STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195460	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELLE TECHE NURSING & REHABILITATION CENTER	**1306 W ADMIRAL DOYLE DR NEW IBERIA, LA 70560**

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 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility was not administered in a manner that enabled it's resources to effectively and efficiently by failing to implement and enforce CDC (Centers for Disease Control) guidelines to help prevent and control the spread of a communicable disease, COVID-19 (Coronavirus Disease 2019) to residents and staff. The facility failed to: 1. develop and implement written policies/procedures related to reused PPE (personal protective equipment) storage to prevent contamination; 2. enforce written policies/procedures to ensure resident and staff compliance with recommended practices for hand hygiene and wearing masks to cover their nose and mouth when confirmed cases of COVID-19 were identified in the facility; and 3. develop and implement policies to ensure social distancing among residents when the facility's administration had knowledge that residents were moving about the facility without masks, gathering in large groups in the smoking courtyard, and not remaining in their rooms. The facility's administration and the facility's corporate office did not seek additional guidance when residents refused to adhere to the recommended infection control practices citing resident rights as the reason for noncompliance. Findings: Cross reference findings at F880 A review of facility document titled, COVID-19 Positive dated 5/6/2020 revealed there was a total of 36 residents who tested positive for COVID-19. A review of facility log titled, Resident COVID-19 Test Tracking Log revealed 6 residents had tested positive for COVID-19 in the last 14 days (between 4/23/2020 and 5/6/2020) with the most recent resident testing positive for COVID-19 on 5/5/2020. A review of facility log titled, Employee COVID-19 Test Tracking Log revealed from 3/30/2020 to 5/5/2020, 17 employees had tested positive for COVID-19. In the last 14 days (between 4/23/2020 and 5/6/2020) two employees tested positive for COVID-19. On 5/6/2020 at 1:00 pm, an interview was conducted with DON who stated as of 5/6/2020 there were 14 COVID-19 positive residents in the facility with 2 COVID-19 positive residents out to the hospital. DON stated there had been 4 resident deaths related to COVID-19. A review of facility policy titled, COVID-19 Positive Employee Returning to Work revealed in part, .when employees return to work who have been COVID positive, a facemask should be worn at all times .these employees should adhere to hand hygiene, respiratory hygiene, and cough etiquette as in CDC's interim infection control guidance . A review of facility policy titled, PPE Policy During COVID-19 Pandemic dated 05/08/2020 revealed in part, Policy: .to ensure that all staff and residents are using appropriate PPE when they are interacting with others .Procedure: .all of this facility's personnel should wear a facemask while they are in the facility .Patients may remove their masks or cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP (healthcare provider), visitors) enter the room. A review of CDC guidance published on 4/15/2020, titled Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, subtitled Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes, revealed HCP should wear a facemask or cloth face covering at all times while they are in the healthcare facility . All HCP should be reminded to practice social distancing when in break rooms or common areas. Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas. Healthcare Personnel Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. Resident Monitoring and Restrictions: Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) . If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others). On 05/06/2020 at 3:23 pm, an interview was conducted with S3ADON on Hall A. S3ADON stated COVID-19 positive residents are in isolation on Hall B. S3ADON stated that newly admitted residents and residents returning from the hospital are placed on isolation on the end of Hall A. S3ADON stated residents in rooms [ROOM NUMBER] are in isolation and that the carts next to the rooms are isolation carts containing PPE for each room. The S3ADON observed the yellow gowns hanging in Hall A near room [ROOM NUMBER] and the surgical gown hanging inside room [ROOM NUMBER] and stated the gowns were used by staff to enter Resident # 3's room. S3ADON stated there was no way of knowing which gown belonged to which staff member. Gowns were observed unlabeled as to which staff it belonged to. On 05/07/2020 at 11:36 am, an interview was conducted with the S6DON who opened all drawers of the isolation container for room [ROOM NUMBER] and observed the container contained one mask with shield and one gown. DON confirmed the mask with shield was not labeled as to which staff it belonged to. The S6DON further stated the mask with shield should have been thrown away