STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195361	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baton Rouge Health Care Center	5550 Thomas Road Baton Rouge, LA 70811

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343 Based on record reviews and interviews, the facility failed to ensure residents, who required the assistance of two staff and a mechanical lift for transfers, remained free of accident hazards for 1 (#1) of 4 (#1, #2, #3, and #R1) residents reviewed. This deficient practice resulted in an actual harm on 05/26/2024 at 7:15 a.m. when S3CNA transferred Resident #1, who required the assistance of 2 staff and a mechanical lift for transfers, from her bed to her wheelchair alone without using a mechanical lift. At 3:30 p.m., Resident #1 complained of pain rated at an 8 on a scale to 10. The resident's left leg was slightly edematous and she yelled out in pain when the leg was moved. Resident #1 was sent to the emergency room and diagnosed with a Closed Fracture of the Left Tibia and Fibula and a Proximal Right Tibial Fracture. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings Review of the facility's undated Lifting Policy revealed the following, in part: 1.5 Policy Two persons are always required for standup lifts and bed lifts. 3.0 Procedure Lifts: Red - Total bed lift 2 people. 4. All staff are responsible for using the required number of staff members for resident transfer and lifts as per the resident's personal lift assessment. Review of Resident#1's clinical records revealed she was admitted to the facility on [DATE] with diagnosis which included: Generalized Muscle Weakness, Congestive Heart Failure, and Muscle Wasting and Atrophy. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #1's MDS, with an ARD of 04/03/2024, revealed the facility assessed her as requiring two-person assistance for transfers. Review of Resident #1's current Care Plans revealed: Problem- I am moderate risk for falls related to I need assist with transfers, weakness secondary to diagnosis of Congestive Heart Failure . Interventions- 02/18/2022- Resident's transfer status has been changed to total bed lift with red pad with 2 staff members . Review of the facility's incident report dated 05/26/2024 at 7:15 a.m. revealed: Incident type: Witnessed Fall Person Preparing Report: S5LPN Incident Description: S3CNA stated she was trying to transfer Resident #1 to wheelchair from bed, Resident #1 was in the wheelchair, stretched her legs out in front of her, and then started to slide out of the wheelchair. S3CNA stated as Resident #1 was sliding out of the wheelchair she was guiding Resident #1 to the floor. S3CNA stated Resident #1 told her she was a total lift transfer. S3CNA stated she didn't know Resident #1 was a total lift. Review of the written staff member statements dated 05/26/2024 revealed the following: Staff member: S3CNA. Staff Statement on fall that occurred on 5/26/2024: This morning at 7:15 a.m., I was getting Resident #1 up for breakfast. Since it's been awhile since I worked with her, I did not know she uses a lift to get up. I started to transfer her into her chair, but she needed to be pulled back. I went to pull her back, and she started to slide. As I was trying to pull her up, I couldn't so I guided her to the floor. Then that's when she said they use the lift on her. Afterwards I lowered the bed and got her back in it, and I let the nurse know and got the proper equipment. Signed S3CNA Staff member: S5LPN. Staff Statement on fall that occurred on 5/26/2024: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	S3CNA notified me Resident #1 was on the floor. S3CNA stated she was trying to transfer the resident to the wheelchair from the bed. The resident was in the wheelchair and stretched her legs out in front of her, she then started to slide out of the wheelchair. S3CNA stated that as the resident was sliding out of the wheelchair she was guided to the floor. S3CNA stated the resident told her she was a total lift transfer. S3CNA told me she didn't know Resident #1 was a total lift, and Resident #1 didn't have a lift pad in the room. I went to the resident's room and noticed that she was lying on the bed. The resident was on her back with her head pointing to the wall and her feet were on the floor with her body perpendicular on bed. I assessed the resident and no injury was noted, skin was intact. The resident complained of no pain at this time. The Resident was transferred with the lift to the wheelchair without any issues or complaints. No signs and symptoms of pain at this time. Signed S5LPN. Review of the Nurse's Notes for Resident #1 revealed the following: 05/26/2024 3:20 p.m.: Resident #1 was lying on right side in bed, moaning and complaining of pain to left leg and hip. Resident #1 stated pain was 8/10. Acetaminophen 650 mg was orally administered at approximately 3:30 p.m. Resident #1's left leg was slightly edematous, unable to move or bend leg without Resident #1 yelling out in pain. Call placed to nurse practitioner with new orders to send to emergency room for evaluation/treatment. Review of the hospital's Tibia Fibula 2 View Left x-ray report dated 05/26/2024 revealed the following: Impression: 1. Proximal left Femoral Hemiarthroplasty. Components appear well seated without evidence of proximal Femoral Periprosthetic fracture or loosening. 2. Acute traumatic fractures of the proximal Tibial and Fibular Metaphyses, displaced up to 2 cm. Review of the Nurse's Notes for Resident #1 revealed the resident returned to the facility from the hospital on 05/29/2024 at 4:59 p.m. Further review revealed the following: 05/30/2024 6:54 a.m.: Upon making rounds Resident #1 noted lying in bed left leg wrapped with ace wrap bandage. Right lower leg noted with bruising and swelling. Leg hot to touch. Resident #1 grimaced with palpation of lateral, inside right lower leg. Resident #1 refused pain meds at this time. Negative for pedal pulse. Call placed to nurse practitioner, order for doppler venous and arterial of right lower leg. 05/30/2024 12:11 p.m.: Order to send to emergency room for evaluation and treatment . Review of the hospital's Fibula 2 View Right x-ray report dated 05/30/2024 revealed the following: Impression: Impression: Osteopenia with proximal tibial fracture. Telephone interviews were unsuccessful with S3CNA on 06/18/2024 at 2:39 p.m. and 3:33 p.m., and on 06/20/2024 at 8:48 a.m. and 11:00 a.