STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43405 Based on review of the Resident Council Meeting minutes and interviews, the facility failed to organize resident group meetings in the facility monthly. Findings: An interview on 07/15/2024 at 2:55 p.m. with resident # 4 revealed the resident council has not had meetings in the last couple of months. Review of the Resident Council Meeting minutes revealed no documentation of resident council meeting minutes since 04/17/2024. An interview on 07/15/2024 at 3:05 p.m. with S15Activity Director confirmed the resident council has not had a meeting since 04/17/2024. An interview on 07/15/2024 at 3:40 p.m. with S2Director of Nursing (DON) confirmed the resident council has not had a meeting since 04/17/2024, and should be done monthly.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on record review and interview, the facility failed to ensure all medical records regarding the resident's code status consistently reflected the resident's wishes for 1 (#2) of 16 residents reviewed in the initial pool screening for advanced directives. Findings: Review of the facility Advance Directive Policy and Procedure revised [DATE] revealed in part: 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. 8. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan. Review of resident #2's medical record revealed she was admitted to the facility on [DATE] with diagnoses of Parkinson's disease, and age-related cognitive decline. Review of resident #2's Annual Minimum Data Set assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 00, which indicated she was severely cognitively impaired. Review of resident #2's medical record revealed a red sticker on the front cover of her record that read No Code. Further review revealed a [DATE] physician's order for Full Code. Review of resident #2's current care plan revealed on [DATE] the resident's code status was a Full Code. Further review of her care plan revealed an intervention that her chart would be noted with proper code status. Review of resident #2's Louisiana Physician Orders for Scope of Treatment (LaPOST) revealed resident #2's wishes were to receive Cardiopulmonary Resuscitation (CPR) in the event she was unresponsive, pulseless and was not breathing. Further review revealed resident #2's family member signed the form on [DATE] and her physician signed the form on [DATE]. An interview on [DATE] at 3:05 p.m. with S2Director of Nursing (DON) revealed she was not aware of the discrepancy in resident #2's code status in her medical record. The surveyor and S2DON reviewed resident #2's medical record and she confirmed there was a discrepancy with the resident's code status when comparing the red No Code sticker to resident 2's LaPOST, physician order, and current care plan, which indicated she was a Full Code.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on record reviews and interviews, the facility failed to immediately notify the physician when a resident had a change in condition for 1 (#186) of 1 (#186) residents reviewed for notification of change by, failing to immediately notify the physician when resident #186's accucheck result was greater than 400 milligrams/deciliter. Findings: Review of resident #186's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses that included Type II diabetes mellitus with diabetic polyneuropathy. Review of the July 2024 physician's orders revealed an order dated 07/08/2024 for resident #186 to have Novolog 100 units/milliliter; give 8 units if accucheck greater than 240 and obtain accuchecks twice a day. Review of the care plans revealed a problem onset: 04/05/2022, altered blood sugars due to diabetes. Further review revealed the documented approaches included accuchecks per physician orders, accuchecks twice a day and to notify the physician if glucose is less than 60 or greater than 400. Review of the July 2024 Medication Administration Record (MAR) revealed that resident #186 was to have an accucheck obtained twice a day at 6:30 a.m. and 4:30 p.m. Further review revealed an accucheck result of 455 on 07/16/2024 at 4:30 p.m. Further review revealed there was no documented parameters on the MAR to indicate when the nurse was required to notify the physician and /or nurse practitioner with the results. Review of the skilled nurse's notes dated 07/16/2024 revealed there was no documentation of the physician and /or nurse practitioner being notified of the accucheck result of 455. During a telephone interview with the nurse practitioner on 07/17/2024 at 12:20 p.m., he confirmed that he had not been notified of resident #186's accucheck result of 455 on 07/16/2024 at 4:30 p.m. During a telephone interview with the physician on 07/17/2024 at 12:25 p.m., he revealed that he was not notified of resident #186 having an accucheck result of 455 on 07/16/2024 at 4:30 p.m. The physician further revealed that he should have been notified of the accucheck result of 455. During an interview with S4Assistant Director of Nursing (ADON) on 07/17/2024 at 10:15 a.m., she confirmed that resident #186 was to have accuchecks obtained twice a day at 6:30 a.m. and 4:30 p.m. S4ADON was notified of resident #186 having a documented accucheck result of 455 on 07/16/2024 at 4:30 p.m. S4ADON confirmed there was no documentation that the physician and/or nurse practitioner were notified of resident #186's accucheck result of 455. S4ADON further confirmed the physician should have been notified when the nurse became aware of resident #186's accucheck result of 455. On 07/17/2024 at approximately 12:40 p.m., S1Administrator and S2Director or Nursing (DON) were notified of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 17835 Based on observations, record reviews, and interviews the facility failed to ensure residents have a right to be treated with respect and dignity, including the right to be free from any physical restraint not required to treat the resident's medical symptoms for 2 (31# and #136) of 3 (#27, #31, and #136) residents investigated for restraints. The facility failed to ensure 1) a pre-restraining assessments was completed and the residents' pelvic restraints were identified on their care plans (#31, #136), and 2) that staff properly applied, monitored, and released a pelvic restraint (#136). Findings: Review of the facility's current Restraint Policies