STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195380	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Skilled Nursing Rehabilitation	9225 Normandie Drive Shreveport, LA 71118

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 Based on record reviews and interviews the facility failed to ensure a resident with wounds or history of wounds received necessary treatment and services, consistent with professional standards of practice, to promote healing, to prevent infection, and to prevent wounds for 3 (#1, #2, and #3) of 3 (#1, #2, and #3) sampled residents. The facility failed to ensure weekly skin assessments were performed and/or a written wound care plan was implemented. Findings: Review of the facility's Prevention of Pressure Ulcers/Injuries with a revision date of November 2017 revealed in part: Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment: 2. Conduct a comprehensive skin assessment upon admission/readmission, including: a. Skin integrity - any evidence of existing or developing pressure ulcers or injuries; b. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Skin problems which are present, or develop later, will be treated according to medical direction. This will be accomplished by making rounds weekly on each resident using the documentation of weekly body audits to determine or identify abnormal skin conditions. Review of the facility's Pressure Ulcer/Injury Risk Assessment with a revision date of November 2017 revealed in part: Purpose: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcer/injuries. General Guidelines: (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The purpose of using the Braden Risk Assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed and which will take time to modify. 3. Once the Braden Risk Assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risk for pressure ulcers/injuries. Resident #1 Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses, including but not limited to, type 2 diabetes, end stage renal disease, and dependence on renal dialysis. Further review of Resident #1's medical record failed to reveal weekly skin assessments had been performed. Review of Resident #1's medical record revealed a wound assessment dated [DATE] which revealed Resident #1 had a history of an unstageable pressure ulcer of the inferior, left gluteus which had been resolved. Review of Resident #1's comprehensive care plan failed to reveal Resident #1 had been care planned for history of actual wound and interventions were in place. During an interview on 08/27/2024 at 2:20 p.m., S2Corporate Nurse confirmed Resident #1 had not had a weekly skin assessment performed since his previous unstageable pressure ulcer had been resolved on 06/27/2024 and should have. During an interview on 08/27/2024 at 2:30 p.m., S3RN (Registered Nurse) reported she was Resident #1's nurse and confirmed she had not performed any weekly skin assessments on Resident #1. During an interview on 08/27/2024 at 3:15 p.m., S4Treatment Nurse reported a new wound could deteriorate fast if it was not treated. S4Treatment Nurse acknowledged weekly skin assessments were not being completed on any of the residents in the facility and should have been. During an interview on 08/27/2024 at 3:20 p.m., S2Corporate Nurse acknowledged Resident #1 had not been care planned for prevention of pressure ulcers. Resident #2 Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses, including but not limited to, dementia, schizoaffective disorder, bipolar type, and major depressive disorder. Further review of Resident #2's medical record failed to reveal weekly skin assessments had been performed. Review of Resident #2's wound assessment dated [DATE] revealed in part, Resident #2 had a history of a sacral DTI (Deep Tissue Injury) which had been resolved. Review of Resident #2's comprehensive care plan failed to reveal Resident #2 had been care planned for history of actual wound and interventions were not in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/2024 at 1:00 p.m., S2Corporate Nurse acknowledged weekly skin assessments had not been completed on Resident #2 and Resident #2 had not been care planned for a history of a wound and should have been. Resident #3 Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses, including but not limited to, muscle wasting and atrophy, type 2 diabetes and anxiety disorder. Further review Resident #3's medical record failed to reveal weekly skin assessments had been performed. Review of Resident #3's wound assessment dated [DATE] revealed in part, Resident #3 had a chronic arterial ulcer of the sacrum which has not resolved. During an interview on 08/29/2024 at 1:00 p.m. S2 Corporate Nurse acknowledged weekly skin assessments had not been performed.