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	07/30/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 2 (#38, #100,) of 2 (#38, #100) sampled residents reviewed for environmental concerns. The facility failed to ensure that residents' wheelchairs were maintained in good repair.Findings:Resident #38 Review of Resident #38's record revealed an admit date of 01/04/2023 with diagnoses including chronic diastolic (congestive) heart failure, left knee primary osteoarthritis and chronic kidney disease. Further review of records revealed a quarterly Minimal Data Set (MDS) assessment dated [DATE] documented Resident #38 utilized a wheelchair for mobility and required moderate assistance with transferring.On 07/28/2025 at 9:53 a.m. and 07/29/2025 at 8:50 a.m., observations of Resident #38's wheelchair revealed the wheelchair arm padding to be cracked and torn.On 07/29/2025 at 9:50 a.m., an observation conducted with S2Director of Nursing (DON) confirmed that Resident #38's wheelchair armrest padding was cracked and torn. Resident #100 Review of Resident #100's medical record revealed an admit date of 01/01/2025 with diagnoses including other Alzheimer's disease, arthritis, asthma and cardiac arrhythmia. Further review of Resident #100's medical record revealed a quarterly Minimal Data Set (MDS) assessment dated [DATE] documented Resident #100 was mobile per wheelchair and required moderate assistance with transfers.On 07/28/2025 at 9:56 a.m. and 07/29/2025 at 8:55 a.m., Resident #100 was observed sitting a wheelchair that had cracked and torn arm padding.An observation on 07/29/2025 at 9:50 a.m. with S2DON confirmed that Resident #100's wheelchair arm padding was cracked and torn.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was free from misappropriation of personal property for 1 (#11) of 1 resident reviewed for personal funds. Findings:Review of the facility's undated Abuse and Neglect Prohibition policy revealed the following in part:Fundamental Information:Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Review of Resident #11's record revealed an admission date of 02/27/2025 with diagnoses including chronic obstructive pulmonary disease, chronic cough, unsheltered homelessness, seizures, personal history of transient ischemic attack, cerebral infarction without residual deficits, chronic respiratory failure with hypoxia, pulmonary fibrosis, chronic kidney disease, other mixed anxiety disorders, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment.Review of the Facility's Reported Incident revealed an allegation of misappropriation of funds/exploitation was reported to the facility on [DATE] by Resident #11 related to his Electronic Banking Transfer (EBT) card having an unauthorized charge on 07/07/2025. S7Certified Nursing Assistant (CNA) was identified as the staff member that had made unauthorized purchases with Resident #11's EBT card on 07/07/2025 and 07/11/2025. The investigation by the facility revealed the allegation was substantiated.Interview on 07/28/2025 at 3:30 p.m. with Resident #11 revealed he had allowed S7CNA to purchase items for him using her grocery store account using his EBT card a couple times in June 2025. Resident #11 further reported that someone had made purchases using his EBT card 2 times during July 2025 on 07/07/2025 and 07/11/2025 and he notified S8Social Services Director (SSD). Resident #11 reported S7CNA was terminated at the end of June 2025. Resident #11 reported he had 2 unauthorized charges of $225.32 and $88.35 in July 2025 on his EBT card. When Resident #11 reported this to the S8SSD, they were able to printout a list of his transaction history for his EBT card from 06/28/2025 through 07/10/2025, the charge for 07/07/2025 was made at a grocery store in the amount of $225.32. Resident #11 reported S8SSD helped him to deactivate his EBT card and setup online account information to help the resident track his purchases. Resident #11 had another unauthorized charge of $88.35 on 07/11/2025. Interview with S8SSD on 07/30/2025 at 8:00 a.m. revealed he was notified by Resident #11 on 07/08/2025 around 10:00 a.m. regarding a CNA from the facility making charges on his EBT card on 07/07/2025 for $225.32. S8SSD reported that Resident #11 had given his EBT card information to a CNA to purchase items for him to be delivered to the facility from a grocery store. S8SSD reported he notified S1Administrator on 07/08/2025 of the allegation of misappropriation of funds/exploitation made by Resident #11. S8SSD reported he and Resident #11 called the EBT program support on 07/09/2025. S8SSD was able to get a printout of Resident #11's transaction history on EBT card from 06/28/2025 through 07/10/2025 and identify the charge on 07/07/2025 in the amount of $225.32 was made at a grocery store. S8SSD reported Resident #11 confirmed he did not authorize this purchase. S8SSD reported they deactivated the resident's card at this time, but Resident #11 reported on 07/12/2025 