STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195473	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Place Healthcare & Rehabilitation Center	3888 North Blvd Baton Rouge, LA 70806

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 Based on record reviews and interviews, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 (#98) of 4 (#68, #72, #98, and #99) residents reviewed for abuse. Findings: Review of the facility's policy titled, Abuse - Prevention and Prohibition Policy and Procedure, effective 03/25/2023, revealed, in part, the following: Purpose: Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. No one shall abuse a resident. The policy applies to covered individuals (the owner, operator, employees, managers, vendors, agency staff, agents or contractors) Policy: To provide a safe, abuse-free environment for all residents. If you suspect verbal, . abuse of a resident, . mistreatment of a resident . I. Types of Abuse: Abuse: is the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or anguish. Our policy presumes that abuse of any resident, ., causes physical harm, pain or mental anguish. Verbal Abuse: is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance or sight, regardless of the resident's age, ability to comprehend or disability. Examples: Name-calling, cursing or yelling at a resident in anger. Threats of harm. II. Procedures (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: 195473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER: Sterling Place Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3888 North Blvd Baton Rouge, LA 70806	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Training. Guidelines for Employees: If a resident starts to show signs of aggressive or catastrophic behavior verbally or physically, remain calm. Do not engage in an argument with the resident. Exit the area to prevent an incident. Resident #98 Review of Resident #98's Clinical Record revealed an admitted [DATE] with diagnoses which included, in part, the following; Anxiety Disorder; Dementia; Cognitive Communication Deficit; Unspecified Psychosis. Review of Resident #98's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2024, indicated resident had a Brief Interview of Mental Status (BIMS) of 5, which indicated resident had severe cognitive impairment. Review of the facility's Incident Report, dated 05/29/2024, revealed, in part, the following: Date/Time of Incident: 05/29/2024 at 7:27 a.m. Incident Type: Verbal Contact-Staff Resident Involved: Resident #98 Staff Involved: S23LPN Description of Incident: Verbal altercation between Resident #98 and S23LPN. S23LPN and Resident #98 were on the elevator alone when Resident #98 touched S23LPN's hair. As elevator opened, S23LPN was observed to be very upset with Resident #98 and they began arguing loudly using inappropriate language and curse words towards each other. Both S23LPN and Resident #98 continued to become increasingly agitated as they cursed at each other louder and louder. Staff members present on the 3rd floor intervened to pull S23LPN into a supply room away from Resident #98 in attempt to deescalate the situation. Resident #98 calmed down until S23LPN exited the supply room and began cursing at him again, which in turn re-escalated the situation. Staff from the 2nd floor heard the commotion and came up to assist with de-escalation and removed S23LPN from the floor. Witnesses: S13ADON, S19ADON, S20CNA, S21UC, S22LPN, S23LPN, and S24LPN. Review of the facility's Incident Report submitted to the State Survey Agency revealed, in part, the following: Date Occurred: 05/29/2024, 7:50 a.m. Accused Allegations: Verbal Abuse Resident Victim: Resident #98 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Accused: S23LPN

Allegation Findings: Substantiated.

Review of a signed Witness Statement written by S19ADON, dated 05/29/2024, revealed, in part, the following:

At approximately 7:28 a.m., S19ADONwas sitting at her desk when she overheard S23LPN and Resident #98 involved in a verbal altercation. S19ADON recalled hearing S23LPN telling Resident #98 that he should not have touched her hair. S23LPN stated that if she let him slide, he would try to touch other things. Other words were exchanged between the two that S19ADON could not hear. S23LPN walked to the supply room as Resident #98 yelled 'F**k You' and threw a book at S23LPN from the nurses station. S23LPN turned around and they both were yelling offensive words, such as, N***a, Black B***h, F***k you. S13ADON, S22LPN and other staff members came up to 3rd floor because they heard the commotion from the 2nd floor. S13ADON took S23LPN into the supply room while others were trying to get Resident #98 into his room. However, Resident #98 would not leave from the nurses' station. S23LPN then came out still talking to Resident #98 and S13ADON took her back into the supply room. Resident #98 hit the supply room door causing myself and another nurse to run out of the office to assist. Resident #98 stated he was going to get his people to kill S23LPN and anyone who gets in his way. Resident #98 then stated he was going to stab her with a pen that he had in his hand. S13ADON and others finally got S23LPN in the elevator.

