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	09/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility failed to ensure:1. The can opener was free of a dried, black substance and metal shavings;2. Ceiling vents in the kitchen were properly cleaned and free of black and brown substances; 3. Ceiling tiles above the steam table were secured and free of a gray fluffy substance;4. The Steamer drip pan was not overflowing a white, liquid substance onto the table and floor; and5. Milk was held at a safe temperature for consumption of 41 degrees Fahrenheit or below prior to being served to residents. This deficient practice had the potential to affect the 57 residents who were served food from the kitchen. Findings: Review of the facility's undated policy titled, Food: Handling and Preparation revealed the following, in part:Procedure:4. Use clean sanitized equipment. Clean and sanitize as you go. Don't wait until the end of the workday. On 09/08/2025 at 8:10 a.m., an initial tour was conducted of the kitchen with S4DM. The following observations were made:The can opener was observed with a large amount of metal shavings and a dried, black substance at the base;Five ceiling vents were observed with a moderate amount of a black substance; One large ceiling vent next to the walk-in cooler was observed with a large amount of a brown, fluffy substance; One tile above the steam table was observed unsecured;One tile above the steam table was observed with a string of a gray, fluffy substance hanging down from it; andThe steamer was observed leaking a white, liquid substance into a drip pan, which had overflowed onto the table and the floor underneath. On 09/08/2025 at 8:37 a.m., an interview was conducted with S4DM. He confirmed the above observations. He stated the kitchen staff were responsible for keeping the kitchen clean. He confirmed the can opener should have been cleaned after each use and had not been. He confirmed the ceiling vents should have been cleaned and had not been. He confirmed the ceiling tiles above the steam table should have been secured and free of a gray, fluffy substance and were not. He confirmed the drip pan underneath the steamer should have been emptied to prevent the overflow of the white, liquid substance onto the table and floor. On 09/08/2025 at 11:06 a.m., a follow-up visit was made of the kitchen with S4DM. An observation was made of dietary staff performing the temperature checks of milk from a plastic container on the serving line. Four 8 oz. plastic containers of milk were observed on the serving line prep table, not on ice, and being placed on resident meal trays. A recording of one milk temperature was measured at 43.2 degrees Fahrenheit. On 09/08/2025 at 11:13 a.m., an interview was conducted with S4DM. He confirmed the above observation and stated the milk on the serving line prep table was available to be served for resident consumption. He stated dairy products should have been maintained at a temperature at or below 41 degrees Fahrenheit. On 09/08/2025 at 1:00 p.m., an interview was conducted with S1ADM. He was made aware of the above observations made during the kitchen tours. He stated he expected the kitchen staff to keep the kitchen clean and sanitary. He confirmed dairy products should be kept at or below 41 degrees Fahrenheit for resident safety.

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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure services were provided by the facility to meet quality professional standards. The facility failed to ensure:1. Nursing staff followed physician's orders and obtained a resident's heart rate prior to medication administration for 1 (#33) of 3 (#19, #33, and #53) residents reviewed for medication administration; 2. Nursing staff followed manufacturer instructions for use of an inhaler to prevent side effects of the medication for 1 (#53) of 3 (#19, #33, and #53) residents reviewed for medication administration; and 3. Nursing staff primed insulin pen needles prior to administering insulin for 1 of 1 (#19) residents reviewed for insulin administration. Findings: Review of the facility's undated policy titled, Medications-Administering revealed, in part: 3. Medications must be administered in accordance with the orders, including any required time frame. 8. The following information must be checked/verified for each resident prior to administering medications.b. Vital signs, if necessary. 1. Review of Resident #33's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Atrial Fibrillation and Essential Hypertension. Review of Resident #33's current Physician Orders revealed the following: Start date: 08/12/2025 Carvedilol Oral Tablet 3.125 mg give one tablet by mouth two times a day. Hold for heart rate less than 50. On 09/09/2025 at 7:45 a.m., an observation was made of S6LPN administering Resident #33's medications. S6LPN administered Carvedilol 3.125 mg to Resident #33. S6LPN did not check Resident #33's heart rate prior to administering his Carvedilol 3.125 mg oral tablet. On 09/09/2025 at 7:48 a.m., an interview was conducted with S6LPN. She confirmed she did not check Resident #33's heart rate prior to administering his Carvedilol 3.125mg tablet as ordered and she should have. On 09/09/2025 at 8:39 a.m., an interview was conducted with S2DON. She was made aware of the above observation made during medication administration for Resident #33. She stated she expected nurses to check a resident's heart rate per physician orders prior to administering a medication. 