STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195537	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Care Center	10145 Florida Blvd Baton Rouge, LA 70815

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (#54) of 13 (#3, #4, #14, #20, #26, #30, #33, #39, #54, #61, #65, #67, and #80) residents observed for dignity during incontinence care. The facility failed to ensure staff greeted the resident and explained the care to be provided. Findings: Review of the facility's General admission and Financial Agreement, packet dated 01/2023 revealed the following: IX Educational Material & Consents B. Residents Rights - Every resident in this facility has the right to: 12. Be treated courteously, fairly, and with the fullest measure of dignity. Review of Resident #54's Clinical Record revealed he was admitted on [DATE] with diagnoses which included the following in part; Unspecified Dementia without behavioral disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, and Cognitive Communication Deficit. Review of Resident #54's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/2025 revealed the provider assessed the resident as having a Brief Interview for Mental Status (BIMS) of 3, indicating the resident was severely cognitively impaired. Further review revealed he was incontinent of bowel and bladder and was dependent on staff for toileting hygiene. On 04/29/2025 at 12:40 a.m., an observation was made of S14CNA entering Resident #54's room to perform perineal care. Resident was noted to be asleep, facing the wall away from S14CNA. Without speaking to the resident or explaining the care she would provide, S14CNA removed Resident #54's blanket. Without speaking to the resident, S14CNA turned Resident #54 to his back. Resident #54 began shaking as S14CNA prepared to perform perineal care. On 04/29/2025 at 1:03 a.m., an interview was conducted with S14CNA. She confirmed the above observations and stated she should have announced her presence before startling Resident #54 awake. She stated she should have greeted the Resident #54 and explained the care she would be providing. (continued on next page)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2025 at 1:28 a.m., an interview was conducted with S2DON. S2DON stated she would expect staff to greet residents when entering the room and explain the care to be provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status. The facility failed to ensure staff accurately coded the correct discharge location for 1 (#93) of 3 (#93, #94, and #95) residents reviewed for closed records. Findings: Review of Resident #93's Discharge Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 01/28/2025 revealed Resident #93 was discharged to a Short-Term General Hospital. Review of Resident #93's January 2025 Physician's Orders revealed the following, in part: 01/24/2025 Discharge home with Home Health. Review of Resident #93's Nurse's Notes revealed the following, in part: 01/28/2025 at 11:10 a.m. Resident exited the facility via manual wheel chair. En route to group home with medications. On 04/30/2025 at 11:40 a.m., an interview was conducted with S15MDS. She reviewed Resident #93's Nurse's Notes and confirmed he discharged to a group home. She reviewed Resident #93's Discharge MDS with an ARD of 01/28/2025 and confirmed it indicated he discharged to a Short-Term General Hospital. She confirmed Resident #93's discharge status was not coded correctly and should have been coded as discharged to home/community. On 04/30/2025 at 1:38 p.m., an interview was conducted with S2DON. She stated she expected MDS nurses to complete all assessments to accurately reflect each residents' discharge status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations, interviews, and record review, the facility failed to implement a person-centered care plan by failing to perform blood sugar monitoring according to sliding scale and monitor the side effects/effectiveness of medications for 4 (#12, #24, #46, and #70) of 4 (#12, #24, #46, and #70) resident's reviewed. Findings: Resident #12 Review of admission Records for Resident #12 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Type 2 Diabetes Mellitus, Major Depressive Disorder, and Anxiety. Review of Quarterly MDS, revealed Resident #12 had BIMS 9, indicating cognitive impairment. Review of Plan of Care for Resident #12 dated 02/24/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the doctor. 2. Problem: Resident uses antidepressant medication Interventions: Administer Antidepressant medications as ordered by physician, monitor and document adverse reactions, side effects and effectiveness as ordered Q Shift. 3. Problem: Resident is on anticoagulant therapy Interventions: Administer Anticoagulant medications as ordered by physician, monitor for side effects and effectiveness. 4. Problem: Resident uses Anxiety medications Intervention: Administer Anti-Anxiety Medications as ordered by physician, monitor for side effects and effectiveness Q Shift. 5. Problem: Resident is on sedative/hypnotic therapy r/t insomnia. Intervention: Administer sedative/hypnotic medications as ordered by physician, monitor for side effects and effectiveness Q Shift. Review of Current Physician's Orders for Resident #12 revealed, in part: 1. Novolin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. 7. Monitor closely for significant side effects of Anti-Anxiety Medications including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift. 8. Observe closely for side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift. 9. Observe closely for side effects of Anti-Depressant medications drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations or other unusual changes in mood or behavior every shift. Review of April 2025 Medication Administration Record for Resident #12 revealed, in part: 1. Novolin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus - no blood sugar documented on 04/27/2025 at 8:00 p.m. 2. Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift 3. Monitor closely for significant side effects of Anti-Anxiety Medications including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift 4. Observe closely for side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift 5. Observe closely for side effects of Anti-Depressant medications including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations or other unusual changes in mood or behavior every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift On 04/29/2025 an interview was conducted with Resident #12. He stated he did not remember if his blood sugar was checked on 04/27/2025 before bedtime. Resident #24 Review of admission Records for Resident #24 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Type 2 Diabetes Mellitus, Schizophrenia, Major Depressive Disorder, Insomnia, and Anxiety Disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Quarterly MDS, with ADR 11/16/2024 revealed Resident #24 had BIMS14, indicating he was cognitively intact. Review of Plan of Care for Resident #24 dated 01/28/2025 included, in part: 1. Problem: Resident has risk for behavior problem r/t Schizophrenia Interventions: Administer medications as ordered, monitor for side effects and effectiveness Q Shift. 2. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the doctor. 3. Problem: Resident uses psychotropic medications r/t Schizophrenia Interventions: Administer medications as ordered, monitor for side effects and effectiveness Q Shift. 4. Problem: Resident uses Anti-Depressant Medications. Interventions: Administer Antidepressant medications as ordered by physician, monitor and document adverse reactions, side effects and effectiveness as ordered Q Shift. Review of Current Physician's Orders for Resident #24 revealed, in part: 1. Humulin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus. 2. Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. 3. Monitor closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms every shift. 4. Observe closely for side effects of Anti-Depressant medications drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations or other unusual changes in mood or behavior every shift. Review of April 2025 Medication Administration Record for Resident #24 revealed, in part: 1. Humulin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus - no blood sugar is documented on 04/27/2025 at 8:00 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift. 3. Monitor closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift. 4. Observe closely for side effects of Anti-Depressant medications including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations or other unusual changes in mood or behavior every shift - not documented as monitored on 04/27/2025 Evening Shift or Night Shift. On 04/12/2025 an interview was conducted with Resident #24, he was unable to provide information. Resident #46 Resident was admitted on [DATE] with diagnosis that included: Cerebral Vascular Disease, Long term use of Insulin, Muscle Weakness, Other lack of Coordination, Type 2 Diabetes Mellitus, and Hypertensive Heart Disease. Review of Quarterly MDS, with ARD of 01/22/2025 revealed he had a BIMS 14 indicating he was cognitively intact. Review of Plan of Care for Resident #46 dated 01/28/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the doctor. 2. Problem: Resident is on anticoagulant therapy. Interventions: Administer Anticoagulant medications as ordered by the physician. Monitor for side effects and effectiveness Q Shift. Review of Current Physician's Orders for Resident #46 revealed, in part: 1. Humulin R Insulin Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. 2. Observe closely for side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift. Review of April 2025 Medication Administration Record for Resident #46 revealed, in part: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Humulin R Insulin Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus - no blood sugar documented on 04/27/2025 at 8:00 p.m. 6. Observe closely for side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift - not documented as monitored on 04/27/2025 Evening or Night Shift. On 04/29/2024 at 9: 30 a.m. an interview was conducted with Resident #46. Resident #46 stated that his blood sugar was not monitored on 04/27/2025 at 8:00 p.m. Resident #70 Review of admission Records for Resident #70 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Alzheimer's Disease, Dementia, Type 2 Diabetes Mellitus, Long Term Use of Insulin, Long Term Use of Anticoagulants, and Glaucoma. Review of Quarterly MDS, with ADR revealed Resident #70 had BIMS 9, indicating he had cognitive impairment. Review of Plan of Care for Resident #70 dated 01/28/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the doctor. Review of Current Physician's Orders for Resident #70 revealed, in part: 1. Humalog Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. 2. Observe closely for side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift. Review of April 2025 Medication Administration Record for Resident #70 revealed, in part: 1. Humalog Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus - no blood sugar documented on 04/27/2025 at 8:00 p.m. 2. Observe closely for side effects of Anticoagulant medication including discolored urine, black (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift - not documented as monitored on 04/27/2025 Evening or Night Shift. On 04/29/2025 attempted interview with Resident #70, he was not able to voice any information about care on 04/27/2025 7:00 p.m. to 7:00a.m. On 04/29/2025 at 2:00 p.m., an interview was conducted with S18LPN. S 18 LPN stated she was working in the facility on 04/27/2025 from 7:00 p.m. to 7:00 a.m. She stated she did not get report and did not know she was assigned to Resident #12, Resident #24, Resident #46, or Resident #70, and did not complete blood sugar monitoring, or observations of these residents. On 04/29/2024 an interview was conducted with S2DON. S2DON stateS2DON stated S18LPN was assigned to Resident #12, Resident #24, Resident #46, and Resident #70. S2DON stated she had spoken with S18LPN who confirmed she did not complete blood sugar monitoring or make observations of Resident #12, Resident #24, Resident #46, or Resident #70 on 04/27/2025 during her 7:00 p.m. -7:00 a.m. shift. S2DON reviewed the Medication Administration Records for Resident #12, Resident #24, Resident #46, and Resident #70 and confirmed there was no documentation of blood sugar checks or monitoring for side effects of medications by S18LPN, and should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received fingernail care to maintain good hygiene for 1 (#198) of 3 (#3, #26, and #198) residents reviewed for ADLs. Findings: Review of the facility's policy dated 08/01/2017 and titled, Bath, Bed Policy and Procedure revealed the following, in part: Procedure: 16. Care of fingernails and toenails are part of the bath. Be certain nails are clean. Review of Resident #198's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Malignant Neoplasm of Brain and Traumatic Hemorrhage of Right Cerebrum Without Loss of