STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195551	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guest House Nursing and Rehabilitation	109 Guest House Drive West Monroe, LA 71292

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review and interviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment witnessed by staff are reported immediately to their supervisor or the Director of Nursing for 1 (#1) of 3 (#1, #2, #3) residents reviewed for abuse. Findings: Review of the facility's policy and procedure for Recognizing Signs and Symptoms of Abuse/Neglect with a revised date of January 2011 revealed: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing (DON) Services immediately. Review of the medical record for resident #1 revealed diagnoses of Alzheimer's disease, depression, Tourette's, lumbago with sciatica, osteoporosis, dementia, reflux, anxiety, and psychotic disorder. Review of the current care plan for resident #1 revealed impaired cognitive short and long term memory loss related to the diagnosis of Alzheimer's disease. Further review of the care plan revealed interventions included for the staff to introduce self to resident when entering room, reorient resident as needed, encourage resident to be out of the room and to administer medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had severe cognitive impairment for daily decision making. Review of the facility's Investigative Report revealed on 04/29/2024 S2Director of Nursing (DON) informed S1Administrator that S5Certified Nursing Assistant (CNA) received word that S3CNA, the CNA that worked with resident #1 on 04/27/2024, raised her voice at resident #1 after she fell on the floor and used improper verbiage with resident #1. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 10:30 a.m., an interview with S5CNA revealed on Monday 04/29/2024 S4Ward Clerk called S5CNA, and informed S5CNA that resident #1 fell on [DATE]. S4 [NAME] Clerk went to help and she saw S3CNA standing over resident #1 with her arm under the resident's arm saying stand up, get up, you aren't hurt, I am not having this today. S4Ward Clerk told S5CNA that she did not report what she saw and heard S3CNA say to resident #1 on 04/27/2024. Further interview with S5CNA revealed she immediately informed S2DON on 04/29/2024 of the conversation she had with S4Ward Clerk on 04/29/2024. On 05/14/2024 at 11:40 a.m., a phone interview with S4Ward Clerk revealed she was at the nurses' station with S6Licensed Practical Nurse (LPN). On 04/27/2024, S4Ward Clerk and S6LPN heard resident #1 yell out. S4Ward Clerk walked to the doorway and saw resident #1 was on the floor and S3CNA was trying to get resident #1 under her arm saying I don't know why you are down there. S4Ward Clerk revealed S3CNA started dragging resident #1 on the floor trying to get her up off of the floor. S4Ward Clerk revealed S3CNA was raising her voice and being mean to resident #1. S4Ward Clerk revealed she did not report the incident that happened on 04/27/2024 between resident #1 and S3CNA until Monday 04/29/2024. On 05/14/2024 at 3:30 p.m., an interview with S2DON revealed S4Ward Clerk should have reported the alleged abuse regarding resident #1 and S3CNA immediately. On 05/15/2024 at 4:10 p.m., an interview with S1Administrator confirmed S4Ward Clerk should have reported the alleged abuse regarding resident #1 and S3CNA immediately.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record review and interviews the facility failed to have documented evidence that allegations of verbal abuse were thoroughly investigated for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed for abuse. Findings: Review of the facility's Abuse Investigations policy dated April 2014 revealed: All reports of resident abuse, neglect, and injuries of unknown source shall be thoroughly and promptly investigation by facility management; 3. The individual conducting the investigation will, at a minimum: c. Interview the person (s) reporting the incident; d. Interview any witnesses to the incident; 5. Witness reports will be obtained in writing. Either the staff member will write his/her statement and sign and date it, or the investigator may obtain the staff statement, read it back to the member and have him/her sign and date it. Review of the medical record for resident #1 revealed diagnoses of Alzheimer's disease, depression, Tourette's, lumbago with sciatica, osteoporosis, dementia, reflux, anxiety, and psychotic disorder. Review of the current care plan for resident #1 revealed impaired cognitive short and long term memory loss related to the diagnosis of Alzheimer's disease. Further review of the care plan revealed interventions included for the staff to introduce self to resident when entering room, reorient resident as needed, encourage resident to be out of the room and to administer medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had severe cognitive impairment for daily decision making. Review of the facility's Investigative Report revealed on 04/29/2024 S2Director of Nursing (DON) informed S1Administrator that S5Certified Nursing Assistant (CNA) received word that S3CNA, the CNA that worked with resident #1 on 04/27/2024, raised her voice at resident #1 after she fell on the floor