| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **195551** | A. BUILDING _____ B. WING _____ | **08/07/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GUEST HOUSE NURSING AND REHABILITATION** | **109 GUEST HOUSE DRIVE WEST MONROE, LA 71292** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, interview, and observation, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (#7) of 2 (#4 and #7) residents with skin tears and 1 of 1 (#7) resident with [MEDICAL CONDITION]. The facility failed to have care plan interventions in place for skin tears and failed to identify a venous ulcer timely.<br>Findings: Review of medical record for resident #7 revealed the resident was admitted on [DATE]. His [DIAGNOSES REDACTED]. back pain, dementia, and [MEDICAL CONDITION] with hallucinations. Review of the Minimum (MDS) data set [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for activities of daily living. The resident was incontinent of bowel and bladder. Review of the Pressure Ulcer Risk assessment dated [DATE] revealed the resident was at risk for developing pressure ulcers. Review of the care plan revealed: - Risk for pressure ulcers related/to impaired mobility - monitor skin daily during care for any signs/symptoms of breakdown, report any new reddened areas or skin breakdown to medical doctor, pressure reducing device to bed and chair, positioning devices such as pillows to prevent bony prominences from contact. - Risk for impaired circulation related to resident has history of [MEDICAL CONDITION] - elevate legs when sitting, monitor [MEDICAL CONDITION]. - 7/16/2020 - Impaired skin integrity related to skin tear great toe, right knee and right and left shin - leg fell of gerichair - place gerichair overlay. - 6/27/2020 - Impaired skin integrity related to skin tear right elbow - rubbed on gerichair arm - place cushion between elbow and chair arm. Review of the August 2020 physician orders [REDACTED]. Review of the weekly body audits revealed the most recent audit was 07/25/2020. The audit revealed: scattered scabs and bruises noted to bilateral upper and lower extremities, treatment in progress to bilateral lower extremities and right arm. Observation on 08/05/2020 at 12:05PM revealed the resident was up in his gerichair in his room. The resident did not have gerisleeves on his bilateral upper extremities or bilateral lower extremities. There is a sign on the wall, Please place gerisleeves on before placing resident in gerichair. There was not any cushion between the resident's right elbow and chair arm. Observation on 08/05/2020 at 1:25PM revealed the resident was up in his gerichair. The resident had 2 scabs and one skin tear on his right arm. The skin tear was bleeding. The resident did not have his gerisleeves on. S4Certified Nursing Assistant (CNA) was present and found one gerisleeve in his drawer. There was not any cushion between the resident's right elbow and chair arm. Interview at this time with S5LPN revealed the resident should have gerisleeves and they might be in the laundry. Observation on 08/06/2020 at 9:00AM revealed the resident was up in his gerichair. The resident had one gerisleeve on his right arm. There was not any cushion between the resident's right elbow and chair arm. Observation on 08/06/2020 at 9:55AM revealed the resident was up in his gerichair. There was not any cushion between the resident's right elbow and chair arm. The resident had his gerisleeves on his upper extremities. Further observation revealed drainage on his right sock. S4CNA removed his sock and the resident had an open area to his medial right great toe. The resident had a dressing on his right 2nd toe dated 08/05/2020. There were not any gerisleeves on his legs. An interview with S4CNA at this time revealed the night shift bathes the resident and has the resident up in the gerichair when S4CNA arrives for his shift. Review of the Wound Assessment Report dated 08/06/2020 revealed: Venous ulcer right great toe base of toe, new wound 1.5 centimeter (cm) x 0.5 cm x 0.1 cm - no infection, no pain, non [MEDICAL CONDITION] wound bed - [MEDICATION NAME] tissue 0%, granulation tissue 100%, slough 0%, eschar 0% wound edges - Border definition well defined - description - normal healthy skin Surrounding skin - pink, slight [MEDICAL CONDITION] Dorsalis pedis - papable weak, posterior tibial - palpable weak Capillary refill less than 3 seconds, affected extremity - red, normal/warm to touch, skin - shiny/taut Physician and responsible party notified - pending treatment orders. An interview on 08/07/2020 at 9:50AM revealed S6Treatment Nurse performed wound care on the 2nd toe of the right foot on 08/05/2020 and did not observe the ulcer on the right great toe. Observation on 08/07/2020 at 1:30PM revealed the resident was up in his gerichair. Further observation revealed the resident had