

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/22/2026
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)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure each resident's drug regimen was free of unnecessary medications. The facility failed to ensure direct care nursing staff documented monitoring results of psychotropic medications for side effects and effectiveness for 1 (#10) of 6 residents reviewed for unnecessary medications. Findings:Review of the facility's policy titled Use of Psychotropic Medication with a revision date of 02/2025 revealed the following, in part:Policy Explanation and Compliance Guidelines:13. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as:d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice. and the resident's comprehensive plan of care. 14. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. Review of Resident #10's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Unspecified Depression, Schizophrenia, and Panic Disorder. Review of Resident #10's Quarterly MDS with an ARD of 04/28/2026 revealed the following, in part: Resident #10 was taking an antidepressant for Depression and anti-anxiety medication for Anxiety. Review of Resident #10's current Physician Orders revealed the following, in part:01/19/2026 Buspirone HCl 5 mg tablet give two tablets by mouth three times a day for Anxiety; 01/19/2026 Remeron 30 mg tablet give one tablet by mouth one time a day for Depression and Insomnia. Further review revealed no orders pertaining to monitoring for effectiveness or monitoring for side effects of psychotropic medications. Review of Resident #10's current Care Plan revealed the following, in part:Problem: The resident uses antianxiety medications related to Anxiety Disorder.Interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift.Problem: The resident uses antidepressant medications related to Depression.Interventions: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Review of Resident #10's Medication Administration Record dated 06/02/2026 through 07/22/2026 revealed the following, in part:01/19/2026 Buspirone HCl 5 mg tablet give two tablets by mouth three times a day was administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m.; and 01/19/2026 Remeron 30 mg tablet give one tablet by mouth one time a day was administered at 8:00 p.m. Further review revealed no documentation pertaining to monitoring for effectiveness or monitoring for side effects of psychotropic medications. Review of Resident #10's Nurses Notes dated 06/02/2026 through 07/22/2026 revealed no documentation pertaining to monitoring for effectiveness or monitoring for side effects of psychotropic medications. On 07/22/2026 at 8:40 a.m., an interview was conducted with S17LPN. She reviewed Resident #10's Physician Orders and MAR (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
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and verified the resident received Remeron for depression daily and Buspirone three times a day for anxiety. She stated for any resident on a psychotropic medication, the computer prompts the nurse during medication administration to sign off monitoring for and documentation of any abnormal side effects and behaviors. She stated if there was a behavior or side effect, the computer prompts the nurse to document a progress note. She stated she monitored Resident #10 for side effects and behaviors of the antidepressant and antianxiety medications. She confirmed she could not find any documentation of monitoring for Resident #10 for behaviors or side effects related to the antidepressant and antianxiety medications, but there should have been. On 07/22/2026 at 8:50 a.m., an interview was conducted with S15MR. She stated she was responsible for reviewing and entering new admission and readmission residents' physician orders into the computer system. She stated for psychotropic medication orders, a monitor was attached to each individual medication which alerts the nurse during medication administration to sign off monitoring and to document any behaviors or side effects of the psychotropic medications. She stated Resident #10's physician orders changed several times due to his hospitalizations and the requirement for the nurses to monitor the medications would fall off the order. She reviewed and confirmed there was no physician ordered task assigned to the nurses to document monitoring of Resident #10's antidepressant and antianxiety medications for behaviors or side effects and there should have been. She confirmed all residents on psychotropic medications should be monitored every shift for side effects and behaviors. On 07/22/2026 at 10:50 a.m., an interview was conducted with S16NP. She stated she relied on the nurse's documentation of any resident's mood, sedation and side effects of the psychotropic medications to determine the response and effectiveness of the medications. On 07/22/2026 at 9:20 a.m., an interview was conducted with S2DON. She confirmed residents on psychotropic medications should have a Physician's Order entered with a task assigned to the nurses to document the monitoring of behaviors and monitoring of side effects of psychotropic medications. She stated S15MR was responsible for entering resident's psychotropic medication monitoring orders and responsible for ensuring the orders were entered correctly. She reviewed Resident #10's Physician orders, MAR and Nurses Notes and confirmed he was prescribed Remeron for Depression and Buspirone for Anxiety. She confirmed there was no documented monitoring by the nurses administering Resident #10's psychotropic medications and there should have been.		