after use. S6DON confirmed reused PPE should be contained and labeled to indicate which staff it belongs to. S6DON confirmed there was no procedure or policy in place for labeling or containing used PPE and stored to prevent contaminating the environment/cart. On 05/07/2020 at 11:18 am, an interview was conducted with S6DON who stated the first COVID-19 case was a positive staff member and that he believed the transmission of COVID-19 is coming from staff. The S6DON and S7Admin were informed of observations of staff not washing hands and of staff observed wearing masks below the nose and under their chin. S6DON and S7Admin stated staff were in-serviced multiple times on how and when to wear a mask. S6DON stated staff should wear the mask to cover the mouth and nose the entire shift. S6DON stated that the facility was aware that staff were wearing masks inappropriately and that staff were sent home if they were observed wearing their mask below the nose and mouth. S6DON stated the facility has a QA to monitor staff compliance and denied any other measures taken to ensure staff compliance with wearing masks appropriately. On 05/07/2020 at 11:18 am, an interview was conducted with S6DON who observed the 13 residents in the smoking courtyard not 6ft apart and stated that S7Admin held resident council meetings and a meeting with smokers to educate on social distancing, but they don't care. S6DON was informed of observations of residents wandering in halls without masks and sharing a cup. S6DON stated residents are non-compliant and this is the only smoking area for residents in the facility. S6DON stated 2 smokers have tested positive for COVID-19. Interview S7Admin who also observed the 13 residents in the smoking courtyard not maintain a distance of 6 feet apart. S6DON and S7Admin stated all residents were given a mask and were in serviced on how and when to wear their mask, but refuse to wear them. Residents were educated to stay in their rooms and maintain a social distance of at least 6 feet, but are non-compliant. S6DON and S7Admin stated corporate administration was aware of resident non-compliance. S6DON and S7Admin stated they as well as corporate administration were aware of large groups of residents gathering in the smoking courtyard not maintaining a distance of at least 6 feet and denied developing or implementing any other polices/procedures to enforce resident compliance with social distancing and wearing their masks. S7Admin denied that Administration and the facility's corporate office sought additional guidance from any governing authority when residents refused to adhere to the recommended infection control practices stating resident rights as the reason for noncompliance.

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.

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BELLE TECHE NURSING & REHABILITATION CENTER	**1306 W ADMIRAL DOYLE DR NEW IBERIA, LA 70560**

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) S7Admin and S6DON denied implementing any other interventions or policies to ensure or enforce resident compliance with social distancing, staying in their rooms, and wearing a masks while outside their room.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews, the facility failed to implement accepted infection control practices and transmission-based precautions to help to prevent and control the spread of an infectious communicable disease (Coronavirus 2019) for 65 out 101 residents in the facility who had not tested positive for Covid 19. The facility failed to ensure: 1. Standard infection control precautions for hand hygiene, and correct wearing of PPE for residents and staff, 2. Staff implemented proper procedures for donning/doffing and handling/storage of PPE 3. Residents were monitored and prevented from entering into an area designated for residents on isolation precautions (#12). Findings: A review of a document titled Lippincott Procedures - Personal protective equipment (PPE), putting on presented by S6DON as facility policy revealed in part, PUTTING ON A FACE MASK position the mask to cover your nose and mouth .retain it for further personal use unless it's contaminated .store it as directed by your facility. A URL was noted at the end of each page of the document with a date of 3/13/2020. A review of a document titled CDC Guidance on Use of Masks, Gowns, and Eye Protection to Conserve Supplies, dated 3/18/2020 presented by S6DON as facility policy revealed extended use of isolation gowns (disposable or cloth), such that the same gown is worn by the same HCP . On 05/06/2020 at 1:15 pm an observation was made of S1WardClerk wearing a surgical face mask under her chin sitting at a desk at the facility's entrance. An interview was conducted with S1WardClerk at this time who stated she was assigned to screen residents and visitors entering into the facility. S1WardClerk continued the interview with her mask under her chin exposing her nose and mouth. S1WardClerk stated staff are to wear their mask at all times for the entire shift per facility protocol. On 05/06/2020 at 1:35 pm, an observation of the outside smoking courtyard revealed a total of 8 residents in wheelchairs with cloth or surgical mask hanging on one ear or under their chin while smoking. Three of the 8 residents were sitting at a table approx. 