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	07/24/2024

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40238 Based on record review and interview the facility failed to electronically transmit encoded, accurate and complete Minimum Data Set (MDS) data to Centers for Medicare and Medicaid (CMS) in a timely manner for 3 (#43,#48, and #94) of 3 (#43,#48, and #94) residents reviewed for the completion of a fourteen day discharge assessment. Findings: Record review revealed resident #43 was admitted to the facility on [DATE] and discharged on [DATE]. The last transmitted MDS assessment in the electronic health record was an admission assessment completed on 03/19/2024. Record review revealed resident #48 was admitted to the facility on [DATE] and discharged on [DATE]. The last transmitted MDS assessment in the electronic health record was an admission assessment completed on 03/05/2024. Record review revealed resident # 94 was admitted to the facility on [DATE] and discharged on [DATE]. The last transmitted MDS assessment in the electronic health record was a quarterly assessment completed on 03/06/2024. On 07/24/2024 at 04:20 p.m., an interview with S2Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) nurse confirmed a minimum data set assessment was not submitted within fourteen days of discharge for resident #43, resident #48, and resident #94.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 19098 Based on observation, record review, and interview the facility failed to develop and implement a comprehensive person-centered care plan for 1 (#66) of 1 (#66) residents identified with a skin rash. Findings: On 07/22/2024 at 10:48 a.m., observation of resident #66 revealed a dark patchy red rash to the face, back and arms. Interview at that time with resident #66 revealed she did not know the cause of the rash. On 07/24/2024 review of the record for resident #66 revealed diagnoses in part of dermatitis, arthritis, stage 3 chronic kidney disease, mild cognitive impairment and atrial fibrillation. Further review of the record revealed resident #66 had allergies to sulfonamide antibiotics. Review of the record also revealed the initial treatment for the rash began on 06/07/2024 with an order for hydrocortisone 1% ointment apply to areas on the face twice a day (BID) for 10 days- avoid the eyes and for Claritin 10 milligrams (mg) by mouth (po) one time a day for 10 days. Further review of the record revealed the following orders for resident #66's rash: 07/01/2024 Benadryl 25mg every 24 hours as needed for itching. 07/08/2024 Claritin 10mg 1 tab po every day for 30 days. Prednisone 10mg 1 tab po every day for 5 days in the morning. Consult dermatology for dermatitis to face/arms. 07/09/2024 Stop prednisone, start Diflucan 100mg po every other day for 4 doses (Fungal Rash). 07/09/2024 Claritin 10mg every day related to Dermatitis give until 08/09/2024. 07/20/2024 Hydralazine hydrochloric acid (HCL) 25mg every day and on 07/26/2024 give 1 po every day for 1 week then stop. On 07/24/2024 review of the current plan of care revealed there were no problems/needs related to the skin condition or rash for resident #66 implemented. On 07/24/2024 at 3:01 p.m., an interview with S1Director of Nursing (DON) confirmed the current plan of care did not address the problems/needs related to the skin condition/rash for resident #66.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098 Based on observations, interviews, and record reviews, the facility failed to provide respiratory care consistent with professional standards of practice for 2 (#25, #71) of 2 (#25, #71) sampled residents reviewed for respiratory care. The facility failed to ensure: 1) a resident's oxygen (O2) was administered as ordered, the O2 tubing was dated, and the nebulizer was dated/stored properly (#25); and 2) a resident's O2 concentrator was clean (#71). Findings: Review of the facility Oxygen Administration (Concentrator or Tank) Policy (no date noted) revealed in part: Humidifier bottles, cannulas and O2 tubing will be changed at least once weekly and dated. Concentrator filter should be cleaned weekly or as needed as well. Resident #25 On 07/23/2024 at 2:11 p.m., review of the record for resident #25 revealed diagnoses in part of hypothyroidism, vascular dementia, atrial fibrillation, major depressive disorder, chronic obstructive pulmonary disease, chronic viral hepatitis C, and sleep apnea. Review of the quarterly Minimum Data Set (MDS) assessment revealed resident #25 was unable to be scored for the Brief Interview Mental Status (BIMS) review due to cognitive impairment. On 07/23/2024 at 9:34 a.m. review of the record revealed physician orders in part with start date noted: 06/29/2024 admit to hospice due to dementia. 