.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/10/2025 at 8:50 a.m. She was lying in bed. Her air mattress pump was not on. An interview was conducted with S6LPN on 06/10/2025 at 10:16 a.m. She stated Resident #54 had a history of Pressure Ulcers and was at risk for Pressure Ulcer development. She stated Resident #54 had an air mattress in place. She stated the mattress pump should have been turned on at all times. An observation was made of Resident #54 with S2DON on 06/10/2025 at 8:52 a.m. An interview was conducted with S2DON at that time. S2DON confirmed the air mattress pump was not on, which meant the mattress was not alternating pressure as intended. She confirmed the air mattress pump should have been on at all times. She confirmed Resident #54's air mattress was an intervention to prevent Pressure Ulcers since the resident was high risk for Pressure Ulcer development.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable infection by failing to ensure staff performed appropriate infection control practices during and after incontinence care for 1 (#61) of 3 (#19, #37, and #61) residents observed for incontinence care. Findings: Review of the facility's policy titled, Catheter Care revealed the following, in part: Policy: It is the policy of this facility to ensure residents with indwelling catheters receive appropriate catheter care. Compliance Guidelines: Female Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). Review of the facility's policy titled, Hand Hygiene revealed the following, in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, patients, residents, and visitors. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene may be performed by using both soap and water or alcohol based hand rub. Hand hygiene should be performed during resident care when moving from a contaminated body site to a clean site. Review of Resident #61's current Physician Orders revealed, in part, to cleanse her catheter daily and as needed with soap and water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at 9:00 a.m., an observation was made of S11LPN performing catheter and incontinence care on Resident #61. S11LPN donned clean gloves and used clean perineal wipes to remove bowel movement off of Resident #61's buttocks. S11LPN then, without changing gloves or performing hand hygiene, placed a clean sheet over Resident #61's torso with her soiled gloves. S11LPN removed her soiled gloves and applied clean gloves without performing hand hygiene. S11LPN obtained a clean wash cloth with soap and water, removed bowel movement off of Resident #61's catheter tubing and then used a perineal wipe to clean bowel movement off of Resident #61's catheter tubing. S11LPN removed her soiled gloves and applied clean gloves without performing hand hygiene. S11LPN then used five wash cloths to clean Resident #61's perineum and each time, placed the soiled wash cloths on the floor. S11LPN obtained a perineal wipe and cleaned bowel movement off of Resident # 61's buttocks, wiping toward the catheter tubing and vaginal area. Then without changing her gloves or performing hand hygiene, S11LPN opened a clean incontinence pad and placed it under Resident #61 with her soiled gloves. S11LPN, without changing gloves or performing hand hygiene, touched Resident #61's right arm and torso to turn Resident #61 toward S11LPN, touched the inside of Resident #61's clean brief, fastened Resident #61's brief, pulled Resident #61's gown down, and placed the sheets and blankets on Resident #61 with soiled gloves. S11LPN opened Resident #61's room door, removed her gown and gloves and exited Resident #61's room without performing hand hygiene. S11LPN went to another hall in the facility, retrieved a linen cart, placed a clean trash bag in the linen cart and put the lid down. Then without performing hand hygiene and using her soiled hands, S11LPN opened the Personal Protective Equipment cart drawer and put on a gown. S11LPN used her soiled hands to tie the gown around her waist and behind her neck. On 06/11/2025 at 9:40 a.m., an interview was conducted with S11LPN. S11LPN confirmed she should have removed her soiled gloves and applied clean gloves after removing bowel movement form Resident #61 and prior to moving to a clean area. S11LPN confirmed she did not perform hand hygiene between glove changes and after removing soiled gloves, and should have. S11LPN confirmed she placed soiled linen on the floor, and should not have. S11LPN confirmed she exited Resident #61's room and retrieved a soiled linen cart from another hallway without sanitizing her hands. S11LPN confirmed she should have wiped away from Resident #61's catheter tubing and vaginal area when removing bowel movement. On 06/11/2025 at 10:57 a.m., an interview was conducted with S2DON. S2DON confirmed staff should change their gloves when soiled and when moving from a contaminated to a clean area during resident care. S2DON confirmed staff should sanitize their hands between glove changes. S2DON confirmed staff should wipe from front to back in a female and should wipe away from catheter tubing while performing incontinence care. S2DON confirmed staff should place dirty linens into the dirty linen basin. S2DON confirmed soiled linen should not have been placed onto the floor.