and Procedures, Restraint Alternatives, (no date noted) revealed the policies and procedures failed to include guidelines regarding pre-restraint assessments, obtaining consents for restraints, initiating the use of restraints, proper use of restraints, and monitoring restraint use. Resident #31 Review of the record for resident #31 revealed an admission of 05/11/2023 with following diagnoses: alcoholic cardiomyopathy, urinary tract infection, metabolic encephalopathy, syphilis, and heart failure. Review of the annual MDS (Minimal Data Set) dated 06/03/2024 revealed resident #31 was assessed to be severely cognitively impaired and was totally dependent on staff for activities of daily living. Review of Section P- Restraints, revealed trunk restraints were used daily. Observations of resident #31 on 07/15/2024 at 1:42 p.m. and 07/16/2024 at 9:00 a.m. revealed resident sitting up in wheelchair with pelvic restraint vest in place. Further observations revealed that the pelvic restraint was tied in the back of the wheelchair and that resident was unable to untie restraint. On 07/17/2024 at 10:50 a.m., resident #31 was observed in his room in a wheelchair with a pelvic restraint in place and tied in the back of wheelchair. Review of the active physician orders for July 2024 revealed an order for a pelvic restraint while up in a wheelchair. The order was written on 06/06/2024. Further record review revealed there was no documentation that a pre-restraint assessment had been performed to determine the least restrictive restraint to be used for resident #31. Review of the care plans revealed they were last updated on 05/20/2024. Further review of the care plans revealed the facility failed to identify his pelvic restraint and there were no approaches for the restraint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2024 at 9:05 a.m, an interview with S6LPN (Licensed Practical Nurse) confirmed resident #31 was wearing a pelvic restraint and he was unable to remove it. On 07/16/2024 at 2:00 p.m., an interview with S2DON (Director of Nursing) and S3LPN/MDS confirmed a pre-restraint assessment was not completed prior to the implementation of a pelvic restraint for resident #31. S3LPN/MDS confirmed there was no care plan for resident #31's pelvic restraint. 22575 Resident #136 Review of resident #136's medical record revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, hemiplegia following cerebral infarction affecting the left non-dominant side, congestive heart failure, abnormalities of gait and mobility, unsteadiness on feet, and other lack of coordination. Review of the Admission MDS dated [DATE] revealed resident #136 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. Further review revealed resident #136 required extensive assistance to total dependence on staff for most activities of daily living. Observations on 07/15/2024 at 1:30 p.m. and at 4:41p.m. revealed resident #136 was in wheelchair in her room with a pelvic restraint in place. Observation on 07/16/2024 at 8:01 a.m. revealed resident #136 was in wheelchair in her room with a pelvic restraint in place. Further observation revealed the pelvic restraint was applied improperly with straps of restraint tied in a tight knot behind the back of the upper part of her wheelchair. An interview with resident #136 at this time revealed that she's comfortable today but sometimes the restraint feels too tight, especially when she goes out to Intensive Outpatient Program (IOP). Observation on 07/16/2024 at 8:30 a.m. revealed resident #136 was in wheelchair in a van to transport her to IOP. Further observation revealed the resident's pelvic restraint was still tied improperly behind her wheelchair in a tight knot. The surveyor informed the transportation staff that a nurse needed to check her restraint before she left the facility. At 8:35 a.m. S2DON observed resident #136's pelvic restraint and confirmed the pelvic restraint was not secured/tied appropriately and should not be tied in a tight knot. S12Certified Nursing Assistant (CNA) got in the van and confirmed resident # 136's pelvic restraint was tied in a tight knot instead of a slip knot. S13CNA also observed the resident's pelvic restraint at this time and she confirmed that she did not tie it correctly, and that it should have been tied in a slip knot. At this time, S12CNA retied the restraint straps in a slip knot before the resident left for IOP. Review of resident #136's July 2024 Physician's Orders revealed an order dated 07/08/2024 that resident may be up in wheelchair with pelvic restraint for doctor appointments and IOP program. There was no physician's order to monitor the restraint and release the restraint every 2 hours. Further review of the resident's medical record revealed there was no documented evidence that staff were monitoring and releasing resident # 136's pelvic restraint. Review of resident #136's record revealed there was no documentation that a pre-restraint assessment had been performed to determine the least restrictive restraint to be used for resident #136. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #136's Physical Restraint Informed Consent dated 07/08/2023 revealed the resident had a pelvic restraint while up in wheelchair for positioning and poor balance due to left hemiplegia to help prevent sliding out of her wheelchair. Review of resident #136's current care plan revealed there was no documented evidence the resident's pelvic restraint was identified and no interventions regarding the safe and proper use of the restraint. An interview on 07/16/2024 at 3:40 p.m. with S3LPN/MDS confirmed there was no pre-restraint assessment and resident #136's pelvic restraint was not identified on her care plan. An interview on 07/17/2024 at 9:30 a.m. with S14Nurse Consultant confirmed there was no pre-restraint assessment and #136's pelvic restraint was not identified on her care plan. During an interview on 07/17/2024 at 3:10 p.m. with S1Administrator and S2DON, they were informed of the following concerns regarding resident #136's pelvic restraint: there was no pre-restraint assessment, restraint was not identified on her care plan, and no documentation the restraint was monitored by staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on record reviews and interviews, the facility failed to conduct comprehensive assessments including 1) a smoking assessment for 1 (#15) of 1 (#15) resident reviewed for smoking, and 2) a pre-restraint assessment for 1 (#136) of 3 (# 27, #31, and #136) residents investigated for restraints. Findings: Resident #15 Review of the facility Smoking Policy revised 10/2023 revealed the following in part: Policy Interpretation and Implementation: 9. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Review of resident #15's medical record revealed he was admitted to the facility on [DATE] with diagnoses including quadriplegia, anxiety disorder, schizoaffective disorder, and dementia. Review of resident #15's quarterly Minimum Data Set assessment dated [DATE] revealed he had a Brief Interview for Mental Status score of 00 which indicated he had severe cognitive impairment. Further review revealed he required limited/ 1 person assistance for most activities of daily living. An observation on 07/17/2024 at 8:22 a.m. revealed resident # 15 was outside in his wheelchair in the designated smoking area with a white smoking apron on. S20Certified Nursing Assistant (CNA) was supervising resident as he smoked his cigarette. An interview with S20CNA at this time revealed resident #15 was an unsafe smoker and had to be monitored by staff. Review of resident #15's Safe Smoking assessment dated [DATE] revealed he was assessed as an unsafe smoker. Further review revealed there was no documented evidence that the facility had conducted a quarterly smoking assessment for resident #15 per the facility policy. An interview with S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) on 07/17/2024 at 2:30 p.m. revealed she had not completed resident #15's quarterly smoking assessments. S3LPN/MDS confirmed the most recent smoking assessment for resident #15 was on 10/31/2022. During an interview with S1Administrator and S2Director of Nursing (DON) on 07/17/2024 at 2:30 p.m. they were informed there was no documentation of quarterly smoking assessments for resident #15 and his most recent assessment was 10/31/2022. Resident #136 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's current Restraint Policies and Procedures, Restraint Alternatives, (no date noted) revealed the policies and procedures failed to include guidelines regarding comprehensive assessments, including pre-restraint assessments. Review of resident #136's medical record revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, hemiplegia following cerebral infarction affecting the left non-dominant side, congestive heart failure, abnormalities of gait and mobility, unsteadiness on feet, and other lack of coordination. Review of the Admission MDS dated [DATE] revealed resident #136 had a Brief Interview for Mental Status score of 15 indicating no cognitive impairment. Further review revealed resident #136 required extensive assistance to total dependence on staff for most activities of daily living. Observations on 07/15/2024 at 1:30 p.m. and at 4:41 p.m. revealed resident #136 was in a wheelchair in her room with a pelvic restraint in place. Review of resident #136's July 2024 Physician's Orders revealed an order dated 07/08/2024 that resident may be up in wheelchair with pelvic restraint for doctor appointments and Intensive Outpatient Program (IOP). Review of resident #136's record revealed there was no documentation that a pre-restraint assessment had been performed to determine the least restrictive restraint to be used for resident #136. Review of resident #136's Physical Restraint Informed Consent dated 07/08/2023 revealed the resident had a pelvic restraint while up in wheelchair for positioning and poor balance due to left hemiplegia to help prevent sliding out of her wheelchair. An interview on 07/16/2024 at 3:40 p.m. with S3LPN/MDS confirmed there was no pre-restraint assessment for resident #136's pelvic restraint. An interview on 07/17/2024 at 9:30 a.m. with S14Nurse Consultant confirmed there was no pre-restraint assessment for resident #136's pelvic restraint. During an interview on 07/17/2024 at 3:10 p.m. with S1Administrator and S2DON, they were informed there was no pre-restraint assessment for resident #136's pelvic restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835 Based on observations, record reviews, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental, and psychosocial needs. The facilitly failed to ensure 1) residents' care plan were developed for restraints and interventions for pelvic restraints (#31, #136); and 2) residents' care plan was not implemented regarding monitoring for bleeding (#24). Resident #31 Review of the record for resident #31 revealed date of admission on 05/11/2023 with following diagnoses: alcoholic cardiomyopathy, urinary tract infection, metabolic encephalopathy, syphilis,and heart failure. Review of the Annual MDS (Minimal Data Set) assessment dated [DATE] revealed resident #31 was assessed to be severely cognitively impaired and was totally dependent on staff for activities of daily living. Further review of the MDS for resident #31 dated 05/20/2024 revealed the following: Section P- Restraints: (2) side rails and trunk restraints used daily. Further review of the MDS section P revealed bed alarms and wander/elopement alarm scored 2 and also used daily. Review of the physician orders dated 06/06/2024 for resident #31 revealed an order for a pelvic restraint while up in wheelchair. Review of the Care plan for resident #31 with last update on 05/20/2024 revealed no care plan and/or approaches for a restraint. Observations of resident #31 on 07/15/2024 and 07/16/2024 revealed resident was sitting up in a wheelchair with pelvic restraint vest in place. Further observations revealed that the pelvic restraint was tied in the back of the wheelchair and that resident was unable to untie restraint. Interview on 07/16/2024 at 2:00 p.m. with S3LPN/MDS (Licensed Practical Nurse/Minimal Data Set) at this time confirmed no care plan was developed for pelvic restraint for resident #31. S3LPN/MDS also confirmed that no pre-restraint assessment was completed for resident #31. 