Consciousness. Further review of the Clinical Record revealed Resident #198 was dependent on staff for ADLs. Review of Resident #198's Bath Documentation dated April 2025 revealed she was scheduled to receive baths on Tuesdays, Thursdays, and Saturdays. Further review revealed she received a bath on 04/29/2025. An observation was made of Resident #198 on 04/28/2025 at 9:04 a.m. Her bilateral fingernails had a black substance underneath. An observation was made of Resident #198 on 04/29/2025 at 8:20 a.m. She was sitting up in bed eating her breakfast. She was eating her French toast stick with her hands. Her fingernails had a black substance under them. An interview was conducted with Resident #198 at that time. She confirmed her fingernails were dirty. She stated she wanted to get in the bath and clean her nails. An observation was made of Resident #198 on 04/29/2025 at 1:11 p.m. Her fingernails had a black substance under them. An interview was conducted with Resident #198 at that time. She stated she had her bath today, but the CNA did not clean under her nails. Resident #198 stated her nails were still dirty. An observation was made of Resident #198's nails with S4LPN present on 04/29/2025 at 1:15 p.m. S4LPN confirmed Resident #198's nails had a black substance underneath them and they needed to be cleaned. S4LPN confirmed Resident #198 was dependent on staff for nail care. An interview was conducted with S5CNA on 04/29/2025 at 1:23 p.m. She stated Resident #198 received a bath today. She stated nail care should have been part of a bath. She confirmed Resident #198 was dependent on staff for ADLs. An interview was conducted with S2DON on 04/29/2025 at 4:04 p.m. She stated the staff should have ensured the cleanliness of residents' nails. She stated resident nail care should have been completed during baths and as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, interviews, and record review, the facility failed to ensure a resident at risk for pressure ulcer development received care consistent with professional standards of practice and based on the comprehensive assessment by failing to float heels while in bed for 1 (#197) of 2 (#8 and #197) residents reviewed with Pressure Ulcers. Findings: Review of the facility's policy dated 11/17/2014 and titled, Pressure Ulcer, Prevention of Policy and Procedure revealed the following, in part: Purpose: To prevent skin breakdown and development of pressure sores. Policy: Pressure Ulcer prevention will be used as ordered and/or as applicable. Procedure: 3. Develop care plan to eliminate or minimize risk factors. d. Pressure relief 7. Use pressure reducing or relieving devices as necessary. Review of Resident #197's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Pressure Ulcer of Sacral Region - Stage 4, Type 2 Diabetes Mellitus without Complications, and Unspecified Severe Protein-Calorie Malnutrition. Review of Resident #197's admission MDS with an ARD of 04/09/2025 revealed a BIMS of 13, which indicated he was cognitively intact. Further review of the MDS revealed he required partial/moderate assistance from staff with rolling from side to side, required substantial/maximal assistance from staff with sitting to lying and lying to sitting, and was at risk for pressure ulcer development. Review of Resident #197's Braden Scale for Predicting Pressure Sore Risk dated 04/16/2025 revealed a score of 15, which indicated he was at risk for pressure ulcer development. Review of Resident #197's current Physician Orders revealed an order to float heels while in bed which started on 04/10/2025. Review of Resident #197's current Care Plan revealed the following, in part: Problem: Risk for impaired skin integrity. Interventions: Utilize pressure relieving devices on appropriate surfaces. An observation was made of Resident #197 on 04/29/2025 at 8:12 a.m. He was lying in bed. His heels were resting on the mattress and not floated. An interview was conducted with Resident #197 at that time. Resident #197 stated the staff had not been floating his heels. (continued on next page)

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	195537	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Care Center	10145 Florida Blvd Baton Rouge, LA 70815

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made of S5CNA performing incontinence care on Resident #197 on 04/29/2025 at 9:30 a.m. Resident #197's heels were resting on the mattress and not floated. An interview was conducted with S6CNA on 04/29/2025 at 10:22 a.m. She confirmed she was Resident #197's CNA on 04/28/2025 from 10:00 p.m. to 6:00 a.m. She confirmed Resident #197's heels were not floated on her shift last night. She confirmed Resident #197 did not refuse to have his heels floated and they should have been floated last night. An observation was made of Resident #197 with S4LPN present on 04/29/2025 at 11:04 a.m. He was lying in bed. His heels were resting on the mattress and not floated. An interview was conducted with S4LPN at that time. S4LPN confirmed Resident #197's heels were not floated. An interview was conducted with S4LPN on 04/29/2025 at 11:25 a.m. She confirmed Resident #197 was at risk for pressure ulcer development and had a physician order to float heels while in bed. She stated Resident #197's heels should have been floated while in bed. An interview was conducted with S5CNA on 04/29/2025 at 1:23 p.m. She confirmed she was Resident #197's CNA from 6:00 a.m. to 2:00 p.m. today. She stated she should have floated Resident #197's heels and had not. An observation was made of Resident #197 on 04/30/2025 at 9:06 a.m. He was lying in bed. His heels were resting on the mattress and not floated. An interview was conducted with S3LPN on 04/30/2025 at 9:29 a.m. She stated Resident #197's mobility status put him at risk for additional pressure ulcer development. She stated Resident #197's heels should have been floated while in bed. An interview was conducted with S2DON on 04/30/2025 at 1:45 p.m. She confirmed Resident #197 was at risk for pressure ulcer development. She confirmed Resident #197's heels should have been floated while in bed to help prevent pressure ulcer development.