he found another charge of $88.35 that was unauthorized on his EBT card again. S8SSD and Resident #11 called EBT program support back and cancelled the resident's EBT card, police were notified and a report was initiated by the police on 07/12/2025 after the second unauthorized purchase was made. S8SSD reported that the police only have a preliminary report and have not made any arrest at this time. S8SSD reported they were unable to print another history of transactions on this card due to it now being deactivatedAn interview with S1Administrator on 07/30/2025 at 8:30 a.m. revealed he was notified on 07/08/2025 by S8SSD of the allegation of misappropriation of funds/exploitation reported by Resident #11 by a CNA on his hall. S1Administrator reported he interviewed Resident #11, they were able to identify that the accused was S7CNA and she had obtained information from Resident #11's EBT card to purchase items for this resident from a grocery store.Review of Resident #11's Transaction History for his EBT card transactions from 06/28/2025 through 07/10/2025 revealed a purchase was made to a grocery store in the amount of $225.32. An interview on 07/30/2025 at 11:10 a.m. with S9CNA revealed she was working a few months ago and Resident #11 had a grocery store order delivered, but the driver from the store needed a pin number for the delivery. Resident #11 told her that S7CNA had the code for his order. S9CNA had to get the delivery code from S10Ward Clerk to give to the driver, but was unsure of the date this happened. An interview on

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure residents were free from physical restraints imposed for the purpose of discipline or convenience for 1 (#16) of 1 residents reviewed for restraints. The facility failed to have documented evidence of releasing the lap tray every two hours for range of motion. Findings:Use of Restraint Policy dated April 2017Policy Interpretation and ImplementationPhysical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which staff applied it given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint.Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove.Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: c. placing a resident in a chair that prevents the resident from rising.Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. treat the medical symptom; b. protect the resident's safety; and c. help the resident attain the highest level of his/her physical or psychological well-being.11. The following safety guidelines shall be implemented and documented while the resident is in restraints:d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed.e. Restrained residents must be repositioned at lease every two (2) hours on all shifts. Review of the medical record for Resident #16 revealed an admission date of 01/02/2025 with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations; unspecified psychosis not due to a substance or known physiological condition; restlessness and agitation and generalized anxiety disorder.Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #16 had severe cognitive impairment for daily decision making. The facility was unable to obtain a Brief Interview for Mental Status (BIMS) score. Further review also revealed Resident #16 was mobile via wheelchair and required partial/moderate assistance with transfers.Observations made on 07/28/2025 at 12:45 p.m., 07/29/2025 at 8:13 a.m., 07/29/2025 at 11:10 a.m., and 07/29/2025 at 3:00 p.m. revealed Resident #16 was sitting in a geri-chair with a lap tray in place.On 07/29/2025 at 12:00 p.m., a review of Resident #16's active July 2025 physician's orders revealed there was no order for the release of the geri-chair lap tray every two hours. Further review of Resident #16's records revealed there was no documentation of the release of the lap tray every two hours.On 07/29/2025 at 1:10 p.m., an interview with S6Certified Nursing Assistant (CNA) was conducted. S6CNA stated Resident #16 could not release the lap tray herself and she was also unaware that Resident #16's lap tray should be released every two hours.On 07/29/2025 at 1:15 p.m., an interview with S5Licensed Practical Nurse (LPN) was conducted. S5LPN stated there was no active order to release Resident #16's lap tray every two hours.On 07/29/2025 at 1:25 p.m., an interview was conducted with S2Director of Nursing (DON), S4 Corporate Consultant, and S3Registered Nurse (RN)-Admin confirmed that there was no order or documentation for releasing the geri-chair lap tray every two hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a thorough investigation was completed for an allegation of misappropriation of property/exploitation for 1 (#7) of 1 resident reviewed for personal funds. Findings:Review of the facility's undated Abuse and Neglect Prohibition revealed the following in part:Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. Fundamental Information:Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.Investigation:1. The