STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195483	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center Point Health Care and Rehab	8225 Summa Avenue Baton Rouge, LA 70809

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, record review and interviews, the facility failed to have sufficient LPN staff to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident based on the facility assessment and observations of untimely medication administration. The deficiency had the potential to affect the facility's total census of 155 residents. Findings:Review of the facility's assessment, dated 05/02/2025, revealed LPN staffing needs for day, evening and night shift required 1 LPN per 23.5 Residents. Review of Facility's Census dated 04/20/2026 revealed Hall A had 52 residents, Hall B had 53 residents, and Hall C had 49 residents. Review of the Posted Daily Staffing Shift Detail revealed 6 LPN's scheduled on the day, evening and night shift on 04/20/2026 and 04/21/2026. An observation was conducted of Hall A, B, and C on 04/20/2026 from 8:33 a.m. to 9:57 a.m. which revealed 2 LPN's providing resident care on Hall A, Hall B, and Hall C. On 04/20/2026 at 9:57 a.m., an observation was made of S3LPN on Hall C. S3LPN was administering Resident #151's 7:30 a.m. and 8:00 a.m. scheduled medications. S3LPN confirmed Resident #151's medication administration was late. S3LPN stated Hall C residents had a higher acuity and she was not able to administer 8:00 a.m. medications timely with the current staffing of 2 LPNs. On 04/20/2026 at 10:40 a.m., an observation was made of S5LPN on Hall C. S5LPN was administering Resident #67's 8:00 a.m. medications. S5LPN confirmed Resident #67's medication administration was late. S5LPN stated Hall C residents had a higher acuity and she was not able to administer 8:00 a.m. medications timely with the current staffing of 2 LPNs. On 04/21/2026 at 10:13 a.m., an interview was conducted with S2ADON. S2ADON stated Hall C had higher acuity residents and 2 LPN's scheduled to provide resident care was not sufficient. On 04/21/2026 at 3:00 p.m., an interview was conducted with S5LPN. S5LPN stated when she began working at the facility, Hall C had 3 LPN's scheduled to provide resident care. S5LPN stated for the last 2 weeks Hall C was assigned 2 LPN's providing resident care. S5LPN stated Hall C had long term care residents and skilled care residents. She stated she was assigned to provide care to 24 long term care residents and S3LPN was assigned to provide care to 25 skilled care residents on Hall C. S5LPN stated on 04/20/2026 she completed scheduled 8:00 a.m. medications after 11:00 a.m. and on 04/21/2026 she completed scheduled 8:00 a.m. medications after 9:30 a.m. She stated residents on Hall C required basic nursing skills and it was not manageable to complete the nursing task timely with only 2 scheduled LPN's providing care. She confirmed on 04/20/2026 and 04/21/2026 she administered and 8:00 a.m. scheduled medications late due to 2 LPN's staffed on Hall C. On 04/21/2026 at 3:00 p.m., an interview was conducted with S3LPN. S3LPN stated when she began working at the facility, Hall C had 3 LPN's scheduled to provide resident care. S3LPN stated for the last 2 weeks Hall C was assigned 2 LPN's providing resident care. S3LPN stated Hall C had long term care residents and skilled care residents. S3LPN stated she was assigned to provide care to 25 skilled care residents and S5LPN was assigned to 24 long term care residents on Hall C. She stated on 04/20/2026 she completed her scheduled 7:30 a.m. and 8:00 a.m. medications after 11:00 a.m. and on 04/21/2026 she completed scheduled 8:00 a.m. medications after 10:00 a.m. She stated residents on Hall C required basic nursing skills and it was not manageable to complete the nursing task timely (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195483	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center Point Health Care and Rehab	8225 Summa Avenue Baton Rouge, LA 70809

