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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195537	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Care Center	10145 Florida Blvd Baton Rouge, LA 70815

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46225 Based on interviews and record reviews, the facility failed to ensure nursing staff communicated a significant change in condition to the resident's physician for 1(#1) of 3 (#1, #2, #3) residents reviewed for notification of change. This deficient practice resulted in an Immediate Jeopardy situation on 07/13/2024 at 5:24 a.m., when Resident #1, a resident who at baseline was active and could independently ambulate, complained of pain to the lower extremities, exhibited swelling to the left knee, and was unable to bear weight or ambulate. S3LPN failed to report Resident #1's significant change in status to the medical provider on call immediately. Resident #1 continued to decline in activities of daily living until 07/15/2024 around 8:00 a.m. when an x-ray was ordered and revealed an acute Left proximal femur fracture and Chondral irregularity of the left femoral head, which could indicate AVN. Resident #1 was transferred to the hospital where he underwent Left Hip Hemiarthroplasty on 07/16/2024. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. On 07/31/2024 at 2:30 p.m. S2DON, S1ADM, and S12RDO were notified of the Past Noncompliance Immediate Jeopardy. Findings: Review of the facility's Change in Condition Policy and Procedure dated 08/27/2018 revealed the following, in part: Purpose: To ensure the resident is assessed promptly when a change in condition is noted. Definitions: Change of condition: is a deviation from a resident's baseline in areas such a physical, cognitive, behavioral, functional, etc. Acute change of condition: is a sudden, clinically important, deviation from a resident's baseline in areas such a physical, cognitive, behavioral, functional, etc. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinically important: means without intervention, may result in complications or death. Procedure: 3. The resident's primary physician or designated alternate will be contacted promptly of a significant change in a resident's status. Review of Resident #1's medical record revealed Resident #1 was admitted to the facility on [DATE]. Review of Resident #1's Departmental Nursing Note dated 07/13/2024 by S3LPN revealed, in part, the following: 5:24 a.m. - Resident #1 complained of pain to his lower extremities from groin area down into thigh. 7:02 a.m. - Resident #1 complained of lower left flank pain. 7:32 a.m. - Resident #1's left knee was swollen, was unable to bear weight to the left lower extremity, and rated his pain as a 6 on a 0-10 pain scale, which worsened when he attempted to rotate it. Departmental Nursing Notes revealed no further documentation between 07/13/2024 at 7:32 a.m. through 07/15/2024 at 11:51 a.m. Further review revealed the medical provider on call was not notified of Resident #1's significant change in condition. A review of Resident #1's Incident Report dated 07/15/2024 revealed the following in part: Physician notified: 07/15/2024 Narrative of incident and description of injuries: It was reported to S6NP Resident #1 was experiencing pain in the left leg, and was currently using a wheel chair for mobility. S6NP ordered an x-ray after assessing Resident #1. X-ray revealed subcapital left femur fracture without displacement. Review of Resident #1's Physician Orders dated July 2024 revealed, in part, the following: -an order dated 07/15/2024 to x-ray left hip, femur, and knee -an order dated 07/15/2024 to send Resident #1 to the emergency room for further evaluation and treatment of left hip pain. Review of the findings of mobile x-ray of the left hip, femur, and knee dated 07/15/2024 revealed an acute left proximal femur fracture, and Chondral irregularity of the left femoral head could indicate AVN. Review of Resident #1's emergency room discharge summary dated 07/19/2024 revealed the following in part: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 presented with a left femur fracture on 07/15/2024. Musculoskeletal: Left hip: Tenderness and bony tenderness present. Decreased range of motion. CT Pelvis without IV Contrast Result Date: 7/15/2024 FINDINGS: Acute traumatic fracture of the upper left femoral neck, impacted up to 1 cm. No other fracture seen. Mild osteoarthritic narrowing both hips. Resident #1 subsequently underwent a Left Hip Hemiarthroplasty on 07/16/2024. On 07/30/2024 at 1:45 p.m., a telephone interview was conducted with S3LPN. She stated on 07/12/2024, she worked the 11:00 p.m.