

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER The Guest House Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident received adequate supervision to prevent falls for a cognitively impaired resident with a known history of refusing to call staff for assistance with mobility and transfers, for 1 (#1) of 3 residents reviewed for falls. Findings: Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, in part; Dementia and History of Falling. Further review revealed a discharge date of 06/25/2026. Review of Resident #1's admission MDS with an ARD of 05/21/2026 revealed a BIMS of 12, which indicated Resident #1 was moderately cognitively impaired. Further review revealed the following:Section GG: Toileting hygiene - coded 03-Partial/moderate assistance-helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.Toilet transfer - coded 02-Substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Review of Resident #1's Fall Risk assessment dated [DATE] revealed the following:Score: 17Category: At RiskAmbulation/Elimination Status: 2. Chair bound-requires assist with eliminationGait/Balance: Decreased muscular coordination Review of Resident #1's Care Plan revealed the following:Problem: Resident has impaired cognitive function/dementia or impaired thought processes related to dementia. Difficulty making decisions, impaired decision making. Long term memory loss, short term memory loss. Interventions: Cue reorient and supervise as needed. Provide resident verbal cues/reminders to assist resident in remembering as appropriate. Problem: Resident had an unwitnessed fall with minor injury 6/23/2026Interventions: An intervention of in-servicing the CNA to not place any resident on the toilet and leave the room and the resident unattended for safety was implemented. (Date initiated: 06/24/26) Review of Resident #1's Nurse's Notes revealed the following:06/23/2026 at 3:10 p.m. - Note Text: Per S3LPN on 6/23/2026 at 3:10 p.m.: CNA came to get hall nurse to assist with changing resident due to resident having continuous diarrhea. Nurse entered resident's room with anti-diarrhea. Hall nurse and CNA noted assist resident from bathtub. CNA reported that resident was in tub with her head to the faucet. Assessed resident. Resident noted with a golf sized hematoma to the left posterior head. Scant amount of blood noted. No other apparent injuries noted. Able to move all extremities. Resident complained of headache. PRN Tylenol given. Neuro checks initiated. On 07/06/2026 at 1:04 p.m., an interview was conducted with S4LPN. S4LPN stated Resident #1 had known history of being confused and combative towards staff. She stated staff would encourage her to sit down and the next second she would be attempting to stand on her again. On 07/06/2026 at 1:28 p.m., an interview was conducted with S7CNA. S7CNA stated Resident #1 was a fall risk. She stated resident was confused and would try to get up and walk without calling for assistance. On 07/07/2026 at 9:03 a.m., an interview was conducted with S2ADON. S2ADON (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195537
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #1 had a history of falls and was difficult to redirect. On 07/07/2026 at 9:30 a.m., an interview was conducted with S5LPN. S5LPN stated Resident #1 was a fall risk and was known to get up on her own without calling for assistance. On 07/07/2026 at 12:40 p.m., an interview was conducted with S3LPN. S3LPN stated Resident #1 had a history of falls and confusion. She stated on 06/23/2026, S8CNAS reported to her she left Resident #1 sitting on the toilet while she went to get supplies and another staff member to assist her. She stated S8CNAS reported when she went back into Resident #1's bathroom, resident was in the bath tub with the back of her head toward the faucet. She stated S8CNAS reported Resident #1 told her that she got into the bathtub to take a bath. She stated S8CNAS should not have left Resident #1 unattended because of her history of falls and confusion. She stated resident had a bump on the back of her head and was sent out to the hospital for further evaluation and treatment. On 07/07/2026 at 1:15 p.m., an interview was conducted with S9CNA. She stated Resident #1 would often attempt to stand without assistance. She stated Resident #1 needed constant redirection in order to prevent falls. She stated due to Resident #1's history of falls and not always following directions she should not have been left alone on the toilet for any length of time. On 07/07/2026 at 1:41 p.m., an interview was conducted with S10CNA. S10CNA stated a confused resident with a history of falls should not be left alone on the toilet for any length of time. On 07/07/2026 at 1:57 p.m., an interview was conducted with S6LPN. S6LPN stated on 06/23/2026, S8CNAS came and asked her to help get Resident #1 cleaned up and off of the toilet. She stated when she went into Resident #1's bathroom with S8CNAS, resident was laying on her back in the bathtub. She stated Resident #1 informed them she had gotten into the bath tub to clean herself off. She stated a resident with a history of falls and not easily redirected should never be left alone on the toilet for any length of time. On 07/07/2026 at 2:13 p.m., an interview was conducted with S8CNAS. S8CNAS stated she was aware Resident #1 was a fall risk. S8CNAS stated on 06/23/2026 she assisted Resident #1 on the toilet. She stated she walked out of Resident #1's room and left her sitting on the toilet. She stated when she went back into Resident #1's bathroom with S6LPN, Resident #1 was in the bathtub with her back toward the faucet. She stated Resident #1 reported to her she knew she was not supposed to get up, but she wanted to get in the tub and wash off. S8CNAS stated Resident #1 complained of the back of her head hurting and had a bump on the back of her head. A full assessment was conducted by S3LPN and Resident #1 was sent out to the hospital. She stated a resident with a history of falls and difficult to redirect should never be left alone on the toilet for any length of time. She confirmed she left Resident #1 unattended on the toilet and should not have. On 07/07/2026 at 1:04 p.m., an interview was conducted with S1DON. S1DON stated Resident #1 was alert but not always oriented. He stated as soon as someone turned away from Resident #1, she would stand up and walk without assistance. S1DON confirmed Resident #1 probably should not have been left alone on the toilet due to known history of falls and difficulty in following directions.		