STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195476	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol House Nursing and Rehab Center	11546 Florida Blvd Baton Rouge, LA 70815

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to notify the State's Long-Term Care Ombudsman of discharges in writing for 1 (Resident #97) of 1 (Resident #97) sampled residents reviewed for transfer and discharge requirements. Findings: Review of the facility's policy titled Transfer and Discharge (including AMA) revealed in part: Policy: It is the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited circumstances. This policy applies to all residents regardless of their payment source. Definitions: Transfer and Discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. 5. The facility will maintain evidence that the notice was sent to the Ombudsman. Review of Resident #97's Electronic Medical Record (EMR) revealed, in part, Resident #97 was admitted to the facility on [DATE] and was transferred from the facility to the local hospital on [DATE]. Review of the facility's Emergency Transfer Log dated 05/01/2025-05/30/2025 revealed no documentation of Resident #97's transferred to the hospital on [DATE]. Review of Resident #97's Nurse's note dated 05/07/2025 at 6:06 p.m. revealed, in part, Resident #97 was transferred on 05/07/2025 at 3:48 p.m. to a local hospital for treatment. On 06/11/25 at 2:26 p.m., an interview was conducted with S1ADM. S1ADM confirmed the facility had not issued a written notice to the facility's assigned Ombudsman when Resident #97 transferred to a local hospital as required.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's discharge assessment was completed and transmitted for 1 (#82) of 2 (#82 and #88) residents reviewed for Resident Assessment. Findings: Review of the facility's policy titled, MDS (Minimum Data Set) 3.0 Completion and dated 05/2023 revealed the following, in part: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop and interdisciplinary care plan. Policy Explanation and Compliance Guidelines: 2. Types of Omnibus Budget Reconciliation Act Assessments i. Death Tracking i. Complete when a resident expires in the facility no later than discharge (death) date plus seven calendar days. 7. Transmission Requirements: a. All assessments shall be transmitted to the designated CMS (Centers for Medicare and Medicaid Services) system within 14 days of completion. Review of Resident #82's Clinical Record revealed she was admitted to the facility on [DATE] and was pronounced deceased in the facility on [DATE]. Review of Resident #82's MDS assessments revealed no discharge assessment was completed. An interview was conducted with S10MDS on [DATE] at 1:07 p.m. She confirmed Resident #82 was admitted to the facility on [DATE] and expired in the facility on [DATE]. She confirmed a discharge MDS assessment should have been completed for Resident #82's and was not. An interview was conducted with S2DON on [DATE] at 1:29 p.m. She reviewed Resident #82's MDS assessments and confirmed a discharge assessment should have been completed and was not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan which met the needs of 2 (#26 and #84) of 24 residents reviewed in the final sample. The facility failed to: 1. Ensure Resident #26 was care planned for his preference of a daily bath; and 2. Ensure Resident #84's soft mitt or splint was in place on right hand at all times This deficient practice had the potential to affect a current census of 97 residents. Findings: Review of the facility's policy titled Care Planning Special Needs, with a revision date of 09/2020 revealed the following: Policy: To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This policy pertains to the following needs: .respiratory care, prostheses . Policy Explanation and Compliance Guidelines: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 6. The person-centered care plan will be developed, based on specific factors identified in assessments and physician orders, and in accordance with the resident's goals and preferences. 7. Medical conditions will be monitored and managed to prevent complications. b. RNs and LPNs will participate in the management of medical conditions by following physician orders . 1. Review of Resident #26's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #26's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2025, revealed a Brief Interview of Mental Status (BIMS) of 13, which indicated he was cognitively intact. Further review revealed he was dependent on staff assistance for bathing. Review of Resident #26's ADL (Activities of Daily Living) Flowsheet, dated June 2025, revealed Resident #26 should receive a bath on Mondays, Wednesdays, and Fridays. Further review revealed no evidence of his preference for a daily bath. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the C.N.A. (Certified Nursing Assistant) Assignment Sheet, dated June 2025, revealed no documentation of Resident #26's preference for a daily bath. Review of Resident #26's current Care Plan revealed the following: Problem: Date initiated 05/12/2025- The resident has an ADL self-care performance deficit related to Cerebrovascular Accident with Residual Effects. Interventions: Bathing/Showering: The resident is totally dependent on staff to provide as scheduled and as necessary. Further review revealed no documentation of the resident's preference for daily baths. On 06/09/2025 at 10:15 a.m., an interview was conducted with Resident #26. He stated he preferred daily bed baths, and he confirmed he informed staff of him wanting daily baths. On 06/10/2025 at 12:25 p.m., an interview was conducted with S15CNA. She stated Resident #26 preferred a daily bath. She stated his bath days on the ADL Flowsheet were scheduled for Monday, Wednesday, and Friday. She stated it was not documented anywhere Resident #26 preferred a daily bath. She stated staff who did not usually work with Resident #26, like agency staff, would not know he preferred a daily bed bath as it was not documented anywhere. On 06/10/2025 at 1:02 p.m., an interview was conducted with S14CNA. She stated Resident #26 preferred a daily bath. She stated his bath days on the ADL Flowsheet were scheduled for Monday, Wednesday, and Friday. She stated she knew Resident #26 was a daily bed bath because the resident and the staff who trained her informed her of this. She confirmed there was no documentation of the resident's preference for daily baths. On 06/10/2025 at 3:32 p.m., an interview was conducted with S16CNA. She stated she was assigned to Resident #26 on 06/08/2025, but was not normally assigned to him. She stated she was unaware of Resident #26's preference for a daily bath as it was not documented on the C.N.A. Assignment Sheet or the ADL Flowsheet. On 06/11/2025 at 12:00 p.m., an interview was conducted with S3ADON. She stated Resident #26 was to receive a daily bed bath per his preference. She confirmed Resident #26's preference for a daily bath was not documented on his care plan, the C.N.A. Assignment Sheet, or ADL Flowsheet and should have been. On 06/11/2025 at 12:22 p.m., an interview was conducted with S10MDS. She stated she was responsible for resident care plans. She stated she would care plan a resident's ADL preferences. She stated she would be notified of a resident's preferences during care plan meetings. She stated she was not aware Resident #26 preferred daily baths. She reviewed Resident #26's current care plan and confirmed Resident #26's care plan did not reflect his preference of a daily bed bath and should have. On 06/11/2025 at 1:06 p.m., an interview was conducted with S2DON. She stated Resident #26 preferred a daily bed bath. She stated he should be care planned for his preference of a daily bath. She reviewed Resident #26's care plan, C.N.A. Assignment Sheet, and ADL Flowsheet and confirmed he was not care planned for his preference of daily baths and should have been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #84's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction, Gastrostomy Status, and Tracheostomy Status. Review of Resident #84's quarterly MDS with an ARD of 05/15/2025, revealed a BIMS was not conducted due to resident being rarely or never understood, indicating severe cognitive impairment. Further review revealed the resident was totally dependent on staff for all self-care activities. Review of Resident #84's current Physician's Orders revealed the following: Start date: 01/09/2025 - Soft mitt to right hand with every 30 minute checks due to pulling tubing. Review of Resident #84's current Care Plan revealed the following: Problem: Date initiated 04/02/2025-Resident has an alteration in musculoskeletal status related to right hand contracture. Resident wears right hand splint usually during the day. Resident wears right hand soft mitt when splint not in use. Interventions Problem: Date initiated 01/08/2025-Resident uses physical restraints (Right hand soft mitt/guard) related to pulling of tubing. On 06/10/2025 at 8:38 a.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 11:39 a.