Review of a signed Witness Statement written by S22LPN, dated 05/29/2024, revealed, in part, the following:

Loud voices were heard coming from the third floor. S13ADON and S22LPN immediately ran up the stairs to the third floor and witnessed Resident #98 and S23LPN having a verbal altercation. S22LPN did not know how the incident started but she did witness S23LPN shouting don't put your f***king hands on me. As S22LPN walked up to Resident #98 to calm him down he stated I was just moving her hair. It was in her face. Resident #98 then continued to go back and forth with S23LPN arguing. S22LPN heard Resident #98 say F**k you black b***h and S23LPN said no, you are the black b***h. F**k you. Resident #98 then stated I'll get my people from the park to come f**k you up. S23LPN shouted I got people to f**k you. S22LPN was able to calm Resident #98 down as S13ADON brought S23LPN in the supply room. When S23LPN came out the supply room she overheard Resident #98 saying I was moving her hair so S23LPN stated I don't care, don't f**king touch me. Resident #98 and S23LPN continued the verbal argument until Resident #98 charged at S23LPN without hitting her and the verbal argument continued with cursing from both parties before S23LPN entered the elevator to go to the 4th floor.

Review of a signed Witness Statement written byS20CNA, dated 05/29/2024, revealed, in part, the following:

S20CNA stated she was on the second floor and heard the shouting commotion getting louder on the third floor so she rushed upstairs. She stated as she exited the elevators she heard S23LPN shouting F**k you to Resident #98.

Review of a signed Witness Statement written by S21UC, dated 05/29/2024, revealed, in part, the following:

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	While on the 3rd floor, she saw Resident #98 get off the elevator. S23LPN was by the nurses' station when Resident #98 touched her. She stated S23LPN told him not to touch her. She said I have asked you before not to touch me. She stated the exchange went back and forth and eventually escalated to both Resident #98 and S23LPN cursing and shouting at each other. An interview was conducted on 07/31/2024 at 3:00 p.m. with S13ADON. She stated she was working on the 2nd floor on the morning of 05/29/2024 when the incident between S23LPN and Resident #98 occurred. She stated she heard shouting from the 3rd floor that continued to get louder so she went up to determine what was occurring. She stated when she arrived to the 3rd floor, S23LPN and Resident #98 were shouting and cursing at each other but still had space between them. She confirmed S23LPN was shouting profanities at Resident #98 causing the situation to escalate rather than attempting to deescalate as she had been trained to do. She stated she immediately grabbed S23LPN and pulled her into the supply room to separate the two in attempt to deescalate the situation. She stated a few minutes later when S23LPN exited the supply room, she immediately began fussing and cursing at Resident #98 which got him agitated all over again. S13ADON stated she and the other staff then pulled S23LPN onto the elevator to get her out of there. She confirmed she would consider a staff member shouting and/or cursing at a resident to be abuse. An interview was conducted on 07/31/2024 at 3:22 p.m. with S24LPN. She stated she was working as a nurse on the 3rd floor on the morning of 05/29/2024 when the incident between S23LPN and Resident #98 occurred. She stated she saw the elevator open on the 3rd floor with S23LPN and Resident #98 inside and both exited. She stated S23LPN approached the nurses' station and she could tell she was not happy. S24LPN stated S23LPN informed her Resident #98 put his hand in her hair and she didn't appreciate it. She stated S23LPN was visibly upset and becoming agitated, as was Resident #98. She stated Resident #98 told S23LPN I didn't mean anything by it. She stated S23LPN began telling Resident #98 to keep his hands to himself. Resident #98 called S23LPN names and cursed at her. S23LPN began shouting curse words at Resident #98. She confirmed she would consider it abuse if a staff member shouted or cursed at a resident for any reason. An interview was conducted on 07/31/2024 at 3:40 p.m. with S2AADM. She confirmed S13ADON made her aware of the verbal altercation between S23LPN and Resident #98 immediately after it occurred. She confirmed a staff member shouting and cursing at a resident would be considered verbal abuse. An interview was conducted on 07/31/2024 at 3:33 p.m. with S1ADM. He confirmed a staff member shouting and cursing at a resident would be considered verbal abuse. He confirmed S13ADON notified him, S2AADM and S12DON of the altercation between S23LPN and Resident #98 immediately after the event occurred.

