

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Capitol House Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11546 Florida Blvd Baton Rouge, LA 70815	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43868</p> <p>Based on observation, interviews, and record review, the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (#82) of 2 (#59 and #82) sampled residents reviewed for dignity. The facility failed to ensure staff communicated with the resident, and explained the care to be provided.</p> <p>Findings:</p> <p>Review of Resident #82's Clinical Record revealed he was admitted on [DATE] with diagnoses, which included Cerebral Infarction, Tracheostomy, and Need for Assistance with Personal Care.</p> <p>Review of Resident #82's admission assessment MDS with an ARD of 05/21/2024 revealed the provider assessed the resident as having a BIMS of 0, indicating the resident was severely cognitively impaired. Further review revealed he was totally dependent on staff for bed mobility, transfers, dressing, toileting, and personal hygiene.</p> <p>On 06/10/2024 at 10:20 a.m., an observation was conducted of Resident #82. S9CNA walked into Resident #82's room, pulled the curtain, and pulled the sheet to turn Resident #82 without explaining the care to be provided.</p> <p>On 06/12/2024 at 3:09 p.m., an interview was conducted with S3ADON. She confirmed she would expect all staff to greet residents when entering the room and explain the care to be provided.</p> <p>On 06/12/2024 at 3:30 p.m., an interview was conducted with S2DON. She confirmed she would expect all staff to greet residents when entering the room and explain care to be provided.</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46308</p> <p>Based on interviews and record review, the facility failed to ensure alleged violations involving neglect were reported immediately to the Administrator and within 24(twenty four) hours after the allegations were made to the state agency for 1of 1 (#70) residents reviewed for neglect.</p> <p>Findings:</p> <p>A review of the facility's policy titled, Reporting Alleged Violations revealed, in part, the following:</p> <p>Policy:</p> <p>The purpose of this policy is to assure that all alleged violations are reported immediately to the facility administrator and other officials.</p> <p>Compliance Guidelines:</p> <p>2. If the alleged violation involves abuse or results in serious bodily injury, it must be reported immediately but no later than 2 hours after the allegation is made.</p> <p>4. The alleged violations must be reported to the administrator of the facility and to other officials (including to the State Agency and Adult Protective Services where state law provides jurisdiction in long term care facilities) in accordance with state law through established procedures.</p> <p>A review of the clinical record revealed Resident #70 was admitted to the facility on [DATE]. Resident #70's diagnosis included Encounter for Attention to Tracheostomy.</p> <p>A review of Resident #70's Nurse's Notes from 05/17/2024 revealed:</p> <p>05/17/2024 at 4:00a.m.- Signed by S10LPN- Summoned to room by charge nurse while assisting with care of resident. Upon entering resident room, resident lying with head turned to right side. Condition stable. Resident noted to have large amount of larvae exiting from mouth area. Ambulance called to transport resident out of facility.</p> <p>A review of the facility's Investigative Report turned in to state agency revealed the incident with Resident #70 having maggots coming from his mouth was discovered on 05/17/2024 at 5:00 a.m. Further review revealed an investigative report was not entered into the system until 05/20/2024 at 12:18 p.m.</p> <p>On 06/12/2024 at 3:05 p.m., an interview was conducted with S1ADM. She confirmed she did not report the incident within 24 hours to the state agency. She confirmed she reported the incident on 05/20/2024 and it should have been reported within 24 hours of the incident.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46308</p> <p>Based on observation, record review and interview the provider failed to ensure the care plan was implemented for 1 (#70) of 4 (#67, #70, #77, and #299) residents sampled for Pressure Ulcers were turned and repositioned every 2 hours per Physician Orders.</p> <p>Findings:</p> <p>Review of Resident #70's face sheet/clinical record revealed the resident was admitted to the facility on [DATE]. Resident #70's diagnosis included, in part: Unspecified Open Wound of Lower Back and Pelvis.</p> <p>Review of Resident #70's Physician Orders from April 2024 to current revealed the following, in part,</p> <p>04/23/2024 Every 2 hour turns.</p> <p>Review of Resident #70's current Care Plan revealed;</p> <p>Problem Onset: 12/04/2023- I have a stage 4 to my Right Shoulder. I receive wound care as ordered by my Physician.</p> <p>Intervention: Every 2 hours turn and reposition as needed.</p> <p>On 06/13/2024 at 8:30 a.m., an observation was made with S1ADM of the facility's video surveillance of Resident #70's room on 05/16/2024 from 7:30 p.m. until 05/17/2024 at 4:00 a.m. S10LPN exited Resident #70's room on 05/16/2024 at 9:19 p.m. S11CNA's shift started on 05/16/2024 at 10 p.m. S11CNA never entered Resident #70's room until 05/17/2024 at 3:48 a.m. No nursing or CNA staff entered the room until 05/17/2024 at 3:40 a.m., when S13LPN entered room for wound care.</p> <p>On 06/13/2024 at 10:00 a.m., an interview was conducted with S1ADM. S1ADM verified a nurse did not enter Resident #70's room on 05/16/2024 from 9:19 p.m. until 05/17/2024 at 3:40 a.m. She also verified a CNA did not enter Resident #70's room on 05/16/2024 from 9:48 p.m. until 05/17/2024 at 3:48 a.m. She stated that nurses and CNAs should be making rounds every 2 hours and she confirmed they did not.</p> <p>On 06/13/2024 at 1:10 p.m., an interview was conducted with S2DON. She reviewed Resident #70's care plan. She confirmed Resident #70's care plan had an intervention for him to be turned every 2 hours. She further confirmed the CNA or nurse did not enter Resident # 70's room from 5/16/2024 at 9:48 p.m. until 05/17/2024 at 3:40 a.m. She stated Resident #70 should have been turned and repositioned every 2 hours and he was not.</p>