STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195620	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POINTE COUPEE HEALTHCARE	**1820 FALSE RIVER ROAD NEW ROADS, LA 70760**

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents, by failing to ensure: 1.) Residents weights were being monitored (Resident #3 and Resident #9); 2.) Residents received assistance with transfers (Resident #11); 3.) Residents baths were given as scheduled (Resident #7 and Resident #11); 4.) There was enough staff available to provide incontinent care to a Resident (#8) that resided on the COVID-19 wing; The facility census was 95. Findings: Resident #3 Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE]. He had diagnoses, which included Cerebral Infarction due to Embolism, Metabolic [MEDICAL CONDITION], Vitamin Deficiency, Protein-Calorie Malnutrition, [MEDICAL CONDITION], Dysphagia, Dementia, Hypertensive [MEDICAL CONDITION] with Heart Failure, GERD, Type 2 Diabetes Mellitus, and [MEDICAL CONDITION]. Review of Resident #3's Weight Change History dated 01/02/2020 through 03/26/2020 revealed the resident was weighed weekly with the last documented weight on 03/26/2020. There were no weights noted after 03/26/2020. An interview was conducted with S21MDS on 05/18/2020 at 10:00 a.m. She confirmed Resident #3's last documented weight was on 03/26/2020 and he had been being weighed weekly prior to that. She stated she did not know why the resident had not been weighed since 03/26/2020. She stated S4ADON was responsible monitoring the resident's weights. An interview was conducted with S4ADON on 05/18/2020 at 10:26 a.m. She reviewed Resident #3's weights and confirmed he was last weighed on 03/26/2020 and had been weighed weekly prior to that. She stated she did not know why the resident had not been weighed after 03/26/2020. Resident #7 Review of Resident #7's clinical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the quarterly MDS with an ARD of 04/03/2020 revealed Resident #7 had a BIMS of 11, which indicated he was moderately cognitively impaired. He required extensive two plus person assistance bathing. Review of Resident #7's Task Care Plan revealed he should receive a bed bath every morning. Review of Resident #7's Bath report from March 2020 through April 2020 revealed, in part, no documentation Resident #7 had completed a bed bath, whirlpool, or shower on the following dates: 03/12/2020 to 03/17/2020, 03/19/2020, 03/26/2020, 03/31/2020 to 04/14/2020, 04/16/2020, 04/22/2020 to 04/25/2020, 04/28/2020 and 04/29/2020. Further review revealed Resident #7 resisted care on 03/29/2020 and 03/30/2020. There was no check mark indicating Resident #7 had refused to be bathed on any of the above dates. A telephone interview was conducted with S19CNA on 05/13/2020 at 1:12 p.m. She confirmed she worked with Resident #7. She stated Resident #7 was to receive a daily bed bath. She stated the CNA's were to document each time a resident received a bath. She confirmed she was responsible for bathing Resident #7 and did not know if the resident had missed any baths. A telephone interview was conducted with S5SW on 05/14/2020 at 9:42 a.m. She stated Resident #7's family had contacted her on 04/17/2020 with concerns that the resident had not been bathed. She stated she was unsure if the resident had or had not been bathed at the time the family contacted her. A telephone interview was conducted with S23LPN on 05/13/2020 at 11:27 a.m. She confirmed she cared for Resident #7. She stated Resident #7 was to be bathed daily, and it should be documented in his record. She stated Resident #7's family had contacted her with concerns that the resident was not being bathed. She stated she did not know if Resident #7 had gone any days without being bathed. A telephone interview was conducted with S5SW on 05/14/2020 at 9:42 a.m. She stated all residents were weighed monthly if they do not have an order specifying otherwise. She stated the facility had a restorative aide who was weighing residents, but stated that aide was out sick. She stated she had been so busy she was unsure whose was handling weights at this time. An interview was conducted with S2DON on 05/15/2020 at 2:00 p.m. She confirmed there was no documentation Resident #7 received a bath on the above dates. She stated she did not know if the resident was bathed. She confirmed she had no way of knowing if the resident had been bathed or not. Resident #8 Review of the clinical record for Resident #8 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the most recent MDS assessment with an ARD of 04/07/2020 for Resident #8 revealed the resident had a BIMS of 15. The resident also required limited assistance with 2 or more persons for toileting and bed mobility. Review of Resident #8's current Care Plan revealed the resident required limited to