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 1:50 p.m., an observation was made of Resident #84 lying in bed with no soft mitt or splint noted on the resident's right hand. On 06/10/2025 at 3:24 p.m., an interview was conducted with S8LPN. She reviewed Resident #84's current Physician's Orders, and stated Resident #84 should always have either a soft mitt or a splint on her right hand due to the possibility of the resident pulling on her tubes. S8LPN observed and confirmed Resident #84 did not have a mitt or splint in place on her right hand and should have. On 06/10/2025 at 3:35 p.m., an interview was conducted with S3ADON. She reviewed Resident #84's Physician's Orders and confirmed Resident #84 should have a soft mitt or splint on her right hand at all times.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident with a Pressure Ulcer and at high risk for Pressure Ulcer development received care consistent with professional standards of practice and based on the comprehensive assessment by failing to ensure an air mattress was properly implemented for 1 (#54) of 3 (#45, #54, #150) residents reviewed with Pressure Ulcers. Findings: Review of the facility's policy titled, Pressure Injury Prevention and Management with a revision date of 07/2024 revealed the following, in part: Policy: This facility is committed to the prevention of avoidable pressure injuries, to provide treatment and services to heal the pressure ulcer/injury, and the development of additional pressure ulcers/injuries. Policy Explanation and Compliance Guidelines: Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Provide appropriate, pressure-distributing support surfaces. Review of Resident #54's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Chronic Respiratory Failure, Anoxic Brain Damage, Muscle Wasting and Atrophy, and History of Pressure Ulcers. Review of Resident #54's Quarterly MDS with an ARD of 04/15/2025 revealed a Brief Interview for Mental Status (BIMS) was unable to be conducted, which revealed she was severely cognitively impaired. Further review revealed Resident #54 was at risk for Pressure Ulcer development and was dependent on staff for turning and repositioning. Review of Resident #54's Braden Scale for Predicting Pressure Ulcer Risk dated 04/15/2025 revealed a score of 11, which indicated she was at high risk for Pressure Ulcer development. Review of Resident #54's current Physician Orders revealed, in part: A Low Air Loss Mattress on her bed. Review of Resident #54's current Care Plan revealed the following, in part: History of Pressure Ulcers Problem: 06/04/2025 Stage 1 Pressure Ulcer to Right Hip. Interventions: Low Air Loss Mattress on bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made of Resident #54 on 06/09/2025 at 8:36 a.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/09/2025 at 12:40 p.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/09/2025 at 1:40 p.m. She was lying in bed. Her air mattress pump was not on. An observation was made of Resident #54 on 06/10/2025 at 8:50 a.m. She was lying in bed. Her air mattress pump was not on. An interview was conducted with S6LPN on 06/10/2025 at 10:16 a.m. She stated Resident #54 had a history of Pressure Ulcers and was at risk for Pressure Ulcer development. She stated Resident #54 had an air mattress in place. She stated the mattress pump should have been turned on at all times. An observation was made of Resident #54 with S2DON on 06/10/2025 at 8:52 a.m. An interview was conducted with S2DON at that time. S2DON confirmed the air mattress pump was not on, which meant the mattress was not alternating pressure as intended. She confirmed the air mattress pump should have been on at all times. She confirmed Resident #54's air mattress was an intervention to prevent Pressure Ulcers since the resident was high risk for Pressure Ulcer development.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to administer parenteral fluids consistent with professional standards of practice for 1 of 1 (#300) resident reviewed for IV (Intravenous) therapy. The facility failed to monitor and flush a vascular device according to professional standards. The deficient practice had the potential to affect all residents who may require IV antibiotic or fluid therapy. Findings: Review of the facility's Policy dated 09/2024 titled, Intravenous Therapy-LTC revealed, in part: Policy: The facility will adhere to accepted standards of practice regarding infusion practices. Compliance Guidelines: 11. IV sites are checked per facility protocol . 13. IV documentation is recorded in the nurses' notes and/or Medication Administration Record (MAR). Intermittent Medication Infusion: 1. Review and verify practitioner's order for infusion solution or medication . 