-7:00 a.m. shift. She stated S7CNA notified her Resident #1 had leg pain before her shift ended on 07/13/2024. She confirmed Resident #1 toileted and ambulated without assistance prior to this day. S3LPN stated when Resident #1 was transferred from the wheelchair to the bed, he was not at his baseline mobility because he was unable to bear weight to the left leg or ambulate. She stated on the morning of 07/13/2024, she observed Resident #1's left knee was swollen and he verbally complained of pain when his left leg was rotated. She confirmed this was a significant change in condition for Resident #1. S3LPN confirmed she did not notify the medical provider on call on the morning of 07/13/2024 when she observed a significant change in condition. On 07/30/2024 at 10:38 a.m., an interview was conducted with S5LPN. She stated she worked 07/13/2024 and 07/14/2024 from 7:00 a.m.-7:00 p.m. S5LPN confirmed Resident #1 had a significant change in condition when he could not ambulate and was incontinent on 07/13/2024. She confirmed any significant change in a resident's condition should be reported immediately to the provider. She denied reporting Resident #1's change in condition to the provider on call, and should have. On 07/30/2024 at 11:26 a.m., an interview was conducted with S10ADON. He confirmed Resident #1 experienced a significant change in condition, and the nurse should have notified the on-call nurse practitioner immediately, and this had not been done. On 07/30/2024 at 2:23 p.m., an interview was conducted with S6NP. On 07/15/2024 around 8:00 a.m., S6NP stated S4LPN notified her Resident #1 had been using a wheelchair over the weekend and was complaining of left lower extremity pain. S6NP confirmed the resident's baseline mobility status was ambulatory without assistance or assistive devices. S6NP reported her assessment of Resident #1's left knee revealed generalized swelling and he was not able to bear weight on the left leg. S6NP stated Resident #1 stated, Ouch, stop. when she attempted to assist him to a standing position. She confirmed this was a significant change in condition and she should have been notified immediately of his new onset pain and decline in mobility. She confirmed if she had been notified on 07/13/2024 when staff initially discovered Resident #1's significant change in condition, she would have ordered an x-ray at that time. S6NP confirmed the delay in notification caused Resident #1 to experience a decline in ROM, mobility, and prolonged pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/31/2024 at 11:05 a.m. an interview was conducted with S2DON. S2DON confirmed any significant change in a resident's condition should be reported immediately to the medical provider. She stated if a change occurred on the weekend or after hours, the medical provider on call should be notified immediately. She confirmed prior to 07/13/2024, Resident #1 could ambulate without assistance. S2DON confirmed when it was discovered Resident #1 could not bear weight on his left leg, exhibited pain, exhibited left knee swelling, and could not ambulate on 07/13/2024 at 5:24 a.m., this was a significant change in condition, and the nurse should have notified the on-call provider immediately. The facility has implemented the following actions to correct the deficient practice: On 07/15/2024 the following Quality Improvement Project was initiated and included the following: Topics Reviewed: Resident #1 was found to have a fracture of unknown origin. Resident is not cognitively able to recall if an incident occurred. Action Plan: A. Interview staff who worked with resident prior to the x-ray to assist in determining if any staff were aware of any incident which may have caused injury. B. Identify a timeline according to witness statements of when the injury possible occurred. C. Reviewed camera footage to assist with identifying any occurrence which may have caused the injury of unknown origin. D. Unable to identify a direct cause and time of this injury. E. Completed an audit for all fall interventions to assist with fall prevention. F. Completed an in-service to all nursing staff related to fall prevention on 07/15/2024. G. Completed an in-service to all nursing staff related to identifying and reporting changes in a resident's condition on 07/15/2024. Recommended Follow up: A. The DON or designee will review fall devices on 3 residents at random twice weekly. B. The DON or designee will review nursing documentation of 3 residents twice weekly to ensure changes in condition are reported to the Nurse Practitioner/Medical Doctor timely. In addition, administrative nursing team reviews all nursing notes daily. These notes are discussed and reviewed daily in morning meetings with all department head staff. C. The DON or designee will make rounds on 2 cognitively impaired residents weekly to ensure there is no change in their transfer/ambulation status. Findings: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After approximately a week of monitoring to ensure no more adverse findings, the facility obtained substantial compliance on 07/23/2024. No further issues were noted with nurse documentation or reporting resident status changes. Facility continues to monitor per QA plan to maintain compliance.