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide pharmaceutical services, including procedures that assure the dispensing and administering of all drugs and biologicals to meet the needs of each resident. The facility failed to ensure medications were administered for 4 (#12, #24, #46, and #70) of 4 (#12, #24, #46, and #70) residents reviewed for medication administration. Findings: Resident #12 Review of admission Records for Resident #12 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Type 2 Diabetes Mellitus, Hyperlipidemia, and Insomnia. Review of Quarterly MDS (Minimum Data Set), with ARD (Assessment Data Reference) of 01/29/2025 for Resident #12 revealed he had a BIMS of 9, indicating cognitive impairment. Review of Plan of Care for Resident #12 dated 02/24/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the physician. 2. Problem: Resident is on sedative/hypnotic therapy related to insomnia. Intervention: Administer sedative/hypnotic medications as ordered by physician. Review of Current Physician's Orders for Resident #12 revealed, in part: 1. Novolin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus. 2. Lantus Solostar 100 u/ml inject 30 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus. 3. Atorvastatin Calcium Oral Tablet 40 mg give one tablet by mouth at bedtime related to Hyperlipidemia. 4. Melatonin oral tablet 5 mg give one tablet by mouth at bedtime for insomnia. 5. Metoclopramide HCL Oral tablet 5 mg give one tablet by mouth at bedtime for nausea. Review of April 2025 Medication Administration Record for Resident #12 revealed, in part: 1. Novolin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subcutaneously one time a day related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 2. Lantus Solostar 100 u/ml inject 30 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus not documented as administered on 04/27/2025 at 8:00 p.m. 3. Atorvastatin Calcium Oral Tablet 40 mg give one tablet by mouth at bedtime related to Hyperlipidemia - not documented as administered on 04/27/2025 at 8:00 p.m. 4. Melatonin oral tablet 5 mg give one tablet by mouth at bedtime for insomnia - not documented as administered on 04/27/2025 at 8:00 p.m. 5. Metoclopramide HCL Oral tablet 5 mg give one tablet by mouth at bedtime for Nausea - not documented as administered on 04/27/2025 at 8:00 p.m. On 04/29/2025 at 1:00 p.m., an interview was conducted with Resident #12. He stated he did not remember if he received medications on 04/27/2025 at 8:00 p.m. Resident #24 Review of admission Records for Resident #24 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Type 2 Diabetes Mellitus, Schizophrenia, and Hyperlipidemia. Review of Quarterly MDS, with ADR 11/16/2024 for Resident #24 revealed he had a BIMS of 14, indicating he was cognitively intact. Review of Plan of Care for Resident #24 dated 01/28/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Administer Diabetes medications as ordered by the physician. 2. Problem: Resident has risk for behavior problem r/t Schizophrenia Interventions: Administer medications as ordered. 3. Problem: Resident uses psychotropic medications r/t Schizophrenia Interventions: Administer medications as ordered. Review of Current Physician's Orders for Resident #24 revealed, in part: 1. Humulin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus. 2. Lantus Solostar 100 u/ml inject 30 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Atorvastatin Calcium Oral Tablet 20 mg give one tablet by mouth at bedtime related to Hyperlipidemia. 4. Trazadone HCL Oral Tablet 150 mg give one tablet by mouth at bedtime related to Schizophrenia. Review of April 2025 Medication Administration Record for Resident #24 revealed, in part: 1. Humulin R Injection Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0 ; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD , subcutaneously one time a day related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 2. Lantus Solostar 100 u/ml inject 30 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 3. Atorvastatin Calcium Oral Tablet 20 mg give one tablet by mouth at bedtime related to Hyperlipidemia - not documented as administered on 04/27/2025 at 8:00 p.m. 4. Trazadone HCL Oral Tablet 150 mg give one tablet by mouth at bedtime related to Schizophrenia - not documented as administered on 04/27/2025 at 8:00 p.m. On 04/12/2025 at 1:10 p.m., attempted an interview was conducted with Resident #24, he was unable to provide information. Resident #46 Review of admission Records for Resident #46 revealed he was admitted on [DATE] with diagnosis that included: Cerebral Vascular Disease, Long term use of Insulin, Muscle Weakness, Other lack of Coordination, Type 2 Diabetes Mellitus, and Hypertensive Heart Disease. Review of Quarterly MDS, with ARD of 01/22/2025 for Resident #46 revealed he had a BIMS of 14 indicating he was cognitively intact. Review of Plan of Care for Resident #46 dated 01/28/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the physician. 2. Problem: Resident is on anticoagulant therapy. Interventions: Administer Anticoagulant medications as ordered by the physician. Review of Current Physician's Orders for Resident #46 revealed, in part: 1. Humulin R Insulin Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Lantus Solostar 100 u/ml inject 20 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus 3. Eliquis Oral Tablet 2.5 mg give one tablet by mouth two times a day related to Atrial Fibrillation. 4. Atorvastatin Calcium 80 mg tablet give one tablet orally one time a day related to Hyperlipidemia. Review of April 2025 Medication Administration Record for Resident #46 revealed, in part: 1. Humulin R Insulin Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 2. Lantus Solostar 100 u/ml inject 20 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 3. Eliquis Oral Tablet 2.5 mg give one tablet by mouth two times a day related to Atrial Fibrillation - not documented as administered on 04/27/2025 at 8:00 p.m. 4. Atorvastatin Calcium 80 mg tablet give one tablet orally one time a day related to Hyperlipidemia - not documented as administered on 04/27/2025 at 8:00 p.m. On 04/29/2024 at 9:30 a.m., an interview was conducted with Resident #46. Resident #46 stated he was not administered medications on 04/27/2025 at 8:00 p.m., including Humulin R Insulin, Lantus, Eliquis, and Atorvastatin. Resident #70 Review of admission Records for Resident #70 revealed he was admitted to the facility on [DATE] with diagnosis that included, in part: Type 2 Diabetes Mellitus, Long Term Use of Insulin, Long Term Use of Anticoagulants, and Glaucoma. Review of Quarterly MDS, revealed he had a BIMS of 9, indicating cognitive impairment. Review of Plan of Care for Resident #70 dated 01/28/2025 included, in part: 1. Problem: Resident has Diabetes Mellitus Interventions: Diabetes medications as ordered by the physician. 