

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 04/11/2024
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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965</p> <p>Based on observation, interviews, and record review, the facility failed to promote and facilitate resident self-determination through support of the resident's choice of when to get out bed for 1 (#28) of 4 (#1, #28, #53, and #89) residents reviewed for resident rights.</p> <p>Findings:</p> <p>Review of Resident #28's Clinical record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Hemiplegia Following Unspecified Cerebrovascular Disease Affecting Left Non-dominant Side, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #28's MDS with and ARD of 03/20/2024 revealed a BIMS of 10, which indicated moderate cognitive impairment. Further review revealed she required extensive assistance with transfers.</p> <p>Review of Resident #28's current Care Plan revealed the following, in part:</p> <p>Problem: I require staff assistance with ADLs.</p> <p>Interventions:</p> <p>I require assistance with transfers; and</p> <p>Transfer me on my strong side</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 2:23 p.m. She stated Resident #28 told her she needed to be out of bed at 10:00 a.m. She confirmed Resident #28 was not out of bed. She confirmed Resident #28 was not assisted out of bed when she requested.</p> <p>An observation was made of Resident #28 on 04/11/2024 at 2:30 p.m. She was seated in her wheelchair and her family member was present in her room.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Resident #28 and her family member on 04/11/2024 at 2:30 p.m. Resident #28 stated she liked to get up at 10:00 a.m. daily. Resident #28 stated this morning she asked S5CNA to assist her into her wheelchair. Resident #28 stated a staff member never came to assist her out of bed. Resident #28's family member stated she just arrived to the facility and Resident #28 was still in bed. Resident #28's family member stated she transferred the resident from the bed into the wheelchair.</p> <p>An interview was conducted with S4LPN on 04/11/2024 at 2:27 p.m. She stated Resident #28 required assistance of one staff member for transfers. She stated during medication pass on 04/11/2024, S5CNA notified her S5CNA was unable to assist Resident #28 out of bed independently. She stated she told S5CNA to go get another CNA for assistance. She stated she just realized S5CNA did not get Resident #28 out of bed. She confirmed Resident #28's family member transferred her from the bed to her wheelchair. She confirmed Resident #28 should have been assisted out of bed when she requested.</p> <p>An interview was conducted with S3CNAS on 04/11/2024 at 4:08 p.m. She stated Resident #28 wanted to get out of the bed daily between 9:30 a.m. and 10:00 a.m. She stated Resident #28 reported S5CNA did not transfer her out of bed this morning, 04/11/2024. She stated Resident #28 should have been transferred out of the bed when she requested.</p> <p>An interview was conducted with S2DON on 04/11/2024 at 4:43 p.m. She stated Resident #28 should have been transferred out of bed by staff when requested and should not have had to wait until her family member arrived.</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>42681</p> <p>Based on interviews and record review the facility failed to ensure residents received mail on Saturdays for 4 (#6, #51, #53 and #66) of 17 residents reviewed for mail during resident council. This deficient practice had the potential to affect 92 residents residing in the facility.</p> <p>Findings:</p> <p>Review of the facility's General Admission & Financial Agreement, reviewed on 04/09/2024, dated 01/2023, revealed, in part:</p> <p>Mail: The resident has the right to privacy in written communications including the right to:</p> <p>a. Send and promptly receive mail that is unopened.</p> <p>During the resident council meeting on 04/08/2024 at 2:00 p.m. Resident #6, Resident #51, Resident #53 and Resident #66 all stated mail was not delivered on Saturdays and was held until the following Monday.</p> <p>An interview was conducted with S5AD on 04/08/2024 at 2:10 p.m. She stated she and S4FIN were responsible for distributing resident's mail. She verbalized she works Monday through Friday and there was no one present to deliver mail to residents on Saturdays. She confirmed all mail and packages delivered to the facility on the weekends were held and distributed to residents on the following Monday.</p> <p>An interview was conducted with S4FIN on 04/09/2024 at 1:42 p.m. She stated she serves as backup to S5AD for distributing resident's mail. She confirmed she works Monday through Friday and there was no employee present to deliver mail to residents on Saturdays. She confirmed all mail and packages delivered to the facility on the weekends were held and distributed to residents on the following Monday. S4FIN defined promptly as within 24-hours.