facility will conduct an investigation of any alleged abuse/neglect or misappropriation of resident property in accordance with state law.Review of Resident #11's record revealed an admission date of 02/27/2025 with diagnoses including chronic obstructive pulmonary disease, chronic cough, unsheltered homelessness, other seizures, personal history of transient ischemic attach, cerebral infarction without residual deficits, chronic respiratory failure with hypoxia, pulmonary fibrosis, chronic kidney disease, other mixed anxiety disorders and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment.Review of the Facility's Reported Incident revealed an allegation of misappropriation of funds/exploitation was reported to the facility on [DATE] by Resident #11 related to his Electronic Banking Transfer (EBT) card having an unauthorized charge on 07/07/2025. S7Certified Nursing Aide (CNA) was identified as the staff member that had made unauthorized purchases with Resident #11's EBT card on 07/07/2025 and 07/11/2025. The investigation by the facility revealed the allegation was substantiated.Interview on 07/28/2025 at 3:30 p.m. with Resident #11 revealed he had allowed S7CNA to purchase items for him using her grocery store account using his EBT card a couple times in June 2025. Resident #11 further reported that someone had made purchases using his EBT card 2 times during July 2025 on 07/07/2025 and 07/11/2025 and he notified S8Social Services Director (SSD). Resident #11 reported S7CNA was terminated at the end of June 2025. Resident #11 reported he had 2 unauthorized charges of $225.32 and $88.35 in July 2025 on his EBT card. Resident #11 reported this to the S8SSD and they were able to printout a list of his transaction history for his EBT card from 06/28/2025 through 07/10/2025, the charge for 07/07/2025 was made at a grocery store in the amount of $225.32. Resident #11 reported S8SSD helped him to deactivate his EBT card and setup online account information to help the resident track his purchases. Resident #11 had another unauthorized charge of $88. 35 on 07/11/2025. Interview with S8SSD on 07/30/2025 at 8:00 a.m. revealed he was notified by Resident #11 on 07/08/2025 around 10:00 a.m. regarding a CNA from the facility making charges on his EBT card on 07/07/2025 for $225.32. S8SSD reported that Resident #11 had given his EBT card information to a CNA to purchase items for him to be delivered to the facility from a grocery store. S8SSD reported he notified S1 Administrator on 07/08/2025 of the allegation of misappropriation of funds/exploitation made by Resident #11. S8SSD reported he and Resident #11 called the EBT program support on 07/09/2025. S8SSD was able to get a printout of Resident #11's transaction history on EBT card from 06/28/2025 through 07/10/2025 and identify the charge on 07/07/2025 in the amount of $225.32 was made at a grocery store. S8SSD reported Resident #11 confirmed he did not authorize this purchase. S8SSD reported they deactivated the resident's card at this time, but Resident #11 reported on 07/12/2025 resident found another charge of $88.35 that was unauthorized on his EBT card again. S8SSD and Resident #11 called EBT program support back and cancelled the resident's EBT card, police were notified and a report was initiated by the police on 07/12/2025 after the second unauthorized purchase was made. S8SSD reported that the police only have a preliminary report and have not made any arrest at this time. S8SSD reported they were unable to print another history of transaction on this card due to it now being deactivated. An interview with S1Administrator on 07/30/2025 at 8:30 a.m. revealed he was notified on 07/08/2025 by S8SSD of the allegation of misappropriation of funds/exploitation reported by Resident #11 by a CNA on his hall. S1Administrator reported he interviewed Resident #11, they were able to identify that the accused was S7CNA, and she had obtained information from Resident #11's EBT card to purchase items for this resident from a grocery store.Review of Resident #11's Transaction History for his EBT card transactions from 06/28/2025 through 07/10/2025 revealed a purchase was made to a grocery store in the amount of $225.32. An interview on 07/30/2025 at 2:30 p.m. with S1Administrator confirmed the facility failed to ensure a thorough investigation was completed for the