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46225 Based on interviews and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice when the nursing staff failed to recognize, monitor, intervene, and document a resident's significant change in condition to avoid delayed treatment for 1(#1) of 3 (#1, #2, and #3) residents reviewed for injuries which required hospitalization . This deficient practice resulted in an Immediate Jeopardy situation on 07/13/2024 at 5:24 a.m., when Resident #1, a cognitively impaired resident who at baseline ambulated independently without pain, was observed by staff to have new onset pain to the lower extremities, swelling to the left knee, and was unable to bear weight or ambulate. Resident #1 continued to exhibit signs of pain, decreased mobility, decline in activities of daily living, limited range of motion as well a new onset incontinence between the dates of 07/13/2024 through 07/15/2024. On 07/15/2024 around 8:00 a.m., an x-ray was ordered and revealed an acute Left proximal femur fracture and Chondral irregularity of the left femoral head. Resident #1 was transferred to the hospital where he underwent Left Hip Hemiarthroplasty on 07/16/2024. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. On 07/31/2024 at 2:30 p.m. S2DON, S1ADM, and S12RDO were notified of the Past Noncompliance Immediate Jeopardy. Findings: Cross Reference F580 Review of Resident #1's medical record revealed Resident #1 was admitted to the facility on [DATE]. Review of the Annual MDS (Minimum Data Sheet) with ARD (Assessment Reference Date) of 04/17/2024 revealed in part: Resident #1 had a BIMS (Brief Interview Mental Status) score of 3 which indicated he was severely cognitively impaired. Resident #1 had no impairment to his lower extremities, required supervision or touching assistance with toileting, showering, upper body dressing, personal hygiene, sitting to standing, chair/bed to chair transfer, and walking 10 and 50 feet. Resident #1 had no use of mobility devices. Resident #1 was noted to always be continent of bowel and bladder. Review of the Significant Change MDS with ARD of 07/25/2024 revealed in part: Resident #1 had a BIMS score of 2 which indicated he was severely cognitively impaired. Resident #1 had impairment on one side of his lower extremity related to functional limitation in range of motion. Partial/moderate assistance was required with showering, sitting to standing, chair/bed to chair transfer, and walking 10 feet. The resident required a wheelchair. Resident #1 was noted to be frequently incontinent of urine and always incontinent of bowel. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician Orders dated July 2024 revealed a standing order dated 07/13/2024 for Tylenol 325 mg 2 tablets by mouth PRN pain was initiated by S3LPN. Review of Resident #1's MAR dated July 2024 revealed, in part, S5LPN administered Tylenol 325 mg 2 tablets by mouth to the resident on 07/13/2024 at 8:39 a.m. for pain. Review of Resident #1's Departmental Nursing Note dated 07/13/2024 by S3LPN revealed, in part, the following: 5:24 a.m., Resident #1 complained of pain to his lower extremities from the groin area down into the thigh. 7:02 a.m., Resident #1 complained of lower left flank pain. 7:32 a.m., Resident #1's left knee was swollen, was unable to bear weight to the left lower extremity, and rated his pain as a 6 on a 0-10 pain scale, which worsened when he attempted to rotate it. Communicated to oncoming shift nurse as well as CNA's for today. Tylenol per standing orders is available. Further review revealed no documentation of physician notification of change or resident status from 07/13/2024 at 7:32 a.m. through 07/15/2024 at 11:51 a.m. A review of the Incident Report dated 07/15/2024 at 11:50 a.m. revealed the following: Narrative of incident and description of injuries: It was reported to S6NP that the resident is experiencing pain in the left leg. Resident is currently using a wheel chair for mobility. S6NP ordered an x-ray after assessing the resident. Mobile x-ray ordered and completed. X-ray revealed subcapital left femur fracture without displacement. Review of the findings of mobile x-ray of the left hip, femur, and knee dated 07/15/2024 revealed an acute left proximal femur fracture, and Chondral irregularity of the left femoral head could indicate AVN. Review of Resident #1's emergency room discharge summary dated 07/19/2024 revealed the following in part: Resident #1 presented with a left femur fracture on 07/15/2024. Musculoskeletal: Left hip: Tenderness and bony tenderness present. Decreased range of motion. CT Pelvis without IV Contrast Result Date: 7/15/2024 Findings: Acute traumatic fracture of the upper left femoral neck, impacted up to 1 cm. No other fracture seen. Mild osteoarthritic narrowing both hips. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 subsequently underwent a Left Hip Hemiarthroplasty on 07/16/2024. On 07/30/2024 at 12:35 p.m., an interview was attempted with Resident #1. Resident #1 was oriented to self only and pleasantly confused. Resident #1 was unable to state what happened to his hip due to cognitive impairment. On 07/30/2024 at 9:34 a.m., an interview was conducted with S8CNA. S8CNA confirmed she was familiar with Resident #1 and prior to 07/14/2024, Resident #1 was ambulatory without assistance or pain and continent. S8CNA stated on 07/14/2024 at the beginning of her shift, she observed Resident #1 in a wheelchair, and was unable able to walk. S8CNA stated Resident #1 rubbed his left leg and verbalized pain to the left leg when asked. S8CNA stated she notified S5LPN of this. S8CNA stated during her shift on 07/14/2024 from 6:00 a.m. through 2:00 p.m., Resident #1 was a 2 person assist to get into bed, was incontinent, and was unable to bear weight on his left leg. S8CNA confirmed Resident #1 had a big change in condition when she saw him on 07/14/2024 because he could no longer bear weight on his left leg, ambulate independently, was complaining of pain, and incontinent. On 07/30/2024 at 9:50 a.m., an interview was conducted with S7CNA. S7CNA confirmed she worked on 07/12/2024 from 6:00 a.m. to 10:00 p.m., 07/13/2024 from 6:00 a.m. to 2:00 p.m., and 07/14/2024 from 6:00 a.m. to 10:00 p.m. She stated on 07/12/2024, Resident #1 ambulated as usual without assistance or pain, was continent, and had no falls or injury throughout her shift. On the morning of 07/13/2024, S7CNA stated Resident #1 was in bed complaining of leg pain, and unable to stand or bear weight. S7CNA stated S3LPN was immediately notified of Resident #1's complaint of leg pain and unable to stand. S7CNA stated on 07/14/2024, Resident #1 grimaced when he moved and was still unable to bear weight, stand or ambulate. S7CNA stated Resident #1 fiddled with his pants, appeared restless and couldn't keep still at times. S7CNA stated she reported this to the nurse. S7CNA stated during her shifts on 07/13/2024 and 07/14/2024, Resident #1 was unable to sit on the commode without complaints of leg pain, was incontinent and wore a brief all weekend. On 07/30/2024 at 10:07 a.m., an interview was conducted with S4LPN. S4LPN stated when she left the facility at 3:00 p.m. on 07/12/2024, Resident #1 ambulated without difficulty and did not have any complaints of pain. S4LPN stated on 07/15/2024, she observed Resident #1 in a wheelchair. She stated Resident #1 verbalized pain and difficulty with standing. She denied administering anything for pain to Resident #1 on 07/15/2024. She confirmed she notified S6NP on 07/15/2024 of the resident's condition, but failed to document his inability to bear weight on the left leg, ambulate, or complaints of pain, in the medical record. On 07/30/2024 at 10:38 a.m., an interview was conducted with S5LPN. She stated she worked 07/13/2024 and 07/14/2024 from 7:00 a.m. to 7:00 p.m. S5LPN confirmed Resident #1 had always ambulated without assistance or pain and was continent before she saw him on the morning of 07/13/2024. She confirmed he could not bear weight on his left leg, ambulate and was incontinent on 07/13/2024 and 07/14/2024 which was a significant change in condition. S5LPN stated she did not observe Resident #1 with verbal complaints or nonverbal signs of pain. S5LPN stated the off-going nurse on the morning of 07/13/2024 told her he had a diagnosis of Gout, and it was probably flaring. S5LPN stated she administered Tylenol to Resident #1 once on 07/13/2024 in the morning. S5LPN confirmed Resident #1 was not administered Tylenol for Gout symptoms in the past. S5LPN denied reporting Resident #1's change in condition to the provider, increasing his monitoring, intervening, or documenting his change in the nurses' notes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/30/2024 at 11:26 a.m., an interview was conducted with S10ADON. S10ADON confirmed he completed the incident investigation for Resident #1 on 07/15/2024 at 11:50 a.m. S10ADON confirmed the video footage showed Resident #1 ambulate down the hallway without assistance or difficulty on 07/12/2024 at 7:30 p.m. S10ADON stated Resident #1 was not seen again until 07/13/2024 at 6:53 a.m. in a wheelchair being transferred by a CNA to the day room. S10ADON confirmed Resident #1 experienced a significant change in condition, and experienced a decline in mobility. S10ADON confirmed the nurse should have intervened immediately and notified the on-call nurse practitioner to ensure the resident was treated. S10ADON further confirmed ongoing monitoring of Resident #1's condition and interventions should have documented in the nurses' notes. On 07/30/2024 at 1:45 p.m., a telephone interview was conducted with S3LPN. S3LPN stated on 07/12/2024, she worked the 11:00 p.m. to 7:00 a.m. shift. S3LPN confirmed Resident #1 toileted and ambulated without assistance or pain previously. S3LPN stated S7CNA notified her Resident #1 had leg pain. S3LPN confirmed when Resident #1 was transferred from the wheelchair to the bed, he was not at his baseline mobility because he was unable to bear weight to the left leg or ambulate. S3LPN stated on the morning of 07/13/2024, she observed Resident #1's left knee was swollen and Resident #1 verbally complained of pain when his left leg was rotated. S3LPN stated she thought Resident #1 had a history of Gout. S3LPN confirmed she didn't notify the medical provider on 07/13/2024 of Resident #1's knee swelling, new inability to ambulate, or new onset of pain, and should have done so immediately. S3LPN confirmed she entered the standing order for Tylenol in the computer, but did not administer it. S3LPN stated she didn't give Resident #1 any Tylenol for pain or notify the medical provider because it was the end of her shift, and she had already stayed over an extra hour. S3LPN confirmed not notifying the medical provider immediately on 07/13/2024 delayed the resident's treatment. On 07/30/2024 at 2:23 p.m., an interview was conducted with S6NP. On 07/15/2024 around 8:00 a.m., S6NP stated S4LPN notified her Resident #1 had been using a wheelchair over the weekend and was complaining of left lower extremity pain. S6NP confirmed the resident's baseline mobility status was ambulatory without assistance or assistive devices. S6NP reported her assessment of Resident #1's left knee revealed generalized swelling and he was not able to bear weight on the left leg. S6NP stated Resident #1 stated, Ouch, stop. when she attempted to assist him to a standing position. She confirmed this was a significant change in condition and she should have been notified immediately of his new onset pain and decline in mobility. She confirmed if she had been notified on 07/13/2024 when staff initially discovered Resident #1's significant change in condition, she would have ordered an x-ray at that time. S6NP confirmed the delay in notification caused Resident #1 to experience a decline in ROM, mobility, and a prolonged pain. On 07/31/2024 at 11:05 a.m., an interview was conducted with S2DON. S2DON confirmed any significant change in a resident's condition should be reported immediately to the medical provider. S2DON stated if a change occurred on the weekend or after hours, the medical provider on call should be notified immediately. S2DON confirmed prior to 07/13/2024, Resident #1 could ambulate without assistance. S2DON confirmed when it was discovered Resident #1 could not bear weight on his left leg, exhibited pain, and could not ambulate on 07/13/2024 at 5:24 a.m., the on-call provider should have been notified immediately, and was not. S2DON confirmed there was no documentation in the nurses' notes related to follow up assessments of decline in ROM, mobility, pain, or PRN pain medication administration after 07/13/2024 at 7:32 a.m. until 07/15/2024 at 11:51 a.m. S2DON further confirmed Resident #1's treatment was delayed and he suffered pain with a decline in mobility and ROM. The facility has implemented the following actions to correct the deficient practice: (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/15/2024 the following Quality Improvement Project was initiated and included the following: Topics Reviewed: Resident #1 was found to have a fracture of unknown origin. Resident is not cognitively able to recall if an incident occurred. Action Plan: A. Interview staff who worked with resident prior to the x-ray to assist in determining if any staff were aware of any incident which may have caused injury. B. Identify a timeline according to witness statements of when the injury possible occurred. C. Reviewed camera footage to assist with identifying any occurrence which may have caused the injury of unknown origin. D. Unable to identify a direct cause and time of this injury. E. Completed an audit for all fall interventions to assist with fall prevention. F. Completed an in-service to all nursing staff related to fall prevention on. G. Completed an in-service to all nursing staff related to identifying and reporting changes in a resident's condition. Recommended Follow up: A. The DON or designee will review fall devices on 3 residents at random twice weekly. B. The DON or designee will review nursing documentation of 3 residents twice weekly to ensure changes in condition are reported to the Nurse Practitioner/Medical Doctor timely. In addition, administrative nursing team reviews all nursing notes daily. These notes are discussed and reviewed daily in morning meetings with all department head staff. C. The DON or designee will make rounds on 2 cognitively impaired residents weekly to ensure there is no change in their transfer/ambulation status. Findings: After approximately a week of monitoring to ensure no more adverse findings, the facility obtained substantial compliance on 07/23/2024. No further issues were noted with nurse documentation or reporting resident status changes. Facility continues to monitor per QA plan to maintain compliance.