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Telephone interviews were unsuccessful with S5LPN on 06/18/2024 at 2:45 p.m., and 3:35 p.m., and on 06/20/2024 at 10:57 a.m., and 12:15 p.m. On 06/18/2024 at 1:40 p.m., an interview was conducted with S6SUP. She stated Resident #1 required total assistance with ADLs, 2 staff member assistance with turning, and bed lift for transferring. She stated she was aware of the incident with S3CNA and Resident #1 on 05/26/2024. She stated Resident #1's injuries could have been avoided had S3CNA asked for assistance and transferred the resident using the correct lift equipment and number of staff. On 06/20/2024 at 10:15 a.m., an interview was conducted with S2DON. He stated according to the written statement, S3CNA stated on 05/26/2024, she was transferring Resident #1 alone without a lift to the chair and Resident #1 began to slide down to the floor. He stated the resident did not initially complain of pain. He stated when the resident began to complain of pain she was sent to the emergency room to be evaluated. He stated on 05/28/2024, the hospital notified the facility that Resident #1 had a fracture to her left leg. He stated S3CNA was suspended pending the completion of the investigation, and last worked on 05/26/2024. He stated he interviewed Resident #1 while she was in the hospital, and the resident told him S3CNA was transferring her from the bed to the chair alone, without using the lift and dropped her. He stated while the investigation was on going, all staff received in-service training on lifts and transfers, over bed care plans, and lift policy. He stated all staff received a pre and posttest on lift and transfers as well as what the signs on the wall care plans indicate about a resident. He stated original staff was trained starting the day of the fall on 05/26/2024 and completed in full on 06/05/2024. He stated S3CNA gave a final statement on 05/30/2024 and she then admitted to transferring Resident#1 alone without a lift and dropped her on 05/26/2024, she was terminated on 05/30/2024. He stated S3CNA should have used the bed lift and the assistance of another staff member to transfer Resident #1 and did not. On 06/20/2024 at 11:10 a.m., an interview was conducted with S7ADON. She stated she was working as the weekend supervisor on 05/26/2024. She stated S5LPN told her S3CNA reported she lowered Resident #1 to the floor while attempting to transfer her. She stated on 05/26/2024 S3CNA told her she was trying to transferring Resident #1 from her bed to the wheelchair. The CNA explained once she transferred the resident to the wheelchair, Resident #1 began to slide down and she then assisted her to the floor. She stated S3CNA admitted she did not use the lift or another staff member to assist her during the transfer. She stated S3CNA told her she thought Resident #1 was a one person assist and did not require the lift. On 06/20/2024 at 12:20 p.m., an interview was conducted with S1ADM. He confirmed Resident #1 was assessed to be a two-person mechanical bed lift for transfers. He stated on 05/26/2024 S3CNA attempted to transfer Resident #1 to her chair without the bed lift or assistance, causing injury to Resident #1. He stated S3CNA should have followed Resident #1's over bed care plan for assistance and lift transfers. The facility has implemented the following actions to correct the deficient practice: 1. Director of Nurses, Assistant Director of Nurses, and CNA Supervisor in-serviced all nursing staff on lift policy/lift status/lift equipment, and resident over bed care plans with attention to resident transfers. 2. Lift dot audit done to ensure accuracy according to Plan of care on 05/26/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3. Nursing Facility Administrator viewed cameras for visual evidence. 4. Nursing Facility Administrator suspended S3CNA immediately during investigation. 5. Continued in-services to all nursing staff on lift policy/lift status/lift equipment and over bed care plans as well as abuse and neglect by Director of Nurses. 6. Director of Nurses or designee will continue to monitor lift and transfers and record on monitoring tool, interview staff during transfer and continue to in-service nursing staff three times per week, for a minimum of 5 weeks. 7. 05/30/2024 S3CNA was terminated. 8. Competition date 06/05/2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975 Based on interviews and record review, the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days and indicated the duration for 1 (#2) of 3 (#1, #2, and #3) sampled residents. Findings: Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE]. Review of Resident #2's June 2024 Physician's Orders revealed an order written on 06/03/2024 for Temazepam 7.5 mg tablet, one tablet by mouth as needed for Insomnia at night. Further review revealed the PRN medication had no stop date or duration. Review of Resident #2's June 2024 Medication Administration Record (MAR) revealed Temazepam 7.5 mg tablet by mouth as needed for Insomnia at night was started on 06/03/2024. Further review revealed the PRN medication had no stop date or duration. On 06/20/2024 at 10:07 a.m., an interview was conducted with S2DON. He reviewed Resident #2's June 2024 MAR and Physician Orders. He confirmed Temazepam was a psychotropic medication and was ordered PRN for longer than 14 days with no stop date or duration.