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to notify the state-designated mental health disability authority promptly for a review when a resident with Mental Disorders or Intellectual Disorders experienced a change in mental or physical status for 1 (#7) of 2 (#7 and #8) residents reviewed for Pre-admission Screening and Resident Review (PASARR).Findings: Review of Resident #7's record revealed an admission date of 06/24/2025 with diagnoses including unspecified dementia mild with mood disturbance, bipolar disorder current episode depressed mild or moderate severity unspecified, panic disorder, insomnia due to other mental disorder, post-traumatic stress disorder acute, hypertension, tachycardia, hypothyroidism, personal history of other mental and behavioral disorders. Further review of the record revealed Resident #7 was admitted to the facility from an inpatient psych facility.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment.Review of Resident #7's Form 142 (Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification) dated 06/18/2025 revealed resident was approved for Medicaid medical eligibility services for a temporary period effective 06/18/2025-09/26/2025 for skilled therapies. Review of Resident #7's record revealed he had combative and aggressive behaviors after he was admitted to the facility and he was transferred back to the inpatient psych facility on 06/27/2025 through 07/10/2025. An interview on 07/30/2025 at 8:00 a.m. with S8Social Service Director (SSD) revealed Resident #7 was admitted on [DATE] from an inpatient psych facility and the PASARR was done by the inpatient psych facility prior to the resident being admitted to the facility. S8SSD confirmed Resident #7 was transferred to an inpatient psych facility on 06/27/2025 due to aggressive and combative behaviors and did not return to the nursing home until 07/10/2025. S8SSD revealed he was not aware he was required to send in a PASARR review to the designated state authority following an inpatient psych stay for Resident #7. S8SSD confirmed he did not send in a PASARR review for Resident #7 after his inpatient psych stay from 06/27/2025 through 07/10/2025. Interview on 07/30/2025 at 8:30 a.m. with S1Administrator confirmed he was not aware that a PASARR review should have been submitted to the designated state authority after an inpatient psych stay for a resident.Review of the consult note from the psych admission dated 06/28/2025 for Resident #7 revealed the reason for admission was aggressive behavior, agitation and mood lability, and discharge diagnoses included aggressive behavior, bipolar, depression, antidepressive discontinuation syndrome and insomnia. Review of the record revealed no documentation of a PASARR review for Resident #7 after an inpatient psych stay from 06/27/2025 through 07/10/2025. Review of Resident #7's PASARR Level I Screen Outcome dated 06/17/2025 revealed PASARR Level I Determination: no level II required. Level I screen indicates - no evidence of a PASARR condition of intellectual/developmental disability or a serious behavioral health condition, if changes occur or new information refutes these findings, a new screen must be submitted. No medications listed and no diagnoses listed on PASARR form. An interview on 07/30/2025 at 2:30 p.m. with S1Administrator confirmed the facility failed to send in a PASARR review on Resident #7 to the designated state authority after he had an inpatient psych stay from 06/27/2025 through 07/10/2025 due to aggressive and combative behaviors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 (#89) of 2 (#63 & #89) sampled residents reviewed for mood/behavior. Findings: Review of the medical record for Resident #89 revealed an admission date of 10/21/2018 with diagnosis of Parkinson's disease, breast cancer, edema, transient ischemic attack, dementia, Post-Traumatic Stress Disorder (PTSD), major depressive disorder, and atrial fibrillation. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively aware and able to make daily decisions. Further review revealed Resident #89 needed maximal assistance with all activities of daily living. Review of section I revealed the resident had a Psychiatric/Mood disorder of Post-Traumatic Stress Disorder (PTSD). Review of Resident #89's current care plan dated 09/10/2024 revealed no documentation that included person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goals for the diagnosis of Post-Traumatic Stress Disorder. Interview on 07/30/2025 at 3:30 p.m. with S2Director of Nursing (DON) confirmed the diagnosis of PTSD was not care planned for Resident #89. S2DON further confirmed there should be a person centered care plan with interventions for PTSD in place for Resident #89.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was as free of accident hazards as is possible by failing to ensure an appropriate intervention was attempted for 1 (#71) of 8 (#2, #4, #9, #10, #18, #36, #71, #89) residents reviewed for accidents.Findings:Review of the medical record for Resident #71 revealed an admission date of 01/14/2025 with diagnoses that included vascular dementia, displaced fracture of middle phalanx of left middle finger, repeated falls, history of transient ischemic attack, and hypertension.