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NAME OF PROVIDER OR SUPPLIER Sterling Place Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3888 North Blvd Baton Rouge, LA 70806	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported immediately, but no later than 2 hours, after the allegation was made to the state survey agency for 1 (#98) of 4 (#68, #72, #98, and #99) residents reviewed for abuse. Findings: Review of the facility's policy titled, Abuse - Prevention and Prohibition Policy and Procedure, effective 03/25/2023, revealed, in part, the following: Purpose: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. No one shall abuse a resident. Policy: To provide a safe, abuse-free environment for all residents. If you suspect verbal, . abuse of a resident, . mistreatment of a resident, Contact the Administrator immediately. Employees should immediately report their knowledge related to abuse allegations to the Administrator. The Administrator shall immediately initiate a report to the state survey agency and the facility's local law enforcement agency; but not less than 2 hours after forming the suspicion of a crime if the alleged violation involves abuse (. verbal abuse .). Review of Resident #98's Clinical Record revealed an admitted [DATE] with diagnoses which included, in part, the following; Anxiety Disorder; Dementia; Cognitive Communication Deficit; Unspecified Psychosis. Review of the facility's Incident Report, dated 05/29/2024, revealed, in part, the following: Date/Time of Incident: 05/29/2024 at 7:27 a.m. Incident Type: Verbal Contact-Staff Resident Involved: Resident #98 Staff Involved: S23LPN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description of Incident: Verbal altercation between Resident #98 and S23LPN. S23LPN and Resident #98 were on the elevator alone when Resident #98 touched S23LPN's hair. As elevator opened, S23LPN was observed to be very upset with Resident #98 and they began arguing loudly using inappropriate language and curse words towards each other. Both S23LPN and Resident #98 continued to become increasingly agitated as they cursed each other louder and louder. Staff members present on the 3rd floor intervened to pull S23LPN into a supply room away from Resident #98 in attempt to deescalate the situation. Resident #98 calmed down until S23LPN exited the supply room and began cursing at him again, which in turn re-escalated the situation. Staff from the 2nd floor heard the commotion and came up to assist with de-escalation and removed S23LPN from the floor. Witnesses: S13ADON, S19ADON, S20CNA, S21UC, S22LPN, S23LPN, S24LPN Review of the facility's Incident Report submitted to the State Survey Agency revealed, in part, the following: Date Occurred: 05/29/2024, 7:50 a.m. Date Reported: 05/29/2024, 1:11 p.m. Accused Allegations: Verbal Abuse Resident Victim: Resident #98 Accused: S23LPN Review of a signed Witness Statement written by S22LPN, dated 05/29/2024, revealed, in part, the following: Loud voices were heard coming from the third floor. S13ADON and S22LPN immediately ran up the stairs to the third floor and witnessed Resident #98 and S23LPN having a verbal altercation. S22LPN did not know how the incident started but she did witness S23LPN shouting don't put your f***king hands on me. As S22LPN walked up to Resident #98 to calm him down he stated I was just moving her hair. It was in her face. Resident #98 then continued to go back and forth with S23LPN arguing. S22LPN heard Resident #98 say F**k you black b***h and S23LPN said no, you are the black b***h. F**k you. Resident #98 then stated I'll get my people from the park to come f**k you up. S23LPN shouted I got people to f**k you. S22LPN was able to calm Resident #98 down as S13ADON brought S23LPN in the supply room. When S23LPN came out the supply room she overheard Resident #98 saying I was moving her hair so S23LPN stated I don't care, don't f**king touch me. Resident #98 and S23LPN continued the verbal argument until Resident #98 charged at S23LPN without hitting her and the verbal argument continued with cursing from both parties before S23LPN entered the elevator to go to the 4th floor. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/31/2024 at 3:00 p.m. with S13ADON. She confirmed she was present for the altercation on 05/29/2024 that occurred shortly after 7:30 a.m. between S23LPN and Resident #98. She stated she was on the 2nd floor and heard shouting from the 3rd floor that continued to get louder. She stated when she arrived to the 3rd floor, S23LPN and Resident #98 were shouting and cursing at each other but still had space between them. She confirmed S23LPN was shouting profanities at Resident #98 causing the situation to escalate rather than attempting to deescalate as she had been trained to do. She stated she immediately grabbed S23LPN and pulled her into the supply room to separate the two in attempt to deescalate the situation. She stated a few minutes later when S23LPN exited the supply room, she immediately began fussing and cursing at Resident #98 which got him agitated all over again. She stated she and the other staff then pulled S23LPN onto the elevator to get her out of there. She confirmed as soon as she was able to remove S23LPN from the 3rd floor and deescalate the situation, she immediately notified S1ADM, S2AADM and S12DON of what occurred. An interview was conducted on 07/31/2024 at 3:33 p.m. with S1ADM. He confirmed he was responsible for submitting the facility's incident reports to the state agency. He confirmed any allegation or suspicion of resident abuse should be reported within 2 hours, including allegations of verbal abuse from a staff member. He confirmed a staff member shouting and cursing at a resident would be considered verbal abuse. He confirmed S13ADON notified him, S2AADM and S12DON of the altercation between S23LPN and Resident #98 immediately after the event occurred. He confirmed he did not submit an incident report to the state agency within 2 hours of being notified of the altercation from S13ADON.

