STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NOTTINGHAM REGIONAL REHAB CENTER	**2828 WESTFORK BATON ROUGE, LA 70816**

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 observation and interviews the facility failed to ensure staff maintained CDC recommended guidelines for COVID-19 prevention, by failing to ensure staff implemented universal use of facemasks while in the facility as evidenced by observations of 7 (S3LPN, S4CNA, S5HSK, S6AD, S7WC, S8T, and S9D) staff removing or improperly wearing masks while in the facility. Findings: On 05/05/2020 at 3:35 p.m., an observation was made of S7WC preparing to screen masked surveyor for entry into the facility. Surveyor was held in the facility library for the screening process. S7WC gathered a no touch thermometer and the screening binder. S7WC entered the library and began the screening process. S7WC was approximately 4-5 feet from masked surveyor, asked screening questions, and recorded responses. S7WC took surveyor temperature and documented the result. S7WC was not wearing a mask during the screening process. On 05/05/2020 at 3:35 p.m., S7WC was observed speaking to a vendor from the facility entrance without a mask. S2RN's attention was called to S7WC not wearing a mask. S2RN called out to S7WC asking where her mask was. S7WC immediately left the facility entrance/lobby without responding to S2RN's question. S2RN was noted to document in her notes. On 05/05/2020 at 3:40 p.m., an observation was made of S8T in the Ward Clerk station without a mask. S2RN approached the Ward Clerk station with surveyor. An observation was simultaneously made of S6AD walking towards the Ward Clerk station. S6AD's mask was improperly placed under the nose with nares exposed. S6AD was observed to adjust the mask into proper position upon realizing the observation had been made. S6AD did not perform hand hygiene. As surveyor and S2RN arrived to the Ward Clerk station, Resident #R7 was observed sitting in a Gerichair in the station. S2RN was observed to document the occurrence. S2RN questioned S8T about the absence of her mask. S8T's response was not audible. On 05/05/2020 at 3:41 p.m., an interview was conducted with S6AD. An inquiry was made to S6AD regarding the improperly placed mask. S6AD stated, I forgot. On 05/05/2020 at 4:01 p.m., an interview was conducted with S5HSK. S5HSK was wearing a mask. During the interview, S5HSK was observed to pull the mask down to the chin and exposing the mouth and nose. S5HSK completed the interview with the mask improperly placed. S5HSK stated the mask had been pulled down because it impaired the ability to talk. On 05/05/2020 at 4:11 p.m., an observation was made of S4CNA standing in a residential hallway with a mask improperly placed on the chin with the mouth and nose exposed. On 05/05/2020 at 4:22 p.m., an observation was made of S4CNA standing in a residential hallway with a mask improperly placed on the chin with the mouth and nose exposed. On 05/05/2020 at 4:23 p.m., an interview was conducted with S4CNA. S4CNA stated the mask had been pulled down to catch a breath and a need to come up for air. S4CNA stated staff were supposed to wear a mask at all times while in the facility. On 05/05/2020 at 5:00 p.m., an observation was made of S3LPN sitting behind a nurse's station without a mask. S3LPN was observed to communicate with a masked resident from across the partition of the nurse's station. S3LPN was observed to use the telephone. On 05/05/2020 at 5:05 p.m., an interview was conducted with S3LPN. S3LPN was not wearing a mask. S3LPN stated staff are supposed to wear masks at all times. S3LPN stated the mask had been removed to conduct a telephone call. On 05/11/2020 at 11:49 p.m., a video observation of the kitchen was made with S2RN from a cellular device. S2RN directed the camera into the kitchen. Self-contained meal tray delivery carts were noted to be lined up for loading. Dietary staff were observed to load resident lunch meals into the meal delivery carts. S9D was observed wearing a mask improperly placed under the nose with nares exposed. S9D was observed to obtain disposable-lidded meal containers from an area of the kitchen and place them onto the meal cart. S2RN asked S9D if the mask were improperly placed. S9D was observed to adjust the mask to cover the nose and walked behind a wall in the kitchen. S2RN was heard conducting a conversation with an individual not visible on the screen. S2RN was heard explaining S9D was wearing a mask with the nose/nares exposed.

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.