

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  04/01/2026
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, and interviews, the facility failed to provide appropriate treatment and services for 1 (#1) resident of 4 residents reviewed for tube feedings. The facility failed to ensure: 1. Resident #1's tube feeding bag was changed every 24 hours; and 2. Resident #1's tube feeding formula and free water flushes were administered per physician's orders. Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with the following diagnoses: Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Cerebral Infarction, Dysphagia following Cerebral Infarction, and Gastrostomy status. Review of Resident #1's Current Physician Orders revealed an order dated 10/23/2025 for enteral feed every shift: Continuous feed: Jevity 1.5 at 70 ml per hour and 170 ml water flush every four hours. On 03/30/2026 at 11:35 a.m., an observation was made of Resident #1's tube feeding infusing at 50 ml per hour, with the pump set at 165 ml flush every 5 hours. The tube feeding was labeled and dated as started on 03/29/2026 at 5:40 a.m. On 03/30/2026 at 2:37 p.m., another observation was made of Resident #1's tube feeding infusing at 50 ml per hour, with the pump set at 165 ml flush every 5 hours. The tube feeding was labeled and dated as started on 03/29/2026 at 5:40 a.m. On 03/30/2026 at 2:40 p.m., an observation and interview was conducted with S2LPN. She observed the aforementioned findings and confirmed Resident #1's tube feeding was infusing at 50 ml per hour, with the pump set to infuse at 165 ml flush every 5 hours. S2LPN confirmed Resident #1's tube feeding was ordered to infuse at 70 ml per hour with 170 ml water flush every four hours and was not infusing at the correct ordered rate. She stated tube feeding and water flushes should be administered at the ordered rate. S2LPN further confirmed the tube feeding was labeled and dated as started on 03/29/2026 at 5:40 a.m. S2LPN confirmed the tube feeding bag should have been changed after 24 hours of use and was not. On 03/30/2026 at 3:35 p.m., an interview was conducted with S1ADON. She was notified of the aforementioned findings. She stated tube feedings and water bags are to be changed every 24 hours. She confirmed it was not acceptable for a tube feeding labeled and dated 03/29/2026 at 5:40 a.m. to still be infusing on 03/30/2026 past 5:40 a.m. She confirmed nurses are expected to administer tube feedings and water flushes at the ordered rate per physician orders.</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
---	-------	-----------