STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195537	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER THE	**11188 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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 record review and interview, the facility failed to implement a comprehensive centered care plan by failing to follow the physician's orders for the administration of [MED] for 1 (#85) of 3 (#83, #84, #85) residents reviewed for closed records. Findings: Record review of the facility's Admit/Return From Hospital Doctor's Order Sheet revealed Resident #85 was admitted to the facility on [DATE] and discharged on [DATE]. According to the facility's Diagnosis/History form dated 0[DATE], Resident #85 had [DIAGNOSES REDACTED]. Record review of Resident #85's admitting physician's orders, dated 0[DATE], revealed the following orders: [MED] [MEDICATION NAME] 100U per /ml injection administer 2 units subcutaneous 3 times daily with meals DX DMI. Below the word subcutaneous was written [MED]. Record review of Resident #85's Baseline Care Plan, dated 0[DATE]20, read: Administer my medications as ordered. Record review on 03/05/2020 of Resident #85's January 2020 Medication Administration Record [REDACTED]#85 in the computer made a mistake and put the order in for every other day instead of every day. S1DON confirmed the resident missed 6 doses of [MED].
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 observations, interviews and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure staff practiced proper hand hygiene and glove use for 1 (#51) of 3 (#36, #51 and #75) residents observed receiving incontinence care. This deficient practice had the potential to affect any of the 60 residents who resided in the facility and received incontinence care; Findings: Review of Resident #51's clinical record revealed an admitted [DATE] and medical [DIAGNOSES REDACTED]. On 03/02/2020 at 12:09 p.m., an observation was made of incontinence care performed by S3CNA and S4CNA for Resident #51. S3CNA and S4CNA placed him in the stand-up lift. S3CNA placed the garbage can with her gloved hand in the area where they were working. S3CNA and S4CNA worked from either side of Resident #51 while he was in a stand up position to remove his brief. S3CNA placed the urine soiled brief in the garbage can. S4CNA retrieved the cleansing wipes from the TV stand and handed them to S3CNA. S3CNA wiped Resident #51's genitals, perineum and buttock area. S3CNA and S4CNA placed a new brief on Resident #51 and removed his pants. S3CNA and S4CNA moved Resident #51 in the lift up to the edge of his bed. S3CNA used the control of the lift to lower Resident #51 into his bed. S3CNA removed his right sock and tennis shoe and S4CNA removed the remaining sock on his left foot. S3CNA and S4CNA disconnected the cloth harness from the lift arms and unfastened Resident #51 from the harness. S3CNA placed the harness across the top of the lift and pushed the lift away from Resident #51's bed. S4CNA removed a clean undershirt from his dresser. S3CNA and S4CNA assisted Resident #51 in putting on the undershirt. S3CNA then grabbed his bare legs and placed them into the bed. S4CNA assisted him with the upper part of his body and adjusted his bare left arm into position. S4CNA rolled him on his left side as S3CNA pulled the bedside curtains back, grabbed his wedge off the floor and placed it behind his back. S3CNA pulled his covers up to his mid-chest. S4CNA rolled his bedside stand next to his bed. S3CNA and S4CNA then removed the gloves used to perform incontinence care. S3CNA did not perform hand hygiene before moving the lift into the hallway. Both CNAs were observed with travel size hand sanitizing bottles clipped to the front of their uniforms. On 03/02/2020 at 12:20 p.m. an interview was conducted with S4CNA. When asked if she should she have changed her gloves and performed hand hygiene directly after performing incontinence care before touching Resident #51, the lift and the items in the room, she responded she and S3CNA were going to clean everything with bleach wipes afterwards. On 03/02/2020 at 12:22 p.m., an interview was conducted with S3CNA. When asked if she should she have changed her gloves and performed hand hygiene directly after performing incontinence care before touching Resident #51, the lift and the items in the room, she responded they were going to clean everything with bleach wipes afterwards. When asked about touching the bedside curtain, the bedclothes, his bare skin, his clothing, etc with the gloves used to perform incontinence care, she responded those were his belongings. On 03/05/2020 at 1:20 p.m., an interview was conducted with S2ADON. After informing S2ADON of the observations made of incontinence care on 03/02/2020 at 12:09 p.m., she stated the staff should have removed their gloves and performed hand hygiene directly after his incontinence care and should not have touched Resident #51, equipment and items in the room with gloves used in incontinence care. On 03/05/2020 at 2:10 p.m., an interview was conducted with S1DON. After informing her of the observations made of incontinence care on 03/02/2020 at 12:09 p.m., she stated the staff should have changed their gloves immediately following the incontinence care and should not have used the same gloves to touch Resident #51, equipment and items in the room.

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.