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>43868</p> <p>Based on record review and interviews, the facility failed to initiate and resolve grievances for 1 (#11) of 2 (#11 and #67) residents reviewed for grievances.</p> <p>Findings:</p> <p>Review of grievance policy titled, Grievance Policy and Procedure; effective 10/10/2022, reviewed on 04/11/2024; revealed the following:</p> <p>Purpose: to support each resident, family member to voice grievances (e.g . lost clothing) and to assure that after receiving a grievance the facility actively seeks resolution and keeps the individual filing the grievance appropriately apprised of its progress toward resolution.</p> <p>Policy: The resident has the right to and the facility must make prompt efforts to resolve grievances.</p> <p>Documentation:</p> <p>1. Document grievances made by a resident, resident's family member . the grievance shall include:</p> <ul style="list-style-type: none"> a. Date the grievance was received. b. A summary statement of the grievance. c. Steps taken to investigate the grievance. d. A summary of the pertinent findings or conclusions regarding the concerns. i. Record the grievance on the facility's Grievance log. <p>Follow Up/Resolution:</p> <p>1. The grievance official/compliance liaison or designee will follow up with the complainant with a resolution within 5 business days of the date that the grievance was filed.</p> <p>Review of the Quarterly MDS with ARD of 02/28/2024 revealed Resident #11 had a BIMS of 2 which indicated severe cognitive impairment.</p> <p>Review of the facility's Grievance Log for March 2024 revealed no grievances were filed for Resident #11.</p> <p>On 04/08/2024 at 10:03 a.m., an interview was conducted with Resident #11's RP. She stated in March 2024 she reported a missing phone charger to the nurse. She stated the nurse looked for the phone charger on the unit but did not find it.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/09/2024 at 8:35 a.m., an interview was conducted with S6CNA. She stated on March 29 2024, Resident #11's RP reported a missing phone charger and she reported it to S7LPN.</p> <p>On 04/09/2024 at 8:55 a.m., an interview was conducted with S7LPN. She stated on March 29, 2024, S6CNA reported Resident #11's phone charger was missing and she looked for it but it was not found. She confirmed she did not report the missing phone charger to administration.</p> <p>On 04/11/2024 at 12:22 p.m., an interview was conducted with S2DON. She confirmed she was not made aware of Resident #11's missing phone charger. She stated missing items should be reported to administration.</p> <p>On 04/11/2024 at 12:30 p.m., an interview was conducted with S1ADM. He confirmed he was not aware of Resident #11's missing phone charger and should be. He stated all staff were aware to report missing items to administration.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good hygiene for 2 (#75 and #88) of 5 (#28, #34, #67, #75, and #88) residents reviewed for ADLs. The facility failed to ensure Resident #75 and Resident #88 received incontinence care timely.</p> <p>Findings:</p> <p>Resident #75</p> <p>Review of Resident #75's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Muscle Wasting and Atrophy and Unspecified Dementia.</p> <p>Review of Resident #75's current Care Plan revealed the following:</p> <p>Problem: I am incontinent of bowel. Staff provides perineal care every two hours and as needed.</p> <p>Problem: I am incontinent of urine. Staff provides perineal care every two hours as needed.</p> <p>Review of Resident #75's Yearly MDS with an ARD of 02/07/2024 revealed a BIMS of 3, which indicated severe cognitive impairment. Further review revealed she was always incontinent of bowel and bladder and was dependent on staff for toileting hygiene.</p> <p>An observation was made of Resident #75 on 04/11/2024 at 11:38 a.m. She was lying in bed. There was a strong urine odor in her room.</p> <p>An observation was made of Resident #75 on 04/11/2024 at 1:15 p.m. There was a strong urine odor in her room.</p> <p>An observation was made of S5CNA performing incontinence care for Resident #75 on 04/11/2024 at 1:41 p.m. There was a strong urine odor in Resident #75's room. Resident #75's incontinence brief, incontinence pad, and fitted sheet were saturated with urine. Resident #75 had stool on her buttocks. S5CNA confirmed Resident #75's incontinence brief, incontinence pad, and fitted sheet were soiled with urine.</p> <p>Resident #88</p> <p>Review of Resident #88's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Parkinson's Disease, Other Abnormalities of Gait and Mobility, Muscle Wasting and Atrophy, Unspecified Lack of Coordination, and Generalized Muscle Weakness.</p> <p>Review of Resident #88's MDS with and ARD of 01/17/2024 revealed a BIMS of 13, which indicated intact cognition.