07/01/2024 oxygen at 3 liters per minute continuous per nasal cannula for shortness of breath or wheezing and to keep the pulse oximeter greater than or equal to 92% and for albuterol sulfate nebulization solution (2.5milligrams/3milliliters) every 4 hours as needed for shortness of breath related to chronic obstructive pulmonary disease (COPD). On 07/22/2024 at 3:35 p.m., an observation of resident #25 revealed oxygen was being administered at 5 liters per minute (lpm) per nasal cannula with no humidification noted and there was no date on the oxygen tubing. Further observation revealed the nebulizer mask was not covered or dated. On 07/23/2024 at 9:45 a.m., an observation again of resident #25 revealed the oxygen continued again at 5 lpm per nasal cannula with no humidification noted and there was no date on the oxygen tubing. Further observation revealed the nebulizer mask was not covered or dated. On 07/24/2024 review of the July 2024 medication administration record (MAR) revealed resident #25 received albuterol sulfate nebulizer on 07/09/2024, 07/10/2024 and 07/11/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the July 2024 MAR revealed record of resident #25 receiving oxygen at 3 liters per minute and keep pulse oximeter greater than or equal to 92%. Review of the documentation on 07/22/2024, 07/23/2024, and 07/24/2024 revealed the nurse documented the oxygen as being delivered at 3 lpm. On 07/23/2024 at 2:50 p.m., observation again of resident #25 oxygen revealed it was being administered again at 5 lpm with no humidification per nasal cannula and no date on the oxygen tubing. Further observation of the room revealed the nebulizer mask was not covered and not dated. 07/23/24 at 3:17 p.m., an observation and interview with S1Director of Nursing (DON) confirmed the oxygen was flowing at 5 lpm per nasal cannula and should not have been flowing at 5 lpm per nasal cannula. S1DON further confirmed the oxygen tubing was not dated and the nebulizer tubing was not covered or dated and should have been. Resident #71 Review of the medical record for resident #71 revealed the resident was admitted on [DATE] with diagnoses including: chronic systolic congestive heart failure, hypertension, and atherosclerotic heart disease. Review of the Admission MDS assessment dated [DATE] revealed resident #71 scored a 10 on the BIMS which indicated he had moderately impaired cognition for daily decision making skills. Observations on 07/22/2024 at 9:10 a.m., 07/23/2024 at 10:30 a.m., and 07/24/2024 at 8:25 a.m., revealed resident #71 was receiving O2 via nasal cannula. Further observation revealed his O2 concentrator had a dirty buildup on both the front panel and the filter on the back of the concentrator. Review of resident #71's July 2024 physician orders revealed an order dated 07/12/2024 for O2 3 lpm continuous via nasal cannula. Review of the record revealed the following care plan for resident #71: administer oxygen therapy as ordered by the physician and to monitor for signs and symptoms of respiratory distress. During an observation of resident #71's O2 concentrator on 07/24/2024 at 2:10 p.m. with the surveyor, S3Licensed Practical Nurse (LPN) confirmed the resident's O2 concentrator had a dirty buildup on both the front panel and the filter on the back of the concentrator. On 07/24/2024 at 4:40 p.m., during an interview with S1DON, she was informed of resident #71's concentrator having a dirty buildup on both the front panel and the filter on the back of the concentrator. S1DON was informed the concentrator was in need of cleaning. 22575

