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	10/02/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42681 43868 Based on interviews and record review, the facility failed to ensure each resident was treated with respect and dignity and cared for them in a manner that promoted enhancement of quality of life for 4 of 4 (#1, #21, #70, and #82) residents reviewed for dignity. Findings: Review of facility's policy titled, Resident Rights, dated 12/2026, revealed, in part: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: b. Be treated with respect, kindness, and dignity. Review of S8CNA's employee file revealed the following: Notice of Expected Improvement Date: 09/28/2024 Nature of Occurrence: Resident #70 reported S8CNA spoke to her in a very strong tone. Expected Improvement or Standard: S8CNA was counseled by her immediate supervisor and the administrator. S8CNA was advised improvement was expected immediately. Signed by: S8CNA and S9CNAS on 09/30/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notice of Expected Improvement Date: 09/27/2024 Nature of Occurrence: S8CNA failed to treat our residents with dignity and respect. Expected Improvement or Standard: S8CNA was informed she was expected to correct this conduct immediately and a positive attitude was expected to be on display at all times while assisting and caring for residents. Signed by: S8CNA, S9CNAS and S1ADM on 09/27/2024. Notice of Expected Improvement Date: 02/25/2024 Nature of Occurrence: S8CNA was willfully disrespectful toward immediate supervisor. Expected Improvement or Standard: S8CNA was counseled on this behavior by the CNA Supervisor. Signed by: S8CNA and S9CNAS on 02/26/2024 Resident #1 Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS with an ARD of 09/11/2024 revealed a BIMS of 14, which indicated the resident's cognitive ability was intact. On 10/02/2024 at 11:10 a.m., an interview was conducted with Resident #1. She stated S8CNA spoke to her in a rude, condescending tone and physically handled her rough when she provided care. She stated the tone of voice S8CNA used when speaking to her felt very disrespectful and rude. Resident #21 Review of Resident #21's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #21's Quarterly MDS with an ARD of 09/04/2024 revealed a BIMS of 12, which indicated the resident's cognitive ability was moderately intact. On 10/02/2024 at 11:14 a.m., an interview was conducted with Resident #21. She stated S8CNA spoke to her in a rude, condescending tone and physically handled her rough when she provided care. She stated the tone of voice S8CNA used when speaking to her felt very disrespectful and rude. Resident #70 Review of Resident #70's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #70's Quarterly MDS with an ARD of 09/04/2024 revealed a BIMS of 11, which indicated the resident's cognitive ability was moderately intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #70's Nurses Notes revealed the following: 09/29/2024 at 4:11 p.m. by S10LPN Resident #70 noted walking up and down the hallway. Resident #70 appeared to be upset. When asked, Resident #70 stated she was upset with S8CNA and was sick of her. On 10/02/2024 at 11:20 a.m., an interview was conducted with Resident #70. She stated on 09/29/2024, her toilet was not working so she received permission from S11RNS to use the bathroom in the empty room across the hall from her room. Resident #70 stated during the 2-10 p.m. shift, she walked across the hall to use the restroom. Resident #70 stated as she approached the empty room, S8CNA stated in a stern, very condescending tone of voice uh uh uh, don't you dare go in that room. Resident #70 stated she explained to S8CNA her toilet was broken and she had permission from S11RNS to use this bathroom. Resident #70 stated S8CNA responded to her in a very stern, agitated tone of voice stating, I am going to find out. Resident #70 stated she felt the tone of voice S8CNA regularly used to communicate with her was very rude and disrespectful. On 10/02/2024 at 10:54 a.m., an interview was conducted with S10LPN. She stated on 09/29/2024, Resident #70 approached her in the hallway and physically appeared to be upset. S10LPN stated Resident #70 reported she was upset with S8CNA because of the way she treats her. S10LPN confirmed she reported this information to administration and to Resident #70's family. On 10/02/2024 at 11:55 a.m., an interview was conducted with S12WC. She confirmed Resident #70 reported a broken toilet on 09/29/2024. She confirmed S11RNS gave Resident #70 permission to use the bathroom in the empty room across the hall from her room. S12WC confirmed on 09/29/2024, she saw Resident #70 coming down the hallway crying following an interaction with S8CNA. Resident #82 Review of Resident #82's Clinical Record revealed she was admitted on [DATE]. Review of Resident #82's MDS with an ARD of 08/29/2024 revealed a BIMS of 15, which indicated the resident's cognitive ability was intact. On 10/02/2024 at 12:16 p.m., an interview was conducted with Resident #82. She confirmed she was very familiar with S8CNA. Resident #82 stated S8CNA interacted and spoke to her rude, cold hearted, and unprofessional. Resident #82 stated on 09/26/2024, she asked S8CNA to apply cream to her skin because the brief had rubbed it. Resident #82 stated S8CNA refused to apply the cream to her skin and left the room. Resident #82 confirmed she reported this behavior and her concerns with the way S8CNA interacted with her to S9CNAS. On 10/02/2024 at 1:27 p.m., an interview with S9CNAS. S9CNAS confirmed all staff should treat all residents with respect and dignity at all times. S9CNAS confirmed on 09/30/2024, S8CNA was counseled and placed on suspension after Resident #82 reported S8CNA's behavior on 09/26/2024 and Resident #70 reported S8CNA's behavior on 09/29/2024. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/2024 at 2:27 p.m., an interview was conducted with S1ADM. He stated he expected all staff to treat all residents with dignity and respect at all times when providing care and services. S1ADM stated Resident #82 reported S8CNA did not interact in a positive manner and was too authoritative, and abrupt when providing care. He stated Resident #70 reported S8CNA treated her very rude and disrespectfully. He confirmed S8CNA was placed on suspension on 09/30/2024 because of the reported behavior.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 Based on observations, interviews and record review, the facility failed to ensure a resident's call light was within reach for 2 (#2 and #83) of 32 residents reviewed during the initial pool. Findings: Review of the facility's policy titled, Call Light/Call Pager Systems, with a revision date of 09/09/2022, revealed the following, in part: Policy: The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. Resident #2 Review of Resident #2's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction and Hemiplegia and Hemiparesis Following Nontraumatic Intracerebral Hemorrhage Affecting Left Non-Dominant Side. Review of Resident #2's current Care Plan revealed the resident was at risk for falls. Interventions included to keep the call bell within reach when in room and answer promptly. On 09/30/2024 at 10:19 a.m., an observation was made of Resident #2 in her room. She was sitting in a Geri chair with her call light tied to the bed rail against the wall and out of reach. An interview was conducted at this time and Resident #2 confirmed she could not reach her call light. On 09/30/2024 at 10:25 a.m., an observation and concurrent interview was conducted with S7CNA. S7CNA observed Resident #2 sitting in a Geri chair in her room with the call light tied to the bed rail next to the wall. S7CNA confirmed Resident #2's call light was out of reach. On 09/30/2024 at 10:29 a.m., an interview was conducted with S4LPN. S4LPN stated Resident #2 was capable of using the call light and it should be kept in reach. Resident #83 Review of Resident #83's Clinical Record revealed the resident was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of Resident #83's current Care Plan revealed the resident was at risk for falls. Interventions included to keep the call light within reach and to encourage the resident to call for assist. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/2024 at 10:56 a.m., an observation was made of Resident #83 in his room. He was sitting in a wheelchair on the side of the bed closest to the room door. The call light was observed tied to the bed rail and not within the resident's reach. An interview was conducted at this time and Resident #83 confirmed he could not reach his call light. On 09/30/2024 at 11:03 a.m., an observation and concurrent interview was conducted with S4LPN. S4LPN observed Resident #83 sitting in a wheelchair with the call light tied to the bed rail and not in the resident's reach. S4LPN confirmed Resident #83's call light was not within reach and should have been. On 09/30/2024 at 4:30 p.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. S2DON confirmed when residents were in their room, their call lights should be in reach.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270 Based on observation, interviews, and record review, the facility failed to provide privacy to residents when receiving assistance with personal care for 1 (#52) of 4 (#15, #52, #70, and #140) residents reviewed for ADL (Activities of Daily Living) care. The facility failed to ensure the privacy curtain was pulled between Resident #52 and his roommate prior to staff initiating assistance to change his soiled brief and bed linens. Findings: Review of the facility's policy titled, Dignity, with a revision date of 02/2021, revealed the following, in part: Policy Statement: Each Resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Review of Resident #52's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses of Pulmonary Fibrosis and Chronic Respiratory Failure with Hypoxia. Review of Resident #52's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 06/19/2024 revealed the resident was always incontinent of bowel and bladder. On 10/01/2024 at 7:54 a.m., an observation revealed S5CNA providing ADL care to Resident #52. Resident #52 shared a room with one other resident, and Resident #52's bed was located closest to the door/entrance into the room. The privacy curtain was not pulled between Resident #52 and his roommate who was observed awake and sitting in a wheelchair near the foot of his bed. Resident #52 was observed in bed uncovered, revealing the resident's unclothed body with just a brief on, which was unfastened. Resident #52's soiled shirt and bed linens were observed on the floor in front of the resident's bed. During the observation, S6CNA entered Resident #52's room, and pushed his roommate out of the room in the wheelchair past Resident #52's bed. On 10/01/2024 at 8:00 a.m., an interview was conducted with S5CNA. S5CNA confirmed the aforementioned observations. S5CNA confirmed she did not pull the privacy curtain between Resident #52 and his roommate and the resident could be visualized by his roommate. S5CNA stated for the dignity and privacy of the resident she should have closed the privacy curtain between Resident #52 and his roommate. On 10/01/2024 at 10:00 a.m., an interview was conducted with S6CNA. S6CNA confirmed the aforementioned observation. S6CNA stated when she entered Resident #52's room the resident was lying in his bed in just a brief, without clothing, and could be visualized by his roommate. S6CNA stated the privacy curtain should have been pulled between Resident #52 and his roommate. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/2024 at 1:40 p.m., an interview was conducted with S3ADON. S3ADON was made aware of the above findings. S3ADON stated staff should have pulled the privacy curtain between Resident #52 and his roommate when providing ADL care. On 10/01/2024 at 1:55 p.m., an interview was conducted with S1ADM. S1ADM was made aware of the above findings. S1ADM confirmed Resident #52's privacy curtain should have been pulled during ADL care to prevent the resident from being visualized by his roommate.