</p> <p>Review of Resident #88's current Care Plan revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Problem: I need assistance with ADLs.</p> <p>Problem: High Risk for Skin Breakdown.</p> <p>Interventions: Keep skin clean and dry</p> <p>An observation was made of Resident #88 on 04/11/2024 at 11:38 a.m. She was lying in bed. There was a strong urine odor in her room.</p> <p>An observation was made of Resident #88 on 04/11/2024 at 1:15 p.m. There was a strong urine odor in her room.</p> <p>An interview was conducted with Resident #88 on 04/11/2024 at 1:55 p.m. She stated the CNA had not been in her room to provide incontinence care today, and she needed to be changed.</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 1:20 p.m. She confirmed she was assigned to Residents #75 and #88 from 6:00 a.m. to 2:00 p.m. today, 04/11/2024. She stated Residents #75 and #88 were both incontinent and she had not provided incontinence care to either one of them during her shift today. She stated she had not been able to perform her duties timely and had not reported that to anyone or asked for assistance.</p> <p>An observation was made of S5CNA performing incontinence care for Resident #88 on 04/11/2024 at 2:08 p.m. Resident #88's incontinence brief, incontinence pad, and top sheet were saturated with urine. S5CNA confirmed Resident #88's brief, incontinence pad, and top sheet were soiled with urine.</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 2:23 p.m. She stated Resident #75 and Resident #88 should have been changed every two hours and should have been changed prior soiling through their linens.</p> <p>An interview was conducted with S3CNAS on 04/11/2024 at 4:08 p.m. She stated Resident #75 was incontinent. She stated if Resident #75 was soiled through her brief, incontinence pad, and fitted sheet, she had gone too long without incontinence care. She stated Resident #88 was usually incontinent but would sometimes go to the bathroom if staff assisted her. She stated if Resident #88 was soiled through her brief, incontinence pad, and top sheet, she had gone too long without incontinence care. She stated incontinence rounds should have been performed every two hours. She stated S5CNA not changing a resident until the end of her shift was unacceptable and if she was unable to complete her tasks, she should have asked for assistance.</p> <p>An interview was conducted with S2DON on 04/11/2024 at 4:43 p.m. She stated incontinence care should have been provided every two hours and not providing incontinence care until the end of a 6:00 a.m. to 2:00 p.m. was unacceptable.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45270</p> <p>Based on observation, interviews, and record review, the facility failed to ensure residents were assessed for risk of entrapment from bedrails and obtain informed consent for bed rails prior to installation for 1 (#41) of 2 (#41 and #49) residents identified for having side rails in use.</p> <p>Findings:</p> <p>Review of the facility's policy titled Side Rail Policy and Procedure, effective 11/25/2014, revealed the following, in part:</p> <p>Policy: We use side rails as appropriate to resident need in creating better bed mobility and positioning, as ordered by physician.</p> <p>Procedure:</p> <p>1. Obtain . consent for use of side rails.</p> <p>Resident #41</p> <p>Review of Resident #41's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Other Specified Extrapryramidal and Movement Disorders, History of Falling, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbances, Generalized Muscle Weakness, and Unspecified Lack of Coordination.</p> <p>Review of Resident #41's MDS with an ARD of 03/20/2024 revealed she had a BIMS of 99, which indicated she was unable to be interviewed. Further review revealed she required substantial/max assist with bed mobility.</p> <p>Review of Resident #41's current Physician Orders revealed the following, in part:</p> <p>Start date 08/24/2023: may use quarter side rails as needed for bed mobility and repositioning.</p> <p>Review of Resident #41's MAR dated November 2023 to April 2024 revealed the following, in part:</p> <p>Start date 08/24/2023: may use quarter side rails as needed for bed mobility and repositioning, marked as implemented daily at 6:00 a.m., 2:00 p.m., and 10:00 p.m.</p> <p>Review of Resident #41's Clinical Record revealed no documentation of Entrapment Risk Assessments for side rails.</p> <p>Review of Resident #41's Clinical Record revealed no documentation of a Consent for side rails.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation was made of Resident #41 on 04/09/2024 at 2:52 p.m. lying in bed with two quarter side rails raised and attached to the bed.</p> <p>An interview was conducted with S10CNA on 04/09/2024 at 2:54 p.m. She stated anytime Resident #41's was in bed her side rails were raised.