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated severe cognitive impairment with daily decision making. Resident #71 required substantial/maximal assistance with sit to lying, lying to sitting, and chair/bed-to-chair transfer. Additionally, the April MDS assessment documented the resident as always continent of bowel and bladder. Review of the in-service training report dated January 2025 revealed Certified Nursing Assistants (CNA) were to round on residents every 2 hours and as needed.Review of the incident report dated 04/27/2025 at 11:40 a.m. revealed that Resident #71 suffered an unwitnessed fall in her room. Resident #71 was found on the floor lying on her left side beside the bed. Resident #71 reported to staff that she rolled out of the bed to go to the bathroom. Resident #71 was assessed and no apparent injuries were found. Review of the active plan of care revealed that Resident #71 was at risk for falls. Further review of the care plan revealed the resident suffered a fall on 04/27/2025. The intervention added on 04/27/2025 for the fall was for the Certified Nursing Assistant (CNA) staff to offer toileting assist when rounding. On 07/30/2025 at 2:00 p.m., S2Director of Nursing (DON) was informed that the intervention to offer toileting assist when rounding was inappropriate because CNA staff had already received in-service training to round on residents and every 2 hours and as needed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 1 (#61) of 1 (#61) residents reviewed for respiratory care. The facility failed to ensure there was signage indicating oxygen in use was posted outside the entrance of Resident #61's room. Findings:Review of the facilities Oxygen Administration policy, revised date of October 2010, revealed in-part: Place an Oxygen in Use sign on the outside of the room entrance door.On 07/29/2025 at 07:52 a.m. an observation of Resident #61 revealed she was receiving oxygen at 4 liters per minute (LPM) via nasal cannula (NC). Further observation revealed there was no signage posted outside Resident #61's room indicating no smoking oxygen in use. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses that included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, encounters for orthopedic aftercare, chronic respiratory failure with hypoxia, other specified interstitial pulmonary diseases, chronic kidney disease stage 4, type 2 diabetes mellitus with hyperglycemia, and paroxysmal atrial fibrillation.Review of the July 2025 Physician orders revealed Oxygen 4 LPM/nasal cannula via concentrator continuously dated 07/02/2025 and bi-level positive airway pressure (BIPAP) to be worn every (q) hour of sleep (HS) with following settings: inspiratory pressure - 12; expiratory pressure - 5; fraction of inspired oxygen (FiO2) - 45. Review of the admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident was cognitively intact and able to make daily decisions. Further review revealed the resident has shortness of breath and wears oxygen.Review of the July 2025 electronic medication administration record revealed documentation Resident #61 received Oxygen at 4 LPM per nasal cannula and the BIPAP q HS as ordered by the physician. On 07/29/2025 at 09:45 a.m. an observation and interview conducted with S2Director of Nursing (DON) outside of Resident #61's room revealed there was no signage indicating no smoking oxygen in use posted outside Resident #61's room. S2DON confirmed Resident #61 receives continuous oxygen at 4 LPM via NC. S2DON further confirmed there should be signage posted outside Resident #61's room indicating no smoking oxygen in use.

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	07/30/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor for any active bleeding or bruising for a resident who received an anticoagulant for 1 (#1) 3 (#1, #61, #71) reviewed for general concerns.Findings:Review of the medical record for Resident #1 revealed an admission date of 06/25/2025 with diagnoses that included acute on chronic congestive heart failure, chronic pulmonary edema, atrial fibrillation and hypertension.Review of the Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated that Resident #1 was cognitively intact with daily decision making. The MDS indicated that the resident received an anticoagulant which is a high risk medication.Review of the current plan of care documented the resident's risk for abnormal bleeding related to anticoagulant therapy. The plan of care also indicated that Resident #71 should be monitored for signs and symptoms of bleeding: bleeding gums, bruises, petechiae, nosebleeds, tarry stools, and hematuria. Review of the July 2025 Physician's Orders documented that the resident had an active order for Eliquis 2.5 milligrams (mg) by mouth twice daily. There was not a physician's order in place to monitor for signs and symptoms of bleeding. Review of the July 2025 Medication Administration Record (MAR) documented that Resident #1 received the Eliquis. Additionally, there was no documentation in present to monitor for signs and symptoms of bleeding. On 07/30/2025 at 2:00 p.m., S2Director of Nursing was informed of the findings related to the absence of monitoring for signs and symptoms of bleeding as indicated per the plan of care.