STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195512	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Retirement Center of Baton Rouge	14686 Old Hammond Hwy. Baton Rouge, LA 70816

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 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 record reviews, observation, and interviews, the facility failed to ensure services provided by the facility met professional standard of quality by failing to ensure nursing staff did not borrow medications from one resident to administer to another resident for 1 (#R2) of 7 (#1, #2, #3, #4, #R1, #R2 and #R3) residents reviewed for pharmaceutical services.Review of the facility's undated policy titled, Medications - Administering revealed the following, in part:Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation:7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 19. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the Director of Nursing Services. Resident #R2Review of Resident #R2's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #R2's current Physician Orders revealed the following, in part:Start date: 03/05/2025 - Regular Insulin Injection Solution 100 unit/mL, inject as per sliding scale: if 0 - 200 = 0 do not administer; 201 - 250 = 2 units; 251 - 300 = 4 units; 301- 350 = 6 units; 351 - 400 = 8 units; 401 - 999 = 10 units and notify MD, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. Resident #R3Review of Resident #R3's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus. Review of Resident #R3's current Physician Orders revealed the following, in part:Start date: 10/01/2024 - Regular Insulin Injection Solution 100 unit/mL, inject as per sliding scale: if 61 - 200 = 0 units; 60 or less notify MD; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 999 = 12 units and notify MD, subcutaneously four times a day related to Type 2 Diabetes Mellitus. An observation was made on 07/23/2025 at 10:30 a.m. of S2LPN administering medications to Resident #R2. S2LPN removed a vial of regular insulin, labelled with Resident #R3's name, from her medication cart. S2LPN withdrew insulin from Resident #R3's insulin vial to administer to Resident #R2. An interview was conducted with S2LPN at that time. S2LPN reviewed the insulin vial and package and confirmed the insulin belonged to Resident #R3. S2LPN stated Resident #R2's insulin vial was available in the facility's medication room. S2LPN confirmed she used Resident #R3's insulin vial to prepare an insulin dose for Resident #R2 and should not have. An interview was conducted with S1DON on 07/24/2025 at 11:41 a.m. S1DON stated every resident had their own insulin vial ordered from the pharmacy, and emergency house stock was available to use if a resident's vial was not available. S1DON was made aware of the above observation. S1DON stated a nurse should never use one resident's insulin vial to administer to a different resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure it was free of significant medication errors for 1 (#R2) of 2 (#R1 and #R2) residents reviewed for medications. The deficient practice had the potential to affect the 56 residents residing in the facility who received medications.Review of the facility's undated policy titled, Medications - Administering revealed the following, in part:Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation:7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Resident #R2Review of Resident #R2's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Type 2 Diabetes Mellitus with Diabetic Neuropathic Arthropathy. Review of Resident #R2's current Physician Orders revealed the following, in part:Start date: 03/05/2025 - Regular Insulin Injection Solution 100 unit/mL, inject as per sliding scale: if 0 - 200 = 0 do not administer; 201 - 250 = 2 units; 251 - 300 = 4 units; 301- 350 = 6 units; 351 - 400 = 8 units; 401 - 999 = 10 units and notify MD, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with Diabetic Neuropathic Arthropathy. An observation was made on 07/23/2025 at 10:34 a.m. of S2LPN administering medications to Resident #R2. S2LPN stated Resident #R2's blood glucose reading was 212 mg/dL, and Resident #R2 required 2 units of regular insulin per the sliding scale. S2LPN withdrew 5 units of regular insulin from a multi-dose vial. An interview was conducted with S2LPN at that time. S2LPN reviewed the syringe and stated she had drawn up 2 units. S2LPN placed the security cap over the needle for transport to Resident #R2's room. Prompt intervention was initiated and facility administration was sought. An interview was conducted with S5CRN on 07/23/2025 at 10:39 a.m. S5CRN observed the insulin syringe S2LPN withdrew, and confirmed the amount as 5 units. S5CRN confirmed preparation of 5 units when the insulin order was for 2 units was a medication error. An interview was conducted with S1DON on 07/24/25 at 11:41 a.m. S1DON stated insulin doses should be prepared to the amount of units ordered by the physician per the sliding scale. S1DON confirmed preparation of 5 units when the order is 2 units was not an acceptable practice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (#R4) of 8 (#1, #2, #3, #4, #R1, #R2, #R3, and #R4) residents observed for infection control practices. The facility failed to ensure:1. Staff used proper personal protective equipment when emptying Resident #R4's urinal; and2. Staff transported linens in a manner to prevent spread of infection.Review of the facility's policy, dated January 2025, titled, Infection Prevention and Control Program revealed the following, in part:Policy: This facility has established and maintains an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Policy Explanation and Compliance Guidelines:5. All staff are responsible for following all policies and procedures related to the program.14. Linens:a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. Review of the facility's policy, dated January 2025, titled, Enhanced Barrier Precautions revealed the following, in part:Policy: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDRO).Definitions: Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).Policy Explanation and Compliance Guidelines:46. Enhanced Barrier Precautions-a. Nursing staff will place residents with any applicable conditions or devices on EBP. An order may be obtained. Applicable conditions and devices:i. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 48. High-contact resident care activities include:d. Providing hygienef. Changing briefs or assisting with toileting Review of Resident #R4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included: Other Fracture of Right Lower Leg, Initial Encounter for Open Fracture Type I or II with External Fixator to Right Lower Leg Review of Resident #R4's current Physician Orders revealed the following, in part:Order date 05/05/2025 Enhanced Barrier Precautions. On 07/23/2025 at 10:21 a.m., an observation was made of S3CNA entering Resident #R4's room. Enhanced Barrier Precaution sign observed hanging eye level on room door. S3CNA was observed to donn gloves. S3CNA did not donn a gown. S3CNA proceeded to remove Resident #R4's urinal from resident's bedside table and empty it into the toilet. On 07/23/2025 at 10:25 a.m., an observation was made of S3CNA removing clean linen from the linen cart on the hallway. S3CNA was observed carrying the clean linen, pressed against her clothing on her upper body, proceeding down the unit hallway, making entry into a resident's room. On 07/24/2025 at 11:30 a.m., an interview was conducted with S4CNA. S4CNA confirmed she provided care for Resident #R4. S4CNA stated she would donn gown and gloves for high-contact activities for Resident #R4, including emptying his urinal. S4CNA stated there were linen bags available on the linen cart to transport clean linen to a resident's room. S4CNA stated she would not have held clean linen against her body while transporting it to a resident's room. On 07/24/2025 at 11:48 a.m., an interview was conducted with S1DON. S1DON confirmed she would expect staff to follow Enhanced Barrier Precautions procedures during high-contact resident activities, including emptying a resident's urinal. S1DON confirmed clean linen should have been transported from the linen cart to a resident's room inside a clean linen bag and not pressed against a staff member's clothing.