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	01/07/2025

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 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** 48912 Based on record reviews, observation, and interviews the facility failed to develop and implement a comprehensive person-centered care plan which met the needs of 2 (#2 and #3) of 3 (#1, #2, and #3) residents reviewed. The facility failed to: 1. Ensure S2ADON followed physician's orders for Resident #2 whom was ordered wheel chair brake extenders; and 2. Ensure Resident #3's care plan was comprehensive and individualized for activities of daily living (ADLs) dependency deficits. Findings: Review of the facility's policy titled, Care Plan Policy and Procedure, dated 05/22/2017 revealed the following, in part: Purpose: The comprehensive plan of care is an interdisciplinary tool used to communicate and address care issues that are relevant to the resident's individual needs. Policy: A comprehensive plan of care will be used to communicate and address care issues that are relevant to the resident's individual needs. 1. Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE], with diagnoses which included Muscle Weakness, Dementia, Alzheimer's Disease, Repeated Falls, and Fracture to Right Femur. Review of Resident #2's active Physician Orders revealed, in part the following: Order date: 11/19/2024-Brake extenders to wheelchair for safety On 01/06/2025 at 11:23 a.m., an observation was made of Resident #2 sitting in dining room. Resident #2 was noted sitting at a table in a wheelchair. An observation of the wheelchair Resident #2 was sitting in revealed no brake extenders. (continued on next page)

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
	195537	A. Building B. Wing	01/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/06/2025 at 11:25 a.m., an interview was conducted with S2ADON. She confirmed she was Resident #2's nurse. She stated nurses were responsible for ensuring brake extenders were in place every shift. S2ADON inspected Resident #2's wheelchair, and confirmed the brake extenders were not in place. S2ADON confirmed the brake extenders should have been in place as physician ordered and they were not. On 01/06/2025 at 2:00 p.m., an interview was conducted with S1DON. She confirmed staff were expected to follow physician's orders and ensure Resident #2's brake extenders were in place as ordered. 2. Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included Fractured R-Femur, Dementia, Pain, and Insomnia. Review of Resident #3's Significant Change MDS with an ARD of 12/25/2024 Section GG revealed, in part the following: Resident #3 was dependent for eating, oral hygiene, toileting, shower/bathe, dressing, and personal hygiene. Review of Resident #3's Care Plan revealed no interventions were developed for ADLs dependency deficits. On 01/07/2025 at 9:29 a.m., an interview was conducted with S3MDS. She stated she was responsible for Care Plans. S3MDS confirmed ADLs dependency deficits should be care planned. S3MDS reviewed Resident #3's Care Plan, and confirmed she was not care planned for her ADLs dependency deficits and should have been. On 01/07/2025 at 2:46 p.m., an interview was conducted with S1DON. She stated residents were to be properly care planned for ADLs dependency deficits. S1DON reviewed Resident #3's Care Plan, and confirmed she was not care planned for ADLs dependency deficits and should have been.

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	01/07/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912 Based on record review and interviews the facility failed to ensure a resident's plan of care was revised by failing to update fall interventions after each fall for 1 (#3) of 3 (#1, #2, and #3) residents reviewed for falls. Findings: Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE], with diagnoses which included Fractured Right Femur, Dementia, Pain, and Insomnia. Review of Resident #3's Nurse's Note dated 12/31/2024 revealed, in part, the following: Nurse called to common lounge area by ward clerk stating resident fell as I entered the area. Resident noted sitting half on wheelchair foot rest with right leg hanging over right foot rest. Resident was seated on lift pad and slid out of wheelchair with some of the pad behind her. Review of the facility's Incident Report dated 12/31/2024 revealed, in part the following: Resident #3 had an unwitnessed fall in lounge. Review of Resident #3's Care Plan revealed it was not revised to include interventions for falls after 12/12/2024. The care plan did not include interventions to address Resident #3's fall that occurred on 12/31/2024. On 01/07/2025 at 9:29 a.m., an interview was conducted with S3MDS. She stated she was responsible for care plans. S3MDS stated she was made aware a resident sustained a fall by reviewing the risk management assessment report which she ran every morning. She stated the report reflected any incident report(s) which had been completed by a nurse. S3MDS stated she was responsible for updating the care plan. She stated an intervention should be updated after each fall. S3MDS reviewed Resident #3's care plan, and confirmed there was no intervention for Resident #3's fall on 12/31/2024 and should have been. On 01/06/2025 at 3:26 p.m., an interview was conducted with S1DON. She stated the Minimum Data Set nurse was responsible for care plan revisions. She stated fall interventions should be updated after each fall. S1DON confirmed Resident #3 did have a fall on 12/31/2024. After reviewing Resident #3's care plan, she confirmed Resident #3's fall on 12/31/2024 should have been care planned with an intervention and was not.