extensive assistance with ADLs which included bed mobility and transfers to the toilet. An interview was held with S24CNA on 05/18/2020 at 9:41 a.m. She stated she worked on the A Hall, which was the facility's COVID wing, on 05/09/2020. She stated when she went in to the resident's room to change her brief, the resident was hollering and was laying on the very edge of the bed. She stated she proceeded to attempt to change the resident's brief and the resident was screaming and flailing her arms. When asked if she attempted to get help to change the resident, she stated the nurse was standing out in the hallway, but the nurse did not come to help her because she was passing medications. She said she was the only CNA that was assigned to the COVID hall that day. Resident #9 Review of the clinical record for Resident #9 revealed the resident was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of Resident 9's weight log dated 05/01/2020 revealed the following: 04/02/2020 - 128lbs (last weight obtained) Review of the Nurse's Notes for Resident #9 revealed the following, in part; 02/17/2020, Late entry from 02/11/2020, weight loss noted. Seven pounds in the last 18 days. Current weight is 133# IBW #125. BMI 22.13. Resident has minimal [MEDICAL CONDITION] noted. She eats most of her meals in her room or in the dining room. Will continue to monitor weekly weights. Signed S4ADON 4/14/2020 weight loss noted 15 pounds in the last 163 days. Current weight is 128 pounds. IBW 125lbs. BMI 21.3. Will continue to monitor weekly. Signed S4ADON. 4/17/2020 - continue with current diet order. Significant weight loss x 6 months. 1. Recommend add 2oz house supplement BID with meds. 2. Continue to monitor weekly weights. 3. Recommend dietary manger update food/snack preferences. S22RD An interview was conducted on 05/12/2020 at 3:00pm with S4ADON. She said she was unsure who had been obtaining resident weights. She said the CNA that usually obtained resident weights had been sick and that duty had not been assigned to another staff member. She said the facility did not have a portable scale to bring to Resident 9's room. She said the staff halted weighing the residents because of fear of exposure to [MEDICAL CONDITION]. She said she was unsure if Resident 9 had lost weight. She confirmed Resident 9 should be weighed weekly and the last documented weight was 04/02/2020. She confirmed the facility had not continued weekly weights because of the COVID -19 virus and decreased staff. An interview was conducted on 05/12/2020 at 3:15pm with S2DON. She confirmed the last weight obtained for Resident 9 was on 04/02/2020. She said staff were unable to bring the scale to the room because of the size of the scale. She said the facility did not have a scale that could be brought to Resident 9's room. She said the staff that usually weighed the residents had been out sick for a few weeks and another employee had not been assigned that duty. She said staff were doing the best they could with so many staff members out with [MEDICAL

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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POINTE COUPEE HEALTHCARE	**1820 FALSE RIVER ROAD NEW ROADS, LA 70760**

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) CONDITION]. She confirmed Resident 9 should have been weighed weekly. Resident #11 A review of Resident #11's medical record revealed the resident was originally admitted to the facility on [DATE] and had a recent re-admission date of [DATE]. The resident's [DIAGNOSES REDACTED]. Further review of documentation revealed the resident was hospitalized from [DATE] - 04/20/2020 due to COVID-19. A review of Physician's Telephone Orders revealed orders that included the following: 04/20/2020 - Resident to be placed on strict isolation due to droplet and airborne transmission related to COVID 19 virus; active infection. Single room isolation. Room bound activities/services. Review of the resident's Care Plan revealed, in part, the following: I am at risk for falls. Onset: 09/18/2019. I use a wheelchair for primary mode of locomotion. I require assistance with transfers. I require assistance with ADLs. Onset:10/22/2019. 04/02/2020 -I require substantial/maximum assistance. I require isolation due to COVID-19 virus. Onset: 04/21/2020 Review of the resident's current MAR indicated [REDACTED]. There was no documentation of a bath provided on 05/04/2020, 05/08/2020 - 05/10/2020, or on 05/13/2020. Review of nursing documentation in the Departmental Notes revealed, in part, the following: 03/17/2020 - Resident needs assistance with ADLs and transfers. Incontinent of bowels. 04/21/2020 - Incontinent of bowel. Needs assistance with ADLs and transfers. Resident is on isolation precautions. 04/28/2020 - Resident needs assistance with ADLs and transfers. Incontinent of bowels. 