STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195621	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Rehabilitation Hospital Snf	8000 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)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 46975 Based on observation and interview, the facility failed to post the names, addresses, and telephone numbers of pertinent state agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. Findings: On 10/28/2024 at 8:40 a.m., an observation of the facility revealed no list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. On 10/29/24 at 9:56 a.m., a tour of the facility was conducted with S1ADM. He confirmed a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit was not posted in the facility.

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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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46975 Based on observations and interviews, the facility failed to ensure the results of the most recent survey was posted in a place readily accessible to residents, and family members and legal representatives of residents. Findings: On 10/28/2024 at 8:40 a.m., an observation was made of the facility. There was no facility binder available with survey results observed. On 10/28/2024 at 10:00 a.m., an observation was made of the facility. There was no facility binder available with survey results observed. On 10/28/24 at 1:03 p.m., a tour of the facility was conducted with S2DON. She could not locate the survey results binder at that time. She stated there was a holder on the wall where the binder was located, but it was no longer there. On 10/29/24 at 9:39 a.m., an interview was conducted with S4US. She stated the 'survey results binder was located behind the nurse's station. S4US pulled a binder from behind the nurse's station which was labeled SNF Survey Results. On 10/29/24 at 9:50 a.m., an interview with conducted with S1ADM. He confirmed he was aware the survey results binder should be readily accessible for residents and/or their family members to view. He stated there was a holder on the wall where the binder was located, but it was no longer there. He confirmed if the survey results binder was behind the nurse's station, it was not readily accessible to residents and/or their family members.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47191 Based on interviews and record review, the facility failed to ensure a resident's discharge assessment accurately reflected the resident's status for 1 of 1 (#16) residents reviewed for MDS. Findings: Review of Resident #16's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #16's discharge MDS with an ARD of 05/23/2024 revealed the following: Section A0410: 2. Unit is neither Medicare nor Medicaid certified On 10/29/2024 at 2:20 p.m., an interview was conducted with S6MDS. She reviewed Resident #16's discharge MDS and stated Section A0410 was coded incorrectly. She confirmed the MDS should have been coded as number 3, Unit is Medicare and/or Medicaid certified, to accurately reflect Resident #16's discharge status. On 10/29/2024 at 2:25 p.m., an interview was conducted with S7MDS. She reviewed Resident #16's discharge MDS and stated Section A0410 was coded incorrectly. She confirmed the MDS should have been coded as number 3, Unit is Medicare and/or Medicaid certified, to accurately reflect Resident #16's discharge status. On 10/29/2024 at 2:30 p.m. an interview was conducted with S1ADM. He reviewed Resident #16's discharge MDS and confirmed Section A0410 was coded incorrectly. He confirmed the MDS should have been coded as number 3, Unit is Medicare and/or Medicaid certified, to accurately reflect Resident #16's discharge status.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46975 Based on record review, observation, and interview, the facility failed to ensure nurse staffing data was posted daily in a prominent location readily accessible to residents and visitors. This deficient practice had the potential to affect any of the 15 residents residing in the facility. Findings: Review of the facility's policy titled Nurse Staffing Posting Information revised on 06/2024, revealed the following: Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. 3. The information posted will be: b. In a prominent place readily accessible to residents and visitors. An observation was made on 10/28/2024 at 8:35 a.m. of the facility. No staffing data sheets were observed. An interview was conducted on 10/28/2024 at 1:00 p.m. with S2DON. She stated the facility did not post daily staffing data sheets in a prominent location readily accessible to residents and visitors. An interview was conducted on 10/29/2024 at 9:56 a.m. with S1ADM. He was notified of the above observation. He confirmed nurse staffing data was not posted daily in a prominent location readily accessible to residents and visitors.

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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** 46981 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of infection for 1 (#25) of 3 (#25, #129, and #179) residents reviewed for infection control. The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) while providing a dressing change to an indwelling medical device for a resident who was on Enhanced Barrier Precautions (EBP). Findings: Review of the facility's policy titled Enhanced Barrier Precautions revised on 03/2024, revealed the following, in part: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 2. Initiation of Enhanced Barrier Precautions: a.ii. Indwelling medical devices (central lines) even if the resident is not known to be infected or colonized with a MDRO. 3.b. High-contact resident care activities include: Device care or use (central line) Review of Resident #25's Clinical Record revealed he was admitted to the facility on [DATE], with diagnoses which included Cervical Spine Osteomyelitis. An observation was made on 10/28/2024 at 10:34 a.m. of the Enhanced Barrier Precautions sign posted on Resident #25's door which revealed the following, in part: Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Device care or use: central line. An observation was made on 10/28/2024 at 10:35 a.m. of S5RN performing a PICC line dressing change for Resident #25. S5RN did not wear a gown while performing Resident #25's central line dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/29/2024 at 2:34 p.m. with S3ADON. S3ADON confirmed when a resident was on EBPs, staff should wear a gown while performing a PICC line dressing change. An interview was conducted on 10/29/2024 at 2:33 p.m. with S2DON. S2DON confirmed when a resident was on EBPs, staff should wear a gown while performing a central line dressing change.