22575 Resident #136 Review of resident #136's medical record revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, hemiplegia following cerebral infarction affecting the left non-dominant side, congestive heart failure, abnormalities of gait and mobility, unsteadiness on feet, and other lack of coordination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS assessment dated [DATE] revealed resident #136 had a Brief Interview for Mental Status score of 15 indicating no cognitive impairment. Further review revealed resident #136 required extensive assistance to total dependence on staff for most activities of daily living. Observations on 07/15/2024 at 1:30 p.m. and at 4:41p.m. revealed resident #136 was in wheelchair in her room with a pelvic restraint in place. Review of resident #136's July 2024 Physician's Orders revealed an order dated 07/08/2024 that resident may be up in wheelchair with pelvic restraint for doctor appointments and Intensive Outpatient Program (IOP). Review of resident #136's record revealed there was no documentation that a pre-restraint assessment had been performed to determine the least restrictive restraint to be used for resident #136. Review of resident #136's current care plan revealed there was no documented evidence the resident's pelvic restraint was identified and no interventions regarding the safe and proper use of the restraint. An interview on 07/16/2024 at 3:40 p.m. with S3LPN/MDS confirmed there was no pre-restraint assessment and resident #136's pelvic restraint was not identified on her care plan. An interview on 07/17/2024 at 9:30 a.m. with S14Nurse Consultant confirmed there was no pre-restraint assessment and #136's pelvic restraint was not identified on her care plan. During an interview on 07/17/2024 at 3:10 p.m. with S1Administrator and S2Director of Nursing (DON), they were informed there was no pre-restraint assessment for resident #136's pelvic restraint and the restraint was not identified on her care plan. 32231 Resident #24 Review of the medical record revealed resident #24 was readmitted to the facility on [DATE] with diagnoses that included neuralgia, obesity, dementia with behavioral problems, late effects of cerebrovascular disease with dementia, chronic lymphedema of legs, left hemiparesis, heart disease, and arthritis. Review of the July 2024 physician's orders revealed an order for resident #24 to have Aspirin 81 milligrams, enteric coated, administer one by mouth every day. Review of the medical record revealed resident #24's care plans included that he was at risk for bleeding and falls, and at risk for limited movement related to neuralgia. Further review of the care plan revealed resident #24 had a risk for bleeding related to Aspirin use, and was identified on 02/03/2022. The documented approaches included to monitor for obvious bleeding: tea colored urine, black tarry stools, or petechiae. Review of the July 2024 Medication Administration Record (MAR) revealed no documenation of resident #24 being monitored for bleeding while taking Aspirin daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/2024 at 4:00 p.m., an interview with S3LPN/MDS confirmed that the approach of monitoring for bleeding had not been implemented, in accordance with resident #24's written plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575 Based on record reviews and interviews, the facility failed to ensure the residents' care plans were revised to meet the residents' needs, by failing to ensure the resident's care plan was revised to include all new fall interventions in a timely manner for 2 (#2, and #24) of 4 (#2, #7, #24, and #31) residents reviewed for falls. Findings: Resident #2 Review of the record for resident #2 revealed she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, paranoid schizophrenia, spinal stenosis, muscle wasting and atrophy, age-related cognitive decline, hallucinations, generalized anxiety disorder, and osteoporosis. Review of resident #2's 07/05/2024 Annual Minimum Data Set (MDS) assessment revealed she had a Brief Interview for Mental Status (BIMS) score of 00, which indicated resident #2 was severely cognitively impaired. Further review revealed she required limited to extensive assistance for most activities of daily living. Review of the facility incident report dated 6/20/24 at 8:40 a.m. revealed resident #2 had a fall in the chapel and her walker was observed at her feet. She did not have an injury; however there was no documentation of a thorough investigation of the above incident and no new interventions were noted in the medical record. Review of the facility incident report dated 6/24/24 at 4:35 p.m. revealed resident #2 had a fall in her room. She was found sitting on the floor with rollator walker flipped over. Resident #2 did not have an injury; however there was no documentation of a thorough investigation of the above incident and no new interventions noted. Review of resident #2's current care plan, revealed she was at high risk for falls. Further review revealed her care plan was revised with the 6/20/2024 fall, but the new intervention, to remind resident to wait for assistance, was not added until 06/26/2024. Further review of resident #2's care plan revealed the resident's bilateral fall mats were not identified on her care plan. An interview on 07/17/2024 at 2:05 p.m. with S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) confirmed the following: Resident #2's new intervention for the 6/20/2024 fall was not revised on her care plan timely, the intervention was not appropriate, and the resident's bilateral fall mats were not identified on her care plan. During an interview on 07/17/2024 at 2:05 p.m. with S1Administrator and S2Director of Nursing (DON), they both were informed of the following: resident #2's new intervention for the 6/20/2024 fall was not revised on her care plan timely, the intervention was not appropriate, the resident's bilateral fall mats were not identified on her care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32231 Resident #24 Review of the medical record revealed resident #24 was readmitted to the facility on [DATE] with diagnoses that included neuralgia, obesity, dementia with behavioral problems, late effects of cerebrovascular disease with dementia, chronic lymphedema of legs, left hemiparesis, heart disease, and arthritis. Review of the incident and accident reports revealed resident #24 was found on his knees while trying to get in the bathroom on 05/09/2024. Review of resident #24's current care plan revealed the care plan was not revised with the resident's fall on 05/09/2024. During an interview with S3LPN/MDS (Licensed Practical Nurse/Minimum Data