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Sterling Place Healthcare & Rehabilitation Center	3888 North Blvd Baton Rouge, LA 70806

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on interviews and record reviews, the facility failed to ensure resident MDS assessments accurately reflected the resident's status for 4 (#11, #68, #100, and #119) of 8 (#10, #11, #23, #68, #100, #109, and #119) residents reviewed for PASRR by failing to correctly code the residents PASRR evaluations. Findings: #11 Review of Resident #11's Clinical Record revealed an admitted [DATE] with diagnoses which included Dementia, Schizoaffective Disorder, Anxiety Disorder, and Major Depressive Disorder. Further review revealed an approved Level II PASRR. Review of Resident #11's Annual MDS with ARD of 06/19/2024 revealed question A1500, Resident evaluated for PASRR, was answered as no. #68 Review of Resident #68's Clinical Record revealed an admitted on 06/20/2023 with diagnoses which included Generalized Anxiety Disorder, Depression, and Bipolar Disorder. Further review revealed an approved Level II PASRR. Review of Resident #68's Annual MDS with ARD of 06/19/2024 revealed question A1500, Resident evaluated for PASRR, was answered as no. #100 Review of Resident #100's Clinical Record revealed an admitted [DATE] with diagnoses, which included, in part, the following; Schizoaffective Disorder; Schizophrenia; Major Depressive Disorder. Further review revealed an approved Level II PASRR. Review of Resident #68's Annual MDS with ARD of 06/26/2024 revealed question A1500, Resident evaluated for PASRR, was answered as no. #119 Review of Resident #119's Clinical Record revealed an admitted [DATE] with diagnoses which included Schizophrenia. Further review revealed an approved Level II PASRR. Review of Resident #119's Annual MDS with ARD of 11/28/2024 revealed question A1500, Resident evaluated for PASRR, was answered as no. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 11:03 a.m., an interview was conducted with with S5MDS. He confirmed he was responsible for Resident #100's annual MDS assessments. He stated comprehensive MDS assessments should include if the resident has a state level II PASRR. He confirmed Resident #100 had an approved state level II PASRR, the MDS did not include the state level PASRR and it should have. On 07/31/2024 at 11:04 a.m., an interview was conducted with S4MDS. She stated she was responsible for Residents #11, #68 and #119 annual MDS assessments. She stated comprehensive MDS assessments should include if the resident has a state level II PASRR. She confirmed Residents #11, #68 and #119 had an approved state level II PASRR, the MDS did not include the state level PASRR and it should have. On 07/31/2024 at 4:44 p.m., an interview was conducted with S2DON. She confirmed the MDS assessments should be accurate for all residents. 44590

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 48333 Based on interview and record review, the facility failed to incorporate the recommendations from Preadmission Screening and Resident Review (PASRR) Level II Determinations and PASRR Evaluation Reports into resident's assessment, care planning, and transitions of care for 3 (#14, #100, and #109) of 8 (#10, #11, #14, #23, #68, #100, #109, and #119) residents reviewed for PASRR. Findings: Review of facility's Policy and Procedure, dated 10/31/2014, revealed the following, in part: Policy: The Facility is required to ensure that the Specialized Service Recommendations indicated on the PASRR/ Level 2 are implemented and documentation of the recommended services is recorded in the resident's clinical record. If the recommended services are refused, the facility should ensure the refusal of such services is documented in the residents' clinical record. Resident #14 Review of Resident #14's Clinical Record revealed an admitted [DATE] with diagnoses, which included, in part, the following: Generalized Epilepsy, Anxiety Disorder, Schizophrenia, Depression, Slurred Speech, and Schizoaffective Disorder. Review of Resident#14's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/2024, indicated resident #14 had a Brief Interview of Mental Status (BIMS) of 5, which indicated resident was severely cognitively impaired. Review of Resident #14's BHSF Form 142, dated 03/12/2024, revealed, in part, the following: Form 142 - Section II: Approved for admission by Level II Authority, effective 03/12/2024 through 03/11/2025. Review of Resident #14's OBH-PASRR Level II Summary and Determination Notice, dated 03/11/2024, effective 03/12/2024 through 03/11/2025, revealed, in part, the following: Recommended Lesser Services: Medication Education; Training in ADLs; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Training in independent living skills; Structured leisure activities; and Evaluation for a diagnosis of dementia. Review of Resident #14's Care Plan revealed no documented care plan present for any of the following services: Medication Education, Training in ADLs, Training in independent living skills, or evaluation for a diagnosis of dementia. An interview was conducted on 07/31/2024 at 9:00 a.m. with Resident #14. He stated he would be willing to participate in the following: medication education, training in ADLs, training in independent living skills, and structured leisure activities, but these services were never offered to him. An interview was conducted on 07/31/2024 at 9:43 a.m. with S16SSD. She confirmed she was responsible for ensuring Level II PASRR recommended services were offered and carried out for each resident. She stated she offered the above services to Resident #14 but he refused. She confirmed she could not provide documented evidence to indicate Resident #14 refused the services. An interview was conducted on 07/31/2023 at 11:03 a.m. with S3MDS. She reviewed Resident #14's care plan and confirmed it did not include the recommended services from his Level II PASRR and should. She confirmed if services were refused, the care plan should reflect that and it did not. Resident #100 Review of Resident #100's Clinical Record revealed an admitted [DATE] with diagnoses, which included, in part, the following; Schizoaffective Disorder; Schizophrenia; and Major Depressive Disorder. Review of Resident #100's most recent MDS, with an ARD of 06/26/2024, indicated resident had a BIMS of 12, which indicated resident was cognitively intact. Review of Resident #100's BHSF Form 142, dated 04/22/2024, revealed, in part, the following: Form 142 - Section II: Approved for admission by Level II Authority, effective 04/22/2024 through 04/21/2025. Review of Resident #100's OBH-PASRR Level II Summary and Determination Notice, dated 04/22/2024, effective 04/22/2024 through 04/21/2025, revealed, in part, the following: Recommended Lesser Services: Training in independent living skills; and Structured leisure activities. Specialized Services Recommendations: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Place Healthcare & Rehabilitation Center	3888 North Blvd Baton Rouge, LA 70806