2. Problem: Resident is on anticoagulant therapy. Interventions: Administer Anticoagulant medications as ordered by the physician. Review of Current Physician's Orders for Resident #70 revealed, in part: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Humalog Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. 2. Lantus Solostar 100 u/ml inject 25 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus 3. Eliquis Oral Tablet 5 mg give one tablet by mouth two times a day related to Chronic Embolism and Thrombosis of Unspecified Deep Veins of Left Proximal Lower Extremity. 4. Latanoprost Ophthalmic Solution 0.005% instill 1 drop in both eyes at bedtime related to Glaucoma. 5. Ropinirole HCL oral tablet 0.5mg give one tablet by mouth at bedtime related to abnormalities of gait and mobility. Review of April 2025 Medication Administration Record for Resident #70 revealed, in part: 1. Humalog Subcutaneous Solution 100u/ML. Inject as per sliding scale: If 0-200 units = 0, if blood sugar is less than 60 give sugar/juice and recheck in 30 minutes and notify MD; 201-250=4 units; 251-300 = 6 units; 301-400 = 8 units; 401-450 = 10 units; 451-999 = 12 units and call MD recheck in 30 minutes, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 2. Lantus Solostar 100 u/ml inject 25 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus - not documented as administered on 04/27/2025 at 8:00 p.m. 3. Eliquis Oral Tablet 5 mg give one tablet by mouth two times a day related to Chronic Embolism and Thrombosis of Unspecified Deep Veins of Left Proximal Lower Extremity - not documented as administered 04/27/2025 at 8:00 p.m. 4. Latanoprost Ophthalmic Solution 0.005% instill 1 drop in both eyes at bedtime related to Glaucoma - not documented as administered on 04/27/2025 at 8:00 p.m. 5. Ropinirole HCL oral tablet 0.5mg give one tablet by mouth at bedtime related to abnormalities of gait and mobility - not documented as given on 04/27/2025 at 8:00 p.m. On 04/29/2025 at 1:15 p.m., attempted an interview with Resident #70; he was not able to voice any information about care on 04/27/2025 7:00 p.m.-7:00 a.m. On 04/29/2025 at 2:00 p.m., an interview was conducted with S18LPN. S18LPN stated she was working in the facility on 04/27/2025 from 7:00 p.m. to 7:00 a.m. She stated she did not get report for Resident #12, Resident #24, Resident #46, or Resident #70, and did not administer medications for any of the above mentioned residents. On 04/29/2024 an interview was conducted with S2DON. S2DON stated she had spoken with S18LPN, and S18LPN confirmed she did not administer medications for Resident #12, Resident #24, Resident #46 , or Resident # 70 during her 7:00 p.m. -7:00 a.m. shift on 04/27/2025. S2DON reviewed the Medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Records for Resident #12, Resident #24, Resident #46, and Resident #70 and confirmed the residents were not administered their 8:00 p.m. medications on 04/27/2025 by S18LPN, and should have been.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, record review and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure: 1. An insulin pen was labeled with an opened date for Resident #82 during an observation of medication administration; 2. Eye Drops were labeled with an opened date on 1(Med Cart b) of 2 (Med Cart a and Med Cart b) medication carts reviewed; and 3. Insulin pens were labeled with an opened date on 1(Med Cart b) of 2 (Med Cart a and Med Cart b) medication carts reviewed. This deficient practice had the potential to affect all of the 98 residents residing in the facility. Findings: On 04/28/2025 at 11:39 a.m., during an observation of medication pass with S17LPN, Resident #82's Novolog FlexPen Subcutaneous Solution Pen was observed to not contain an opened date. On 04/28/2025 at 11:39 a.m., an interview was conducted with S17LPN. S17LPN confirmed Resident #82's Novolog FlexPen Subcutaneous Solution Pen did not have an opened dated and she did not know when the pen was opened. On 04/28/2025 at 12:00 p.m., an observation was made of Med Cart b with S4LPN which revealed the following: Resident #30's Lantus SoloStar Subcutaneous Solution Pen-Injector was opened and had no opened date; and Resident #147's Latanoprost Ophthalmic Solution 0.005% was opened and had no opened date. On 04/28/2025 at 12:00 p.m., an interview was conducted with S4LPN. S4LPN confirmed there was no opened date on Resident #30's Lantus SoloStar Subcutaneous Solution Pen-Injector. S4LPN confirmed she did not know the date when the pen was opened. S4LPN confirmed insulin pens should have an opened date. S4LPN confirmed Resident #147's Latanoprost Ophthalmic Solution 0.005% had no opened date. On 04/29/2025 at 10:37 a.m., an interview was conducted with S2DON. S2DON confirmed nurses were expected to date insulin pens and eye drops when they are opened.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure S16LPN completed and accurately documented interventions on the Medication Administration Record (MAR) for 1 (#94) of 3 (#93, #94, and #95) residents reviewed as closed records. Findings: Review of Resident #94's clinical record revealed the resident was re-admitted to the facility on [DATE] and had diagnoses which included Acute Respiratory Failure with Hypercapnia, Anxiety Disorder, Hypertensive Heart Disease without Heart Failure, and Amyotrophic Lateral Sclerosis. Review of Resident # 94's MAR dated February 2025 revealed the following, in part: Catheter - document the amount of urine output every 8 hours total every shift - No documentation for the day shift on 02/22/2025; Catheter - urine clarity . every shift - No documentation for the day shift on 02/22/2025; Catheter - urine color . every shift - No documentation for the day shift on 02/22/2025; Catheter - urine odor . every shift - No documentation for the day shift on 02/22/2025; Document non-pharmacological interventions implemented during shift . every shift - No documentation for the day shift on 02/22/2025; Enteral Feeding Order every shift Enteral: Check and record residuals every (q) shift. Contact physician if residual exceeds 100 cubic centimeter. - No documentation for the day shift on 02/22/2025; Enteral Feed Order every shift Enteral: check the placement before the initiation of formula, medication administration, and flushing tube or at least q 8 hours. - No documentation for the day shift on 02/22/2025; Enteral Feeding Order every shift Enteral: Document the amount of formula and water provided q 8 hours - total intake q 24 hours - No documentation for the day shift on 02/22/2025; Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. - No documentation for the day shift on 02/22/2025; Observe closely for side effects of Diuretic medication every shift. -No documentation for the day shift on 02/22/2025; and Observe closely for significant side effects of anti-anxiety medication . every shift - No documentation for the day shift on 02/22/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts were made to interview S16LPN and were unsuccessful. On 04/30/2025 at 11:08 a.m., an interview was conducted with S2DON. S2DON confirmed S16LPN cared for Resident #94 on the day shift of 02/22/2025. S2DON reviewed Resident #94's February MAR and confirmed S16LPN did not document on the aforementioned findings. S2DON confirmed she expected nurses to document interventions if they completed them.