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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 interviews and record review, the facility failed to develop and implement an individualized, resident-centered Care Plan with interventions which included the appropriate level and number of staff required for safe bed mobility and ADL care performed while in bed for 1 (#101) of 4 residents reviewed for ADLs. Findings: Review of Resident #101's Clinical Record revealed an initial admission date of 03/27/2026 with diagnoses which included, in part, the following: Functional Quadriplegia; Debility; Acute and Chronic Respiratory Failure with Hypercapnia; Tracheostomy Status; Dependence on Respirator (Ventilator); and a History of Repeated Falls. Further review revealed on 05/28/2026 Resident #101 weighed 263 pounds. Review of Resident #101's Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 05/30/2026, indicated she was assessed to have a Brief Interview of Mental Status score of 04, which indicated she was severely cognitively impaired. Further review revealed she had Bilateral Upper and Lower Extremity Impairment; and was Totally Dependent on staff for all mobility, ADLs and care needs. Review of Resident #101's Fall Risk Assessment, dated 05/29/2026, indicated she was assessed to have a Fall Risk Score of 15, which indicated she was a high risk for falls. Review of Resident #101's Physician's Orders and Therapy Plans of Care revealed no documented evidence to indicate the appropriate level and number of staff assistance required for safe bed mobility and ADL care performed while in bed. Review of Resident #101's Care Plan revealed, in part, the following: Focus Areas including: ADL Self-Care Deficit related to Anoxic Brain Damage and Impaired Mobility; and At Risk for Falls related to Impaired Mobility. Further review revealed no documented evidence to indicate the appropriate level and number of staff assistance required for safe bed mobility and ADL care performed while in bed. Review of the facility's Incident Report for Resident #101, dated 05/30/2026 at 9:18 a.m., revealed, in part, the following: Incident Type: Fall. Incident Description: S6LPN was called to Resident #101's room by S7CNA. S7CNA stated Resident #101 fell off of her bed while he was turning her during resident care. An interview was conducted on 07/21/2026 at 1:56 p.m. with S7CNA. S7CNA confirmed he was Resident #101's assigned CNA on 05/30/2026 when she fell. S7CNA confirmed he was in Resident #101's room changing her by himself when her weight shifted as he rolled her over and he was unable to prevent her from falling to the floor. S7CNA stated at the time of Resident #101's fall, the facility did not have a place he could look to determine how much assistance she required for safe bed mobility and ADL care performed in bed because the facility left it up to the CNA who was assigned to the resident to determine if they should ask for help or not. An interview was conducted on 07/21/2026 at 9:28 a.m. with S6LPN. S6LPN confirmed Resident #101 was non-verbal, unresponsive, unable to assist with any of her care, and weighed over 200 pounds. S6LPN confirmed given Resident #101's status, she would need at least 2 person assistance to safely perform bed mobility and ADL care while in bed. S6LPN confirmed she was Resident #101's nurse when she fell on [DATE]. S6LPN confirmed on 05/30/2026, S7CNA was in Resident #101's room providing her care independently when she fell from her bed to the floor. S6LPN confirmed at the time of Resident #101's fall on 05/30/2026, the facility left it up to the CNA who was assigned to a resident to determine how much assistance they needed to safely perform bed mobility and ADL care while she was bed and did not include this information in any of the resident's Care Plans. An interview was conducted on 07/21/2026 at 11:42 p.m. with S14PTA. S14PTA confirmed he was the facility's Director of Therapy Services and was familiar with Resident #101's capabilities and care needs. S14PTA confirmed Resident #101 would (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	require a minimum of 2 person assistance to safely perform bed mobility and ADL care while in bed. An interview was conducted on 07/21/2026 at 10:10 a.m. with S10MDS. S10MDS confirmed she was responsible for creating Care Plans for all of the resident's in the facility. S10MDS confirmed Resident #101's Care Plan did not indicate the appropriate level and number of staff required to safely perform bed mobility and ADL care while in bed and the facility did not require her to include this information in any of the resident's Care Plans. An interview was conducted on 07/21/2026 at 9:47 