13. Attach 10ml (milliliter) syringe and confirm patency of vascular access device as per protocol. Review of Resident #300's Medical Record revealed resident was admitted to the facility on [DATE] with diagnoses which included Quadriplegia, Acute and Chronic Respiratory Failure with Hypoxia, Pneumonia, and Tracheostomy. Review of Resident #300's Physician Orders, dated 06/10/2025, revealed an order on 06/09/2025 for Midline placement today, and Meropenem Solution Reconstituted 1 GM (gram), use 1 gram intravenously every twelve hours for Klebsiella Pneumoniae for 14 days. Further review revealed no physician orders for an assessment daily, dressing changes, or flushing schedule for Resident #300's maintenance of the Midline venous access device. Review of Resident #300's Medication Administration Record (MAR), dated 06/10/2025, revealed no documented evidence of an assessment daily or flushing schedule for Resident #300's Midline device. On 06/10/2025 at 9:00 a.m., an observation was made of Resident #300's Midline vascular access site in the left, upper arm, during medication administration. S7LPN scrubbed the hub with alcohol for 20 seconds, connected a NS (normal saline) syringe and flushed the Midline device. On 06/10/2025 an interview was conducted with S7LPN, after medication infusion was started. SLPN stated that she knew the device was patent because she observed it being inserted into Resident's left arm yesterday. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/2025 at 4:25 p.m., an interview was conducted with S2DON. S2DON stated all nurses were responsible for ensuring appropriate orders for each resident are documented. S2DON stated she expected nurses to flush a Midline access device in between medication administration with saline and heparin to maintain patency. She reviewed Resident #300's current physician orders and confirmed there was not an order for daily assessment of or flushing her Midline IV device and should have been. She confirmed the nurse should have notified the Practitioner for missing flush orders and documented on MAR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store and prepare food under sanitary conditions by failing to ensure: 1. Ceiling vents in the kitchen were clean, free of rust and debris; 2. Ceiling tiles (6) in the kitchen and (2) in the adjacent Dining areas were free from water stains. The deficiency had the potential to affect 64 residents who were served meals from the kitchen. Findings: On 06/09/2025 at 8:13 a.m., the initial tour of the facility's kitchen was conducted with S4DM. The following observations were made in the presence of S4DM during the initial tour: Main Kitchen/cooking Area: Rusty orange and dirty brown large ceiling vent coverings above serving steam table; Rust stains and flakey black debris noted on large ceiling vent covering in dishwashing room; Ceiling tiles (6), ranging from baseball to softball size, contained stains in main kitchen. On 06/09/2025 at 8:40 a.m., an interview was conducted with S4DM. She verified the ceiling vent coverings were dirty, rusty, and needed cleaning in the main kitchen, dining, and dishwasher room areas. She stated she did not know date of last cleanings performed. She stated S5MS was responsible for cleaning and replacements of all kitchen ceiling vent covers and ceiling tiles. On 06/11/2025 at 8:05 a.m., an observation was made of ceiling tiles in kitchen and above steam serving table with baseball size stain and 2 appromimate16X20 vents with large amount of rust covering entire surface; ceiling tiles (6) in main cooking area of kitchen observed with water stains in size ranging from baseball to softball size. S4DM confirmed aforementioned findings. S4DM stated she did not think areas could be cleaned at this point in time. She stated S5MS was aware of current condition of vents and ceiling tiles. On 06/11/2025 an interview with S5MS was conducted at 8:45 a.m. He stated he was aware of the water stained ceiling tiles (6) and ventilation coverings in the kitchen locations. He further stated the issues were caused by the air condition system, which was located right above the main kitchen area. S5MS confirmed he was responsible for monitoring and cleaning all ventilation coverings and ceiling tiles. He stated he had painted over ceiling vent covering in dishwashing room and had not replaced with a new covering. He confirmed the tiles and covering should have been maintained under sanitary conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/11/2025 an interview with S1ADM was conducted at 8:45 a.m. S1ADM confirmed there was rust on the ventilation coverings in the kitchen areas and six ceiling tiles contained water stains. S1ADM confirmed the ceiling tiles and vent coverings should have been replaced to maintain sanitary conditions in the kitchen and dining room areas, and were not.