05/05/2020 - Incontinent of bowel. Needs assistance with ADLs and transfers. Resident is on isolation precautions. Review of a Significant Change MDS assessment with an ARD of 04/27/2020 revealed, in part, the following: BIMS score - 15, which indicated the resident was cognitively intact. Preferences for Customary Routine and Activities: choose tub, bath, shower, sponge - very important. Functional Status: extensive assist of 2+ persons required for transfers; extensive assist of 1 person required for dressing, personal hygiene; physical help of 1 person required for bathing. Bladder and Bowel: indwelling catheter; occasionally incontinent of bowel. Skin Conditions: at risk for developing PU/injuries. On 05/15/2020 at 11:59 a.m., an observation was performed of Resident #11. She was observed sitting in a wheelchair in her room. She was awake, alert, and oriented to person, place, and time. On 05/15/2020 at 12:00 p.m. an interview was conducted with Resident #11. She verified she had tested positive for COVID-19 and was hospitalized for [REDACTED]. She stated she returned to the facility from the hospital somewhere around the 25th of April. She verified she was admitted to Hall A when she returned from the hospital. She stated she had to stay on that hall when she returned because Hall A was the COVID isolation hall. She stated she had difficulty getting staff to help get her up in her wheelchair while on Hall A. She verified staff had to use a stand-up lift to transfer her from the bed to the wheelchair. She stated she also did not receive daily baths while on Hall A. She stated she liked to get a bath every day, even if it was a bed bath. She stated she may have gotten a bath 1-2 times while on Hall A for 2 weeks. She stated she asked a couple of times to get a bath or to get up in her wheelchair and no one ever came to help. She stated she did not feel like there were enough aides to help the residents when she was on Hall A. She verified she returned to her regular room on Hall B on Tuesday, 05/12/2020. On 05/15/2020 at 2:45 p.m., an interview was conducted with S2DON. She verified the resident preferred to get a bath every morning. She further verified the resident probably did not get a daily bath or assistance to get up in her wheelchair at times while on Hall A. S2DON verified there was sometimes only 1 aide working most day shifts, with 20 or more residents to care for, on that hall up until the past week when agency staff started working in the facility. Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form for the time period of 04/21/2020 - 05/08/2020 revealed the following: in part; 04/21/2020 night shift (10:00 p.m. - 6:00 a.m.), two CNA's and three LPN's. There were five employees in the facility from 10:00 p.m. - 6:00 a.m. The facility census was 97 residents. 05/01/2020 night shift (10:00 p.m. - 6:00 a.m.), three CNA's and two LPN's. There were five employees in the facility from 10:00 p.m. - 6:00 a.m. The facility census was 94 residents. 05/02/2020 Total staffing for the day was negative10.80 hours for the required 2.35 hours per resident. The facility census was 94 residents. 05/06/2020 night shift (10:00 p.m. - 6:00 a.m.), three CNA's and three LPN's. There were six employees in the facility from 10:00 p.m. - 6:00 a.m. The facility census was 90 residents. 05/08/2020 night shift (10:00 p.m. - 6:00 a.m.), two CNA's and four LPN's. There were six employees in the facility from 10:00 p.m. - 6:00 a.m. The facility census was 90 residents. An interview was conducted on 05/15/2020 at 2:30 p.m. with S2DON. She stated Pre-COVID-19 the facility's staffing assignment was scheduled with the following: Four LPN's from 7:00 a.m. - 7:00 p.m. and eight CNA's from 6:00 a.m. - 2:00 p.m. Three LPN's 7:00 p.m. - 7:00 a.m. and four CNA's from 10:00 p.m. - 6:00 a.m. She confirmed the staffing numbers listed above was what she scheduled to take care of the residents in the facility. After reviewing the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Form for 04/21/2020- 05/08/2020, she confirmed the dates listed above indicated the number of employees to care for the residents in the facility was less than what the facility had previously scheduled. She said I have not cut staff at the facility, they are just not coming to work. She said We are doing the best that we can with the staff that we have available. She said resident acuity had increased since COVID-19, but staff availability had decreased. She said Resident #11 did not get out of bed because she did not have staff to get her out of the bed. She said weights were not taken on residents because she did not have staff to weigh them. She said she did not know if residents had received baths as they were supposed to because of not having enough staff. She confirmed there was 37 residents that required incontinent care and 9 residents in the facility that required assistance with turning and reposition.