

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Central Guest House Healthcare & Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 10748 Joor Road Baton Rouge, LA 70818	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received their dietary supplements with each meal for 1 (Resident #1) of 3 residents reviewed for nutrition. Resident #1 Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Quadriplegia, Unspecified Level of Spinal Cord Injury, and Unspecified Protein-Calorie Malnutrition. Review of Resident #1's most recent MDS with an ARD of 03/22/2026, revealed a BIMS of 5, which indicated severe cognitive impairment. Review of Resident #1's current Physician Orders revealed the following, in part: Start date 03/16/2026- Magic cup with meals. Review of Resident #1's most recent Registered Dietician Assessment Summary revealed, in part, the following: Current Diet Order: NAS (No Added Salt) diet. Regular texture, Regular/Thin consistency, double portion meats. Magic cup with meals three times a day. Liquid protein three times a day. House supplement four times a day. Glucerna in the evening with supper. Malnutrition Plan: Provide resident with meals, snacks, and supplements to meet nutrient needs. On 04/20/2026 at 9:25 a.m., an observation was made of Resident #1's breakfast tray and meal ticket with documentation noted for a Magic cup with meals. This item was not noted on Resident #1's breakfast tray. On 04/20/2026 at 9:34 a.m., an observation was made of Resident #1's breakfast tray and meal ticket with S2LPN. She confirmed Resident #1's breakfast tray did not have the ordered magic cup and should have. On 04/20/2026 at 8:22 a.m., an interview was conducted with S3DS. S3DS stated magic cups came from the kitchen. S3DS stated kitchen staff should prepare resident trays according to the resident's meal ticket. She stated if magic cups were on the meal tickets they should be on the resident's tray. On 04/21/2026 at 11:10 p.m., an interview was conducted with S1DON. S1DON stated if a resident had dietary supplements ordered with meals, they should be on the resident's tray as ordered.</p>

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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