3-4 feet wide smoking and talking. The other 4 of the 8 residents were in wheelchairs lined up next to each other left to right along the side of the outside smoking courtyard were not 6ft apart. No staff was present in the outside smoking courtyard or in the hallway near the smoking courtyard entry doors. Other observations revealed the following: 05/06/2020 at 1:45 pm A tour of hallways A, B, and C both ambulatory residents and residents in wheelchairs out of their rooms wearing masks below their nose or chin or no mask at all. 05/06/2020 at 2:15 pm Observation of 10 residents in the outside smoking courtyard not maintaining a 6-foot distance from each other. One staff was observed sitting on bench in courtyard between 2 residents not maintaining a 6-foot distance from each other. The staff member was not redirecting residents to social distance. No ABHR (alcohol based hand rub) station was observed inside the door for use once they reentered the facility. Four (4) residents in wheelchairs were observed propelling themselves in the hallway near the doors of smoking courtyard entry not 6 feet apart from each other. These four residents were observed wearing ear loop and cloth masks under their chin, or hanging on one ear. 05/06/2020 at 2:18 pm Resident #2 was observed smoking then exiting the smoking courtyard without performing hand hygiene. 05/06/2020 at 3:00 pm Observation of the end of Hall A revealed no plastic sheeting partition. Tie wraps were suspended from ceiling. There was no signage posted to indicate which section of the hall was an isolation area. An observation was made of a clear and black plastic container with clear drawers located outside the doorway of room [ROOM NUMBER] (Resident #3's room). Supplies were observed inside the container. The container was visibly dirty on the outside. Two yellow unpackaged/uncovered gowns were hanging from a white plastic hook in the hallway near room [ROOM NUMBER] (Resident #11's room). One blue unpackaged/uncovered surgical gown was hanging in room [ROOM NUMBER] near the door frame. 05/06/2020 at 4:00 pm Observation of smoking courtyard revealed 10 residents not maintaining a distance of 6 foot apart from each other, some residents were not wearing masks while others were wearing masks under their chin. Upon reentering into the facility, the residents did not perform hand hygiene. 05/06/2020 at 4:03 pm Two (2) staff were observed sitting on a bench and one staff sitting on a chair located at the facility's front entrance near the outside handwashing sink. Staff were not observed maintaining a distance of at least 6 feet. S9FloorTech was observed to walked into the parking lot and retrieved an item wrapped in foil paper from someone walking up to the front entrance. S9FloorTech then entered the facility without washing his hands. 05/07/2020 at 9:30 am Three (3) staff were observed sitting outside smoking and talking along the side of the facility's back parking lot. Staff were not at least 6 feet apart and were observed wearing masks hanging on one ear and under their chin. 05/07/2020 at 9:40 am Ten (10) residents were observed in the smoking courtyard. One of the residents was observed wearing a mask. Several residents were observed less than 6 feet apart from each other. There were no markings on the patio concrete or elsewhere in the courtyard to indicate 6 feet of separation. No staff member was present in the courtyard. Resident #9 was observed allowing Resident #10 to drink from his cup. 05/07/2020 at 9:55 am Resident #5 was observed wandering down Hall D without a mask. 05/07/2020 at 10:00 am Resident #6 was observed without a mask walking from a room approximately 60 feet down to the shower room and knocked on the door. Resident #6 returned to the room after there was no answer at the shower door. 05/07/2020 at 10:05 am Resident #7 was observed to walk down the hall to the smoking area with no mask on. 05/07/2020 at 10:23 am S4LPNChargeNurse was observed exiting Resident #3's room wearing a mask with face shield. S4LPNChargeNurse wiped the face shield with a sanitizing wipe and put the mask with shield on top of the isolation container outside the door. The mask with shield was not observed labeled with her name. When she returned, S4LPNChargeNurse was observed placing the facemask with shield into a drawer of the isolation container containing an isolation gown and incontinence briefs. 05/07/2020 at 10:40 am Dietary personnel was observed exiting kitchen and entering the hallway with a mask pulled down under their chin. 05/07/2020 at 10:41 am Resident #5 was observed with his mask in his lap seated in lobby. 05/07/2020 at 10:45 am Eleven (11) residents were observed in the smoking area. Some residents were observed with no masks and less than 6 foot separation was observed between residents. An observation was made of Hall B where COVID-19 positive residents reside. A clothes rack with a surgical gown, hair cover, and face shield and/or face shield with mask hanging on each clothes hanger was observed. 