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed maintain medical records on each resident that were complete and accurately documented for 3 (#1, #3, #8) of 13 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14) residents reviewed. The facility failed to: 1.) accurately document resident's fall (#1); 2.) accurately document resident's meal intake (#3, #8); 3.) accurately document the status of a resident's skin (#8). Findings: 1.) A review of the clinical record for Resident #1 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]., Dysphagia; Oropharyngeal, Unspecified Dementia, Cognitive Communication Deficit, [MEDICAL CONDITIONS], Hypertension. The clinical record indicated his daughter was the responsible party. A review of nurses' notes dated 04/03/2020 5:20 a.m. late entry for 04/01/2020 at 7:30 p.m. revealed the following: in part; I was notified by S14CNA that she found the resident sitting next to his bed on his landing pad when she went in his room to get him ready for bed. No acute distress noted. No complaints of pain, no injury was noted. Range of motion and neurological status at baseline, safety measures remain in place, supervisor, medical doctor and responsible party notified. An interview was conducted on 04/22/2020 at 4:30 p.m. with S6LPN. She said she did not notify Resident #1's daughter of this incident because Resident #1 was not injured and she didn't want to alarm her since it was late in the evening. She stated she documented in the nurses notes that she informed Resident #1's daughter of a possible fall, but confirmed she did not inform Resident #1's daughter of this incident. An interview was conducted on 04/24/2020 at 8:40 a.m. with S2DON. She stated the resident's responsible party should be notified as soon as an accident/incident occurs or when an employee is made aware of an accident/incident. She said after investigating Resident #1's incident on 04/01/2020 she confirmed S6LPN did not notify Resident #1's responsible party but documented in the nurses notes that Resident #1's responsible party was notified. She said all accidents/ incidents should be reported to the responsible party and accurately documented. 2.) Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE]. The resident had diagnoses, which included Cerebral Infarction due to Embolism, Metabolic [MEDICAL CONDITION], Vitamin Deficiency, Protein-Calorie Malnutrition, [MEDICAL CONDITION], Dysphagia, Dementia, Hypertensive [MEDICAL CONDITION] with Heart Failure, GERD, Type 2 Diabetes Mellitus, and [MEDICAL CONDITION]. Review of Resident #3's Care Plan revealed, in part: Onset: 11/25/2019 I have altered diet needs related to diagnoses. Approaches: Monitor and record the amount consumed and monitor my meal percentage consumed and record my intake each meal. Review of Resident #3's Meals report from March 2020 through April 2020 revealed, in part, the resident's meal intake was not recorded on the following dates. 03/01/2020-03/04/2020, 03/08/2020, 03/10/2020, 03/14/2020-03/20/2020, 03/22/2020-03/24/2020, 03/26/2020, 03/27/2020 and 03/30/2020-04/09/2020. Review of the meal intake log for Resident #8 revealed there was no documentation of the resident's meal intake on 03/16/2020-03/19/2020, 03/24/2020, 03/25/2020, 03/26/2020, 04/01/2020-04/27/2020, 05/04/2020, 05/09/2020 and 05/10/2020. An interview was conducted with S4ADON on 05/18/2020 at 10:26 a.m. She reviewed the meal intake logs and confirmed the

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) resident should have entries for percentages consumed for every day he was in the facility. She confirmed the resident did not have meals entered on the above dates and confirmed they should have been. 3.) Review of the clinical record for Resident #8 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of 04/23/2020 hospitalization records for Resident #8 revealed the following: Wound care provided by hospital RN revealed Resident #8 was cleaned and wound was noted to entire buttock area. Area was cleaned with sterile water and Z guard was applied. Bleeding noted to entire buttock area. Review of the Skin Assessments for the resident revealed the resident had body audits conducted on 01/06/2020, 01/13/2020, 01/20/2020, 01/27/2020, 02/16/2020, 02/23/2020, 03/15/2020, 03/22/2020, 03/29/2020, 04/12/2020, 04/19/2020. All of these documented the resident's skin was intact and no documentation the resident had excoriation that was being treated with Zinc. On 05/03/2020, it was documented the resident's skin was not intact. Review of the April 2020 Nurses Notes for Resident #8 revealed no documentation there was any excoriation to the resident's skin that was being treated with Zinc. Further review revealed there was no documentation