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	08/13/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829 Based on record reviews and interviews, the facility failed to ensure nursing staff was competent in providing nursing and related services to assure resident safety and maintain resident's highest practicable physical, mental, and psychological well-being for each resident. The facility failed to ensure: 1) the Certified Nursing Assistants (CNAs) conducted a walk through round and provided a report on residents during shift change and 2) CNAs rounded on residents every 2 hours for 2 (#1, #2) of 3 (#1, #2, #3) sampled residents. Findings: Resident #1 Record review revealed resident #1 was admitted to the facility on [DATE] with diagnoses that included multiple myeloma not having achieved remission, personal history of Non-Hodgkin's lymphoma, adult failure to thrive, unspecified dementia unspecified severity without behavioral disturbance, depression, history of falling, and acute kidney failure unspecified. Review of Assessment Reference Date (ARD) Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated resident #1 was cognitively intact. Resident #1 had no range of motion impairment to upper or lower extremities and ambulated independently without any assisted devices. Resident #1 was independent with eating and oral hygiene. Resident #1 required setup or clean up assistance with personal hygiene and dressing upper body and required supervision or touching assistance with toileting hygiene and putting on/off footwear. Resident #1 required partial/moderate assistance with shower/bathe and dressing lower body. On 08/08/2024 at 9:40 a.m., an interview with S4CNA revealed she worked the day shift (7a.m to 3p.m.) on 08/03/2024 on hall A. S4CNA reported when she arrived to work S3CNA who worked the night shift, told her hi, but did not do a walk through or give her a report on the residents before she left. S4CNA reported she and S5CNA were both assigned to work hall A. S4CNA reported S5CNA was assigned to provide care for resident #1. S4CNA reported after she had finished making rounds on her residents, she started passing out ice water to residents. S4CNA reported around 7:40 a.m. she took ice water to resident #1's room. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/08/2024 at 10:42 a.m., a telephone interview with S3CNA reported she work the night shift (11p.m. to 7:00 a.m.) on hall A on 08/02/2024 and provided care for resident #1. S3CNA reported she checked on resident #1 at 11:00 p.m., 1:00 a.m., 3:00 a.m., and 5:00 a.m. S3CNA reported resident #1 was awake most of the night watching television. S3CNA reported resident #1 did not voice any needs or report any discomfort when she checked on him throughout the night. S3CNA reported she last checked on resident #1 around 5:00 a.m. and he was in his bed watching television. S3CNA revealed resident #1 reported he did not needing anything when she asked him. S3CNA reported she did not do a walk through or give report to the oncoming CNAs before she got off. On 08/08/2024 at 12:13 p.m., a telephone interview with S5CNA revealed he worked the day shift (7 a.m. to 3 p.m.) on 08/03/2024. S5CNA reported he did not receive a report from S3CNA who worked the night shift and they did not do a walk through at shift change. S5CNA reported he and S4CNA were assigned to work the day shift on hall A. S5CNA reported he started his rounds around 7:05 a.m. assisting residents. S5CNA reported he generally assist the residents who are not able to walk and require extensive assistance with their Activities of Daily Living (ADL) first. S5CNA reported he had not made it to resident #1's room until around 8:15 a.m. Resident #2 Record review revealed resident #2 was admitted to the facility on [DATE] with diagnoses that include bradycardia, presence of pacemaker, primary osteoarthritis right hand, idiopathic gout multiple sites, essential hypertension, atherosclerotic heart disease, unspecified atrial fibrillation, mixed hyperlipidemia, obstructive sleep apnea, solitary plasmacytoma not having achieved remission, anemia, type 2 diabetes mellitus without complications, morbid obesity, and multiple myeloma not having achieved remission. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated resident #2 was cognitively intact. Resident #2 required extensive one person assistance with bed mobility, transfers, and toilet use. Resident #2 required supervision one person assistance with eating. Resident #2 was always incontinent of bowel and bladder. Resident #2 was unable to walk and used a wheel chair for ambulation. On 08/08/2024 at 9:40 a.m., an interview with S4CNA revealed she worked the day shift (7a.m to 3p.m.) on 08/03/2024 on hall A. S4CNA reported when she arrived to work S3CNA who worked the night shift, told her hi, but did not do a walk through or give her a report on the residents before she left. S4CNA reported she and S5CNA were both assigned to work hall A. S4CNA reported S5CNA was assigned to provide care for resident #2. S4CNA reported after she had finished making rounds on her residents, she started passing out ice water to residents. S4CNA reported around 7:40 a.m. she took ice water to resident #2's room. On 08/08/2024 at 10:42 a.m., a telephone interview with S3CNA reported she worked the night shift (11p.m. to 7:00 a.m.) on hall A on 08/02/2024 and provided care for resident #2. S3CNA reported she checked on resident #2 at 11:00 p.m., 1:00 a.m., 3:00 a.m., and 5:00 a.m. S3CNA reported she provided incontinent care and brief change for resident #2 when she rounded on him throughout the night. S3CNA reported she last checked on resident #2 around 5:00 a.m. and she brought him 2 cups of coffee per his request. S3CNA reported she did not do a walk through or give report to the oncoming CNAs before she got off. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/08/2024 at 12:13 p.m., a telephone interview with S5CNA revealed he work the day shift (7 a.m. to 3 p. m.) on 08/03/2024. S5CNA reported he did not receive a report from S3CNA who worked the night shift and they did not do a walk through at shift change. S5CNA reported he and S4CNA were assigned to work the day shift on hall A. S5CNA reported he started his rounds around 7:05 a.m. assisting residents. S5CNA reported he generally assist the residents who are not able to walk and require extensive assistance with their Activities of Daily Living (ADL) first. S5CNA reported he had not made it to resident #2's room until around 8:15 a.m. On 08/12/2024 at 8:50 a.m., an interview with S2Director of Nursing (DON) revealed it is expected that the CNAs and nurses make rounds every 2 hours on residents they are assigned to provide care for. S2DON further revealed it is expected that the CNAs and LPNs give report and do a walk through round at the beginning and end of their shifts. On 08/08/2024 at 2:15 p.m., interview with S6CNA Supervisor confirmed she conducted a CNA in-service on 06/19/2024 about transferring, turning, rounding every 2 hours. S6CNA Supervisor revealed CNAs were also informed they were required to do a walk through and give a report with the oncoming CNAs before they get off. The off going CNA and the oncoming CNA are to physically go into the residents' rooms together for the walk through report at the beginning and ending of each shift. Review of the in-service sign in sheet with S6CNA Supervisor revealed S3CNA, S4CNA, and S5CNA's signatures were noted.