STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195396	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BERNICE NURSING AND REHABILITATION CENTER, LLC	**101 REEVES STREET BERNICE, LA 71222**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations and interviews, the facility failed to maintain an infection prevention and control program designated to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections as evidenced by, 1) S3CNA (Certified Nursing Assistant) placing her contaminated PPE (Personal Protective Equipment) on a table designated for clean PPE supplies and 2) S4Housekeeping entering the designated unit where Covid-19 positive residents resided when he was not assigned to work the area and entering without donning the proper PPE. Findings: On 07/06/2020 at 10:35AM, an interview was conducted with S1Administrator. A request was made for an observation of the secured unit that was designated for Covid-19 residents. The area was viewed via the facility's video surveillance camera system with S1Administrator present and operating the video surveillance camera. She revealed that the unit had a storage room for the staff to go into and get their PPE (Protective Personal Equipment) supplies and to store any reusable supplies such as face shields and facemasks. An observation of the room via the video surveillance camera revealed a table that had one two compartment storage container, one three compartment storage container, and one canister of disinfectant wipes that were located on the table top. S1Administrator revealed that the three compartment storage container was used to store clean PPE items such as facemasks and gowns. She further revealed that the two compartment container was used to store clean disposable gloves. During the observation, a staff member was observed walking into the storage room. She sat down at the table that contained the wipes and clean PPE supplies. The staff member removed her hair cover and facemask. She placed the contaminated PPE items on and in direct contact with the table top. She then began to eat a food item. S2DON (Director of Nursing) was present and identified the staff member as S3CNA, an agency worker. After S3CNA finished eating, she retrieved the hair cover and facemask and left the storage room area. Further observation revealed a second, small round table in the storage room. S1Administrator revealed that it was designated for staff use. S1Administrator confirmed that S3CNA should not have placed her contaminated hair cover and facemask on the table top with the clean PPE supplies. Further observation of the designated Covid-19 unit was conducted via the video surveillance camera system. An observation revealed a staff member entering the secure unit, walking past the nurses' station, and down the hallway that was designated for the housing of Covid-19 positive residents. The worker had a facemask and gloves on at that time. S1Administrator identified the worker as S4Housekeeping. She revealed that S4Housekeeping was not designated to work the Covid-19 unit at that time and that all staff entering the unit were to retrieve their PPE supplies which included hair covers, face shields, facemask, shoe covers, gloves, and gowns from the storage room prior to entering the hallway. She confirmed that S4Housekeeping should not have been in the secured unit as he was not assigned to work the unit and he did not have the proper PPE on. On 07/06/2020 at 12:40PM, An interview with S4Housekeeping was conducted. He was questioned regarding the observation in the unit. He revealed that he was taking another worker something. S4Housekeeping revealed that he was not assigned to work the Covid-19 area in the secured unit and was not supposed to go back and forth from the unit to the non-Covid areas. S4Housekeeping further revealed that housekeeping staff assigned to work the Covid -19 unit had to stay on the unit during their shifts.

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.