the nursing staff were applying Zinc to the resident's perineal area for excoriation. An interview was held with S7LPN on 05/13/2020 at 2:09 pm. He stated prior to Resident #8's hospitalization , they had noted some redness to her buttocks but there was a standing physician's orders [REDACTED]. He further stated when they did attempt to apply some, the resident was very combative and refused to allow them to apply it. He stated he thought he documented this in the nurse's notes. He also stated he had noted the resident did not eat for a couple of days leading up to her hospitalization on [DATE]. He did not verbalize the resident went weeks without eating. An interview was held with S16CNA on 05/15/2020 at 9:14 a.m. She confirmed the resident had some redness to her skin on 04/22/2020, the day before she went to the hospital on [DATE]. She stated she informed the nurse the resident needed something applied to her brief area. An interview was held with S8LPN on 05/15/2020 at 1:12 p.m. She confirmed she cared for the resident on the night shift, 04/22/2020. She verified the resident's skin was a little red in her brief area. An interview was held with S4ADON on 05/18/2020 at 12:00 p.m. She verified she could not provide any documentation the resident's skin concerns were addressed. She further verified if the staff were reporting the resident had redness that was being treated, this should have been documented.
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 observations, interviews, and record review, the facility failed to implement acceptable infection control practices and transmission-based precautions to help to prevent and control the spread of an infectious communicable disease (Coronavirus 2019) for 87 of 96 residents that had not been test and confirmed positive for COVID-19. The facility failed to ensure: 1. Staff were not assigned to work with both isolated infectious and non-infectious residents within the facility; 2. Non-infectious residents were not intermingled with infectious residents on an isolated hall; 3. Residents residing on the isolation hall did not wander throughout the building without the use of personal protective equipment (Resident #14); 4. Isolation precautions were adhered to for droplet precautions by allowing the resident's door to remain open (Resident #15); and 5. Staff followed the facility's Policy and Procedure for COVID-19. Findings: Review of the CDC's Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings located at www.cdc.gov/COVID19 revealed, in part: Identification and Management of Ill Residents The facility has criteria and a process for cohorting residents with symptoms of respiratory infection, including dedicating HCP (Healthcare Personnel) to work only on affected units. Review of the Preparing for COVID-19 in Nursing Homes updated on [DATE] and located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html revealed, in part: Identify Space in the Facility that could be dedicated to monitor and care for residents with COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Identify healthcare personnel who will be assigned to work only on the COVID-19 care unit when it is in use. This guidance should be implemented immediately once COVID-19 is suspected: Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated health care personnel. Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19 Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility. A review of the facility's policy and procedure titled, Coronavirus Disease 2019 (COVID-19) Suspected or confirmed case, revealed, in part: Effective Date: [DATE] Purpose: To minimize exposure and infection of the [MEDICAL CONDITION] (COVID-19) within our facility when there is a suspected or known case of COVID-19. This Policy and procedure are in addition to existing infection control and COVID-19 Policies and Procedures. Policy: It is the policy of the facility to follow the State Department of Health and Centers for Disease Control (CDC) guidelines related to COVID-19. Procedure: 5. The resident with known or suspected COVID-19 with be placed in isolation room with the door closed. 6. The facility will restrict residents (to the extent possible) to their rooms except for medically necessary purposes. a. If the residents must leave their room, they will be provided with a facemask, limit movement in the facility, encourage hand hygiene and encourage to perform social distancing (at least 6 feet apart). 7. The resident with an undiagnosed respiratory infection, the staff should follow Standard, Contact, and Droplet precautions (i.e. facemask, gloves, isolation gown) with eye protection when caring for a resident as per physician orders. 8. As an additional measure to limit HCP exposure and conserve PPE, the facility may designate an identified area within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients. 