a.m. with S3ADON. S3ADON confirmed Resident #101's care plan did not indicate the appropriate level and number of staff required to safely perform bed mobility and ADL care while she was bed and the facility did not require this information to be included in any of their resident's Care Plans. S3ADON stated at the time of Resident #101's fall on 05/30/2026, the facility left it up to the CNA who was assigned to a resident to determine how much assistance they needed to safely perform bed mobility and ADL care in bed. An interview was conducted on 07/21/2026 at 10:21 a.m. with S2DON. S2DON confirmed she was present in the facility when Resident #101 fell on [DATE] and interviewed S7CNA immediately following the fall to determine what happened. S2DON confirmed S7CNA was in Resident #101's room providing ADL care for her by himself when her weight shifted and he was unable to prevent her from falling to the floor. S2DON stated at the time of Resident #101's fall on 05/30/2026, the facility left it up to the CNA who was assigned to a resident to determine how much assistance they needed to safely perform bed mobility and ADL care while she was bed and the facility did not require this information to be included in any of their resident's Care Plans.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure services provided met professional standards of quality by failing to ensure nursing staff verified, accurately administered, and accurately documented enteral feedings for 1 (#7) of 2 residents reviewed for enteral feeding. Findings: Review of the facility's policy titled, Care and Management of Feeding Tubes last revised 10/2025 revealed the following, in part: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 1. Feeding tubes will be utilized according to physician/nurse practitioner's orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. Review of the facility's policy titled, Documentation in Medical Record dated 10/2020 revealed the following, in part: Policy: Each patient/resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual. i. False information shall not be documented. Review of Resident #7's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction, Dysphagia, and Gastrostomy Status. Review of Resident #7's current Physician Orders revealed the following, in part: Start date: 06/08/2026 - Three times a day enteral feeding of Glucerna 1.5 bolus 300 mL per PEG at 8:00 a.m., 12:00 p.m., and 4:00 p.m.; and Start date: 02/23/2026 - Continuous enteral feeding of Glucerna 1.5 at 65 mL/hr per PEG from 6:00 p.m. to 6:00 a.m. Review of Resident #7's MAR dated 07/19/2026 revealed a check mark with initials, which indicated S5LPN administered/acknowledged the enteral feeding orders at the following times: Three times a day enteral feeding of Glucerna 1.5 bolus 300 mL per PEG at 12:00 p.m. and 4:00 p.m.; and Start date: 02/23/2026 - Continuous enteral feeding of Glucerna 1.5 at 65 mL/hr per PEG from 6:00 p.m. to 6:00 a.m. on day shift and evening shift. An observation was made of Resident #7 on 07/19/2026 at 12:08 p.m. Resident #7 was lying in bed with enteral feeding of Glucerna 1.5 infusing continuously via pump at 65 mL/hr. A telephone interview was conducted with S5LPN on 07/20/2026 at 1:49 p.m. She confirmed she was assigned to Resident #7 from 6:00 a.m. to 6:00 p.m. on 07/19/2026. She confirmed Resident #7 received continuous enteral feedings of Glucerna 1.5 at 65 mL/hr during her shift on 07/19/2026. She stated she did not administer any bolus enteral feedings to Resident #7 on 07/19/2026. She stated she thought Resident #7 was ordered to receive continuous tube feeding 24/7. She confirmed Resident #7 should have received tube feeding as ordered by the physician. She confirmed she should have verified the enteral feeding order, accurately administered, and accurately documented administration of enteral feedings. An interview was conducted with S2DON on 07/20/2026 at 2:01 p.m. She stated enteral feedings should have been administered as ordered by the physician. She confirmed Resident #7 was ordered to receive bolus enteral feedings during the day and continuous enteral feedings overnight. She stated the nurse should have reviewed, administered and accurately documented Resident #7's enteral feeding as ordered by the physician.