STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195272	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEFFERSON HEALTHCARE CENTER	**2200 JEFFERSON HWY JEFFERSON, LA 70121**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to consistently implement CDC guidelines to help prevent COVID-19 by failing to ensure: 1.) A nurse (S3LicensedPracticalNurse (LPN) wore an isolation gown, and eye protection when entering a resident's room who was in isolation precautions (Resident #1); 2.) An ice chest was not contaminated when a resident (Resident#6) scooped her ice from the ice chest for ice and dropped the scooper into the ice chest; 3.) A nurse (S2 Assistant Director of Nursing (ADON) exited a resident's room who was in isolation (Resident #1) with an isolation gown and gloved hands and proceeded to the isolation cart and sanitized her gloved hands and reached into the isolation cart; 4.) All staff (S4CertifiedNursingAssistant (CNA), S5TrustManager, S6Admissions, S7Admissions, S8WardClerk, and S9LaundryRoomAide) wear face masks according to guidelines. This deficient practice was identified for 1(Resident #1) of 5 sampled residents and 8 (S2ADON, S3LPN, S4CNA, S5TrustManager, S6Admissions, S7Admissions, S8WardClerk, and S9Laundry Aide) of 8 staff identified for compliance with COVID-19 infection control practices. This deficient practice had the potential to affect any of the 140 residents documented on the facility's census. Findings: Review of the facility's policy on COVID-19 Guidance for Admission and Care of COVID-19 for Residents under Red, Yellow and Green designations revealed in part, Yellow-any resident who is newly admitted , hospital returns, or any resident who leaves the facility and returns for any reason, any green level resident that develops symptoms (fever, new cough flulike symptoms, etc.), and any roommate of a positive patient. A resident will be considered yellow quarantine for a period of 14 days. If they have no symptoms after 14 days they may convert to green. Further review of the facility's policy revealed any staff entering a yellow room should be wearing PPE (personal protective equipment) appropriate for droplet precautions to include N-95 or K-95 mask (special type of mask that prevents virus droplets from entering), surgical mask overlay gown and eye protection. Review of the Centers for Medicare and Medicaid Services (CMS) Memo dated 05/18/2020 recommendations for states revealed in part, all staff wear all appropriate personal protective Equipment (PPE) when indicated. Further review revealed staff wear cloth face coverings if not indicated, such as administrative staff. Review of the Centers of Disease Control (CDC's) guidelines for Healthcare Workers Preparing for COVID-19 in Nursing Homes dated 06/25/2020 revealed in part, healthcare workers should wear a face mask at all times when they are in the facility. Review of the facility's list of current COVID-19 positive residents as of 06/29/2020 revealed there were three (3) residents located on the COVID-19 unit as of having a positive COVID-19 test. Resident #1 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Observation 06/29/2020 at 10:45am revealed on Resident #1's door the following signage: Resident on Yellow, Anyone entering this room must be wearing PPE: gloves, N95mask, gown, and eye protection. Aggressive hand hygiene upon exiting and all equipment disposed in biohazard bag or decontaminated if reusable. Further observation revealed S3Licensed Practical Nurse (LPN) exiting Resident #1's room. In an interview on 06/29/2020 at 10:45am, S3LPN when the surveyor questioned him regarding whether he had an isolation gown on while in Resident#1's room, he indicated he did not. Observation on 06/29/2020 at 10:48am revealed S3LPN at the isolation cart, sanitizing his hands, placing an isolation gown on and gloves. Further observation revealed no eye protection in place on his face. Observation 06/29/2020 at 10:50am revealed S3LPN entered Resident #1's room with a face mask, gloves, and gown in place. Further observation revealed no eye protection in place. In an interview on 06/29/2020 at 11:05am, when the surveyor questioned S3LPN why he was not wearing an isolation gown when he entered Resident #1's room earlier he said he was not wearing an isolation gown, he said I was not thinking. He acknowledged he should have been wearing an isolation gown when he entered Resident#1's room. Observation on 06/29/2020 at 11:25am revealed an ice chest unattended in the a hallway. Further observation revealed Resident #6 walk with her walker to the ice chest. Further observation revealed Resident #6 to take the scooper and dip the scooper into the ice chest to fill her metal container with ice. She placed her metal container above the ice while she scooped ice into her cup. Further observation revealed she then dropped the scooper into the ice chest and closed the top of the chest. Further observation revealed no facility staff present. In an interview on 0629/2020 at 11:30am, S2Assistant Director of Nursing acknowledged Resident #6 should not have been scooping her own ice, the scooper should not be put in the ice chest and she acknowledged it was an infection control issue. She further acknowledged S3LPN should have been wearing an isolation gown and proper PPE when entering an isolation room. Observation on 06/29/2020 at 12:15pm while in the clean area of Laundry Room revealed S9LaundryRoomAide without a facial mask while handling clean linen. In an interview on 06/29/2020 at 12:30pm with S10Laundry/Housekeeping Supervisor acknowledged S9Laundry Room Aide should have been wearing a facial mask. Observation on 06/29/2020 at 12:45pm, S2ADON entered into Resident #1's isolation room with an isolation gown, mask, goggles, and gloves. Further observation after a few minutes passed revealed she then exited Resident #1's room with the isolation gown still on, face mask, goggles gloves and walked over to the isolation cart down the hallway. Before touching the draw to the isolation cart she reached up to the hand sanitizer located on top of the cart, and sanitized her gloved hands with sanitizer then proceeded to remove a soft white object off the cart. She then proceeded back into Resident #1's room. In an interview on 06/29/2020 at 1:51pm, S2ADON indicated the Medical Director wants [MEDICAL TREATMENT] residents in yellow isolation due to these residents leave the building at least 3 times weekly. Observation on 06/30/2020 at 9:10am of office b revealed S5TrustManager and S6Admissions with no facial masks. Further observation at 9:18am revealed S6Admissions without a facial mask sitting within 3 feet of S7Admissions. Observations on 06/30/2020 at 9:12am, 9:14 am, 9:16am, 9:20am and 9:27am on hallway a revealed S8WardClerk without a facial mask which was hanging from her ear while sitting at the nurse's station. Observation on 07/01/2020 at 08:30am, while this surveyor was walking through the activity room revealed S4CNA sitting in the activity room sitting at a table placing pegs in a table game. Further observation revealed a plastic drink bottle with cup upside down over it. Further observation revealed her face mask to be around her neck and not on her face. Observation on 07/01/2020 at 8:35am while the surveyor walked into the activity room revealed S4CNA sitting at the activity room at the table with a table game, placing pegs in the game board. Further observation revealed no face mask on but it was around her neck. Further observation revealed no food around her only a plastic bottled drink with a cup upside down on it. In an interview on 07/01/2020 at 8:35am, when the surveyor asked her about whether or not she should be wearing her facemask, she indicated she was eating and forgot to put it back on. Observations on 07/01/2020 at 9:00am and 9:20am of office b revealed S6Admissions and S7Admissions in the administrative office with facial masks pulled under their chins not covering their mouths or noses while sitting within 3 feet from one another. In an interview on 07/01/2020 at 12:30pm, S1Administrator acknowledged S3/LPN should have been wearing an isolation gown when entering an isolation room. When the surveyor indicated observing a resident getting her own ice and dropping the scooper back in the ice chest and he further indicated he was surprised to hear this because the CNA's are usually on top of that. S1Administrator was notified of the findings of employees without face masks.

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.