small scabs on both lower extremities and feet. There were not any gerisleeves to his lower extremities. There was not any cushion between the resident's right elbow and chair arm. Review of the Activities of Daily Living flow sheet revealed bath, whirlpool, or shower 3 x weekly Tuesday, Thursday, and Saturday. Further review revealed resident #7 received nail care on 08/05/2020 (hands and feet) and the bath was checked for 08/01/2020 and 08/04/2020. An interview with S5LPN on 08/07/2020 at 1:40PM revealed the night shift baths resident #7. Review of the August 2020 Medication Administration Record [REDACTED]. On 08/07/2020 at 2:00PM, S1Administrator and S2Director of Nursing (DON) were notified that the resident did not have his gerisleeves on his bilateral upper extremities(BUE)/bilateral lower extremities(BLE) from 8/05/2020 through 08/07/2020 or the cushion between the resident's right arm and gerichair. S2DON was notified that the venous ulcer was not identified by the staff during daily care. |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and interviews the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing. The facility failed to perform weekly skin assessments for 3 (4, 6, 8) of 5 (4, 5, 6, 7, and 8) residents at risk for developing pressure ulcers and failed to have evidence that the residents were turned and repositioned every two hours as stated in the care plan for 4 (#4, 5, 6, and 8) of 5 (#4, 5, 6, 7, and 8) residents at risk for developing pressure ulcers. Findings: Resident 4 Review of the medical record for sampled resident #4 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the August 2020 physician orders [REDACTED]. dry, apply [MEDICATION NAME] to wound bed, then calcium alginate, cover with a foam dressing, and change Monday, Wednesday, and Friday and as needed for soilage and dislodgement. Review of the Braden scale dated 06/11/2020 revealed the resident was at risk for pressure ulcers and requires frequent repositioning with maximum assistance. Review of the current care plan revealed the resident required assistance with activities of daily living related to impaired mobility. The resident requires extensive assistance with bed mobility, transfers, and set up meal and assist as needed. Further review of the care plan revealed the resident was at risk for developing pressure ulcers related to impaired mobility. The resident required assistance with turning and repositioning as needed. Review of the significant change Minimum Data Set ((MDS) dated [DATE] revealed the resident was totally dependent with one person assistance for bed mobility, transferring, dressing, eating, toilet use and hygiene. Further review of the MDS revealed the facility was unable to determine the Brief Interview for Mental Status (BIMS) score for resident #4. Review of the weekly skin assessments revealed from 5/2020 - present revealed the only weekly body audits that was presented to the surveyor was for 6/23/2020, 6/30/2020, 7 07/7/2020, 7/14/2020 and 7/21/2020. Review of the medical record revealed no documentation of the |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **195551** | A. BUILDING _____ B. WING _____ | **08/07/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GUEST HOUSE NURSING AND REHABILITATION** | **109 GUEST HOUSE DRIVE WEST MONROE, LA 71292** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>resident being turned and repositioned as stated in the care plan. On 08/05/2020 at 11:00AM an interview with S2DON (Director of Nursing) revealed there were no weekly skin assessments consistently performed for resident #4. On 08/06/2020 at 9:30AM an interview with S3CNA (Certified Nursing Assistant) Supervisor revealed they do not document turning and repositioning in the activity of daily living flowsheets. Further interview with S3CNA Supervisor revealed they just go by the turning schedule on the wall to determine what position the resident should be turned. On 08/06/2020 at 10:00AM an interview with S8LPN (Licensed Practical Nurse) revealed the resident needed to be turned and respositioned by the staff. On 08/07/2020 at 2:00PM an interview with S2DON revealed there was no documentation of turning and repositioning every two hours for resident #4. Resident 5 Review of the medical record for sampled resident #5 revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the August 2020 physician orders [REDACTED]. Review of the current care plan revealed the resident was at risk for for pressure ulcers related to impaired mobility. Monitor skin every day and turn and reposition every two hours. Further review of the care plan revealed the resident had impaired mobility and required extensive to total assistance of two people for transfers with the lift. Review of the quarterly MDS (Minimum Data Set) dated 06/08/2020 revealed the facility was unable to