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	08/27/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure an RN (Registered Nurse) was on duty for 8 consecutive hours a day, 7 days a week for 4 days within the Fiscal Year, Quarter 2 2025 (January 1-March 31). Findings:Review of the facility's Payroll Based Journal (PBJ) Staffing Data Report for FY Quarter 2 2025 (January 1-March 31) revealed there were no consecutive 8 hours of RN coverage for 3 days within the quarter. Review of the RN time cards revealed on 02/01/2025 and 02/02/2025, the RN did not work 8 consecutive hours within the 24 hour period. Further review of the RN time cards revealed no RN worked on 03/05/2025. During an interview on 08/27/2025 at 1:00 p.m. with S1Administrator, he reported he was responsible for completing the PBJ staffing report. S1Administratior reviewed the PBJ for FY Quarter 2 2025 (January 1-March 31). S1Administrator confirmed there was not 8 hours of consecutive RN coverage for 02/01/2025 and 02/02/2025 and no RN worked in the facility on 03/05/2025.

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide form CMS (Centers for Medicare and Medicaid Services) 10123- Notice of Medicare Non-Coverage (NOMNC) as required for 1 (#31) of 3 (#2, #11 and #31) residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Notification. The facility had a census of 37 residents. Findings: A review of Resident #31's SNF Beneficiary Notification Review form revealed the facility initiated the resident's discharge from Medicare Part A services when benefit days were not exhausted. Resident #31 was discharged from Medicare Part A services on 7/31/2025. Further review of Resident #31's record failed to reveal a Notice of Medicare Non-Coverage (NOMNC) form was provided to the resident. On 08/27/2025 at 10:50 a.m., an interview was conducted with S2Director of Nursing (DON). S2DON confirmed she was responsible for providing the Beneficiary Notifications (NOMNC forms) to the residents. S2DON stated Resident #31's discharge from therapy was facility initiated and the resident also had skilled benefit days remaining at the time of the discharge. S2DON reported she did not know Resident #31 required a NOMNC form.

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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 review and interviews, the facility failed to ensure residents were free from physical restraints imposed for the purpose of discipline or convenience for 1 (#44) of 1 (#44) residents reviewed for restraints. The facility failed to 1) obtain a consent, 2) have a physician's order and 3) failed to assess the resident prior to placing the resident in a restraint. Findings:Review of the facility's policy for the Use of Restraints dated April 2017 revealed the following in part:Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls.When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.Policy Interpretation and Implementation 1. Physical 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.9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint.12. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to ensure the least possible discomfort to the resident.b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used.c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record.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 least every two (2) hours on all shifts. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), schizophrenia, major depressive disorder, anxiety disorder, insomnia, vascular dementia, and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and unable to make daily decisions. Review of the functional limitation in range of motion revealed the resident did not have any impairments in the upper or lower extremities. Further review revealed the resident was dependent on staff for all activities of daily living and mobility. Review of the Physical Restraint section of the MDS revealed no restraints used. Review of the medical record revealed no documented evidence of an assessment prior to the use of a geri-chair and lap tray, no consent from the resident or the Responsible Party and there was no physician's order for a geri-chair.Observations on 08/26/2025 at 10:10 a.m. and 2:30 p.m. revealed Resident #44 was sitting up in a geri chair with lap tray in place in his room. Observation on 08/27/2025 at 08:15 a.m. revealed Resident #44 was sitting up in a geri chair with lap tray in place being fed his breakfast by the Certified Nursing Assistant (CNA). Interview with S8CNA at this time stated Resident #44 was placed in the geri chair with lap tray daily when out of bed. During an interview on 08/26/2025 at 09:35 a.m. with S9Licensed Practical Nurse (LPN), S9LPN stated there was not an order for the geri chair and lap tray or a care plan because the facility was trying it out to see if it would work for the resident, prior to doing the assessment, care plan or getting the physician's order.During an interview on 08/27/2025 at 03:50 p.m. with the S2Director of Nursing (DON), S2DON confirmed Resident #44 was placed in the geri chair with a lap tray when out of bed since admission without having a pre-restraining assessment, a written order from the physician or obtaining a consent from the resident or responsible party.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 1 (#39) of 2 (#15, #39) residents reviewed for pressure ulcers. The facility failed to provide a low air loss mattress for resident #39. Findings:Resident #39Review of the medical record for Resident #39 revealed an admission date of 05/30/2025 with diagnoses that included hemiplegia and hemiparesis following non-traumatic intracranial hemorrhage affecting right dominant side, pressure ulcer of sacral region stage 4, and hypertension.Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview for Mental Status (BIMS) score was unable to be obtained and indicated the resident is severely cognitively impaired for daily decision making. Per the MDS, the resident required substantial/maximal assist with bed mobility and was dependent with toileting. The resident utilized an indwelling catheter. Interventions for the resident's stage 4 pressure injury included a pressure reducing device for the bed. Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 06/03/2025 revealed a score of 12 which indicated the resident is at high risk for pressure ulcer development. Review of the Electronic Order Summary Report as of 08/26/2025 revealed an order dated 01/29/2025- low air loss mattress.Review of the active plan of care addressed Resident #39's pressure ulcer and included an intervention to maintain a pressure reduction mattress to bed. The order for a low air loss mattress was not noted as an intervention to address the pressure ulcer. On 08/26/2025 at 1:59 p.m., an interview with S5CNA (Certified Nursing Assistant), revealed that the resident was to have a low air loss device in place to his pressure reducing mattress.On 08/26/2025 at 2:12 p.m., a follow-up observation with S5CNA at Resident #39's bedside revealed a deflated low air loss device on top of the resident's pressure reducing mattress. When S5CNA was questioned about how the device inflates, she reported that the pump to inflate the device was missing. On 08/26/2025 at 2:20 p.m., arrived to Resident #39's bedside with S2DON (Director of Nursing) who observed the deflated low air loss device and confirmed that the intervention was not implemented as ordered. On 08/27/2025 at 3:30 p.m., arrived to Resident #39's room for follow-up observation related to the low air loss device with S7Maintenance. It was noted that the low air loss device was deflated and this was confirmed by S7Maintenance.On 08/27/2025 at 4:00 p.m., S2DON was informed of the additional finding of the deflated low air loss device for Resident #39.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide thickened liquids as ordered by the physician for 1(#18) of 3 (#1, #4, & #18) residents reviewed for nutrition. Findings: Review of Resident #18's medical record revealed an initial admit date of 08/20/2018 and a readmit date of 12/19/2023. Further review revealed a primary diagnosis of chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated a yes response for C. Mechanically altered diet-require change in texture of food or liquids (e.g., pureed food, thickened liquids). Further review of the MDS revealed the resident had a Brief Interview of Mental Status (BIMS) score of 7 which indicated moderately impaired cognitive skills for daily decision making. Review of the August 2025 physician orders revealed an order for honey/moderately thick consistency liquids. Review of Resident #18's most recent care plan with a review date of 08/14/2025 revealed the resident had an alteration in nutrition: (gluten free, pureed with honey thick liquids). Review of the Dysphagia Evaluation completed on 11/20/2024 by a speech therapist revealed a recommendation for honey thickened liquid for pleasure. Observations on 08/25/2025 at 9:08 a.m. and 9:20 a.m. and on 08/26/2025 at 8:31 a.m. revealed Resident #18 was sitting upright in a chair with a bedside table in front of her with an 8-ounce water bottle opened with a straw. Further observation of the water bottle revealed the water was not thickened. There was also an open container with unopened packages of thickener on the resident's nightstand. Further observation of the room revealed a note on the resident's wall beside her bed stating, All liquids to be nectar thickened liquids only. In an interview with S4Certified Nursing Assistant (CNA) on 08/25/2025 at 12:55 p.m., S4CNA said she was told by the nurse that Resident #18 was supposed to have thickened liquids. She acknowledged there had been signage about thickened liquids on Resident #18's wall. In an interview with S2Director of Nursing (DON) on 08/26/2025 at 11:09 a.m., S2DON confirmed Resident #18 was supposed to receive thickened liquids and should not be drinking unthickened liquids. In an interview with S6Licensed Practical Nurse (LPN) on 08/27/2025 at 1:05 p.m., S6LPN confirmed Resident #18 was supposed to only have thickened liquids. In an interview with S3Speech Therapist (ST) on 08/27/2025 at 2:00 p.m., S3ST indicated the last time she saw Resident #18, S3ST recommended thickened liquids.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to ensure infection control measures were practiced to provide a safe, sanitary environment and help prevent the development and transmission of infection for 1 (#22) of 1 residents reviewed for respiratory care. The facility failed to store and dispose of suctioning equipment appropriately for Resident #22. Findings: Review of the facility's undated policy for Suctioning the Upper Airway (nasopharyngeal or oropharyngeal suctioning) revealed the following, in part: General Guidelines: 5. Oropharyngeal suctioning is performed using aseptic technique. Equipment and Supplies6. Curve-tipped #10 to #16 French catheter; with suction control port or adapter (nasopharyngeal) or Yankauer or opened tipped catheter (if oral secretions are thick and copious.) After Suctioning4. Discard water or saline in commode. Dispose of cup in designated receptacle.5. Empty and rinse collection container if necessary or as indicated by facility protocol. Review of the medical record revealed Resident #22 had an initial admission date of 02/15/2017 and a most recent admission date of 08/28/2020 with a primary diagnosis of transient cerebral ischemic attack, unspecified. Review of the August 2025 physician orders revealed an order dated 10/01/2025 for oral suctioning as needed. On 08/25/2025 at 9:28 a.m., Resident #22 was observed in her room sitting in a geri chair on the right side of the bed. Further observation revealed suction equipment on the side table with liquid in the clear canister of the machine and the connected Yankauer suctioning tip with a substance spread out inside in an uneven pattern which was white in color. The Yankauer suctioning tip was lodged uncovered between the wall and the side table standing in an upright position and was available for reuse. Further observation revealed new suctioning tips were not available in the resident's room at this time. During an interview on 08/25/2025 at 9:37 a.m. with S6Licensed Practical Nurse (LPN), S6LPN reported the suctioning machine and the Yankauer suctioning tip should not have been left out after being used and that it should have been cleaned and stored properly. S6LPN reported Resident #22 required suctioning at times and S6LPN did not know who had used the equipment last. During an interview with S2Director of Nursing (DON) on 08/27/2025 at 11:09 a.m., S2DON acknowledged the suctioning equipment should be cleaned and stored after each use, in addition to the Yankauer suctioning tip being covered in a clear plastic type of covering. S2DON acknowledged she was aware of the equipment being out in Resident #22's room but did not know who used the equipment and failed to store and dispose of the suctioning equipment appropriately.