10 clothes hangers of PPE were observed in total to be uncovered, unpackaged and unlabeled as to which staff the set of PPE belonged to or if it was clean or used/contaminated. 05/07/2020 at 11:05 am Resident #8 was observed visiting Resident #13 inside of his room. Neither resident had a mask on. 05/07/2020 at 11:15 am Four (4) residents were observed in the smoking area with less than 6-foot separation between the majority of the residents. Not all residents had a mask on. 1 of the 14 residents had a [MEDICAL CONDITION] with no mask on. A staff member was seated outside with residents, but was not observed enforcing a 6-foot separation nor encouraging residents to put their mask on. Interviews with staff and residents: 05/06/2020 at 1:30 pm, an interview was conducted with S2LPN who stated she is assigned to Hall A. S2LPN stated newly admitted , residents returning from the hospital and those residents pending COVID-19 test results are isolated on the end of Hall A. She stated the isolated area of Hall A is closed off with a plastic sheeting partition. On 05/06/2020 at 2:00 pm, an interview was conducted with Resident #1 who stated that residents were given masks, but some of them do not wear them when they are outside their rooms. Resident #1's 14-day Admission Assessment MDS (Minimum Data Set) dated 03/14/2020 revealed the resident has a BIMS (Brief Interview for Mental Status) score of 15 indicating the resident is cognitively intact. On 05/06/2020 at 2:18 pm, in an interview conducted with Resident #2, the resident stated there are usually a lot of residents in the smoking area and that not everyone (residents) wear a mask all the time. The resident stated he was educated on handwashing and that he washed his hands often. He could not comment on if other residents were compliant with handwashing. Resident #2's 14 day Admission Assessment MDS (Minimum Data Set) dated 04/05/2020 revealed the resident has a BIMS (Brief Interview for Mental Status) score of 9 indicating moderately impaired cognition. On 05/06/2020 at 3:04 pm, an interview was conducted with Resident #4, who is in isolation on Hall A, in front his room. Resident #4 stated there was a plastic sheeting partition sectioning off the end of the Hall A (4 rooms), but that the plastic sheeting partition was taken down today. Resident #4 stated residents were instructed not to cross the plastic sheeting partition, but that residents would come down the hall past the plastic sheeting partition all the time. During the interview, Resident #12 was observed with a [MEDICAL CONDITION], in a wheelchair. Resident #12 propelled himself in his wheelchair down Hall A past the tie wraps suspended from the ceiling and into the isolation area of Hall A and approached Resident #4's room. Resident #4 told Resident #12 leave, you know you aren't supposed to be down here. Resident #12 was non-verbal and did not leave the area. Resident #4 stated Resident #12's room is a few doors down Hall A and that Resident #12 comes down to this area of Hall A all the time. Resident #4 stated even when the plastic sheeting partition was up, Resident #12 would roll his wheelchair past the plastic sheeting partition and into the isolation area. Observation of Hall A revealed no staff. Resident #4's Entry Tracking MDS (Minimum Data Set) dated 05/01/2020 revealed no entry for a BIMS (Brief Interview for Mental Status) score. On 05/06/2020 at 3:11 pm, the S3ADON arrived to remove Resident #12 from the isolation area of the hallway. An

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) interview was conducted with S3ADON stated there was a plastic sheeting partition to section off the isolation area of Hall A as an alert for staff and residents not to enter this area. S3ADON confirmed the plastic sheeting partition was no longer there and stated she was not sure when it was taken down. S3ADON was asked if the plastic sheeting partition was an effective measure to keep residents out or stop residents from entering this area of the hallway, and S3DON confirmed it was not. S3ADON was asked if staff monitor the isolation area of Hall A, and she replied if there is no CNA (Certified Nursing Assistant) or nurse on the hall, there is no way to ensure a resident does not enter this area of the hallway. During the interview with S3ADON, Resident #12 again entered the isolation area of Hall A in his wheelchair. S3ADON confirmed there is currently no other intervention in place to prevent a resident from entering the isolation area of Hall A. S3ADON confirmed there was no signage posted indicating residents should not enter the area due to residents on isolation. On 05/06/2020 at 3:23 pm, an interview was conducted with S3ADON on Hall A. S3ADON stated COVID-19 positive residents are in isolation on Hall B. S3ADON stated that newly admitted residents and residents returning from the hospital are placed on isolation on the end of Hall A. S3ADON stated rooms 1, 2, 3, and 4 are reserved for residents in isolation. S3ADON stated Residents #3, #4 and #11 are in isolation and that the carts next to the rooms are isolation carts containing PPE for each room. S3ADON observed the debris on the container outside room [ROOM NUMBER]. S3ADON observed the debris on the container and confirmed the container was dirty. The S3ADON opened the drawers of the black/clear container next to room [ROOM NUMBER] and observed the inside of the drawers were dirty. 