and used improper verbiage with resident #1. On 05/14/2024 at 10:30 a.m., an interview with S5CNA revealed on Monday 04/29/2024 S4Ward Clerk called S5CNA, and informed S5CNA that resident #1 fell on [DATE]. S4 [NAME] Clerk went to help and she saw S3CNA standing over resident #1 with her arm under the resident's arm saying stand up, get up, you aren't hurt, I am not having this today. S4Ward Clerk told S5CNA that she did not report what she saw and heard S3CNA say to resident #1 on 04/27/2024. Further interview with S5CNA revealed she immediately informed S2DON on 04/29/2024 of the conversation she had with S4Ward Clerk on 04/29/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 11:40 a.m., a phone interview with S4Ward Clerk revealed she was at the nurses' station with S6Licensed Practical Nurse (LPN). On 04/27/2024, S4Ward Clerk and S6LPN heard resident #1 yell out. S4Ward Clerk walked to the doorway and saw resident #1 was on the floor and S3CNA was trying to get resident #1 under her arm saying I don't know why you are down there. S4Ward Clerk revealed S3CNA started dragging resident #1 on the floor trying to get her up off of the floor. S4Ward Clerk revealed S3CNA was raising her voice and being mean to resident #1. S4Ward Clerk revealed that neither S1Administrator nor S2DON asked her to give a statement or interview about the incident that occurred on 04/27/2024. On 05/14/2024 at 4:20 p.m., review of the video footage with S1Administrator revealed S7CNA was seen in the video assisting resident #1 during the incident on 04/27/2024. There was no audio to the video footage and the incident in question took place out of the line of site for the camera. On 05/15/2024 at 3:30 p.m., a phone interview with S7CNA revealed on 04/27/2024 she heard resident #1 holler and she went to help. S7CNA revealed resident #1 was on the floor and S3CNA was trying to assist her. S7CNA revealed she did not witness any staff member being abusive to resident #1. S7CNA revealed that neither S1Administrator nor S2DON asked her to give a statement or interview about the incident that occurred on 04/27/2024. Review of the facility's investigative report revealed no documented evidence of a statement or an interview obtained from S4Ward Clerk or S7CNA regarding the incident with resident #1 and S3CNA that occurred on 04/27/2024. On 05/14/2024 at 3:30 p.m., an interview with S2DON revealed she did not interview or get a statement from S4Ward Clerk or from S7CNA regarding the alleged abuse to resident #1 by S3CNA. On 05/15/2024 at 11:30 a.m., an interview with S1Administrator revealed he did not interview or get a statement from S4Ward Clerk or S7CNA regarding the alleged abuse to resident #1 by S3CNA.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 18118 Based on record reviews and interview, the facility failed to ensure the State Adverse Actions Website checks were completed for Certified Nursing Assistants (CNA) monthly for 4 (S3CNA, S8CNA, S10CNA, and S11CNA) of 5 (S3CNA, S8CNA, S10CNA, S11CNA and S12CNA) personnel files reviewed. Findings: Review of S3CNA's personnel file revealed a hire date of 03/20/2024. Further review of S3CNA's personnel file revealed there was a State Adverse Action check upon hire. Further review of the personnel file revealed there was no documented evidence of State Adverse Action checks obtained monthly. Review of S8CNA's personnel file revealed a hire date of 05/15/2023. Further review of S8CNA's personnel file revealed there was a State Adverse Action check upon hire. Further review of the personnel file revealed there was no documented evidence of State Adverse Action checks obtained monthly. Review of S10CNA's personnel file revealed a hire date of 02/28/2024. Further review of S10CNA's personnel file revealed there was a State Adverse Action check upon hire. Further review of the personnel file revealed there was no documented evidence of State Adverse Action checks obtained monthly. Review of S11CNA's personnel file revealed a hire date of 02/23/2024. Further review of S11CNA's personnel file revealed there was a State Adverse Action check upon hire. Further review of the personnel file revealed there was no documented evidence of State Adverse Action checks obtained monthly. On 05/15/2024 at 3:20 p.m., an interview with S9Clerical confirmed State Adverse Action checks were not obtained monthly.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 18118 Based on record review and interview, the facility failed to ensure it was in compliance with state laws by failing to obtain criminal history checks upon hire for 1 (S8Certified Nursing Assistant) (CNA) of 5 (S3CNA, S8CNA, S10CNA, S11CNA and S12CNA) personnel files reviewed. Findings: The current Long Term Minimum Licensing Standards, statute 9759 A. states the nursing facility shall have statewide criminal history checks performed on non-licensed personnel to include CNAs. Review of the personnel file for S8CNA revealed a hire date of 05/15/2023. Further review of S8CNA's personnel file revealed no documented evidence of a criminal history check obtained upon hire. On 05/15/2024 at 3:20 p.m., an interview with S9Clerical confirmed there was no documented evidence of a criminal history background check obtained upon hire for S8CNA.