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Community Psychiatric Support and Treatment (CPST); and Psychosocial Rehabilitation (PSR) - Group. Review of Resident #100's Clinical Record revealed no documented evidence to indicate the facility offered or implemented any of the following: Training in Independent Living Skills, Structured Leisure Activities, CPST; or PSR-Group. Review of Resident #100's Care Plan revealed no documented care plan present for any of the following services: Training in Independent Living Skills, Structured Leisure Activities, CPST; or PSR-Group. An interview was conducted on 07/30/2024 at 1:32 p.m. with Resident #100. She confirmed she would enjoy participating in Training in Independent Living Skills, Structured Leisure Activities, CPST; or PSR-Group because she enjoyed doing new things and being around other people. She confirmed she did not recall being offered any of those services in the past and if she had, she would not have refused them. An interview was conducted on 07/31/2024 at 9:50 a.m. with S16SSD. She stated she offered the above services to Resident #100 but she refused. She confirmed she could not provide documented evidence to indicate Resident #100 refused the services. An interview was conducted on 07/30/2024 at 11:03 with S5MDS. He reviewed Resident #100's careplan and confirmed it did not include the recommended services from her Level II PSARR and should. He confirmed if services were refused, the care plan should reflect that and it did not. Resident #109 Review of Resident #109's Clinical Record revealed an admitted [DATE] with diagnoses which included, in part, the following; Anxiety Disorder. Review of Resident #109's most recent MDS, with an ARD of 12/28/2023, indicated resident had a BIMS of 11, which indicated resident was moderately cognitively intact. Review of Resident #109's BHSF Form 142, dated 04/30/2024, revealed, in part, the following: Form 142 - Section II: Approved for admission by Level II Authority, effective 05/01/2024 through 04/30/2025. Review of Resident #109's OBH-PASRR Level II Summary and Determination Notice, dated 04/30/2024, effective 05/01/2024 through 04/30/2025, revealed, in part, the following: Recommended Lesser Services: Structured leisure activities. Specialized Services Recommendations: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CPST. Review of Resident #109's Care Plan revealed no documented care plan present for any of the following services: Structured leisure activities and CPST. An interview was conducted on 07/30/2024 at 1:30 p.m. with Resident #109. She confirmed she did not recall being offered any of the services identified in her Level II PASRR in the past and if she had, she would not have refused them. An interview was conducted on 07/31/2024 at 9:50 a.m. with S16SSD. She stated she offered the above services to Resident #109 but she refused. She confirmed she could not provide documented evidence to indicate Resident #109 refused the services. An interview was conducted on 07/30/2024 at 11:03 with S5MDS. He reviewed Resident #109's careplan and confirmed it did not include the recommended services from her Level II PSARR and should. He confirmed if services were refused, the care plan should reflect that and it did not. An interview was conducted on 07/31/2024 at 9:57 a.m. with S1ADM. He confirmed he would expect residents to be offered and careplanned for all services recommended by their Level II PASRRs. He confirmed he would expect staff to document when those services were offered, especially if the services were refused by the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out ADLs received the necessary services to maintain good grooming and personal hygiene for 2 (#40 and #119) of 2 (#40 and #119) residents reviewed for ADL's. The facility failed to clean and trim fingernails for Residents #40 and #119. Findings: #40 Review of Resident #40's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Hemiplegia following Cerebral Vascular Accident Affecting Left Non-Dominant Side, Lack of Coordination, and Type 2 Diabetes Mellitus. Review of Resident #40's Annual MDS with an ARD of 06/19/2024 revealed Resident #40 had a BIMS of 8, which indicated moderate cognitive impairment. Further review revealed Resident #40 was dependent on staff for ADL's. Review of Resident #40's July Physician Orders revealed the following: 11/17/2023 Assess and trim fingernails and toenails monthly and as needed. On 07/29/2024 at 8:39 a.m., an observation was conducted of Resident #40. Her fingernails are noted to be 1/2 to 1 cm long with black stuff under multiple fingernails. She stated she would like her nails trimmed and cleaned. On 07/30/2024 at 8:52 a.m., an observation was conducted of Resident #40 eating breakfast in her bed. Her fingernails are noted to be 1/2 to 1 cm long with black stuff under multiple fingernails. On 07/30/2024 at 9:54 a.m., an interview was conducted with S8CNA. She stated she was assigned to Resident #40 and provided her morning ADL care on 07/29/2024. She stated the wound care nurse was responsible for cleaning and trimming fingernails and she did not clean the nails during her morning ADL care on 07/29/2024. On 07/30/2024 at 1:08 p.m., an interview was conducted with S17LPN. She stated the floor nurse would assess fingernails weekly during the scheduled skin assessment. She confirmed she never assessed, cleaned, or trimmed