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829 Based on record review and interviews the facility failed to ensure that the pharmacist reported any irregularities to the physician and director of nursing for 1 (#15) of 5 (#15, #23, #37, #51, #59) residents reviewed for unnecessary medications. The pharmacist failed to identify that resident #15 was receiving as needed (prn) doses of the psychotropic medication clonazepam beyond 14 days without a documented rationale and duration date for administration. Findings: Record review revealed resident #15 was admitted to the facility 02/09/2019 with diagnoses that included Alzheimer's disease, unspecified dementia, major depressive disorder, essential hypertension, insomnia, anxiety disorder, psychiatric disorder with delusions due to known physiological condition, and Tourette's disorder. Review of the active July 2024 physician orders revealed an order dated 05/23/2024 for clonazepam 0.5 milligram (mg) tablet give one tablet by mouth every day prn for agitation. Further review revealed there was no evidence of a stop date. Review of the quarterly minimum data set assessment dated [DATE] revealed a brief interview mental status score of 3 which indicated severe cognitive impairment. Review of the narcotic log revealed resident #15 received prn clonazepam 0.5 mg on multiple days in May, June, and July 2024. Review of the resident's medical record revealed no recorded reasoning by the physician for the continuation of clonazepam 0.5 mg by mouth every day prn for agitation order. Review of the monthly drug regimen by the consultant pharmacist dated 06/19/2024 revealed no documentation by the consultant pharmacist to address the prn medication clonazepam. On 07/24/2024 at 8:35 a.m., an interview with S4Licensed Practical Nurse (LPN) revealed resident #15 occasionally needed the prn dose of clonazepam 0.5 mg due to behaviors such as hollering out for her momma, crying, and making repetitive noises. On 07/24/2024 at 11:35 a.m., an interview with S1Director of Nursing (DON) confirmed resident #15 had an order for clonazepam 0.5 mg by mouth every day prn for agitation that was ordered on 05/23/2024 with no stop date. S1DON confirmed there was no documented evidence from the physician regarding a documented rationale for extended use of the prn medication clonazepam. S1DON further confirmed there was no documented evidence of the consultant pharmacist identifying and notifying the physician or the director of nursing of the ongoing need for the prn medication clonazepam.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829 Based on record review and interviews, the facility failed to ensure that each resident was free from unnecessary medication use for 1 (#15) of 5 (#15, #23, #37, #51, #59) residents reviewed for unnecessary medications. The facility failed to have a documented rationale in the resident's medical record to indicate the duration of an as needed (prn) psychotropic medication to be extended beyond 14 days of use for resident #15 who received the prn medication clonazepam. Findings: Record review revealed resident #15 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, unspecified dementia, major depressive disorder, essential hypertension, insomnia, anxiety disorder, psychiatric disorder with delusions due to known physiological condition, and Tourette's disorder. Review of the active July 2024 physician orders revealed an order dated 05/23/2024 for clonazepam 0.5 milligram(mg) tablet give one tablet by mouth every day prn for agitation. Further review revealed there was no evidence of a stop date. Review of the quarterly minimum data set assessment dated [DATE] revealed a brief interview mental status score of 3 which indicated severe cognitive impairment. Review of the narcotic log revealed resident #15 received prn clonazepam 0.5 mg on multiple days in May, June, and July 2024. Review of the resident #15 medical record revealed no recorded reasoning by the physician for the continuation of clonazepam 0.5 mg by mouth every day prn for agitation order. On 07/24/2024 at 8:35 a.m., an interview with S4Licensed Practical Nurse (LPN) revealed resident #15 occasionally needed the prn dose of clonazepam 0.5 mg due to behaviors such as hollering out for her momma, crying, and making repetitive noises. On 07/24/2024 at 11:35 a.m., an interview with S1Director of Nursing (DON) confirmed resident #15 had an order for clonazepam 0.5 mg by mouth every day prn for agitation that was ordered on 05/23/2024 with no stop date. S1DON confirmed there was no documented evidence from the physician regarding a documented rationale for extended use of the prn medication clonazepam.