

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Center Point Health Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8225 Summa Avenue Baton Rouge, LA 70809	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners, and effectively transition them to post discharge care and the reduction of factors leading to preventable readmissions for 1 (#1) of 2 (#1 and #3) residents reviewed for discharge. The facility failed to ensure: 1. The discharge needs of the resident were identified and resulted in the development of a discharge plan;2. Involve the interdisciplinary team in the ongoing process of developing the discharge plan;3. Document the resident had been asked about their interest in receiving information regarding returning to the community; and 4. Create a discharge summary that included a post-discharge plan indicating where the resident planned to reside, any arrangements that had been made for the resident's follow-up care and any post-discharge medical and non-medical services. Review of the facility's policy titled, Transfer and Discharge (Including AMA) and dated 04/2025 revealed the following, in part:Policy Explanation and Compliance Guidelines:12. Anticipated Discharges to the Communitya. Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care. b. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.ii. A final summary of the resident's statusiv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative which will assist the resident to adjust to his or her new living environment.e. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge.f. Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative.Review of Resident #1's clinical record revealed he was initially admitted to the facility on [DATE] and discharged from the facility on 07/22/2025. Further review of his clinical record revealed no documentation of Resident #1's discharge planning process and an adequate, discharge summary. Review of Resident #1's Discharge MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/22/2025 revealed a BIMS (Brief Interview for Mental Status) score of 15, which indicated he was cognitively intact. On 09/10/2025 at 4:34 p.m., an interview was conducted with Resident #1. He stated he did not voice interest to staff pertaining to living within the community independently. He stated the facility was his home. He stated he did voice interest in going to rehab, but thought he would return to the facility after his treatment program was completed. On 09/10/2025 at 11:00 a.m., an interview was conducted with S2FADM. She stated Resident #1 resided at the facility for several years. She stated he was very independent and expressed to staff an interest in discharging from the facility to live within the community independently. She stated due to his history of alcohol abuse, he was discharged from the facility to Avenues Recovery Center with the understanding that he would then transition to community living. She stated she expected Avenues Recovery Center to assist Resident #1 with securing a permanent placement after his 45-day treatment program was completed. On 09/10/2025 at 11:19 a.m., an interview was conducted with S4SW. She stated during Resident #1's stay at the facility, he voiced interest in going to rehab and living within the community independently. She stated on 07/22/2025, she and Resident #1 participated in a phone call conference with an admission coordinator from Avenues Recover Center regarding their detox and rehabilitation program. She stated Resident #1 gave consent to admit to Avenues Recovery Center and was discharged from the facility effective on 07/22/2025. She stated she expected Avenues Recovery Center to assist Resident #1 with securing a permanent placement after his 45-day treatment program was completed.On 09/11/2025 at 10:02 a.m., an interview was conducted with S5NP. She stated she began working at the facility after Resident #1's discharge. She stated, however, if a resident wished to voluntarily discharge from the facility, their intent to discharge would need to be documented, an assessment would need to be completed by either the Nurse Practitioner or Physician to determine their capability to care for self and determine post-discharge needs. She further stated the resident's medical record should also feature a discharge order and an adequate, discharge summary to indicate the end of care at the facility and transition to the next level of care. On 09/11/2025 at 10:27 a.m., an interview was</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide the resident or RP (Responsible Party) with written notice, which specifies the duration of the bed-hold policy at the time of transfer to the hospital for 2 (#2 and #3) of 3 (#1, #2, and #3) sampled residents. Review of the facility's Bed Hold and Returns policy, revised on 04/2025, revealed, in part: Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Policy Explanation and Compliance Guidelines: 1. The facility will issue (2) written notice of bed hold policy to the resident/or resident representative as follows: 1. As part of the admission packet and 2. At the time of a transfer to the hospital or a therapeutic leave. The facility will provide the resident and/or the resident representative written information that specifies: a. the duration of the State bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: i. The resident requires the services which the facility provides; ii. The resident is eligible for Medicare skilled services or Medicaid nursing facility services. 4. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. Resident #2 Review of Resident #2's Clinical Record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, which included Unsteadiness on Feet, Abnormalities of Gait and Mobility, Morbid Obesity, Unspecified Lack of Coordination, and Need for Assistance with Personal Care. Review of Resident #2's quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident was cognitively intact. Review of Physician Orders dated 07/10/2025 through 09/09/2025 revealed the following: 07/10/2025- Okay to transfer to Rehabilitation for evaluation and treatment. Review of Resident #2's record revealed no documented evidence, and the facility was unable to present any documentation showing Resident #2 or Resident #2's RP had received written notification of the bed hold policy when Resident #2 was transferred to the Rehabilitation hospital on [DATE]. Review of the facility's Emergency Transfer Log revealed Resident #2 was transferred to a local Rehabilitation hospital for therapy on 07/10/2025 with a return to facility date of 07/29/2025. On 09/10/2025 at 9:20 a.m., an interview was conducted with Resident #2. Resident #2 confirmed she was transferred to a local Rehabilitation hospital in July 2025, and stayed there for about 2 weeks for exercise, and to get stronger. Resident #2 confirmed she was not given any written information or notice, which specified the duration of the bed hold policy. She further confirmed she did not sign any forms related to a bed hold policy prior to her transfer on 07/10/2025. Resident #3 Review of Resident #3's Clinical Record revealed Resident #3 as admitted to the facility on [DATE] with diagnoses, which included Displaced Bimalleolar Fracture of Right Lower Leg, and Other Abnormalities of Gait and Mobility. Review of Resident #3's admission Minimum Data Set (MDS), dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident was cognitively intact. Review of Physician Orders dated 07/11/2025 through 08/08/2025 revealed the following: 08/08/2025- Resident to be transferred to local hospital for surgery to right foot. Review of Resident #3's record revealed no documented evidence, and the facility was unable to present any documentation showing Resident #3 or Resident #3's RP had received written notification of the bed hold policy when Resident #3 was transferred to the local hospital on [DATE]. Review of the facility's Emergency Transfer Log revealed Resident #3 was transferred to a local hospital for surgery on 08/08/2025. On 09/11/2025 at 10:27 a.m., an interview was conducted with S3DON. S3DON confirmed Residents #2 and #3 were transferred from the facility on the aforementioned dates. S3DON confirmed there was no documented evidence the facility provided Residents #2, #3 or their RPs with a dated and signed written notice, which specified the duration of the bed-hold policy at the time of their transfers to the hospital, and there should have been. On 09/11/2025 at 11:27 a.m., an interview was conducted with S1ADM. S1ADM confirmed there was no documented evidence the facility provided Residents #2, #3 or their RPs with a dated and signed written notice, which specified the duration of the bed-hold policy at the time of their transfers to the hospital, and there should have been.</p>		