Set) on 04/16/2024 at 4:00 p. m., she was notified of the findings regarding the plan of care not addressing resident #24's documented fall on the date of 05/09/2024. After reviewing the resident's care plan, S3LPN/MDS staff confirmed the plan of care had not been revised after the resident's fall on 05/09/2024. On 07/17/2024 at approximately 12:40 p.m., S1Administrator and S2Director of Nursing were notified of the findings regarding the care plan not being revised to address resident #24's fall on 05/09/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22575 Based on observations, interviews and record reviews, the facility failed to ensure residents remained as free of accident hazards as possible for 2 (#2, #31) of 4 (#2, #7, #24, and #31) residents reviewed for accidents. The facility failed to ensure: 1) a thorough investigation was conducted for a resident's falls, staff placed a resident's fall mat in proper place, the resident's care plan was revised to include all new fall interventions in a timely manner, and the fall interventions were appropriate for the type of incident that occurred (#2); and 2) an investigation was conducted for an injury of unknown origin (#31). Findings: Resident #2 Review of the facility policy Accidents and Incidents - Investigating and Reporting revised July 2017 revealed the following in part: Policy Statement: All accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator. Review of the record for resident #2 revealed she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, paranoid schizophrenia, spinal stenosis, muscle wasting and atrophy, age-related cognitive decline, hallucinations, generalized anxiety disorder, and osteoporosis. Review of resident #2's 07/05/2024 Annual Minimum Data Set (MDS) assessment revealed she had a Brief Interview for Mental Status (BIMS) score of 00, which indicated resident #2 was severely cognitively impaired. Further review revealed she required limited to extensive assistance for most activities of daily living. Review of the fall risk assessment dated [DATE] for resident #2 revealed she had a score of 8, which indicated she was at a low risk for falls. An interview on 07/17/2024 at 2:05 p.m. with S3Licensed Practical Nurse (LPN/MDS) confirmed resident #2 was at a high risk for falls with recent falls in June 2024. She confirmed the above fall risk assessment should have indicated she was at a high risk for falls. On 07/16/2024 at 4:15 p.m., resident #2 was observed in her room in bed with her eyes closed. The fall mat on the left side of the bed was positioned improperly underneath her bed. On 07/16/2024 at 10:50 a.m. resident #2 was observed in her room in bed. The fall mat on the left side of the bed was positioned improperly underneath her bed. On 07/16/2024 at 5:00 p.m. the surveyor and S11Certified Nursing Assistant (CNA) observed resident #2's fall mat on the left side of the bed was positioned improperly underneath her bed. An interview with S11CNA at this time confirmed the fall mat should have been placed on the floor to the left of the resident's bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility incident report dated 6/20/24 at 8:40 a.m. revealed resident #2 had a fall in the chapel and her walker was observed at her feet. She did not have an injury; however there was no documentation of a thorough investigation of the above incident and no new interventions were noted in the medical record. Review of the facility incident report dated 6/24/24 at 4:35 p.m. revealed resident #2 had a fall in her room. She was found sitting on floor with rollator walker flipped over. Resident #2 did not have an injury; however there was no documentation of a thorough investigation of the above incident and no new interventions noted. Review of resident #2's current care plan, revealed she was at a high risk for falls. Further review revealed her care plan was revised with the 6/20/2024 fall, but the new intervention was not added until 06/26/2024. Also the intervention was to remind resident to wait for assistance before trying to get up out of chair. This was an inappropriate intervention due to the resident's severe cognitive impairment and the fall occurred while she was using her walker. Further review of resident #2's care plan revealed the resident's bilateral fall mats were not identified on her care plan. An interview on 07/17/2024 at 2:05 p.m. with S3LPN/MDS confirmed the following: Resident #2's new intervention for the 6/20/2024 fall was not revised on her care plan timely, the intervention was not appropriate, and the resident's bilateral fall mats were not identified on her care plan. During an interview on 07/17/2024 at 2:05 p.m. with S1Administrator and S2Director of Nursing (DON), they both were informed of the following: there was no thorough investigation of resident #2's 6/20/2024 and 6/24/2024 falls, staff placed the resident's fall mat underneath her bed while she was in the bed, resident #2's new intervention for the 6/20/2024 fall was not revised on her care plan timely, the intervention was not appropriate, the resident's bilateral fall mats were not identified on her care plan. 17835 Resident #31 Review of the record for resident #31 revealed date of admission on 05/11/2023 with following diagnoses: alcoholic cardiomyopathy, urinary tract infection, metabolic encephalopathy, syphilis, and heart failure. Review of annual MDS (Minimal Data Set) assessment dated [DATE] revealed resident #31 was assessed to be severely cognitively impaired. Review of the fall risk assessment dated [DATE] for resident #31 revealed he had a score of 10, which indicated he was at a high risk for falls. Review of resident #31's care plan with last update on 05/20/2024 revealed he was at risk for falls related to an unsteady gait. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurses' notes for resident #31 dated 05/25/2024 at 8:20 a.m. revealed that a housekeeper walked into resident #31's room and saw him lying on the floor. S5LPN entered his room and noted that he was lying on his right side with blood coming from the side of his right eye. Resident#31 was sent to a local hospital for evaluation. Review of nurses' note dated 05/25/2024 at 3:00 p.m. revealed resident #31 returned to facility via ambulance; stable condition; sitting in wheelchair; continues on 30 minute monitoring; 4 sutures noted above right eye. Observations of resident #31 on 07/15/2024 at 1:42 p,m, and 07/16/2024 at 9:00 a.m. revealed he was sitting up in wheelchair with a pelvic restraint vest in place. Resident #31 had a Wanderguard in place and he self-propelled his wheel chair in the hallway. On 07/16/2024 at 10:15 a.m. surveyor requested 05/25/2024 incident and accident report and investigation regarding resident #31's injury of unknown origin. Interview with S9LPN/treatment (Licensed Practical Nurse) on 07/17/2024 at 2:30 p.m. confirmed documentation on 05/25/2024 of a laceration above resident #31's right eye. Interview with S2DON (Director of Nursing) on 07/17/2024 at 3:00 p.m. revealed that she was unable to locate 05/25/2024 incident and accident report and investigation regarding resident #31's injury of unknown origin. Further interview with S2DON confirmed there was no 05/25/2024 investigation completed regarding resident #31's incident of unknown origin. Review of incident/accident report dated 04/14/2024 at 5:50 p.m. for resident #31 revealed S10CNA (Certified Nursing Assistant) pointed out to S8LPN that resident #31 has small laceration to left eye; origin unknown. Neuro-checks implemented; first aide given to injury and will continue to observe. S8LPN notified and began head injury scale on 04/14/2024 for 24 hours with no issues noted. Further review revealed no investigation was done to determine injury of unknown origin to laceration of left eye to resident #31. Interview with S9LPN/treatment on 07/17/2024 at 2:30 p.m. confirmed she had no 04/14/2024 documentation of a laceration above resident #31's left eye. Interview with S2DON on 07/17/2024 at 3:00 p.m. revealed that an investigation was not done for injury of unknown origin on above incident dated 04/14/2024. Further interview with S2DON revealed that she did not document the wound on the weekly status report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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** 43405 Based on record reviews, and interviews, the facility failed to ensure that nursing staff are able to demonstrate competency in skills necessary to care for resident needs for 3 (#236, #27, and #186) of 3 (#236, #27, and #186) residents records reviewed. The facility failed by 1) not having documentation of sites for administration of insulin and by having omitted medications for resident #236, 2) not having a fall mat and bed alarm in place for resident #27 as ordered by the physician, and 3) not having documentation of accucheck results for resident #186 as ordered by the physician. Findings: Review of the Administering Medication Policy and Procedure revised April 2019, revealed in part 4. Medications are administered in accordance with prescriber orders, including any required time frames 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23. As required or indicated for a medication, the individual administered the medication records in the resident's medical record: b. the dosage; d. the injection site (if applicable); e. any results achieved and when those results were observed. Resident #236 Review of the medical record for resident #236 revealed an admitted [DATE], and readmitted [DATE] with diagnoses including diabetes mellitus, human immunodeficiency virus disease, pressure ulcer of sacral region stage 4, functional quadriplegia, paraplegia, dysphagia, cerebrovascular accident, anemia, urinary tract infection, other peripheral vascular disease, and type 2 diabetes mellitus. Review of the most recent discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact. Review of the July 2024 Physician's Orders revealed the following orders dated 07/08/2024: -Diflucan 100 milligrams (mg) 1 per tube (PT) every (q) morning (am) -Sulfamethoxazole-Trimethoprim 200-40/5 milliliters (ml) suspension- 4 teaspoons (tsp) (20 ml Per peg twice a day (bid) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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	-Azithromycin 200 mg/5 ml- 6 tsp (30 cubic centimeters (cc)) by peg tube weekly -Sliding scale with Humulin R insulin <70 hypoglycemia protocol- give coke or apple juice, 151-200=2 Units (U), 201-250= 4 U, 251-300= 6 U, 301-350= 8 U, 351-400= 10 U and notify the physician -Lantus 8 U subcutaneously (SQ) q evening (pm) -Accu-checks before meals (ac) and at hour of sleep (hs) Review of the July 2024 Medication Administration Record (MAR) revealed the following: -No documentation of location of site for the administration of Lantus 8 U SQ q pm -No documentation of administration of Azithromycin 200 mg/5 ml- 6 tsp (30 cc) by peg tube weekly, indefinitely on 07/09/2024 and 07/16/2024 at 7:00 a.m. -No documentation of Sulfamethoxazole-Trimethroprim 200-40/5 ml suspension- 4 tablespoons (20 ml) per peg bid administered on 07/09/2024 for a.m. and p.m. doses; -No documentation of administration of Zidovudine 10 mg/ml give 30 ml PT bid on 07/09/2024 for 7:00 a.m. and 7:00 p.m. doses -No documentation of site administered for sliding scale Humulin R insulin administered to resident #236 on the following dates and times: 07/09/2024 through 07/17/2024 for 6:30 a.m., 07/10/2024, 07/12/2024, 07/14/2024, and 07/16/2024 at 11:30 a.m., 07/09/2024 through 07/11/2024, 07/15/2024 and 07/16/2024 at 4:30 p.m., and 07/08/2024, 07/11/2024, 07/15/2024, and 07/16/2024 at 9:00 p.m. An interview on 07/17/2024 at 12:52 p.m. with S2Director of Nursing (DON) confirmed no documentation of administration site for Lantus from 07/08/2024 through 07/16/2024; no documentation of administration of Diflucan on 07/09/2024, no documentation of administration of Azithromycin on 07/09/2024 and 07/16/2024, no documentation of administration of Sulfamethoxazole-trimethoprim and Zidovudine on 07/09/2024 for 7:00 a.m. or 7:00 p.m. doses. S2DON also confirmed no documentation of site administered for sliding scale Humulin R insulin administered to resident #236 on the following dates and times: 07/09/2024 through 07/17/2024 for 6:30 a.m., 07/10/2024, 07/12/2024, 07/14/2024, and 07/16/2024 at 11:30 a.m., 07/09/2024 through 07/11/2024, 07/15/2024 and 07/16/2024 at 4:30 p.m., and 07/08/2024, 07/11/2024, 07/15/2024, and 07/16/2024 at 9:00 p.m. 32231 Resident #27 Review of the medical record revealed resident #27 was admitted to the facility on [DATE] with diagnoses including unspecified glaucoma, and primary open-angle glaucoma, stage unspecified. Review of the annual minimum data set assessment dated [DATE] revealed resident #27 had a documented brief interview for mental status score of 00 according to section c: cognitive status. A score of 00-07 indicated the resident had severe cognitive impairment with daily decision making. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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	Review of the fall risk assessment dated [DATE] revealed a score of 14. According to the scoring scale documented on the fall risk assessment form, a total score of 10 or above indicated resident #27 was at a high risk for falls. Review of the 2024 physician's orders revealed an order dated 05/16/2024 for resident #27 to have a bed alarm, the staff were to answer promptly when it was activated, and for fall mats times 2 as fall precautions. During the survey dates of 05/15/2024 through 05/16/2024, observations of resident #27's room revealed there were no visible fall mats on the floor and no bed alarm on the resident's bed. Review of the July 2024 medication administration record revealed that the bed alarm and fall mats times 2 was documented daily on the day, evening, and night shifts from 07/01/2024 through the 07/16/2024. On 07/16/2024 at 4:13 p.m., S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) was notified of the physician's order for resident #24 to have a bed alarm and the staff were to answer promptly when activated. An observation of resident's room with S3LPN/MDS was conducted after the interview. During the observation, S3LPN/MDS confirmed there was no bed alarm/pad in the resident's room including on his bed. During a telephone interview with S3LPN/MDS on 07/16/2024 at 4:40 p.m., she confirmed there were no falls and bed alarm observed in resident #27's room. She further onfirmed the documented approaches of the fall mats and bed alarm had not been implemented, in accordance with the physician's orders. During an interview with S1Administrator and S2Director of Nursing on 07/17/2024 at approximately 12:40 p. m., they were notified of the above findings. Resident #186 Review of resident #186's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses that included Type II diabetes mellitus with diabetic polyneuropathy. Review of the July 2024 physician's orders revealed an order dated 07/08/2024 for resident #186 to have Novolog 100 units/milliliter; give 8 units if accucheck greater than 240 (milligrams/deciliter), and to obtain the accuchecks twice a day. Review of the care plan revealed a problem onset of 04/05/2022; altered blood sugars due to diabetes. Further review revealed the documented approaches included accuchecks per physician orders, accuchecks twice a day, and notify the physician if the glucose was less than 60 or greater than 400. Review of the July 2024 MAR revealed that resident #186 was to have an accucheck obtained twice a day at 6:30 a.m. and 4:30 p.m. Further review of the MAR revealed there was no documentation of an accucheck result being obtained on the date of 07/15/2024 at 6:30 a.m. Review of the skilled nurse's notes dated 07/15/2024 revealed there was no documentation to indicate why the accucheck had not been obtained at 6:30 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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	During a telephone interview on 07/17/2024 at 12:20 p.m. with the nurse practitioner, he confirmed that he was not aware of an accucheck not being obtained on 07/15/2024 for resident #186. During a telephone interview on 07/17/2024 at 12:25 p.m. with the physician, confirmed that he was not aware of an accucheck not being obtained on 07/15/2024 for resident #186. During an interview with S4Assistant Director of Nursing (ADON) on 07/17/2024 at 10:15 a.m., she confirmed that resident #186 was to have accuchecks obtained twice a day at 6:30 a.m. and 4:30 p.m. After a record review was completed, S4ADON confirmed that there was no documentation to indicate why resident #186 did not have an accucheck result on 07/15/2024 at 6:30 a.m., as ordered by the physician. On 07/17/2024 at approximately 12:40 p.m., S1Administrator and S2Director of Nursing were notified of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 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. 32231 Based on review of the personnel records, the facility failed to ensure the State Adverse Actions Website checks were completed for Certified Nursing Assistants (CNA) monthly for 6 (S10CNA, S11CNA, S12CNA, S17CNA, S18CNA, and S19CNA) of 6 (S10CNA, S11CNA, S12CNA, S17CNA, S18CNA, and S19CNA) personnel files reviewed. Findings: Review of S10CNA's personnel file revealed a hire date of 09/08/2022. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. Review of S11CNA's personnel file revealed a hire date of 12/06/1994. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. Review of S12CNA's personnel file revealed a hire date of 06/14/2010. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. Review of S17CNA's personnel file revealed a hire date of 03/25/2024. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. Review of S18CNA's personnel file revealed a hire date of 02/08/2024. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. Review of S19CNA's personnel file revealed a hire date of 10/10/2023. Review revealed there was documentation of a State Adverse Actions check on 04/23/2024. Further review revealed there was no documentation of a State Adverse Actions check after the date of 04/23/2024 through the present date of 07/17/2024. On 07/17/2024 at 5:35 p.m., an interview with S1Administrator confirmed that monthly State Adverse Action checks were not being done monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 17835 Based on observations, review of the policy, and interview, the facility failed to ensure that all drugs and biologicals are stored in locked compartments by having an open medication cart, unlocked and drawers open with medications in direct view and staff not present. The medication cart was in a place where residents and unauthorized staff could access the medication cart. Findings: Review of facility's policy and procedure for Administering Medications (revised April 2019) revealed the following: During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Observation on 07/17/2024 at 7:08 