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with only 2 scheduled LPN's providing care. She confirmed on 04/20/2026 and 04/21/2026 she administered 7:30 and 8:00 a.m. scheduled medications late due to 2 LPN's staffed on Hall C. On 04/21/2026 at 11:46 a.m., an interview was conducted with S6NP. She stated residents residing on Hall C were very sick and required a high acuity of nursing care. S6NP stated Hall C needed 3 LPNs scheduled to provider resident care on all shifts. On 04/21/2026 at 1:36 p.m., an interview was conducted with S1ADM. S1ADM confirmed on 04/20/2026 and 04/21/2026 the facility had 6 LPN's scheduled on the day, evening and night shift with 2 LPN assigned to Hall A, Hall B and Hall C. She confirmed the facility assessment stated 1 LPN per 23.5 residents but the LPN's could manage nursing care for 2 additional residents, for a total of 25 residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews and record reviews, the facility failed to ensure the medication error rate was less than 5% by having a medication error rate of 36% during the medication administration observation. A total of 36 opportunities were observed, which included 13 medication errors for Resident #151 out of 5 residents observed for medication administration. This failed practice had the potential to affect any of the 155 residents currently residing in the facility. Review of the facilities policy titled, Medication Administration with a revised date of 04/2022, revealed, in part:11. Compare medication with MAR to verify resident name, medication name, form, dose, route and time.b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Review of Resident #151's current Physician Orders and MAR revealed the following medications were scheduled for administration at 7:30 a.m.Pantoprazole Sodium Tablet Delayed Release 40 MG, Give 1 tablet by mouth one time a day; and the following medications were scheduled at 8:00 a.m. Amlodipine Besylate 10 MG, Give 1 tablet by mouth one time a day;Arginaid two times a day;Ascorbic Acid 500 MG, Give 1 tablet by mouth one time a day;Aspirin 81 MG, Give 1 tablet by mouth one time a day;Atorvastatin Calcium 40 MG, Give 1 tablet by mouth one time a day;Clopidogrel Bisulfate 75 MG, Give 1 tablet by mouth one time a day;Escitalopram Oxalate 10 MG, Give 1 tablet by mouth one time a day;Isosorbide Mononitrate Extended Release 24 Hour 30 MG, Give 1 tablet by mouth one time a day;Multiple Vitamin Tablet Give 1 tablet by mouth one time a day;Zinc Sulfate 220 MG, Give 1 capsule by mouth one time a day andMetoprolol Succinate Extended Release 24 Hour 25 MG, Give 1 tablet by mouth one time a day. On 04/20/2026 at 9:57 a.m., an observation was made of S3LPN administering Resident #151's scheduled 7:30 a.m. and 8:00 a.m. medications. S3LPN confirmed she did not administer the scheduled 7:30 a.m. and 8:00 a.m. medications within the standard timeframe of one hour before or one hour after the scheduled time and Metoprolol was not available for administration. On 04/21/2026 at 1:36 p.m., an interview was conducted with S1ADM. S1ADM stated scheduled 7:30 a.m. and 8:00 a.m. medications administered at 9:57 a.m. was considered late. She confirmed it was a professional standard that nurses administer medications one hour prior to or one hour after the scheduled time and all medications should be available for administration at the scheduled time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interviews, and record review, the facility failed to ensure medications were properly stored in 1 (MedCart 1) of 4 medication carts observed for medication storage.Review of the facility's policy titled Medication Storage dated 01/2026 revealed in part, the following:1.a. All drugs will be stored in locked compartments (medication carts).An observation was made on 04/21/2026 at 2:32 p.m. of MedCart 1 unlocked, unsupervised, and located outside the nurses' station. Multiple residents were observed walking near the unlocked, unsupervised medication cart. An interview was conducted on 04/21/2026 at 2:40 p.m. with S2ADON. She confirmed MedCart 1 was unlocked and supervised. She opened the top drawer of MedCart 1 and observed 3 medication cups, each with loose pills located inside. She confirmed loose pills should not have been located in the medication cart and confirmed all medication carts should have been locked when unattended by a nurse.An interview was conducted on 04/22/2026 at 2:45 p.m. with S12ADM. She confirmed loose pills should not have been located in the medication cart and confirmed all medication carts should have been locked when unattended by a nurse.