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection. The facility failed to ensure staff performed hand hygiene and proper glove use for 11 (#3, #14, #20, #26, #30, #33, #39, #54, #61, #65, and #67) of 13 (#3, #4, #14, #20, #26, #30, #33, #39, #54, #61, #65, #67, and #80) resident's observed for incontinence care. Findings: Review of the facility's policy titled, Perineal Care Policy and Procedure with an effective date of 11/17/2015, revealed the following, in part: Purpose: 2. To prevent infection . Procedure: 5. Wash hands. 6. Put on disposable gloves. 13. Female perineal care. 14. Male perineal care. 20. Remove gloves. Wash hands. 21. Replace top bed linen as appropriate. 22. Make resident comfortable and or reposition resident as appropriate. Review of the facility's policy titled, Hand Hygiene Policy and Procedure with an effective date of 07/01/2020, revealed the following, in part: Purpose: 1. To provide guidance and procedure to hand hygiene when providing direct care to residents. 2. To reduce the potential transmission of germs to residents. Policy: Hand hygiene shall be performed: 3. Before and after direct resident contact for which hand hygiene is indicated by acceptable professional practice. 22. After removing gloves . (continued on next page)

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	195537	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Care Center	10145 Florida Blvd Baton Rouge, LA 70815

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	23. If hands will be moving from a contaminated body site to a clean body site during patient care. Resident #3 Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #3's Care Plan revealed the following, in part: Problem: 10/15/2024-Bladder incontinence related to Cerebrovascular Accident with left sided hemiplegia Intervention: Clean peri-area with each incontinence episode. On 04/29/2025 at 12:23 a.m., an observation was made of S9CNA performing incontinence care for Resident #3. Without performing hand hygiene, S9CNA donned clean gloves, unfastened Resident #3's brief, cleaned urine from Resident #3's perineal area with perineal wipes, assisted Resident #3 to turn to the right side and cleaned Resident #3's perineum and buttocks with perineal wipes. S9CNA removed the soiled gloves and without performing hand hygiene donned clean gloves. S9CNA applied a clean brief, assisted Resident #3 to turn to the left side, and removed the soiled brief. Wearing the same gloves, S9CNA fastened the clean brief, adjusted the bed linens, placed a pillow under Resident #3's left leg, picked up the bed remote and raised the head of bed, moved the bedside table in reach, removed the gloves, and washed her hands. Resident #14 Review of Resident #14's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #14's Care Plan revealed the following, in part: Problem: 02/21/2025-Risk for Urinary Tract Infection . Intervention: Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas. On 04/29/2025 at 12:48 a.m., an observation was made of S6CNA performing incontinence care for Resident #14. Without performing hand hygiene, S6CNA donned cleaned gloves, unfastened Resident #14's brief, cleaned urine from Resident #14's perineal area with perineal wipes and assisted Resident #14 to turn to the right side. Wearing the same gloves, S6CNA cleaned feces from Resident #14's perineum and buttocks with perineal wipes and removed her left soiled glove. Without performing hand hygiene, S6CNA donned a clean left glove and continued to clean feces from Resident #14's perineum and buttocks with perineal wipes and removed her left soiled glove. Without performing hand hygiene, S6CNA again donned a clean left glove and continued to clean feces from Resident #14's perineum and buttocks with perineal wipes, removed the soiled brief and placed it in the trash can and removed both soiled gloves. Without performing hand hygiene, S6CNA donned clean gloves, applied a protective barrier cream to Resident #14's buttocks and perineum and placed a clean brief underneath Resident #14. Without performing hand hygiene, S6CNA removed the soiled gloves, donned clean gloves, assisted Resident #14 to turn to the left side, then her back and fastened the clean brief. S6CNA adjusted Resident' #14's bed linens, pillows, elevated the head of the bed and placed the call light in reach. S6CNA removed her gloves, without performing hand hygiene, picked up the trash bag and exited the room, placing the trash bag in a grey barrel and then sanitized her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #20 Review of Resident #20's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #20's Care Plan revealed the following, in part: Problem: 01/08/2025 - Resident has bladder incontinence related to activity intolerance Intervention: Change every 2 hours and as needed. Clean peri area with each incontinent episode. Incontinent: check every 2 hours and as required for incontinence. Wash hands, rinse, and dry perineum. On 04/29/2025 at 12:52 a.m., an observation was made of S14CNA performing incontinence care for Resident #20. S14CNA donned clean gloves and removed Resident #20's wet brief. Wearing the same soiled gloves, S14CNA cleaned Resident #20's perineal area, assisted Resident #20 in turning to the opposite side and removed the brief from Resident #20. Without performing hand hygiene or removing soiled gloves, S14CNA placed a clean brief under Resident #20 and assisted Resident #20 in turning back over, fastened both sets of tabs on the brief, straightened Resident #20's gown and pulled the comforter over her. S14CNA removed her gloves and performed hand hygiene before exiting the room. Resident #26 Review of Resident #26's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #26's Care Plan revealed the following, in part: Problem: 02/07/2025-Bowel incontinence