STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195380	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GUEST HOUSE SKILLED NURSING REHABILITATION (THE)	**9225 NORMANDIE DRIVE SHREVEPORT, LA 71118**

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** - 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 interview the facility failed to ensure a plan of care had been developed for 1 (#2) of 5 sampled residents reviewed for comprehensive plan of care. The facility failed to ensure a plan of care for depression and anxiety, risk of falls, ADLs (activities of daily living) self-care deficit, impaired mobility, urine retention and indwelling catheter was developed for Resident #2. Findings: Review of Resident #2's Medical Records revealed an admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's 07/20/2020 MDS (minimal data set) Assessment revealed: Section G: Functional Status: Locomotion on/off unit, bed mobility, transfer, dressing, personal hygiene, bathing extensive assistance with one person assist; toilet use supervision with one person assist; Eating limited assistance with one person assist. Mobility device - walker/wheelchair. Section H: Bladder and Bowel - indwelling catheter; bowel - occasionally incontinent. Section I: Active [DIAGNOSES REDACTED].#2's September 2020 physician's orders [REDACTED]. 16french; balloon 5cc (cubic centimeters) 6/19/2020: [MEDICATION NAME] 0.25mg tablet give 1 po QHS (hour of sleep) Monitor for anxiolytic medication every shift Review of Resident #2's Assessment Notes: Therapy Screen Request 6/25/2020 Physical Therapy - gait disturbance, balance disturbance Occupational Therapy - difficulty performing ADLs, decreased safety awareness, difficulty with toileting and/or transfers Failed to reveal Fall Evaluation Tool was completed Review of Resident #2's Care Plan failed to reveal a plan of care was developed to address depression and anxiety, risk for falls, ADL self-deficit care, impaired mobility, urine retention and indwelling catheter. During an interview and review of Resident #2's Care Plan on 9/30/2020 at 11:50 AM S3 LPN/MDS (licensed practical nurse) confirmed Resident #2 was not care planned for depression and anxiety while receiving an antidepressant and antianxiety medication, risk of falls, ADL self-care deficit, impaired mobility, urine retention and indwelling catheter and should have been.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on record reviews and interviews the facility failed to revise the comprehensive plan of care for 1 (#3) out of 5 sampled residents reviewed for plan of care. The facility failed to revise the care plan to include appropriate approaches for assistance with transfers for resident #3. Findings: Resident #3 was admitted to the facility 8/8/18 and readmitted [DATE] with [DIAGNOSES REDACTED]. Review of resident #3's Yearly 7/17/2020 and Readmit 8/3/2020 MDS (Minimum Data Set) revealed resident had limited functional status and required extensive assistance with two persons in bed mobility, transfers, and toilet use. Review of resident #3's current Plan of Care revealed resident had a self-care deficit related to inability to perform ADLs (activities of daily living) with approach to assist with transfers as needed. During an interview and review of resident #3s Plan of Care S2 DON (director of nursing) and S7 Corporate Nurse both agreed the care plan should have been updated to reflect the resident's current functional status and need for extensive assistance with two persons for transfers and it was not.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.