a.m. revealed the medication cart for hall A was located in the hallway. Further observation revealed the cart was unlocked, and drawers were opened with medications in direct view. No nurse or staff members were present on the hallway at that time. Resident #306 was observed self-ambulating in a wheelchair, and passed by the open medication cart. Observation on 07/17/2024 at 7:10 a.m. revealed that S2Director of Nursing (DON) entered the hall A and also observed the medication cart unlocked with open drawers and left unattended. S2DON then notified S7Licensed Practical Nurse (LPN), responsible for the unlocked cart, to return to the cart and lock the cart. S7LPN was located behind a closed door assisting resident #236 when the medication cart was observed unlocked on hall A. Observation on 07/17/2024 at 7:54 a.m. revealed the medication cart for hall A was observed once again unlocked with no staff in view of the cart. Interview on 07/17/2024 at 7:15 a.m. with S2DON confirmed that the medication cart was to be locked when medications were not being prepared and the nurse was not in view of the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32231 Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety as evidence by, 1) having dirty serving trays on a rolling cart, 2) having a grime build up on the kitchen cabinets, shelves, and window ledge, 3) storing an expired nutritional supplement in the refrigerator, and 4) storing food items that belonged to an employee in the storage room and available for resident use. Findings: During an initial tour of the kitchen on [DATE] at 8:10 a.m., an observation revealed a rolling cart located near the steam table. Further observation revealed there were six serving (meal) trays that had old dried food particles on the trays. Further observations revealed there were large amounts of thick, black grime build up on shelves that were located in the bottom and top cabinets throughout the kitchen. The dirty shelves had various cooking pots, pans, and /or eating utensils stored on them. After the initial tour of the kitchen was completed, a tour of the outside storage room revealed one, eight ounce carton of Boost stored inside of the refrigerator. Observation of the carton revealed a use by date of , d+[DATE]. Further observation of the storage room revealed a small box that contained 2 boxes of macaroni and cheese, one box of wheat noodles, two cans of pork and beans, and one can of black beans. The can of black beans had approximately one half of the label stained with a dark colored unknown substance. S16Dietary [NAME] was present during the observations of the kitchen and outside storage room. She reported that a visitor had left the box of food items for an employee and she (S16Dietary Cook) had placed the box in the storage room for an employee. S16Dietary [NAME] confirmed that the kitchen cabinets and window ledge were dirty and needed to be cleaned and the serving trays contained old dried food particles. S16Dietary [NAME] further confirmed the carton of Boost was expired, and the box of food items left for the employee should not have been stored in outside storage room and available for resident use. On [DATE] at approximately 8:45 a.m., S1Administrator was notified of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 22575 Based on interviews and review of the facility's Infection Control Records, the facility failed to ensure the Infection Preventionist, who is responsible for the facility's infection prevention and control program, had completed specialized training in infection prevention and control. Findings: Review of the facility's Infection Control Records revealed there was no documented evidence the Infection Preventionist, S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS), had completed specialized training in infection prevention and control. An interview with S3Licensed Practical Nurse/Minimum Data Set (LPN/MDS) on 7/16/2024 at 1:30 p.m. revealed she had not completed the Infection Preventionist Training. An interview with S2Director of Nursing on 7/17/2024 at 3:10 p.m. confirmed S3LPN/MDS had not completed the Infection Preventionist Training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 32231 Based on observation and interview, the facility failed to maintain all mechanical equipment in safe operating condition by having shavings on the manual can opener. Findings: During an initial tour of the kitchen on 07/15/2024 at 8:10 a.m., an observation revealed a large can opener with a buildup of metal shavings on the blade. Further observation revealed S16Dietary [NAME] began opening a large can of canned sweet green peas, for the lunch service. She was notified of the buildup of the metal shavings and confirmed that the can opener blade needed to be cleaned. On 07/15/2024 at approximately 8:45 a.m., S1Administrator was notified of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 32231 Based on review of the personnel records and interviews, the facility failed to ensure all required in-service training for Certified Nurse Aides (CNA) included dementia management training for 6 (S10CNA, S11CNA, S12CNA, S17CNA, S18CNA and S19CNA) of 6 (S10CNA, S11CNA, S12CNA, S17CNA, S18CNA, and S19CNA) personnel files reviewed. Findings: Review of S10CNA's personnel file revealed a hire date of 09/08/2022. Further review revealed there was no documentation of dementia care management training. Review of S11CNA's personnel file revealed a hire date of 12/06/1994. Further review revealed there was no documentation of dementia care management training. Review of S12CNA's personnel file revealed a hire date of 06/14/2010. Further review revealed there was no documentation of dementia care management training. Review of S17CNA's personnel file revealed a hire date of 03/25/2024. Further review revealed there was no documentation of dementia care management training. Review of S18CNA's personnel file revealed a hire date of 02/08/2024. Further review revealed there was no documentation of dementia care management training. Review of S19CNA's personnel file revealed a hire date of 10/10/2023. Further review revealed there was no documentation of dementia care management training. On 07/17/2024 at 5:40 p.m., an interview with S1Director of Nursing confirmed that dementia care training had not been provided to the CNAs listed above.