Intervention: Provide pericare after each incontinent episode Problem: 02/07/2025-Bladder incontinence Intervention: Clean peri-area with each incontinence episode On 04/29/2025 at 12:32 a.m., an observation was made of S9CNA performing incontinence care for Resident #26. Without performing hand hygiene, S9CNA donned clean gloves, unfastened the brief, assisted Resident #26 to turn to the left side, cleaned feces from Resident #26's perineum with perineal wipes, removed the soiled gloves. Without performing hand hygiene, S9CNA donned clean gloves, placed a clean brief underneath Resident #26, assisted her to turn to the right side, removed the soiled brief and placed it in the trash can. Wearing the same soiled gloves, S9CNA fastened the clean brief, assisted Resident #26 to her back, and adjusted her gown, pillows, linens and head of bed with the bed remote. S9CNA picked up the trash bag, removed her gloves and washed her hands. Resident #30 Review of Resident #30's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #30's Care Plan revealed the following, in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Problem: 01/31/2025-Bowel incontinence Intervention: Provide pericare after each incontinent episode Problem: 01/31/2025-Bladder incontinence Intervention: Clean peri-area with each incontinence episode On 04/29/2025 at 1:00 a.m., an observation was made of S6CNA performing incontinence care for Resident #30. Without performing hand hygiene, S6CNA donned cleaned gloves, unfastened Resident #30's brief, cleaned urine from Resident #30's perineal area with perineal wipes and assisted Resident #30 to turn to the right side. S6CNA removed the soiled brief, placed it in the trash can and removed the soiled gloves. Without performing hand hygiene, S6CNA donned clean gloves, placed a clean brief underneath Resident #30, applied protectant barrier ointment with her left gloved hand and removed the left soiled glove. Without performing hand hygiene, S6CNA donned a clean glove to her left hand, assisted Resident #30 to turn on her back and fastened the brief. S6CNA removed the gloves, adjusted the height and head of the bed with the bed remote, adjusted the linens, picked up the trash bag and exited the room placing it in the grey barrel in the hall, and then sanitized her hands. Resident #33 Review of Resident #33's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #33's Care Plan revealed the following, in part: Problem: 10/15/2024 - Resident has bladder incontinence related to Alzheimer's Intervention: Clean peri-area with each incontinence episode, Check every 2 hours and as required for incontinence. Wash rinse and dry perineum. Problem: 02/18/2025 - Resident has bowel incontinence Intervention: Check resident every 2 hours and assist with toileting as needed, Provide pericare after each incontinent episode. On 04/29/2025 at 12:25 a.m., an observation was made of S13CNA performing incontinence care for Resident #33. S13CNA performed hand hygiene, donned clean gloves and cleaned Resident #33's perineal area. Wearing the same soiled gloves, S13CNA placed a clean brief beneath Resident #33, fastened the brief's tabs, turned Resident #33 to her other side and fastened the brief's second set of tabs, adjusted Resident #33's gown and placed the comforter over her. S13CNA then removed her gloves and performed hand hygiene. Resident #39 Review of Resident #39's Clinical Record revealed he was admitted to the facility on [DATE]. Review of Resident #39's Care Plan revealed the following, in part: Problem: 02/25/2025 - Resident requires staff assistance for ADL care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #61's gown and covered her with the comforter. S14CNA then removed her gloves and performed hand hygiene. Resident #65 Review of Resident #65's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #65's Care Plan revealed the following, in part: Problem: 09/20/2024-Bladder incontinence Intervention: Clean peri-area with each incontinence episode On 04/29/2025 at 12:10 a.m., an observation was made of S9CNA performing incontinence care for Resident #65. Without performing hand hygiene, S9CNA donned clean gloves, cleaned Resident #65's perineal area with perineal wipes and assisted Resident #65 to turn to the right side, and cleaned feces from Resident #65's perineum and buttocks with perineal wipes. S9CNA removed her soiled gloves, without performing hand hygiene, opened the room door, went to the linen cart and removed more perineal wipes. S9CNA entered Resident #65's room and closed the door. Without performing hand hygiene, S9CNA donned clean gloves and continued to clean feces from Resident #65's perineum and buttocks with perineal wipes. S9CNA removed the soiled brief and placed it in the trash can. Wearing the same soiled gloves, S9CNA applied a clean brief underneath Resident #65, turned the resident to the left side, adjusted the pads and sheets underneath Resident #65, fastened the brief, adjusted Resident #65's gown, bed linens, picked up the bed remote and elevated the height and head of bed. S9CNA removed her soiled gloves, picked the trash bag out of the trash can, opened the room door, placed the bag in the grey barrel and then washed her hands. Resident #67 Review of Resident #67's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #67's Care Plan revealed the following, in part: Problem: 10/04/2024 - Resident has bowel incontinence related to dementia Interventions: Provide pericare after each incontinent episode Problem: 10/03/2024 - Resident has bladder incontinence related to Dementia Intervention: Clean peri-area with each incontinence episode On 04/29/2025 at 12:14 a.m., an observation was made of S13CNA performing perineal care for Resident #67. S13CNA performed hand hygiene, donned clean gloves, cleaned urine from Resident #67's perineal area, and removed Resident #67's wet brief. Then using the same soiled gloves and without performing hand hygiene, S13CNA placed a clean brief beneath Resident #67, turned Resident #67 to her other side, pulled the brief fully beneath her, fastened the tabs, adjusted Resident #67's clothes and pulled the comforter over her. S13CNA then removed her gloves and performed hand hygiene. On 04/29/2025 at 12:33 a.m., an interview was conducted with S13CNA. S13CNA confirmed the above (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observations for Resident #s 33, 39, and 67 and stated she should have performed hand hygiene and changed her gloves during resident care when going from dirty to clean. On 04/29/2025 at 12:40 a.m., an