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#26) of 3 (#10, #19, and #26) residents reviewed for Activities of Daily Living (ADL). The facility failed to ensure nursing staff accurately documented Resident #26's baths. Findings: Review of Resident #26's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #26's Quarterly MDS with an ARD of 04/28/2025 revealed he was dependent on staff assistance for bathing. Review of the C.N.A. (Certified Nursing Assistant) Assignment Sheet dated June 2025 revealed Resident #26 should receive a bath Monday through Saturday. Review of Resident #26's ADL (Activities of Daily Living) Flowsheet dated 06/01/2025 to 06/11/2025 revealed no documentation a bath was given on 06/03/2025, 06/05/2025 or 06/07/2025. Review of Resident #26's Nurses' Notes dated June 2025 revealed no documented evidence of refusals of baths. On 06/10/2025 at 3:22 p.m., a telephone interview was conducted with S13CNA. She verified she was assigned to Resident #26 on 06/07/2025 and gave him a bed bath. She confirmed she did not document his bed bath on 06/07/2025, and should have. On 06/11/2025 at 11:52 a.m., an interview was conducted with S14CNA. She verified she was assigned to Resident #26 on 06/03/2025 and 06/05/2025 and gave Resident #26 a bed bath. She reviewed Resident #26's ADL Flowsheet dated June 2025 and confirmed she did not document the baths were given. She confirmed Resident #26's baths were not accurately documented and should have been. On 06/11/2025 at 12:00 p.m., an interview was conducted with S3ADON. She stated Resident #26 was to receive a daily bed bath. She reviewed Resident #26's ADL Flowsheet dated June 2025 and confirmed the CNAs were not documenting the daily baths. She confirmed the documentation did not show a bath was performed on the above mentioned dates and should have. On 06/11/2025 at 1:06 p.m., an interview was conducted with S2DON. She stated Resident #26 preferred a daily bed bath. She reviewed Resident #26's ADL Flowsheet dated June 2025 and confirmed there was no documentation Resident #26 received a bath on the above mentioned dates. She confirmed Resident #26's baths were not accurately documented and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195476	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol House Nursing and Rehab Center	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)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to meet Hospice requirements by failing to maintain a system to ensure a hospice resident's Clinical Binder contained documentation of Hospice Nurse Visit notes for 1 (#81) of 1 resident reviewed for hospice care. This deficient practice had the potential to affect any of the residents receiving hospice services in the facility. Findings: Review of the facility's policy titled Hospice Services Facility Agreement, with a revision date of 10/2020 revealed the following: Policy: It is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. A review of Resident #81's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed Resident #81 was a patient of a local hospice agency with a Certification Period of 04/03/2025 through 07/01/2025. A review of Resident #81's hospice binder revealed resident was admitted to the hospice agency on 04/03/2025. Further review revealed no Hospice Nurse Visit notes were contained in the binder. On 06/10/25 at 3:52 p.m. an interview was conducted with the Hospice Liaison. She reviewed Resident #81's hospice binder and confirmed there were no hospice progress notes in the binder. On 06/10/25 at 4:37 p.m. an interview was conducted with S8LPN. She reviewed Resident #81's hospice binder and confirmed there were no hospice progress notes in the binder. On 06/11/25 at 11:42 a.m. an interview was conducted with hospice nurse. She confirmed she had not placed documentation with resident #81's weekly assessments in the facility's hospice binder. On 06/11/25 at 2:10 p.m. an interview was conducted with S9CRN. She confirmed hospice progress notes should be updated and kept in the resident's hospice binder. On 6/11/25 at 2:10 p.m. an interview was conducted with S2DON. She confirmed hospice progress notes should be updated and kept in the resident's hospice binder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195476	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol House Nursing and Rehab Center	11546 Florida Blvd Baton Rouge, LA 70815