2.Review of the facility's medication insert for Fluticasone Furoate-Vilanterol 100-25 mcg powder, revealed in part:After each dose, rinse your mouth with water and spit it out. Do not swallow the water. Review of Resident #53's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis, which included Chronic Obstructive Pulmonary Disease. Review of Resident #53's current Physician Orders revealed the following: Start date: 07/16/2025 Fluticasone Furoate-Vilanterol 100-25 mcg one puff inhale orally one time a day. On 09/09/2025 at 8:10 a.m., an observation was made of S7LPN administering Resident #53's medications. She administered one inhalation of Fluticasone Furoate-Vilanterol 100-25mcg to Resident #53. S7LPN exited the room and did not offer or instruct Resident #53 to rinse her mouth with water after the inhaler was administered. On 09/09/2025 at 8:25 a.m., an interview was conducted with S7LPN. She confirmed she did not have Resident #53 rinse her mouth out with water after administration of the Fluticasone inhaler and should have. On 09/09/2025 at 8:39 a.m., an interview was conducted with S2DON. She was made aware of the above observation made during medication administration for Resident #53. She stated she expected the nurses to have residents rinse their mouth out with water after administration of an inhaled medication. 3. Review of the Humalog insulin pen manufacturer's guidelines revealed the insulin pen needle should always be primed with 2 units of insulin after applying the needle and prior to drawing up the insulin dose. Review of Resident #19's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis, which included Type 2 Diabetes Mellitus with Hyperglycemia. Review of Resident #19's current Physician Orders revealed the following: Start date: 10/01/2024 Humalog Injection Solution 100 units/mL inject 15 units subcutaneously three times a day. On 09/09/2025 at 11:13 a.m., an observation was made of S6LPN administering Resident #19's Humalog 15 units subcutaneously. S6LPN applied the insulin pen needle, dialed up 15 units of insulin, and administered the insulin. S6LPN did not prime the insulin pen needle prior to administering the insulin. On 09/09/2025 at 11:18 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., an interview was conducted with S6LPN. She confirmed she did not prime the insulin pen needle prior to administering insulin to Resident #19 and was not aware she should have. On 09/09/2025 at 3:01 p.m., an interview was conducted with S2DON. She was made aware of the above observation made during medication administration for Resident #19. She stated she expected nurses to prime insulin pen needles prior to administering the ordered dose of insulin.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to ensure garbage and waste were properly contained in the outdoor trash dumpsters.Findings:On 09/08/2025 at 8:48 a.m., an observation was made of the facilities dumpster area with S4DM. Two air conditioner window units, one mattress, one power chair, and multiple wooden crates and boxes were observed discarded on the ground surrounding two dumpsters. Scattered trash was observed on the ground next to and around the two dumpsters.On 09/08/2025 at 8:50 a.m., an interview was conducted with S4DM. He observed and confirmed the above findings in the dumpster area. He stated S5MS was responsible for keeping the dumpster area clean. On 09/08/2025 at 9:11 a.m., an interview was conducted with S5MS. He stated he was responsible for keeping the dumpster area clean. He observed the above findings and confirmed the dumpster area should be kept clean and was not. On 09/08/2025 at 8:54 a.m., an interview was conducted with S1ADM. He stated S5MS was responsible for keeping the dumpster area clean. He observed and confirmed the above findings. He confirmed the dumpster area should be kept clean and was not.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide services with reasonable accommodation of needs by failing to ensure a resident's call light was within reach for 1 (#5) of 16 residents reviewed in the final sample. Review of the facility's undated policy titled, Call Light, Answering, revealed the following, in part:Purpose: The purpose of this procedure is to respond to the resident's requests and needs. Key Procedural Points:5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Steps in the Procedure:9. Position the call light within easy reach of the resident. Review of Resident #5's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses of Unsteadiness on Feet, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right non-dominant side, Difficulty in Walking, Generalized Muscle Weakness, and Other Lack of Coordination. Review of Resident #5's current Care Plan revealed following, in part:Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit related to Hemiplegia and Hemiparesis following Cerebral Infarction affecting right non-dominant side and Impaired balance.Interventions: transfer: The resident requires assistance by 1 staff to move between surfaces daily and as necessary. Encourage the resident to use bell to call for assistance. Focus: The resident has an alteration in musculoskeletal status related to compression fracture of lumbar vertebrae.Interventions: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. On 09/08/2025 at 10:08 a.m., an observation was made of Resident #5 in her room. She was lying in bed. The call light was observed lying on the floor at the foot of the bed. An interview was conducted with Resident #5 at that time, and Resident #5 confirmed she could not reach her call light. On 09/09/2025 at 8:39 a.m., an observation was made of Resident #5 in her room. She was lying in bed. The call light was observed lying on the floor at the foot of the bed and not within reach. On 09/09/2025 at 8:50 a.m., an observation was made of Resident #5 with S7LPN. An interview was conducted with S7LPN at that time. S7LPN confirmed Resident #5's call light was on the floor at the foot of the bed and not within reach. S7LPN confirmed Resident #5's call light should have been within reach. On 09/10/2025 at 11:29 a.m., an interview was conducted with S2DON. S2DON was notified of the above findings. S2DON confirmed Resident #5's call light should have been within reach at all times when in her room. S2DON confirmed call lights should never be on the floor and should always be within residents' reach.