</p> <p>An interview was conducted with S9LPN on 04/09/2024 at 12:20 p.m. She stated on 03/19/2024, she assessed Resident #41's side rails for proper function but had not assessed for risk of entrapment.</p> <p>An interview was conducted with S2DON on 04/11/2024 at 12:19 p.m. She stated she was unable to provide any documentation to indicate Resident #41's representative had given consent for the quarter side rails as ordered on 08/24/2023. She stated she was unable to provide any documentation of an entrapment risk assessment being performed for Resident #41's side rails.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure each nurse aide was able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 2 (#28 and #34) of 5 (#28, #34, #67, #75, and #88) residents reviewed for ADLs.</p> <p>Findings:</p> <p>Review of the Certified Nursing Assistant (CNA) Orientation Proficiency Form, dated effective 12/4/2017, revealed the following, in part: Print out each policy pertaining to each topic that is applicable in policy tech and ensure the employee reviews the policy.</p> <p>Further review revealed the following topics, in part: Scheduled Care Monitor: Documentation of ADLs, how to code ADLs, how to use Kiosk, scheduled care and unscheduled care, Keeping residents dry (changing gown, diaper and linens), Perineal Care, Transferring Residents (two person assist, Hoyer lift, stand up life safety with transfers) and AM/PM Care.</p> <p>Resident #28</p> <p>Review of Resident #28's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Hemiplegia Following Unspecified Cerebrovascular Disease Affecting Left Non-dominant Side, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #28's MDS with an ARD of 03/20/2024 revealed she had a BIMS of 10, which indicated moderate cognitive impairment. Further review revealed she required extensive assistance with transfers.</p> <p>Review of Resident #28's current Care Plan revealed the following, in part:</p> <p>Problem: I require staff assistance with ADLs.</p> <p>Interventions: I require assistance with transfers; and</p> <p>Transfer me on my strong side</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 2:23 p.m. She stated Resident #28 reported she needed to be out of bed at 10:00 a.m. She confirmed she did not transfer Resident #28 out of bed. She stated she went into the room to assist Resident #28 out of bed, and she was unable to get her up by herself. She stated Resident #28 asked her to get another staff member to assist. She stated she informed S4LPN she was unable to get Resident #28 out of bed by herself but she did not ask for assistance. She stated she was unsure how to identify a resident's transfer status or how much assistance they required with ADLs. She stated she would ask the resident or assess the resident.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with S4LPN on 04/11/2024 at 2:27 p.m. She stated, this morning during medication pass, S5CNA notified her she was unable to assist Resident #28 out of bed independently. She stated Resident #28 required assistance of one staff member for transfers. She stated she told S5CNA to get another CNA for assistance. She stated she now realized S5CNA did not get Resident #28 out of bed.</p> <p>An interview was conducted with Resident #28 and her family member on 04/11/2024 at 2:30 p.m. She stated this morning, she asked S5CNA to get her up into her wheelchair. She stated S5CNA told her she did not know how to transfer her. She stated she felt S5CNA was incompetent to assist with the transfer and asked S5CNA for assistance of another staff member.</p> <p>Resident #34</p> <p>Review of Resident #34's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Fracture of Neck of Left Femur, Idiopathic Progressive Neuropathy, Generalized Muscle Weakness, and Morbid Obesity.</p> <p>Review of Resident #34's MDS with and ARD of 01/10/2024 revealed she had a BIMS of 14, which indicated she was cognitively intact. Further review revealed she required partial/moderate assistance with bathing.</p> <p>Review of Resident #34's current Care Plan revealed the following, in part:</p> <p>Problem: I require extensive to dependent assistance times 1-2 staff for ADL's. Staff assist me with ADL's.</p> <p>Interventions: I prefer a bed bath; Assist me with bathing.</p> <p>An interview was conducted with Resident #34 on 04/11/2024 at 1:38 p.m. She stated she asked S5CNA this morning to give her a bath. She stated when S5CNA gave her the bed bath S5CNA asked her with every step of the bath now what should I do? She stated S5CNA was very inexperienced.