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide each resident with adequate supervision and assistance in order to prevent accidents by failing to ensure each resident was assessed to determine the appropriate level and number of staff required for safe bed mobility and ADL care performed while in their bed for 1 (#101) of 4 residents reviewed for ADLs. Findings: Review of the facility's ADL Policy and Procedure, revised 04/2022, revealed, in part, the following: Policy Explanation and Compliance Guidelines:3. A resident who is unable to carry out ADLs will receive the necessary services to maintain good. personal hygiene. Review of the facility's Turning and Repositioning Policy and Procedure, revised 07/2023, revealed, in part, the following: 6. Use the appropriate number of staff to perform the tasks safely. Review of the facility's Incident Report for Resident #101, dated 05/30/2026 at 9:18 a.m., revealed, in part, the following: Incident Type: Fall.Incident Description: S6LPN was called to Resident #101's room by S7CNA. S7CNA stated Resident #101 fell off her bed while he was turning her for resident care. Review of Resident #101's Clinical Record revealed an initial admission date of 03/27/2026 with diagnoses which included, in part, the following; Functional Quadriplegia; Debility; Acute and Chronic Respiratory Failure with Hypercapnia; Tracheostomy Status; Dependence on Respirator (Ventilator); and a History of Repeated Falls. Further review revealed on 05/28/2026 Resident #101 weighed 263 pounds. Review of Resident #101's Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 05/30/2026, indicated she was assessed to have a Brief Interview of Mental Status Score of 04, which indicated she was severely cognitively impaired. Further review revealed she had Bilateral Upper and Lower Extremity Impairment; and was Totally Dependent on staff for all mobility, ADLs and care needs. Review of Resident #101's Fall Risk Assessment, dated 05/29/2026, indicated she was assessed to have a Fall Risk Score of 15, which indicated she was at a high risk for falls. Review of Resident #101's Physical and Occupational Therapy Evaluations, Assessments and Treatment Plans revealed no documented evidence to indicate she was assessed to determine the appropriate level and number of staff assistance required for safe mobility, ADLs and care needs performed while in bed. Review of Resident #101's Care Plan revealed no documented evidence to indicate she was assessed to determine the appropriate level and number of staff assistance required for safe mobility, ADLs and care needs performed while in bed. Review of Resident #101's Physician Orders revealed no documented evidence to indicate she was assessed to determine the appropriate level and number of staff assistance required for safe mobility, ADLs and care needs performed while in bed. An interview was conducted on 07/21/2026 at 1:56 p.m. with S7CNA. S7CNA confirmed he was Resident #101's assigned CNA on 05/30/2026 when she fell. S7CNA confirmed on 05/30/2026, he was in Resident #101's room changing her by himself when her weight shifted as he rolled her over and he was unable to prevent her from falling to the floor. S7CNA confirmed at the time of Resident #101's fall, the facility left it up to the CNA assigned to a resident to determine how much assistance they needed when performing bed mobility and ADL care in bed. S7CNA confirmed he thought he would be able to safely perform the task without the assistance of another staff member. An interview was conducted on 07/21/2026 at 9:28 a.m. with S6LPN. S6LPN confirmed Resident #101 was non-verbal, unresponsive, unable to assist with any of her care, and weighed over 200 pounds. S6LPN confirmed the nurses were not responsible for assessing the level of assistance a resident required for safe bed mobility and ADL care performed in bed; however, given Resident #101's status, she felt she needed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at least 2 person assistance to safely perform these tasks. S6LPN confirmed she was Resident #101's nurse when she fell on [DATE]. S6LPN stated at the time of Resident #101's fall, the facility left it up to the CNA assigned to a resident to determine how much assistance they needed when performing bed mobility and ADL care in bed. S6LPN confirmed on 05/30/2026, S7CNA was in Resident #101's room providing her care independently when she fell from her bed to the floor. An interview was conducted on 07/21/2026 at 10:59 a.m. with S8CNA. S8CNA stated Resident #101 was obese and unable to control her own body weight so she would never feel safe performing her care in bed with any less than 3 people. An interview was conducted on 07/21/2026 at 10:10 a.m. with S10MDS. S10MDS confirmed she was not responsible for assessing the level of assistance a resident required for safe bed mobility and ADL care performed in bed. An interview was conducted on 07/21/2026 at 11:42 p.m. with S14PTA. S14PTA confirmed he was familiar with Resident #101 and in his opinion she required a minimum of 2 person assistance to safely perform bed mobility