Resident #40's fingernails. She further confirmed she worked on 07/28/2024 and was assigned to complete the scheduled skin assessment and did not provide nail care. #119 Review of Resident #119's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnoses which included Schizophrenia, Weakness, and Generalized Arthritis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #119's Quarterly MDS with an ARD of 07/17/2024 revealed Resident #119 had a BIMS of 3, which indicated severe cognitive impairment. Further review revealed Resident #119 required supervision assistance for ADLs. Review of Resident #119's July Physician Orders revealed the following: 11/28/2023 Assess and trim fingernails and toenails monthly and as needed. On 07/29/2024 at 8:33 a.m., an observation was conducted of Resident #119 laying in his bed. His fingernails are noted to be 1/2 cm long with black stuff under multiple fingernails. He stated he would like his nails trimmed and cleaned. On 07/30/2024 at 8:31 a.m., an observation was conducted of Resident #119 laying in his bed. His fingernails are noted to be 1/2 cm long with black stuff under multiple fingernails. He stated he would like his nails trimmed and cleaned. On 07/30/2024 at 9:54 a.m., an interview was conducted with S7CNA. She stated she was assigned to Resident #119 and provided his morning ADL care today. She stated the wound care nurse was responsible for cleaning and trimming fingernails and she did not clean the nails during her morning ADL care this morning. On 07/30/2024 at 10:17 a.m., an interview was conducted with S6WC. She stated she assessed and trimmed fingernails for all residents monthly. She stated the assigned floor nurse was responsible for weekly fingernail assessment and care if needed. She further stated CNAs should be cleaning under the nails during baths. On 07/30/2024 at 10:19 a.m., an observation of Resident #40 and #119 was conducted with S6WC. She confirmed Resident #40's fingernails were dirty and should have been trimmed. She stated the staff nurse should assess fingernails weekly and trim them or inform her if they are not comfortable. She stated she was not made aware Resident #40's fingernails needed trimming. She further confirmed Resident #119's fingernails were dirty and should have been cleaned during morning ADL care. She stated it was a normal length for him because sometimes he did not like them cut short. On 07/31/2024 at 4:44 p.m., an interview was conducted with S12DON. She stated CNA's were responsible for cleaning under the fingernails during morning ADL care and nurses assessed fingernail care weekly with the scheduled skin assessment. She confirmed fingernails should not have black under them and should be trimmed as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615 Based on observations, interviews, and policy review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety. This had the potential to affect 126 residents who were served meals from the kitchen. Findings: Review of the facility's policy titled Storage Of Refrigerated Food revealed the following: Policy: The facility will ensure the quality and safety of refrigerated food through acceptable storage practices. Procedure: 4. All non-hazardous, opened foods are labeled with name of food and date stored 5. Foods are labeled with date to be discarded or the date stored. An observation was made on [DATE] at 8:45 a.m. of the facility's walk-in refrigerator with S10AM. The following was observed: - 6 8 oz plastic containers of whole milk with expiration date of [DATE] An observation was made on [DATE] at 8:50 a.m. of the facility's refrigerator #2 with S10AM. The following was observed: - 1 plastic package of opened turkey with no discard date An observation was made on [DATE] at 8:55 a.m. of the facility's dry food storage room with S10AM. The following was observed: - 1 open plastic bag of yellow cake mix, with no discard date - 1 open bag of powdered sugar box, unsealed, with no discard date - 1 16 oz plastic container of chili powder, unable to read open date, no discard date An interview was conducted on [DATE] at 9:00 a.m. with S10AM. She confirmed the above observations. She confirmed the above food items were available for resident use. She confirmed all expired food items should have been discarded. She confirmed all opened food items should have a label including both opened and expiration dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on [DATE] at 5:45 p.m. with S1ADM. S1ADM confirmed all food storage items should be labeled and checked for both opened and expiration dates.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44590 44615 Based on observations and interviews, the facility failed to maintain a safe, functional, sanitary and comfortable environment for 5 of 5 (a, b, c, d, e) rooms observed for environmental concerns. The facility failed to ensure maintenance of: 1. The walls, door frame and facing, and ceiling tiles in Room a; 2. Water entering the interior of Room a; 3. Water entering from windows and from ceiling above electrical outlet in Room b; 4. Ceiling tiles and prevention of sagging, black discolorations for Room c; 5. The walls and flooring of Room d; 6. Sanitary conditions for cleaning station, eye wash station, and ceiling tiles of Room e Findings: Room a On 07/29/2024 at 8:45 a.m., an observation was made of Room a. One ceiling tile was hanging and not in place above the