9. If an outbreak occurs within the facility, the facility will dedicate HCP that are assigned to care only for these patients during their shift . An interview was conducted with S1ADM on [DATE] at 10:35 a.m. He said Hall A (COVID-19 isolation hall) was recognized as the hot spot for COVID-19 in the facility. He stated there were seven residents residing on the COVID-19 isolation hall that were asymptomatic and had not been tested for COVID-19. He said the facility assigned a nurse, a CNA, and a housekeeper to work only on the COVID-19 isolation hall. He stated the designated employees remained on the COVID-19 isolation hall. He said the designated staff were not allowed to go on another hall after entering the COVID-19 isolation hall. He reported residents were to remain on the COVID-19 isolation hall and doors were closed to prevent residents from wandering off the hall. A video interview was conducted with Resident #14 on [DATE] at 3:00 p.m. He was awake, alert, and answered questions appropriately. Resident #14 stated he was not allowed to go out of his room at this time because of COVID-19. A review of the face sheet for Resident #14 revealed the resident was admitted to the facility on [DATE] and resided in room A9 on the COVID-19 isolation hall. He had diagnoses, which included Malignant Neoplasm of the Brain, Hypertension, Anxiety, Major [MEDICAL CONDITIONS], and Pseudobulbar affect. Review of the MDS with an ARD [DATE] revealed Resident #14 had BIMS of 14, which indicated he was cognitively intact. Review of the Departmental Notes dated [DATE] and [DATE] revealed Resident #14 displayed wandering behaviors. An observation was made on [DATE] at 7:40 p.m. of Resident #14 ambulating from the direction of Hall C towards the nursing station. Resident #14 did not have a facemask or any other personal protective equipment on at that time. Resident #14 continued to walk towards the nurse's station, around it, and then entered the isolation hall. Three nurses were present near the nurse's station and did not redirect, educate, assist, or offer personal protective equipment to Resident #14. A review of the Daily Assignment Sheet and Staffing Information form dated [DATE] revealed, in part: 7:00 p.m. to 7:00 a.m., S10LPN was assigned Hall D, S9LPN was assigned the Hall C, and S11LPN was assigned Hall B. Further review revealed there was not an LPN assigned to Hall A (COVID-19 isolation hall) during this shift. An interview was conducted with S9LPN on [DATE] at 7:35 p.m. She stated the LPN's worked 7:00 p.m. to 7:00 a.m. She stated she was assigned Hall C and rooms A13 through A18 on the COVID-19 isolation hall. She stated S10LPN was assigned Hall D and rooms A1 through A12 on the COVID-19 isolation hall. She stated S11LPN was assigned Hall B and rooms A19 through A28 on the COVID-19 isolation hall. She stated S13LPN was assigned to be a floating CNA, and worked between all four halls. She confirmed the COVID-19 isolation hall did not have designated staff to work on it during the shift and the LPNs working on [DATE] 7:00 p.m. to 7:00 a.m. were caring for COVID-19 positive and Non-COVID-19 residents during the shift. An interview was conducted with S4ADON on [DATE] at 7:37 p.m. She confirmed the above staffing information and the facility had not assigned designated staff to work only on Hall A (COVID-19 isolation hall). An observation was made on [DATE] at 7:42 p.m. of a large white dry erase board in front of the nursing station. The board had information about color-coded signage. It explained green was universal precautions and red meant to stop before entering because the resident was on droplet precautions. An observation was made on [DATE] at 7:45 p.m. of Hall C. Resident #15 was observed lying in her bed with the entry door to her room fully open. The sign, printed in black and white, on the resident's door revealed isolation droplet precautions. Review of Resident #15's Chest X-Ray dated [DATE] revealed, in part: Impression: Congestion versus [MEDICAL CONDITION]/atypical pneumonitis. An interview was conducted with S2DON on [DATE] at 7:50 p.m. She stated Resident #14 was confused and wandered. She stated Resident #14 resided on Hall A, which was the COVID-19 isolation hall. She stated Hall A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195620	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POINTE COUPEE HEALTHCARE	**1820 FALSE RIVER ROAD NEW ROADS, LA 70760**