and in bed incontinence care. S14PTA confirmed he was the facility's Director of Therapy Services and his department was not responsible for assessing the level of assistance a resident required for safe bed mobility and ADL care performed in bed. An interview was conducted on 07/21/2026 at 9:47 a.m. with S3ADON. S3ADON confirmed she was the facility's CNA Supervisor and confirmed the facility did not assess the level of assistance a resident required for safe bed mobility and ADL care performed in bed. S3ADON confirmed at the time of Resident #101's fall on 05/30/2026, the facility left it up to the CNA who was assigned to a resident to determine how much assistance they needed to safely perform a resident's bed mobility and ADL care in bed. An interview was conducted on 07/21/2026 at 10:21 a.m. with S2DON. S2DON confirmed she was present in the facility when Resident #101 fell on [DATE] and interviewed S7CNA immediately following the fall to determine what happened. S2DON confirmed S7CNA was in Resident #101's room providing her ADL care by himself when her weight shifted and he was unable to prevent her from falling to the floor. S2DON stated at the time of Resident #101's fall on 05/30/2026, the facility left it up to the CNA who was assigned to a resident to determine how much assistance they needed to safely perform a resident's bed mobility and ADL care in bed. S2DON confirmed the facility did not ensure each resident was assessed for the level of staff assistance required to safely complete these resident care tasks.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure a resident fed by enteral means received treatment and services to prevent complications by failing to administer enteral feedings as ordered by the physician for 1 (#7) of 2 residents reviewed for enteral feeding. Findings: Review of the facility's policy titled, Care and Management of Feeding Tubes last revised 10/2025 revealed the following, in part: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 1. Feeding tubes will be utilized according to physician/nurse practitioner's orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. Review of Resident #7's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction, Dysphagia, and Gastrostomy Status. Review of Resident #7's Significant Change MDS with an ARD of 05/04/2026 revealed he had an enteral feeding tube and received 51% or more of nutrition and 501 mL/day or more of hydration through his enteral feeding tube. Review of Resident #7's current Care Plan revealed the following, in part: Problem: The resident requires tube feeding related to Dysphagia. Interventions: The resident needs assistance from staff with enteral feeding and water flushes. See Medical Doctor's orders for current feeding order. Review of Resident #7's current Physician Orders revealed the following, in part: Start date: 06/08/2026 - Three times a day enteral feeding of Glucerna 1.5 bolus 300 mL per PEG at 8:00 a.m., 12:00 p.m., and 4:00 p.m.; and Start date: 02/23/2026 - Continuous enteral feeding of Glucerna 1.5 at 65 mL/hr per PEG from 6:00 p.m. to 6:00 a.m. An observation was made of Resident #7 on 07/19/2026 at 12:08 p.m. Resident #7 was lying in bed with an enteral feeding of Glucerna 1.5 infusing continuously via pump at 65 mL/hr. A telephone interview was conducted with S5LPN on 07/20/2026 at 1:49 p.m. She confirmed she was assigned to Resident #7 from 6:00 a.m. to 6:00 p.m. on 07/19/2026. She confirmed Resident #7 received a continuous enteral feeding of Glucerna 1.5 at 65mL/hr during her shift on 07/19/2026. She stated she did not administer any bolus enteral feedings to Resident #7 on 07/19/2026. She stated she thought Resident #7 was ordered to receive continuous enteral feedings 24/7. She confirmed Resident #7 should have received enteral feedings as ordered by the physician. An interview was conducted with S2DON on 07/20/2026 at 2:01 p.m. She confirmed Resident #7 was ordered to receive bolus enteral feedings during the day and continuous enteral feedings overnight. She stated enteral feedings should have been administered as ordered by the physician.