television. There was black, spotty staining noted at the top of all walls where the ceiling is joined in the room and around the door frame. The door facing had a green, fuzzy staining on it. There was one corner ceiling tile in the bathroom with stains/discoloration. On 07/30/2024 at 10:08 a.m., an observation was made of Room a. One ceiling tile was hanging and not in place above the television. There was black, spotty staining noted at the top of all walls where the ceiling is joined in the room and around the door frame. The door facing had a green, fuzzy staining on it. There was one corner ceiling tile in the bathroom with stains/discoloration. On 07/30/2024 at 11:00 a.m., an observation was made of Room a with S12DON present. An interview was conducted with S12DON at that time. S12DON confirmed the above observations and stated Room a looked like water had dripped around the door and top of the walls. S12DON confirmed she was unaware of the findings. On 07/30/2024 at 3:35 p.m., an interview was conducted with S1ADM. He confirmed S12DON informed him of the above findings. S1ADM confirmed black staining on the walls was not comfortable and homelike. Room b (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/29/2024 at 9:25 a.m., an observation was made of Room b. On the interior wall to the left of the window and air conditioning unit, water lines were noted 15 inches wide from the ceiling halfway down the wall. On the interior wall to the right of the window and air conditioning unit with Resident #66's bed against it, the bead board on the bottom half of the wall was warped with water lines present. Two half dollar sized holes were on the exterior wall with a black substance surrounding them and extending outward to the rest of the wall. The sheet rocked upper half of the wall contained signs of water damage with water mark stains of varying colors throughout with peeling and bubbling. The bead boarded bottom half of the wall contained two electrical outlets, one outlet was in use running the room's air conditioner and one outlet was not in use. 100% of the bead board, including the areas immediately surrounding the electrical outlets, were warped and had water mark stains of varying colors. The baseboards on the exterior wall were laying on the floor, not attached to the wall. The metal trim surrounding the window contained rust throughout. The window glass contained dried water lines coming from the top of the window downward toward the room's air conditioner located directly beneath the window. On 07/29/2024 at 9:25 a.m., an interview was conducted with Resident #66. She confirmed Room a had been in rough shape since she moved in this past January. She confirmed she made numerous complaints in attempt to get it fixed since she moved in. She stated every time it rained, water came in from around the window and from the ceiling tiles along the exterior wall. She stated any time she spoke with anyone at the facility, they told her the repairs would have to wait until her floor was remodeled because they weren't doing anything until then. On 07/30/2024 at 1:40 p.m., an observation was conducted of Room b. On the interior wall to the left of the window and air conditioning unit, water lines were noted 15 inches wide from the ceiling halfway down the wall. On the interior wall to the right of the window and air conditioning unit with Resident #66's bed against it, the bead board on the bottom half of the wall was warped with water lines present. Two half dollar sized holes were on the exterior wall with a black substance surrounding them and extending outward to the rest of the wall. The sheet rocked upper half of the wall contained signs of water damage with water mark stains of varying colors throughout with peeling and bubbling. The bead boarded bottom half of the wall contained two electrical outlets, one outlet was in use running the room's air conditioner and one outlet was not in use. 100% of the bead board, including the areas immediately surrounding the electrical outlets, were warped and had water mark stains of varying colors. The baseboards on the exterior wall were laying on the floor, not attached to the wall. The metal trim surrounding the window contained rust throughout. The window glass contained dried water lines coming from the top of the window downward toward the room's air conditioner located directly beneath the window. On 07/30/2024 at 3:20 p.m., an interview was conducted with S18CNA. She confirmed she was regularly assigned to Resident #66. She confirmed during periods of heavy rain or high wind and rain, she had seen water come in from around the window in Room a and run down the walls and around the air conditioner. She confirmed staff had mopped water up from the floor along the exterior wall. She confirmed she reported the issue to maintenance in the past but was told it wouldn't be fixed until the remodel of the third floor took place so she quit reporting it. On 07/30/2024 at 3:40 p.m., an observation was made of Room b with S15M. An interview was conducted with S15M at that time. He stated he was not aware of the damage to Room a. He confirmed the presence of damage to the exterior and two interior walls and the lack of baseboards being in place. He stated the damage appeared to be water damage, including surrounding two electrical outlets. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/2024 at 4:00 p.m., an observation was made of Room b with S14MS. An interview was conducted with S14MS at that time. He stated he was not aware of the damage to Room b. He confirmed the presence of damage to the exterior and two interior walls and the lack of baseboards being in place. He stated the damage appeared to be water damage, including surrounding two electrical outlets. On 07/30/2024 at 4:00 p.m., an observation was made of Room b with S1ADM. An interview was conducted with S1ADM at that time. He stated he was not aware of the damage to Room b. He confirmed the presence of damage to the exterior and two interior walls and the lack of baseboards being in place. He stated the damage appeared to be water damage, including surrounding two electrical outlets. He confirmed the facility was aware of some on-going issues with exterior windows leaking but it was a big process to get them resealed and was going to cost a bunch of money so it had not been done yet. He confirmed resident rooms should be maintained for safety and in good repair at all times and Room b was not. Room c On 07/29/24 at 10:10 a.m., an observation was made of Room c. There were five water stained ceiling tiles in the hallway between the kitchen and dry storage room. One ceiling tile had green/black discolorations, softball size, and the entire tile was sagging downward toward the floor. S14MS was walking through the hallway during the observation, and an interview was conducted with S14MS. S14MS verified the ceiling tiles were an ongoing challenge. He confirmed the ceiling tiles should have been changed. Room d On 07/29/2024 at 8:45 a.m., an observation was made of Room d with a 4x10 inch piece of vinyl wood floor plank missing. The wall on the right side of the room had black and greenish widespread circles and was fuzzy in spots. On 07/30/2024 at 10:55 a.m. an observation was made of vinyl floor plank still missing 4x10 piece and wall on right side of room black and greenish widespread circles fuzzy in spots had been freshly painted over. Room e On 07/31/2024 at 10:15 a.m., an observation was made of Room e with S25HK and S9HKS. There was a large amount of debris/dirt in the sink with an eye wash station. The floor was covered with dirt and debris, and in the right back corner of Room e, there was a drain with raised edges. The drain area had blackish colored, sludge, water with a foul smell. S9HKS said Room e had been a long time issue. S9HKS pointed to the floor drain area and said that is where housekeeping staff dump all dirty water mop buckets. There were three large opened ceiling areas with missing tiles and visible ceiling wiring. S25HK stated the ceilings had been open for the past three days. S9HKS stated the above issues had been reported to S1ADM and requested for improvements to the area, but they had not been done. On 07/31/2024 at 5:45 p.m., an interview was conducted with S1ADM. He stated S9HKS notified him earlier today of observations made in Room e. He stated he was aware of the cleanliness/sanitation issue, foul odor, and flooring dirty with sludge around the drain. He stated he was aware of the eye wash station location in this room. S1ADM stated the condition of Room e was not acceptable.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44615 Based on observations and interviews, the facility failed to maintain an effective pest control program by failing to ensure the facility was free of pests and insects. This deficient practice had the potential to affect 128 residents who currently reside in the facility. Findings: An observation was made on 07/29/2024 at 8:45 a.m. of a small roach crawling across floor in main kitchen food preparation area. An observation was made on 07/29/2024 at 8:48 a.m. of a dead roach, close to clean pans. Further observations revealed small, black, grains of rice size particles on the main kitchen floor. An interview was conducted with S10AM on 07/29/2024 at 8:50 a.m. She stated that kitchen staff were responsible for making Management aware of pest observations. S10AM verified insect sightings in kitchen areas had been reported to Administration. An observation was made on 07/29/2024 at 8:55 a.m. of dead insects and small, black particles on the floor in food storage room. An observation was made on 07/29/2029 at 8:49 a.m. of a small spider crawling inside main kitchen area. S10AM verified recent insect and pest control issues. An observation was made on 07/29/2024 at 9:10 a.m. midway down the short side of Hall 3 of a cockroach, 3 inches in length, crawling on the lid of the yellow rolling bin utilized for dirty linens. The dirty linen bin was located in the hallway 3 feet from the clean linen cart. An interview was conducted on 07/29/2024 at 9:12 a.m. with S25CNA. She confirmed a roach was crawling on the lid of the yellow rolling bin utilized for dirty linens and roughly 3 feet from the clean linen cart. An observation was made on 07/29/2024 at 12:00 p.m. of a large cockroach crawling on the ceiling approximately 1ft. from door entry into dry food storage room. An observation was made on 07/30/2024 at 11:10 a.m. of a fly hovering over steam table during food temperature checks. S26C was observed waving her arms rapidly over the prepared food service table to shoo the fly away. An interview was conducted on 07/31/2024 at 5:45 p.m. with S1ADM. He stated he was aware there was a pest problem and increased pest control services were needed.