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	(continued... from page 3) was changed into a COVID-19 isolation hall in March of 2020. She stated not all residents on Hall A were COVID-19 positive or symptomatic. She confirmed Resident #14 had resided on Hall A prior to March of 2020. She stated Resident #14 was cognitively impaired and wandered. She stated staff had attempted to educate him, but he was unable to retain the information due to his cognitive impairment. She stated Resident #14 refused to wear personal protective equipment. She confirmed Resident #14 wandered off the COVD-19 isolation hall and throughout the facility without the use of PPE. She stated Resident #15 was placed on isolation precautions on [DATE] at 10:00 a.m. because she was exhibiting signs and symptoms of COVID-19. She stated Resident #15's chest x-ray showed atypical pneumonitis. She stated the isolation precaution signs placed on the exterior of the resident's doors were color-coded. She stated the droplet precaution signage should be printed with red coloring and placed on the door. She confirmed Resident #15's door should have been completely closed and the signage on the door should have been printed in red as opposed to black and white. She stated she did not know why the door was open or why her staff had printed the sign in black and white. She stated the nursing staff had refused to be designated to work the COVID-19 isolation hall, but would agree to split the hall during the shift. She confirmed the facility did not have designated staff assigned to the COVID-19 isolation hall. She provided a daily census by halls and highlighted the residents that were COVID-19 positive in yellow. She explained the residents in rooms A2, A3, A5, A6, A10, A11, A15, A17, and A23 were confirmed positive for COVID-19. She stated residents in rooms A1, A4, A9, A13, A14, A20, A24, and A26 were asymptomatic and not suspected to have COVID-19. She stated residents in rooms A18, C1, and C2 were pending COVID-19 results. She confirmed the COVID-19 isolation hall housed both COVID-19 positive residents and Non-COVID-19 positive or symptomatic residents. She stated the facility was not moving residents on and off the COVID-19 hall, but if a resident went to the hospital and was tested positive for COVID-19, they were returned to the COVID-19 isolation hall. She stated the facility had confirmed positive residents on Hall A, Hall B, and Hall C. A telephone interview was conducted on [DATE] at 2:15 p.m. with S2DON and S3CN. S2DON stated Resident #15 was claustrophobic and that was why her door was open while she was on droplet precautions. She asked surveyors what she supposed to do if the resident refused to have her door shut, should we just take her rights away? S3CN stated the facility staffed three LPNs on the night shift, and those three LPNs would be assigned one hall and then would split the rooms on Hall A. She stated this was how the facility was staffed on the night shift prior to COVID-19. She stated the facility provided continuity of care by continuing to staff the way they did prior to COVID-19 and did not follow the CDC recommendations to designate a staff member to the COVID-19 isolation hall. S3CN explained the first COVID-19 positive case was a resident who had resided on the COVID-19 isolation hall. She stated per the facility's policy all the residents on that hall had been exposed, including Resident #14, to COVID-19 and would not be moved off the hall. She stated the facility had not quarantined the other residents residing on the COVID-19 isolation hall for 14 days to determine if they were asymptomatic and could be moved off the hall. She confirmed the facility had residents test positive for COVID-19 that resided on Hall B and Hall C as well. She did not answer when asked why the residents on Hall B and Hall C were not considered exposed at this time. Review of the Facility's COVID-19 Tracking Log provided on [DATE] revealed confirmed COVID-19 cases that were identified in the facility from [DATE]-[DATE]: Week [DATE]-[DATE]- 1 Resident that resided on A hall was tested and confirmed positive for COVID-19. Total number of cases was 1. Week [DATE]-[DATE]- 8 Residents that resided on A hall were tested and confirmed positive for COVID-19 which increased the facility's total positive cases to 9. Week [DATE]-[DATE]- 9 Residents, 8 that resided on A hall and 1 that resided on B hall, were tested and confirmed positive for COVID-19 which increased the facility's total positive cases to 18. Week [DATE]-[DATE]- 3 Residents, 2 that resided on A hall and 1 that resided on B hall, were tested and confirmed positive for COVID-19 which increased the facility's total positive cases to 21. Week [DATE]-[DATE]- 2 Residents that resided on B hall were tested and confirmed positive for COVID-19 which increased the facility's total positive cases to 23. [DATE], [DATE] and [DATE]- 3 Residents, 1 that resided on C hall and 2 on B hall, were tested and confirmed positive for COVID-19 which increased the facility's total positive cases to 26. Further review of the tracking log revealed of those 26 confirmed cases, 13 of those residents had expired as of [DATE].