STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195438	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANDMARK NURSING & REHAB CTR	**1611 WELLERMAN ROAD WEST MONROE, LA 71291**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on record reviews and interviews, the facility failed to promptly notify the resident and representative of a change in room for 2 (#1, #3) of 3 residents reviewed for hospitalization s. The facility failed to notify resident #1 and #3's resident representative after the residents had a documented room change. Findings: Resident #1 Review of the nurses' notes dated 05/10/2020 at 3:15PM revealed documentation of resident #1 being sent out of the facility to the hospital. Review of the nurses' notes dated 05/16/2020 at 2:45PM revealed documentation of resident #1 being readmitted to the nursing facility to an isolation room located on the 500 hall. There was no documented evidence of the resident representative being notified of resident #1's room change to the isolation room or when resident #1 was transferred back to 100 hall on 5/28/2020. Resident #3 Review of the nurses' notes dated 04/21/2020 at 9:47PM revealed documentation of resident #3 being sent out of facility to the hospital. Review of the nurses' notes dated 04/28/2020 at 10:04AM revealed documentation of resident #3 being readmitted to the nursing facility to an isolation room on the 100 hall. Review of the nurses' noted dated 04/30/2020 at 2:31PM revealed received from 100 hall to isolation room located on the 200 hall. The notes was signed per S8LPN (licensed practical nurse). There was no documented evidence of the resident representative being notified of resident #3's room change. On 07/22/2020 at 12:48PM, an interview with S8LPN was conducted and she was questioned regarding resident representative notification of the change. She revealed that she did recall resident #3 having a room change, but she thought that whoever does the transfers from room to room did it. S8LPN confirmed that she had not notified the resident's representative of the room change. On 07/22/2020 at 2:10PM, an interview with S1Administrator was conducted. She was questioned regarding resident representative notification after a resident has a room change. She revealed that the facility has sheets that tells who was notified and who notifies the representative. She further revealed that the nurse usually notifies the family when a resident had returned. She revealed that she could not find the room change sheets and confirmed that she could not find any documentation that family was notified of a room change for residents #1 and #3.
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, record review, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections by: 1.) staff (S4CNA) storing pericare cleansers in her own personal locker space and in scrub pockets with contaminated gloves before and after using on resident #4 who had a recent [DIAGNOSES REDACTED].) staff (S5CNA) touching her contaminated KN95 face mask with bare and ungloved hands, placing the mask in her scrub pocket, and failing to perform hand hygiene after touching the contaminated face mask prior to donning clean PPE. Reviewed 3 sampled residents for urinary tract infections (#1, #3, #4) out of a total of 6 sampled residents and total facility census 119. Findings: 1. Review of the medical record revealed resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the medical record revealed that resident #4 had recent [DIAGNOSES REDACTED]. Review of the medical record revealed care planning for problem onset: toileting deficit: incontinent of bowel and bladder related to dementia, subdural hematoma, impaired cognition, and overactive bladder. The documented approaches included, but was not limited to: check for incontinence care at least every 2 hours. Cleanse periarea/buttocks with Perifresh perineal cleanser. Pat dry. Apply Periguard ointment as a preventative measure. CNA (certified nursing assissant) may leave at bedside. Report skin conditions, signs of breakdown or redness. On 07/21/2020 at 11:00AM, an observation revealed resident #4 sitting up in her wheelchair in her room. S3CNA and S4CNA were present and getting ready to perform pericare. S3CNA and S4CNA explained that they needed to perform pericare and then assisted the resident in bed. S4CNA prepared the bedside table and placed a towel on the table along with a bath basin and clean washcloths. Further observation revealed one bottle of Perifresh, one bottle of DermaVera (skin and hair cleanser), and one tube of Periguard (skin protectant) ointment in her scrub pockets. During the observation of pericare, S4CNA retrieved the Perifresh and DermaVera bottles from her scrub pockets and used each during the pericare procedure. After each use, she would return the bottles to her scrub pockets. After the resident's front perineal area was cleaned, S3CNA and S4CNA repositioned resident #4 on her right side. S4CNA retrieved the bottle of Perifresh and DermaVera and placed the bottles on the resident's bedside table. She cleaned the resident's buttocks area with the cleansers and after each use she placed them back on the bedside table. S4CNA then applied the Periguard to the buttocks area. S4CNA then returned the ointment to her scrub pocket. Further observation was conducted. After completing pericare, S4CNA donned a clean pair of disposable gloves and with the assistance of S3CNA, they again repositioned resident #4 in bed. S4CNA was observed returning the bottles of Perifresh and DermaVera to her scrub pockets with the same contaminated gloved hands that she repositioned the resident with. S4CNA did not clean the bottles of Perifresh, DermaVera, and tube of Periguard ointment with any type of disinfectant after removing/returning them from her scrub pocket, prior to and after use for resident #4. After the procedure was completed an interview with S4CNA was conducted and she was questioned regarding the pericare cleansers and ointments being placed in her scrub pockets. She revealed that the cleansers and ointment were from her personal supply that she keeps in her employee locker. On 07/21/2020 at 12:08PM, an interview with S7DON (director of nursing) was conducted and she was notified of the findings regarding the Perifresh, DermaVera, and Periguard being stored in S4CNA's personal locker prior to use and the cleansers and ointment being placed in S4CNA's personal scrub pockets prior to, during, and after pericare for resident #4. S7DON was further notified of S4CNA handling the pericare cleanser bottles with her dirty, contaminated gloves and placing them back in her scrub pockets for possible further use on other residents. S2DON confirmed that the pericare cleansers and ointment were contaminated and should not be available for other possible resident use. 2. On 07/20/2020 at 12:37PM, an observation of the isolation unit (section of 500 hall that was designed for non-Covid-19 positive residents) revealed S5CNA preparing to don PPE. S5CNA had a KN95 face mask in place at that time. Further observation revealed a small dresser containing clean PPE supplies that was located in the hallway, outside of the resident's room. S5CNA donned a clean gown that she retrieved from the dresser. After donning the gown, she removed her KN95 face mask with her bare and ungloved hands. She placed the face mask inside of her left scrub pocket. S5CNA then retrieved and donned a clean pair of shoe covers and a clean face shield. Further observation was conducted. S5CNA removed a pair of disposable gloves from her scrub pocket and applied to gloves to both hands. She then picked an unopened can of coke from the dresser top and walked into the resident's room. S5CNA did not perform hand hygiene after she touched the contaminated face mask with her bare and ungloved hands and prior to donning the clean PPE items. On 07/20/2020 at 12:57PM, an interview with S6LPN (Licensed Practical Nurse) was conducted and she was notified of the findings regarding S5CNA during the PPE donning/doffing procedure. She revealed that all PPE should be kept at the doorway and once it is put on it is no longer clean. She further revealed that when it is taken off, it should be

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) thrown in the trash. She confirmed that S5CNA should not have put the contaminated mask in her pocket. On 07/20/2020 at 1:32PM, an interview with S2ADON (assistant director of nursing) also the facility's designated infection control preventionist, was conducted and she was notified of the findings regarding S5CNA during the PPE donning/doffing procedure. S2ADON revealed that each room (referring to the isolation rooms) had PPE for staff use. S2ADON confirmed that the PPE is for single use, no PPE is to be placed in the employee's pockets, and employees should wash hands and apply hand gel prior to going into a resident's room. Review of the Staff Skill: Personal Protective Equipment (PPE) Application / Removal revealed S5CNA had received in-serving on 03/25/2020.