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure medication carts were free of expired multi-dose insulin which was available for resident use. This deficient practice was observed on 1 (Cart 1) of 3 medication carts reviewed. Findings: Review of the facility's policy last revised on 04/2021 and titled Multiple-Dose Vials revealed the following, in part: Policy: It is the policy of the facility to ensure proper and safe use of multi-dose vials of medication. Policy Explanation and Compliance Guidelines: B.) if a multi-dose has been opened or accessed (needle punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Review of [NAME]-Lilly manufacturer guidelines for Humulin R revealed the following, in part: Preparing the Dose: Do not use Humulin R past the expiration date printed on the label or 31 days after first use. Review of Norvo Nordisk manufacturer guidelines for Novolin R revealed the following, in part: Open multi-dose vials must be discarded 42 days after the first puncture. An observation was conducted on [DATE] at 9:18 a.m. of Cart 1 with S4LPN. Cart 1 revealed the following: 1 opened and punctured multi-dose vial of Humulin R dated [DATE] with [NAME]-Lilly as manufacturer; and 1 opened and punctured multi-dose vial of Humulin R dated [DATE] with [NAME]-Lilly as manufacturer. An interview was conducted on [DATE] at 9:20 a.m. with S4LPN. S4LPN stated multi-dose insulin should only be available for administration on the medication cart for a maximum of 30 days after the labeled open date. S4LPN confirmed the two vials were opened longer than 30 days and should not be available for resident administration after more than 30 days past the opened date. An interview was conducted on [DATE] at 10:05 a.m. with S2DON. S2DON confirmed multi-dose vials of insulin should not be kept on the medication carts longer than 30 days after the labeled open date and should be disposed of after 30 days. A second observation was conducted on [DATE] at 12:20 p.m. of Cart 1 with S4LPN. Cart 1 revealed the following: 1 opened and punctured multi-dose vial of Novolin R dated [DATE] with Norvo Nordisk as manufacturer. An interview was conducted on [DATE] at 12:20 p.m. with S4LPN. S4LPN confirmed the above named multi-dose vial of insulin was opened longer than 30 days and should not be available for resident administration after more than 30 days past the opened date. An interview was conducted on [DATE] at 1:00 p.m. with S2DON. S2DON confirmed the above multi-dose insulin vials were expired per the manufacturer guidelines and should not have been available for resident administration on the medication cart.		

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 07/22/2026
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)		
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, observation and interviews, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#5) of 3 residents reviewed for Pressure Ulcers. The facility failed to ensure nursing staff accurately documented physician orders and wound care provided for Resident #5's Left Heel Pressure Ulcer. Findings: Review of the facility's policy dated 10/2020, titled Documentation in Medical Record revealed the following, in part:Policy:Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through . accurate . documentation.Policy Explanation and Compliance Guidelines:1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.3. Principles of documentation include, but are not limited to:b. Documentation shall be accurate. Review of Resident #5's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Stage 4 Pressure Ulcer of Left Heel. Review of Resident #5's Physician Orders dated July 2026 revealed the following, in part:Start Date: 07/10/2026 Right Heel Pressure Ulcer clean with wound cleanser, pat dry, paint with betadine, and cover with dry dressing every other day until resolved. Review of Resident #5's Treatment Administration Record dated July 2026 revealed the following, in part:Start date: 07/10/2026 Right Heel Pressure Ulcer clean with wound cleanser, pat dry, paint with betadine, and cover with dry dressing every other day until resolved was documented as performed on 07/10/2026, 07/12/2026, 07/14/2026, 07/16/2026, 07/18/2026 and 07/20/2026. Review of Resident #5's Wound Care Assessments dated July 2026 revealed no documented evidence of a Right Heel Pressure Ulcer. On 07/20/2026 at 8:52 a.m., an observation was made of wound care for Resident #5 with S18WC. S18WC performed wound care to Resident #5's Left Heel Pressure Ulcer. Further observation revealed Resident #5 did not have a Right Heel Pressure Ulcer. On 07/20/2026 at 9:15 a.m., an interview was conducted with S18WC. She reviewed Resident #5's clinical record and confirmed she entered the wound care order for a Right Heel Pressure Ulcer on 07/10/2026. She stated the wound care order should have been entered for Resident #5's Left Heel Pressure Ulcer. She confirmed she inaccurately documented Resident #5's wound care order and wound care. On 07/21/2026 at 11:50 a.m., an interview was conducted with S2DON. She reviewed Resident #5's clinical record and confirmed Resident #5 had a Left Heel Pressure Ulcer. She confirmed Resident #5's wound care orders and wound care were not accurately documented and should have been.		