1 bouffant hat, 1 box of gloves, shoe coverings and incontinence briefs were observed inside the drawers of the container. S3ADON confirmed the inside of the container drawers were visibly dirty and needed to be cleaned. S3ADON confirmed clean PPE supplies should not be kept in a dirty container. The S3ADON observed the yellow gowns hanging in Hall A near room [ROOM NUMBER] and the surgical gown hanging inside room [ROOM NUMBER] and stated the gowns were used by staff to enter Resident # 3's room. S3ADON stated there was no way of knowing which gown belonged to which staff member or if the gowns were clean or contaminated. On 05/06/2020 at 3:37 pm, an interview was conducted with S6DON and S7Admin on Hall A. S6DON observed the debris on the isolation container and interior drawers. S6DON confirmed the container contained PPE and that the container was dirty and needed to be cleaned. On 05/07/2020 at 9:49 am, an interview was conducted with S4LPNChargeNurse who was preparing to provide care to Resident #3. S4LPNChargeNurse stated after caring for the resident, she will wipe her mask with face shield with a sanitizing wipe, let it dry then place it into the drawer of the isolation container outside the resident's door. On 05/07/2020 at 10:03 am, an interview was conducted with S5Housekeeping who stated she dons full PPE (N95 mask, surgical mask, gloves, gown, hair cover, shoe cover, and shield) when she cleans isolation rooms on Hall A and Hall B. She stated she puts her used mask with shield and blue surgical gown in a drawer in the housekeeping cleaning supply closet located on Hall A for reuse. She stated when she works on Hall B, she places her used gown and mask with shield in the housekeeping cleaning supply closet on Hall B for reuse. An observation was made of S5Housekeeping obtaining an unpackaged surgical gown and mask with shield from the last a drawer of cabinet the housekeeping cleaning supply closet. The mask and gown was not observed labeled with her name or initials. On 05/07/2020 at 10:51 am, an interview was conducted with S8LPN who stated she is assigned to care for COVID-19 positive residents on Hall B today. S8LPN stated the PPE on the clothes hangers is reused by staff for the entire shift. She confirmed items on the hanger were previously used surgical gown, hair cover, and face shield and/or face shield with mask. After caring for a resident, staff hang their used PPE back on the hanger for use later in the shift. S8LPN confirmed the PPE is not labeled as to which staff it belonged to or if it was clean or used/contaminated. On 05/07/2020 at 11:18 am, an interview was conducted with S6DON who stated the first COVID-19 case was a positive staff member and that he believed the transmission of COVID-19 is coming from staff. The S6DON and S7Admin were informed of observations of staff not washing hands and of staff observed wearing masks below the nose and under their chin S6DON who observed the 13 residents in the smoking courtyard not maintain a distance of at least 6 feet apart and stated that S7Admin held resident council meeting and meeting with smokers to educate on social distancing, but they don't care. S6DON was informed of observations of residents wandering in halls without masks and sharing a cup. S6DON stated residents are non-compliant and this is the only smoking area for residents in the facility. S6DON stated 2 smokers have tested positive for COVID-19. On 05/07/2020 at 11:25 am, an interview was conducted with S7Admin who also observed the 13 residents in the smoking courtyard not maintain a distance of at least 6 feet apart. S7Admin denied that administration and the facility's corporate office sought additional guidance when residents refused to adhere to the recommended infection control practices stating resident rights as the reason for noncompliance. S7Admin and S6DON did not indicate implementing any other interventions to ensure or enforce resident compliance with social distancing, staying in their rooms, and wearing a masks while outside their room. On 05/07/2020 at 11:36 am, an interview was conducted with the S6DON who opened all drawers of the isolation container for room [ROOM NUMBER] and observed the container contained one mask with shield and one gown. S6DON confirmed the mask with shield was not labeled as to which staff it belonged to. The S6DON further stated the mask with shield should have been thrown away after use. S6DON confirmed reused PPE should be contained and labeled to indicate which staff it belongs to or if was clean or used/contaminated.