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection by failing to perform proper hand hygiene and gloving practices for 2 (#1 and #106) of 8 residents observed during direct care.Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection by failing to perform proper hand hygiene and gloving practices for 2 (#1 and #106) of 8 residents observed during direct care. Findings: Review of the facility's policy titled Hand Hygiene, with an effective date of 10/2025, 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. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines:2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hand Hygiene Table:Use either soap and water or alcohol based hand rub when:Before and after handling clean or soiled dressingsAfter handling items potentially contaminated with blood, body fluids, secretions, or excretionsWhen, during resident care, moving from a contaminated body site to a clean body siteAfter assistance with personal body functions 6. Additional considerations:a. 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. Resident #1Review of Resident #1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Tracheostomy and Non-Traumatic Intracranial Hemorrhage. On 04/21/2026 at 8:39 a.m., an observation was made of S11RT performing oral care and tracheostomy care for Resident #1. S11RT provided oral care to Resident #1. Then without removing soiled gloves and performing hand hygiene, S11RT removed Resident #1's tracheostomy dressing, cleaned the tracheostomy site, and removed the inner cannula of the tracheostomy. Then without removing soiled gloves and performing hand hygiene, S11RT put a new inner cannula in the tracheostomy and then applied a clean dressing to the tracheostomy site.Then S11RT removed her gloves and washed her hands. On 04/21/2026 at 8:45 a.m., an interview was conducted with S11RT. She confirmed the above observation. S11RT stated she was unaware she was supposed to remove her gloves and perform hand hygiene between oral care and tracheostomy care. She stated she was unaware she was supposed to remove her gloves and perform hand hygiene when moving from a contaminated body site to a clean body site. Resident #106Review of Resident #106's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Stage 4 Pressure Ulcer of Sacral Region. On 04/20/2026 at 1:21 p.m., an observation was made of S13WC and S14WC performing wound care to Resident #106's sacral pressure ulcer. S13WC and S14WC donned clean gloves and gowns. S14WC cleaned Resident #106's pressure ulcer. S14WC removed her soiled gloves, and without performing hand hygiene, applied clean gloves. S14WC applied the dressing to the wound. S14WC removed her soiled gown and gloves, and without performing hand hygiene, exited the room. S14WC proceeded to look through 3 drawers on the wound care cart at the door for tape. S14WC handed the tape to S13WC and S13WC secure the dressing. S13WC removed his gown and gloves and performed hand hygiene prior to exiting the room. On 04/20/2026 at 1:32 p.m., an interview was conducted with S14WC. She confirmed the above observation. She confirmed she should have performed hand hygiene between glove changes and prior to exiting Resident #106's room. On 04/21/2026 at 3:19 p.m., an interview was conducted with S9IP. She was made aware of Resident #106's incontinence and wound care observations. She confirmed hand hygiene should be performed between glove changes and prior to exiting a resident's room. On 04/22/2026 at 10:20 a.m., an interview was conducted with S1DON. She was made aware of Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#1's oral care and tracheostomy care observation. She confirmed gloves should have been changed and hand hygiene performed between Resident #1's oral care and tracheostomy care. She further confirmed any time a staff member moved from a contaminated body site to a clean body site, gloves should be changed and hand hygiene performed. S1DON was made aware of Resident #106's incontinence and wound care observations. She confirmed hand hygiene should have been performed between glove changes and prior to exiting the resident's room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure resident's room was clean and maintained in a sanitary manner for 1 (#101) of 2 sampled residents reviewed for environment. The facility failed to ensure Resident #101's room and restroom were properly cleaned and free of odor.Review of the facility's policy titled Routine Cleaning and Disinfection, with an effective date of 10/2025, revealed the following, in part:Policy:It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Policy Explanation and Compliance Guidelines:3. Consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas12. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. Review of Resident #101's clinical record revealed she was admitted to the facility on [DATE] with a diagnosis of Glaucoma. Review of Resident #101's Quarterly MDS with an ARD of 01/07/2026 revealed a BIMS of 13, which indicated she was cognitively intact. On 04/20/2026 at 9:03 a.m., an observation was made of Resident #101's room and restroom. Upon entering Resident #101's room, a foul smell was noted. A large cobweb was observed in her room above the air conditioning unit, at the bottom of Resident #101's window. An observation of Resident #101's restroom revealed a black substance on the restroom floor with a stronger foul odor noted upon opening the restroom door. An observation of the shower revealed a cobweb between two shampoo bottles on the shower wall. On 04/21/2026 at 12:24 p.m., an interview was conducted with Resident #101. She stated she used her restroom and was able use her toilet independently. She stated she could not see her floors due to her eyesight and would not know if they were cleaned or not. She stated she did not refuse for housekeeping to clean her room. At that time, an observation was made of Resident #101's room and restroom. There was a cobweb