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable infection by failing to ensure staff performed appropriate infection control practices during and after incontinence care for 1 (#61) of 3 (#19, #37, and #61) residents observed for incontinence care. Findings: Review of the facility's policy titled, Catheter Care revealed the following, in part: Policy: It is the policy of this facility to ensure residents with indwelling catheters receive appropriate catheter care. Compliance Guidelines: Female Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). Review of the facility's policy titled, Hand Hygiene revealed the following, in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, patients, residents, and visitors. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene may be performed by using both soap and water or alcohol based hand rub. Hand hygiene should be performed during resident care when moving from a contaminated body site to a clean site. Review of Resident #61's current Physician Orders revealed, in part, to cleanse her catheter daily and as needed with soap and water. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195476	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol House Nursing and Rehab Center	11546 Florida Blvd Baton Rouge, LA 70815

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at 9:00 a.m., an observation was made of S11LPN performing catheter and incontinence care on Resident #61. S11LPN donned clean gloves and used clean perineal wipes to remove bowel movement off of Resident #61's buttocks. S11LPN then, without changing gloves or performing hand hygiene, placed a clean sheet over Resident #61's torso with her soiled gloves. S11LPN removed her soiled gloves and applied clean gloves without performing hand hygiene. S11LPN obtained a clean wash cloth with soap and water, removed bowel movement off of Resident #61's catheter tubing and then used a perineal wipe to clean bowel movement off of Resident #61's catheter tubing. S11LPN removed her soiled gloves and applied clean gloves without performing hand hygiene. S11LPN then used five wash cloths to clean Resident #61's perineum and each time, placed the soiled wash cloths on the floor. S11LPN obtained a perineal wipe and cleaned bowel movement off of Resident # 61's buttocks, wiping toward the catheter tubing and vaginal area. Then without changing her gloves or performing hand hygiene, S11LPN opened a clean incontinence pad and placed it under Resident #61 with her soiled gloves. S11LPN, without changing gloves or performing hand hygiene, touched Resident #61's right arm and torso to turn Resident #61 toward S11LPN, touched the inside of Resident #61's clean brief, fastened Resident #61's brief, pulled Resident #61's gown down, and placed the sheets and blankets on Resident #61 with soiled gloves. S11LPN opened Resident #61's room door, removed her gown and gloves and exited Resident #61's room without performing hand hygiene. S11LPN went to another hall in the facility, retrieved a linen cart, placed a clean trash bag in the linen cart and put the lid down. Then without performing hand hygiene and using her soiled hands, S11LPN opened the Personal Protective Equipment cart drawer and put on a gown. S11LPN used her soiled hands to tie the gown around her waist and behind her neck. On 06/11/2025 at 9:40 a.m., an interview was conducted with S11LPN. S11LPN confirmed she should have removed her soiled gloves and applied clean gloves after removing bowel movement form Resident #61 and prior to moving to a clean area. S11LPN confirmed she did not perform hand hygiene between glove changes and after removing soiled gloves, and should have. S11LPN confirmed she placed soiled linen on the floor, and should not have. S11LPN confirmed she exited Resident #61's room and retrieved a soiled linen cart from another hallway without sanitizing her hands. S11LPN confirmed she should have wiped away from Resident #61's catheter tubing and vaginal area when removing bowel movement. On 06/11/2025 at 10:57 a.m., an interview was conducted with S2DON. S2DON confirmed staff should change their gloves when soiled and when moving from a contaminated to a clean area during resident care. S2DON confirmed staff should sanitize their hands between glove changes. S2DON confirmed staff should wipe from front to back in a female and should wipe away from catheter tubing while performing incontinence care. S2DON confirmed staff should place dirty linens into the dirty linen basin. S2DON confirmed soiled linen should not have been placed onto the floor.