</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 1:04 p.m. She stated she was assigned to Resident #34 today, on 04/11/2024, from 6:00 a.m. to 2:00 p.m. She stated she was hired on 04/08/2024 and had not received a computer login or training on the facility's computer system. She stated without computer access, she would not know what care the residents needed unless she asked the nurse or S3CNAS. She stated on her first day of training she was with the CNA on the hall observing care. She stated on her second day she participated in resident care with another CNA, but did not have to return demonstrate care. She stated today, 04/11/2024 she was by herself caring for the residents. She stated neither of the CNAs she worked with, nor S3CNAS did check offs or watched her demonstrate care. She stated she identified what care each resident needed by observing the residents and asking the residents what they needed. She stated Resident #34 requested a bath this morning and she provided the bed bath by herself. She stated no staff or S3CNAS had observed her provide a resident a bed bath. She stated she did not ask any other staff member or S3CNAS for assistance during her shift.</p> <p>(continued on next page)</p>		

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 04/11/2024
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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with S3CNAS on 04/11/2024 at 4:05 p.m. She stated Resident #28 reported to her she felt S5CNA was incompetent to transfer her. She stated S5CNA should have been able to identify how much assistance each resident needed for transfers. She stated S5CNA should have retrieved assistance from another staff member to transfer Resident #28 out of the bed when she requested. She stated she was unaware when S5CNA gave Resident #34 a bath today, S5CNA asked the resident how to provide the bath. She stated S5CNA should have been competent to perform a bed bath. She stated this morning was S5CNA's fourth day working at the facility and she was by herself on the hall. She stated she was aware S5CNA did not have a computer login or access to the resident records. She reviewed the CNA Orientation Proficiency Packet and stated it was the check off list for the CNAs' training. She confirmed she completed and signed the CNA Orientation Proficiency Packet for S5CNA on 04/08/2024, and by signing the form, she was saying S5CNA was competent. She stated she did not observe S5CNA return demonstrate providing care or bathing the residents to ensure competency.</p> <p>An interview was conducted with S2DON on 04/11/2024 at 4:42 p.m. She stated S3CNAS was responsible for going over all competencies with the CNAs upon hire. She reviewed the CNA Orientation Proficiency Checklist for S5CNA dated 04/08/2024, and confirmed S3CNAS signed off and documented S5CNA's orientation was complete and that she was competent in all CNA tasks. She stated without computer access, the CNA did not have access to the resident's clinical record, which included the assistance each resident required. She stated S5CNA should not have provided care to residents without knowing how much assistance each resident required for the specific task and/or ADL. She stated she was unaware Resident #34 reported S5CNA did not know how to give her a bed bath and that she asked the resident what to do during care. She confirmed S5CNA should have been competent in performing bed baths and transfers prior to working independently.</p> <p>An interview was conducted with S1ADM on 04/11/2024 at 5:10 p.m. He stated S3CNAS was responsible for training the CNAs and to ensure they were competent. He stated S3CNAS was responsible to follow-up, review, and sign off the CNA Orientation Checklist after ensuring the CNA's competence. He reviewed the CNA Orientation Proficiency checklist for S5CNA dated 04/08/2024. He confirmed by S3CNAS signing off the checklist, she was saying S5CNA was competent in the listed task. He stated he expected staff working with residents to have computer access to know what care each resident required. He stated S2DON should follow up and make sure the CNA staff were competent.</p> <p>45270</p>		

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NAME OF PROVIDER OR SUPPLIER The Guest House Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10145 Florida Blvd Baton Rouge, LA 70815	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965</p> <p>Based on interviews and record reviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident residing in the facility. The facility failed to have an effective system in place to ensure S5CNA was competent in skills and techniques for 2 (#28 and #34) of 5 (#28, #34, #67, #75, and #88) residents reviewed for ADLs.</p> <p>Findings:</p> <p>Resident #28</p> <p>Review of Resident #28's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Hemiplegia Following Unspecified Cerebrovascular Disease Affecting Left Non-dominant Side, Cerebral Infarction, and Generalized Muscle Weakness.</p> <p>Review of Resident #28's current Care Plan revealed the following, in part:</p> <p>Problem: I require staff assistance with ADLs.