observed on top of her air conditioning unit, at the base of her window. An observation of her restroom revealed there was a black substance over her restroom floor and the base of the toilet. The toilet paper holder on the wall next to the toilet was broken. Part of the toilet paper holder was stuck under the baseboard behind the toilet, as the baseboard was observed coming off of the wall. A strong foul odor was present in the restroom. On 04/21/2026 at 2:32 p.m., an observation was made of Resident #101's restroom with S7CNA. S7CNA confirmed there was a foul odor in the restroom. She confirmed the restroom was dirty and needed to be cleaned. S7CNA stated Resident #101 was independent for toileting so she was unsure how long the restroom had been like that. On 04/21/2026 at 1:42 p.m., an interview was conducted with S8HSK. S8HSK stated she was responsible for cleaning Resident #101's room and restroom. S8HSK stated Resident #101 had never refused for her room to be cleaned. At that time, an observation was made of Resident #101's room and restroom with S8HSK. S8HSK confirmed there was a cobweb above Resident #101's air conditioning unit and in the shower between the shampoo bottles and should not have been. She stated Resident #101's restroom smelled like sewage. She confirmed the toilet paper holder on the wall was broken and part of the toilet paper holder was stuck under the baseboard behind the toilet, as the baseboard was coming off of the wall. She confirmed there was a black substance all over Resident #101's bathroom floor. She stated she cleaned the restroom floor, but it did not help the state of the restroom. She stated she reported the restroom odor and restroom status to S9IP in February 2026. She confirmed Resident #101's room and restroom should be have been clean and sanitary. Review of the facility's Maintenance Log dated February 2026-current revealed no entries for Resident #101's room/restroom. On 04/21/2026 at 2:45 p.m., an interview was conducted with S9IP. S9IP stated the state of Resident #101's restroom was brought to her attention last week. She stated reported it S10MD. She stated S10MD stated he was going to check it out. On 04/21/2026 at 2:51 p.m., an interview was conducted with S10MD. He stated he was notified about the state of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #101's restroom approximately a month ago. He stated he did not document it in his maintenance log. He stated Resident #101 had ongoing issues with her restroom. He stated we are going to take care of it. He confirmed as of 04/21/2026, nothing had been initiated to fix Resident #101's restroom issues. On 04/21/2026 at 2:57 p.m., an observation was made of Resident #101's restroom with S10MD. He confirmed there was a foul odor in Resident #101's restroom and confirmed the toilet paper holder was off of the wall. S10MD observed the baseboards and confirmed part of the toilet paper holder was stuck into the baseboard behind the resident's toilet. He confirmed there was a black substance on the restroom floors. He stated the restroom needed a good cleaning and needed cleaned with bleach before he could tell what needed fixed. On 04/22/2026 at 10:15 a.m., an interview was conducted with S12ADM. She stated she was notified of Resident #101's restroom status on 04/21/2026. S12ADM was made aware of all observations above. S12ADM confirmed Resident #101's room and restroom should have been clean and sanitary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure prescribed medications were available for administration for 1 (#151) of 5 residents reviewed for medication availability. This failed practice had the potential to affect any of the 152 residents currently residing in the facility.Review of facility's policy titled Medication Reordering revealed the following, in part:2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner.3. When administering medications, nurses must monitor remaining supply and reorder medications timely to prevent omissions, time permitting. Review of Resident #151's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnosis including Essential Hypertension. Review of Resident #151's April 2026 Physician Orders revealed an order for Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG, Give 1 tablet by mouth one time a day.Review of Resident #151's April 2026 MAR revealed an order Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG, scheduled for 8:00 a.m. administration. An observation and interview was conducted on 04/20/2026 at 9:57 a.m. with S3LPN during medication administration. Observation revealed S3LPN did not have Metoprolol on the medication cart or in the medication storage room to be administered to Resident #151. S3LPN confirmed she did not have the Metoprolol to administer to Resident #151. S3LPN confirmed the medication was not reordered from the pharmacy as of 04/20/2026, and should have been reordered by any nurse administering medications 7 days in advance prior to running out to ensure the facility had the medication available for administration. An interview was conducted with S4PHAR on 04/21/2026 at 12:43 p.m. S4PHAR stated the process to reorder medications was for staff to log into PCC and complete a reorder request. S4PHAR confirmed he had not received a reorder request for Resident #151's Metoprolol prior to 04/20/2026. An interview was conducted with S2ADON on 04/21/2026 at 10:13 a.m. S2ADON stated the process for ordering medications was to send an order when they had 7 medication pills remaining. S2ADON confirmed Resident #151's Metoprolol should have been available to administer on 04/20/2026 during the scheduled 8:00 a.m. medication administration time. An interview was conducted on 04/21/2026 at 1:36 p.m. with S1ADM. S1ADM confirmed medications ordered by the physician should be available for administration for the residents at all times. S1ADM further confirmed she expected nurses to request medication refills from the pharmacy prior to running out.