interview was conducted with S9CNA. S9CNA stated hand hygiene should be performed before, sometimes during, and after resident care. S9CNA confirmed the above observations for Resident #3, Resident #26, and Resident #65. S9CNA confirmed she should have performed hand hygiene before resident care and during resident care when going from dirty to clean. On 04/29/2025 at 1:03 a.m., an interview was conducted with S14CNA. S14CNA confirmed the above observations for Resident #s 20, 54, and 61 and stated she should have performed hand hygiene and changed her gloves during resident care when going from dirty to clean. On 04/29/2025 at 1:05 a.m., an interview was conducted with S6CNA. S6CNA stated hand hygiene should be performed before and after resident care. S6CNA confirmed the above observations for Resident #14 and Resident #30. S6CNA confirmed she should have performed hand hygiene when changing her gloves and during resident care when going from dirty to clean. On 04/29/2025 at 1:30 a.m., an interview was conducted with S2DON. S2DON stated staff should perform hand hygiene before and after incontinence care for residents. S2DON confirmed staff should perform hand hygiene during incontinence care when going from dirty to clean. S2DON stated she would expect staff to change their gloves after providing perineal care and when going from dirty to clean.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure there was a functioning call system to allow residents to call for staff assistance for 1 (#26) of 5 (#1, #14, #26, #79, and #197) residents reviewed for environment. This deficient practice had the potential to affect any of the 98 residents residing in the facility who utilized the call light system. Findings: Review of the facility's policy titled, Resident Call Light System Policy and Procedure with an effective date of 09/14/2022, revealed the following, in part: Purpose: 1. To provide a communication system with audible or visual signals to allow residents to call for staff assistance from their bedsides . The communication system should relay the call directly to a centralized staff work area. 3. To assure call system is in proper working order. Review of the facility's Daily Maintenance Log dated April 2025 revealed the following, in part: Date of Issue: 04/27/2025, Location: Resident #26's room, Maintenance Issue: Call light won't turn off. Date of Issue: 04/27/2025, Location: Resident #26's room, Maintenance Issue: Light-call keeps going off-Resident #26. Review of Resident #26's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #26's Quarterly MDS with an ARD of 03/19/2025 revealed a BIMS of 14, which indicated she was cognitively intact. Further review revealed Resident #26 required staff assistance with toileting and personal hygiene. On 04/28/2025 at 10:48 a.m., an interview was conducted with Resident #26. She stated her call light stopped working yesterday, on 04/27/2025. She stated staff tried to fix it, but could not. A piece of tape was observed on the call light box on the wall. There were two call light cords observed in Resident #26's room in reach. Each call light was tested by Resident #26 and the surveyor and both were observed not to function or illuminate outside of the room. On 04/28/2025 at 11:35 a.m., an observation was made of Resident #26's call lights with S12CNAS. She stated Resident #26 was oriented and able to use her call light. She tested the call light and confirmed the call light did not function or illuminate outside of the room for Resident #26. She reviewed the Maintenance Log book and confirmed there were two entries dated 04/27/2025 for Resident #26's call light not functioning. She stated staff should have contacted S10MS when Resident #26's call light stopped functioning on 04/27/2025. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/2025 at 11:47 a.m., an observation was made of Resident #26's call lights with S10MS and S11FT. S10MS and S11FT confirmed the call light did not function or illuminate outside of the room for Resident #26. On 04/29/2025 at 12:50 p.m., an interview was conducted with S10MS. He stated he reviewed the Maintenance Log book on the morning of 04/28/2025 and saw two entries dated 04/27/2025 for Resident #26's call light not functioning. He stated he was not notified by staff on 04/27/2025 about Resident #26's call light. He stated he assessed the call light around 8:30 a.m. on 04/28/2025 and confirmed it was not functioning. He stated staff should have notified him or S1ADM on 04/27/2025 about Resident #26's call light not functioning. On 04/29/2025 at 3:02 p.m., a telephone interview was conducted with S8LPN. She verified she worked on 04/27/2025 from 7:00 p.m. to 7:00 a.m. and was assigned to Resident #26. She stated Resident #26 required staff assistance with ADLs and used her call light. She stated during her shift on 04/27/2025, Resident #26's call light was broken. She stated the call light stayed on, kept alarming and would not turn off. She stated she placed tape on the call light box in Resident #26's room to keep it from alarming. She confirmed she did not contact S10MS or Administrative staff about Resident #26's call light not functioning. She stated she documented the call light issue in the Maintenance Log book knowing S10MS would be at the facility in the morning, on 04/28/2025. On 04/30/2025 at 8:32 a.m., a telephone interview was conducted with S7LPN. She verified she worked on 04/27/2025 from 7:00 a.m. to 7:00 p.m. and was assigned to Resident #26. She stated Resident #26 required staff assistance with ADLs and used her call light. She stated during her shift on 04/27/2025, sometime after lunch, Resident #26's call light broke, would not turn off, she tried to repair it, but could not. She stated she documented the call light issue in the Maintenance Log book at the nurses' station. She confirmed she did not contact S10MS or Administrative staff about Resident #26's call light not functioning. On 04/30/2025 at 12:05 p.m., an interview was conducted with S1ADM and S2DON. S2DON stated when a resident had a non-functioning call light, staff should write the issue in the Maintenance Log book and contact the Maintenance Supervisor. S2DON stated if the Maintenance Supervisor did not answer, S1ADM should be notified. S1ADM and S2DON stated they were made aware of Resident #26's call light not functioning on 04/28/2025 by S10MS after he reviewed the Maintenance Log book. S1ADM and S2DON confirmed staff should have contacted S10MS or S1ADM on 04/27/2025 to address Resident #26's nonfunctioning call light.