determine the Brief Interview for Mental Status (BIMS) score for resident #5. Further review of the MDS revealed the resident required total assistance with one person physical assistance for bed mobility, dressing, eating and hygiene. The resident required total assistance with two or more persons for transferring and toilet use. Review of the Braden Risk Assessments for developing pressure ulcers dated 06/04/2020 revealed the resident was at risk for pressure ulcers. Review of the medical record revealed no documentation of the resident being turned and repositioned every two hours as stated in the care plan. On 08/06/2020 at 2:00PM an interview with S3CNA Supervisor revealed the CNAs just go by the turn schedule on the wall to determine which position the resident should be placed. On 08/07/2020 at 10:15AM with S7LPN (Licensed Practical Nurse) revealed resident #5 required total assistance by staff to be turned and repositioned. On 08/07/2020 at 2:00PM an interview with S2DON revealed there was no documentation of the resident being turned and repositioned. Resident 6 Review of the medial record for resident #6 revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the August 2020 physician orders [REDACTED]. Review of the Braden scale pressure ulcer risk assessment dated [DATE] revealed the resident was at risk for developing pressure ulcers.<br>Review of the current care plan revealed the resident was at risk for pressure ulcer related to impaired mobility and to assist with turning and repositioning as needed and required extensive to total assistance with activities of daily living. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. Further review of the MDS revealed the resident required total assistance with one person assistance for bed mobility, dressing and hygiene. The resident required total assistance with two persons physical assistance with transfers and toilet use. Review of the medical record revealed no documentation of the resident being turned and repositioned as stated in the care plan. On 08/05/2020 the weekly body audits from May 2020 - present was requested. The facility was unable to produce any weekly body audits for resident #6. On 08/06/2020 at 2:00PM an interview with S3CNA (Certified Nursing Assistant) Supervisor revealed the CNAs just go by the turn schedule on the wall to determine which position the resident should be placed. On 08/7/2020 at 10:05AM an interview with S7LPN (Licensed Practical Nurse) revealed the resident needed to be turned and repositioned by the staff. On 08/07/2020 at 2:00PM an interview with S2DON (Director of Nursing) revealed there was no documentation of turn and repositioning, and no documentation of weekly body audits. Resident 8 Review of the medical record for sampled resident #8 revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the current care plan revealed the resident was at risk for for developing pressure ulcers related to impaired mobility. The resident required assistance with turning and repositioning as needed. Review of the MDS (Minimum Data Set) dated 05/12/2020 revealed the resident had severely impaired cognitive skills for daily decision making. Further review of the MDS revealed the resident required extensive assistance with one person assist for bed mobility, toilet use, hygiene and dressing. Review of the Braden scale for pressure ulcers dated 05/12/2020 revealed the resident was at risk for developing pressure ulcers. On 08/06/2020 at 4:00PM, observation of the resident's room revealed a turn schedule was not on the wall. Review of the medical record revealed no documentation of the resident being turned and repositioned every two hours. On 08/05/2020 the weekly body audits from May 2020 - present was requested. The facility was unable to produce any weekly body audits for resident #8. On 08/07/2020 at 9:55AM interview with S5LPN (Licensed Practical Nurse) revealed the resident needed to be turned and repositioned by the staff. On 08/07/2020 at 12:00PM an interview with S3CNA (Certified Nursing Assistant) Supervisor revealed they do not record turning and repositioning and they just go by the turn schedule on the wall. At this time, S3CNA Supervisor was informed that the resident did not have a turning and repositioning schedule on the wall. On 08/07/2020 at 2:00PM an interview with S2DON (Director of Nursing) revealed there was no documentation of monitoring for weekly body audits and no documentation of turning and repositioning. S2DON was informed that a turning and repositioning schedule was not on the resident's wall. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews, review of policies and procedures, and interviews the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise by failing to accurately record meal intake for 3 (4, 5, and 6) of 4 (4, 5, 6, and 8) records reviewed for weight loss. Findings: Resident 4 Review of the medical record for sampled resident #4 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the August 2020 physician orders [REDACTED]. Further review of the physician orders [REDACTED]. Review of the current care plan revealed the resident is at risk for alteration in nutrition - requires therapeutic diet. Poor appetite upon admission. Assist the resident with meals and eating as needed, monitor intake every shift, serve diet as ordered and the resident receives tube feedings. Review of the significant change MDS (Minimum Data Set) dated 06/13/2020 revealed the resident was totally dependent for activities of daily living and required 1 person assistance with eating. Further review of the MDS revealed the facility was unable to determine the resident's Brief Interview for Mental Status (BIMS) score. Review of the Malnutrition Risk Assessments dated 06/11/2020 revealed the resident was at risk for malnutrition. Review of the Percutaneous Endoscopic Gastrostomy (PEG) tube policy revealed intake and output should be monitored every shift. Review of the medical record revealed sampled resident #4 had weight loss. Further review of the medical record the resident had an admission weight of 113 pounds and the resident's current weight is 102 pounds. Review of the medical record revealed no documentation of tube feeding intake being monitored and no documentation of the percentage of meal intake being montiored every meal. Review of the Activities of Daily Living (ADL) flowsheet for June 2020, July 2020 and August 2020 revealed there was no documentation that meal intake percentages were being documented for every meal and the PEG tube intake was not being documented by the nurses. On 08/05/2020 at 3:15PM an interview with S2DON (Director of Nursing) revealed there was not any intake documentation for the tube feeding administered. S2DON revealed the meal intake percentages were not documented for every meal on every day. On 08/06/2020 at 10:00AM an interview with S8LPN (Licensed Practical Nurse) revealed the resident needed assistance with eating. Resident 5 Review of the medical record for sampled resident #5 revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the August 2020 physician orders [REDACTED]. Review of the current care plan revealed the resident had alteration in nutrition and required a therapeutic diet and to monitor intake every shift. Review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the facility was unable to determine the resident's Brief Interview for Mental Status (BIMS) score. Further review of the MDS revealed the resident required total assistance with one person for eating. Review of the Malnutrition Risk assessment dated [DATE] revealed the resident was at risk for malnutrition. Review of the medical record revealed the resdient had weight loss. Further review of the medical record revealed weights for resident #5 - 03/04/2020 - 132 pounds, 04/03/2020 - 134 pounds, 05/07/2020 - 128 pounds, 06/03/2020 - 130 pounds, 07/16/2020 - 126 pounds and 08/05/2020 - 125.8 pounds. On 08/06/2020 at 9:30AM interview with S7LPN (Licensed Practical Nurse) revealed the staff feed the resident. Review of the medical record revealed no documentation of meal intake percentages for every meal as stated in the care plan. On 08/07/2020 at 2:00PM an interview with S2DON (Director of Nursing) revealed there was no documentation of monitoring for food intake as stated in the care plan. Resident 6 Review of the medical record for resident #6 revealed an admission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the Malnutrition Risk assessment dated [DATE] revealed the resident was at risk for malnutrition. Review of the current care plan revealed the resident was at risk for alteration in nutrition - serve diet as ordered, assist with meals and eating as needed, and monitor intake every shift. Review of the MDS dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and required setup help with meals. Review of the medical record |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **195551** | A. BUILDING _____ B. WING _____ | **08/07/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GUEST HOUSE NURSING AND REHABILITATION** | **109 GUEST HOUSE DRIVE WEST MONROE, LA 71292** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0692<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>revealed the resident had weight loss. Further review of the medical record revealed the following weights - 04/03/2020 - 260 pounds, 05/07/2020 - 263 pounds, 06/03/2020 -264 pounds, and 08/04/2020 - 247 pounds. Review of the medical record revealed no documentation of meal percentage intake for every meal. On 08/07/2020 at 2:00PM an interview with S2DON (Director of Nursing) revealed there was no documentation of monitoring for food intake. |