</p> <p>Interventions: I require assistance with transfers; and</p> <p>Transfer me on my strong side</p> <p>An interview was conducted with S5CNA on 04/11/2024 at 2:23 p.m. She stated Resident #28 reported she needed to be out of bed at 10:00 a.m. She confirmed she did not transfer Resident #28 out of bed. She stated she went into the room to assist Resident #28 out of bed, and she was unable to get her up by herself. She stated Resident #28 asked her to get another staff member to assist. She stated she informed S4LPN she was unable to get Resident #28 out of bed by herself but she did not ask for assistance. She stated she was unsure how to identify a resident's transfer status or how much assistance they required with ADLs.</p> <p>Resident #34</p> <p>Review of Resident #34's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Fracture of Neck of Left Femur, Idiopathic Progressive Neuropathy, Generalized Muscle Weakness, and Morbid Obesity.</p> <p>Review of Resident #34's current Care Plan revealed the following, in part:</p> <p>Problem: I require extensive to dependent assistance times 1-2 staff for ADL's. Staff assist me with ADL's.</p> <p>Interventions: I prefer a bed bath; Assist me with bathing.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with S5CNA on 04/11/2024 at 1:04 p.m. She stated she was hired on 04/08/2024, had not received a computer login or training on the facility's computer system. She stated without computer access, she would not know what care the residents needed unless she asked the nurse or S3CNAS. She stated, on her first day of training, she was with the CNA on the hall observing care. She stated on her second day, she participated in resident care with another CNA, but did not have to return demonstrate care. She stated today, 04/11/2024, she was by herself caring for the residents. She stated neither of the CNAs she worked with, she was unsure of their names, nor S3CNAS did check offs or watched her demonstrate care. She stated she identified what care each resident needed by observing the residents and asking the residents what they needed. She stated Resident #34 requested a bath this morning, and she provided the bed bath by herself. She stated no staff or S3CNAS had observed her provide a resident a bed bath prior to giving Resident #34 a bed bath this morning. She stated she worked alone today and did not ask any other staff member or S3CNAS for assistance during her shift.</p> <p>An interview was conducted with S3CNAS on 04/11/2024 at 4:05 p.m. She stated Resident #28 reported to her she felt S5CNA was incompetent to transfer her. She stated she was unaware when S5CNA gave Resident #34 a bath today, S5CNA asked the resident how to provide the bath. She stated this morning was S5CNA's third day working at the facility and she was by herself on the hall. She stated she was aware S5CNA did not have a computer login or access to the resident records. She reviewed the CNA Orientation Proficiency Packet and stated it was the check off list for the CNAs' training. She confirmed she completed and signed the CNA Orientation Proficiency Packet for S5CNA on 04/08/2024, and by signing the form, she was saying S5CNA was competent. She stated she did not observe S5CNA return demonstrate providing care or bathing the residents and should have before signing her CNA Orientation Proficiency Packet.</p> <p>An interview was conducted with S2DON on 04/11/2024 at 4:42 p.m. She stated S3CNAS was responsible for going over all competencies with the CNAs upon hire. She reviewed the CNA Orientation Proficiency Checklist for S5CNA dated 04/08/2024, and confirmed S3CNAS signed off and documented S5CNA's orientation was complete and that she was competent in all CNA tasks. She stated without computer access, the CNA did not have access to the resident's clinical record, which included the assistance each resident required. She stated S5CNA should not have provided care to residents without knowing how much assistance each resident required for the specific task and/or ADL. She confirmed S3CNAS should have ensured S5CNA was competent in performing bed baths and transfers prior to working independently. She stated she and S8ADON were S3CNAS supervisors. She stated she and S8ADON did not check behind S3CNAS to ensure the CNA staff were trained effectively and competent.</p> <p>An interview was conducted with S1ADM on 04/11/2024 at 5:10 p.m. He stated S3CNAS was responsible for training the CNAs and to ensure they were competent. He stated S3CNAS was responsible to follow up, review, and sign off the CNA orientation checklist after ensuring the CNA's competence. He reviewed the CNA Orientation Proficiency checklist for S5CNA dated 04/08/2024. He confirmed by S3CNAS signing off the checklist, she was saying S5CNA was competent in the listed tasks. He stated staff working with residents should have computer access to ensure they are aware what each resident required when providing care to them. He stated S2DON should follow up and make sure the CNA staff were competent.</p> <p>45270</p>		