

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2024
NAME OF PROVIDER OR SUPPLIER Guest House Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 (#1) of 2 (#1 and #2) resident records reviewed, by assessing that bed rails were not indicated for a resident who was identified as having bed rails in use.</p> <p>Findings:</p> <p>Review of the medical record revealed a recent admitted [DATE]. The resident's diagnoses included in part vascular dementia, moderate with behavioral disturbance and a history of falls.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had a brief interview for mental status score of 03 indicating the resident had severe cognitive impairment with his daily decision making skills.</p> <p>Observation on 12/23/2024 at 10:20 a.m. and 12/26/2024 at approximately 8:40 a.m. revealed resident #1 had 1/4 bed rails, one intact to each side of the resident's bed frame. Both rails were upright and in a locked position.</p> <p>Review of the Bed Rail assessment dated [DATE] at 6:54 a.m. revealed a check mark next to Side Rails/Assist Bar not indicated at this time. The assessment was signed by S3Registered Nurse (RN).</p> <p>On 12/26/2024 at 12:03 p.m., during a telephone interview, S3RN was notified of the findings regarding a check mark being documented next to side rails/assist bar are not indicated at this time. S3RN confirmed that she had completed the Bed Rail assessment dated [DATE] at 6:54 a.m. for resident #1. She revealed that she had been informed by the facility's previous Director of Nursing (DON) that by marking the use of bed rails, the facility had shown a high indicator use for restraints. She revealed that she had done what she had been told to do by her DON, at that time. S3RN confirmed the assessment was inaccurate.</p> <p>On 12/26/2024 at approximately 11:55 a.m., S1Administrator and S2Regional Director of Operations were notified of the above findings regarding resident #1.</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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 32231</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails prior to installation for 2 (#1 and #2) of 2 (#1 and #2) residents reviewed for accident hazards. The facility failed to have documented evidence of an assessment for the risk of entrapment from bed rails for residents identified as having 1/4 bed rails in use.</p> <p>Findings:</p> <p>Resident #1</p> <p>Review of the medical record for resident #1 revealed a recent admitted [DATE]. The resident's diagnoses included in part vascular dementia, moderate with behavioral disturbance and a history of falls.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had a Brief Interview for Mental Status (BIMS) score of 03 indicating the resident had severe cognitive impairment with his daily decision making skills.</p> <p>Observations on 12/23/2024 at 10:20 a.m. and 12/26/2024 at approximately 8:40 a.m. revealed resident 1/4 bed rails, one intact to each side of the resident #1's bedframe. Both rails were upright and in a locked position.</p> <p>Review of the medical record revealed there was no documented evidence of resident #1 being assessed for risk of entrapment for bed rails of any kind.</p> <p>Review of the Bed Rail assessment dated [DATE] at 6:54 a.m. revealed a check mark next to Side Rails/Assist Bar not indicated at this time. The assessment was signed by S3Registered Nurse (RN).</p> <p>On 12/26/2024 at 12:03 p.m., during a telephone interview, S3RN was notified of the findings regarding a check mark being documented next to side rails/assist bar are not indicated at this time. S3RN confirmed that she had completed the Bed Rail assessment dated [DATE] at 6:54 a.m. for resident #1. She revealed that she had been informed by the previous Director of Nursing (DON) that by marking the use of bed rails, the facility had shown a high indicator use for restraints. S3RN further confirmed that she could not recall if resident #1 actually required the use of the bed rails at the time she had completed the assessment on 12/18/2024 nor if resident #1 required the use of bed rails at the present time.</p> <p>On 12/26/2024 at approximately 2:00 p.m., an interview with S4Maintenance Supervisor was notified of the findings regarding resident #1 having 1/4 bed rails, one intact to each side of the bedframe. S4Maintenance Supervisor confirmed that he did not have any documentation to indicate that resident #1 was assessed for the risk of entrapment for bed rails of any kind.</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 - Few</p>	<p>On 12/26/2024 at approximately 11:55 a.m., S1Administrator and S2Regional Director of Operations were notified of the above findings regarding resident #1.</p> <p>Resident #2</p> <p>Review of the medical record revealed that resident #2 was admitted to the facility on [DATE] with diagnoses including, left femur fracture with joint replacement, major depressive disorder, and insomnia.</p> <p>Review of the Admission MDS assessment dated [DATE] revealed resident #2 had a BIMS score of 08 indicating that resident #2 had moderate cognitive impairment with daily decision making skills.</p> <p>On 12/26/2024 at 8:25 a.m. and 12/30/2024 at 9:39 a.m., observations revealed resident #2 had 1/4 bed rails, one intact to each side of the bedframe. Both bed rails were observed in an upright and locked position.</p> <p>Review of the medical record revealed there was no documented evidence of resident #2 being assessed for the risk of entrapment for bed rails of any kind.</p> <p>On 12/26/2024 at approximately 2:00 p.m., an interview with S4Maintenance Supervisor was notified of the findings regarding resident #2 having 1/4 bed rails, one intact to each side of the bedframe. S4Maintenance Supervisor confirmed that he did not have any documentation to indicate that resident #2 was assessed for the risk of entrapment for bed rails of any kind.</p> <p>On 12/26/2024 at approximately 11:55 a.m., S1Administrator and S2Regional Director of Operations were notified of the above findings regarding resident #2.</p>

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231</p> <p>Based on record reviews and interviews, the facility failed to ensure that before allowing an individual to serve as a nurse aide, a facility must receive receive registry verification that the individual has met competency evaluation requirements for 1 Certified Nursing Assistant (S5CNA) of 3 (S5CNA, S6CNA, and S7CNA) personnel files reviewed. The facility allowed an employee to work as a CNA with an expired and out of State certification.</p> <p>Findings:</p> <p>Review of S5CNA's personnel file revealed his date of hire was on [DATE]. Further review revealed that S5CNA received his nurse aide certification in a different state from which he was currently employed. Review further revealed the certification had expired on [DATE].</p> <p>On [DATE] at 8:15 a.m., an interview with S1Administrator confirmed that S5CNA did not have a current nurse aide certification in the state he was currently employed.</p> <p>On [DATE] at 9:53 a.m., an interview with S8CNA Supervisor confirmed that S5CNA had provided services to residents after his nurse aide certification had expired on [DATE].</p>