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents with an identified mental health diagnosis were referred for a Pre-admission Screening and Resident Review (PASARR) Level II evaluation as required for 1 of 1 (#4) resident reviewed for PASARR.Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Type 2 Diabetes Mellitus. Further review revealed an additional medical diagnosis of Schizoaffective Disorder, Bipolar Type with an onset date of 10/01/2020.Review of Resident #4's PASARR Level I dated 05/06/2013 revealed no mental health diagnoses were selected. Further review revealed no review for a Level II evaluation and determination had been submitted for Resident #4 following his diagnosis of Schizoaffective Disorder, Bipolar Type.An interview was conducted on 09/09/2025 at 11:45 a.m. with S1ADM. He reviewed Resident #4's PASARR Level I dated 05/06/2013 and diagnoses. He stated Resident #4 had a diagnosis of Schizoaffective Disorder, Bipolar Type acquired on 10/01/2020 and should have been referred for a PASARR Level II evaluation.

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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 a Comprehensive Person-Centered Care Plan for 1 of 1 (#53) residents reviewed for activities of daily living (ADL). Review of Resident #53's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Displaced Intertrochanteric Fracture of Left Femur.Review of Resident #53's current Care Plan revealed the following:Focus: The resident has an ADL self-care performance deficit related to activity intolerance.Interventions: Bed Mobility: The resident requires (specify what assistance) by (X) staff to turn and reposition in bed (specify frequency) and as necessary.Dressing: The resident requires (specify what assistance) by (X) staff to dress.Eating: The resident is able to: (specify).Personal hygiene/oral care: The resident is able to: (specify).Transfer: The resident is totally dependent on (X) staff for transferring.An interview was conducted on 09/09/2025 at 12:40 p.m. with S8MDS. She reviewed Resident #53's current Care Plan. She stated she was responsible for completing Resident #53's Care Plan. She confirmed the Comprehensive Person-Centered Care Plan for Resident #53 was incomplete and should have been completed.An interview was conducted on 09/09/2025 at 12:46 p.m. with S3RNCO. She reviewed Resident #53's current Care Plan. She confirmed the Comprehensive Person-Centered Care Plan for Resident #53 was incomplete and should have been completed.

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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 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 record review, observations, and interviews, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding by failing to ensure tube feeding formula, tubing, and free water bags were changed in appropriate timeframe for 1 (#8) of 3 (#6, #8, and #43) residents reviewed for tube feedings.Review of the facility's undated policy titled, Enteral Feedings-Safety Precautions revealed in part, the following:2. The facility will follow accepted best practices in enteral nutrition.5. Hang times:c. Closed-system enteral formulas have a hang time of 24-48 hours, per manufacturer's instructions.Review of the Clinical Record for Resident #8 revealed she was admitted to the facility on [DATE] with diagnoses, which included Dysphagia Following Cerebral Infarction. Further review revealed a diagnosis of Gastrostomy Status on [DATE].Review of the current Physician Orders for Resident #8 revealed, in part, the following:Jevity 1.5 at 45 mL/hr per gastrostomy tube daily.Change peg feeding bag every 24 hours.An observation was made on [DATE] at 8:15 a.m. of tube feeding solution spiked and hanging in Resident #8's room currently not infusing since Resident #8 was unavailable at this time. Further observations revealed the tube feeding solution bottle to be dated [DATE] with no time documented, and a written expiration date of [DATE] with no time documented. Observed the tube feeding solution bottle label read: Precautions: Hang product up to 48 hours after initial connection. Observed bag of free water label read: Do not use for greater than 24 hours.An observation was made on [DATE] at 10:10 a.m. of tube feeding solution spiked and hanging in Resident #8's room currently infusing. Further observations revealed the tube feeding solution bottle to be dated [DATE] with no time documented, and a written expiration date of [DATE] with no time documented. Observed the tube feeding solution bottle label read: Precautions: Hang product up to 48 hours after initial connection. Observed bag of free water label read: Do not use for greater than 24 hours. Observed brown, dried tube feeding formula inside the tube feeding solution bottle.An interview was conducted on [DATE] at 12:40 p.m. with S9LPN. She stated she provided care to Resident #8 on [DATE]. She stated when Resident #8 returned to the facility on [DATE], she initiated the already spiked tube feeding solution bottle that was already hanging and began infusing it. She confirmed a new tube feeding solution kit should have been used and it was not.An interview was conducted on [DATE] at 1:08 p.m. with S2DON. She observed Resident #8's tube feeding solution currently infusing with a label dated [DATE] with no time documented and an expired written date of [DATE] with no time documented. She confirmed nursing staff should follow manufactures guidelines in regard to tube feeding solution and supplies.

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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. Based on observations, record review, and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure medication carts were free of loose pills for 1 of 1 (Cart A) medication carts reviewed.Findings: Review of the facility's undated policy titled, Medications-Storage, revealed, the following, in part:Policy:The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation:1. Drugs and biologicals shall be stored in the packing, containers, or other dispensing systems in which they are received. On 09/08/2025 at 3:40 p.m., an observation was made of Cart A with S3RNCO, which revealed thirteen and a half loose pills on the bottom of the cart's drawers. On 09/08/2025 at 3:50 p.m., an interview was conducted with S3RNCO. She stated the nurses should check the medication carts daily for loose medications. S3RNCO confirmed the above pills were loose in the cart and should not have been. On 09/08/2025 at 4:10 p.m., an interview was conducted with S2DON. She stated she expected the nursing staff to perform medication cart checks daily, which included checking for any loose medications in the cart's drawers. She was made aware of the above observation and confirmed medications should not be loose in the cart.

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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 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 reviews and interviews, the facility failed to ensure residents' Medication Administration Records (MAR) were accurately documented for 1 (#8) of 3 (#6, #8, and #43) residents reviewed for tube feedings.Review of the facility's undated policy titled, Documentation revealed in part, the following:12. Personnel will be expected to document timely, accurately, and completely.Review of the Clinical Record for Resident #8 revealed she was admitted to the facility on [DATE] with diagnoses, which included Dysphagia Following Cerebral Infarction. Further review revealed a diagnosis of Gastrostomy Status on [DATE].Review of the current Physician Orders for Resident #8 revealed in part, the following:Change gastrostomy feeding bag every 24 hours.Review of the [DATE] MAR for Resident #8 revealed in part, the following:Change peg feeding bag every 24 hours. Documented as completed on [DATE] at 5:00 a.m. by S9LPN.An observation was made on [DATE] at 10:10 a.m. of tube feeding solution spiked and hanging in Resident #8's room currently infusing. Observed tube feeding solution bottle to be dated [DATE]. Observed tube feeding solution bottle to have a written expiration date of [DATE].An interview was conducted on [DATE] at 12:40 p.m. with S9LPN. She stated she provided care to Resident #8 on [DATE] to [DATE]. She stated she did not change the tube feeding solution bottle on the morning of [DATE]. She stated she documented on the MAR that she did change it and should not have documented this task as completed since it was not completed.An interview was conducted on [DATE] at 1:08 p.m. with S2DON. She observed Resident #8's tube feeding solution currently infusing with a label dated [DATE] and an expired written date of [DATE]. She reviewed Resident #8's [DATE] MAR and confirmed nurses should not document tasks as completed unless they complete them.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, observation, and interview, the facility failed to ensure posted nurse staffing data included the total number and the actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift.This deficient practice had the potential to affect any of the 60 residents residing in the facility.Findings: Review of the Nursing Staffing Data form dated 09/08/2025 revealed the following: Resident Census: 61Total Number: CNA-16; LPN-8; RN-2; Totals-26Actual Hours: CNA-120; LPN-60; RN-15; Totals-195 On 09/08/2025 at 10:15 a.m., an observation was made of the bulletin board on the wall outside the Dining Room. The form titled Nurse Staffing Data dated 09/08/2025 was observed. The total number and actual hours worked for licensed and unlicensed staff directly responsible for resident care was not documented per shift. On 09/08/2025 at 10:30 a.m., an interview was conducted with S1ADM. He reviewed the Nurse Staffing Data Form dated 09/08/2025 and confirmed the total number and actual hours worked for licensed and unlicensed staff directly responsible for resident care was not documented per shift.