STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195430	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLFAX REUNION NURSING AND REHABILITATION CENTER	**366 WEBB SMITH DRIVE COLFAX, LA 71417**

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	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to maintain infection control and prevention COVID-19 by failing to don the appropriate PPE while caring for residents on assigned units and failing to properly don PPE. This failed practice had the potential to affect all 92 residents residing in the facility. Findings: Review of the facility's addendum to policy titled, Precautionary Measures for Increase in Source Control for COVID Prevention dated 07/24/2020 read in part, We are treating each hall like the residents are positive to control containment. Gowns, gloves, face shields, and mask are to be worn. Interview on 07/24/2020 at 11:05 a.m. of S3 LPN revealed she received an N95 mask last week, but it got damaged. Observation at that time revealed she was noted wearing a cloth mask which kept slipping down her face uncovering her nose. She stated the elastic was loose on the mask. She stated she was working D-hall and E-Hall (isolation Hall). She revealed there was no special PPE she had to wear on the isolation hall. She stated she tested every resident's temperature and pulse oximetry twice a day. She stated she wiped off the pulse ox with alcohol prep between each use and the thermometer did not touch any resident, therefore she did not wipe it down between each use. She stated she was assigned to check vital signs on several residents daily and did not remember the last time she wiped down a blood pressure cuff. She stated she checking the resident's BP on the isolation hall and not wiping the B/P cuff after each use. She stated she was not instructed on cleaning equipment between each resident use. Interview on 07/24/2020 at 12:35 p.m. with S1Adm revealed he had 4 boxes of 30 each of KN95 mask in the facility. He stated he had over 500 KN95 mask in the storage unit outside and was going out to retrieve them. S1 Adm confirmed S3 LPN, who was working on the isolation hall should have been wearing a KN95 mask, due to her mask not staying on properly. He immediately took a KN95 mask to her to replace her cloth mask that was not functioning properly. Observation on 07/27/2020 at 8:25 a.m. revealed S2 ICN brought a disposable gown for the surveyor to don upon entrance. Interview with S2 ICN at that time revealed the facility had just implemented gowns were to be worn on all resident halls by staff, and to be changed between each resident. During the interview with S21 CNA, an observation was noted that the CNA on the hall was going in and out of resident's rooms and did not have a gown on. Two additional CNAs who were not wearing gowns, entered the D-hall (non-isolation hall) and began going in and out of rooms passing out meal trays. S2 ICN walked away and did not reply further. Observation on 07/27/2020 at 8:27 a.m. revealed S4 CNA entered Resident #3's room and elevated the HOB and began to feed the resident. She was observed not wearing a gown. Interview with S4 CNA at that time revealed she did not even have time to don her gown which was still on the cart. She stated when she arrived to work that morning she was given a mask, face shield, and gowns to wear. Interview on 07/27/2020 at 8:50 a.m. with S2 ICN revealed the facility decided gowns were a precautionary measure and staff were to change gowns between each resident on the isolation hall. She stated the staff that worked on the non-isolation halls could wear the same gown between residents. She stated they started in-servicing staff on Friday 07/24/2020, about the PPE changes, but had not in-serviced everyone yet. During the interview with S2 1CN, an observation was noted where S6 LPN was on the D-Hall and did not have a gown on. She confirmed there was definitely a break in communication and everyone would have to be in-serviced. Observation on 07/27/2020 at 9:50 a.m. revealed S5 CNA, was on the B-Hall and was not wearing a face shield or gown. Interview with S5 CNA at that time revealed she had taken her gown and face shield off, during her break and forgot to put them back on before returning to hall again. Interview on 07/27/2020 at 11:02 a.m. with S6 LPN, confirmed she did not have on a gown earlier, but should have. She stated she had not been to work since last Thursday (07/23/2020) and did not know the new PPE requirements. She stated she now has to don a disposable gown, N95 mask, and face shield while on duty. She stated she had to change gowns between residents on the isolation hall. She also revealed when she worked on 07/23/2020, she was not changing gowns between residents on the isolation hall. Observation on 07/29/2020 at 8:12 a.m. of S7 LPN, revealed she was working on A-Hall and was only wearing an N95 mask. Interview with S7 LPN on 07/29/2020 at that time confirmed she should also have a face shield and gown on. She revealed she had been in-serviced on Sunday (7/26/2020) that staff were required to wear N95 mask, face shields and gowns while on duty. She then pointed out the supplies in the corner which included the required equipment. She continued the interview without donning her required PPE. Several observations on 07/23/2020, 07/24/2020, 07/27/2020, and 07/28/2020 did not reveal any posted signs on the A-Hall, B-Hall, C-Hall (COVID unit), D-Hall, or E Hall (isolation unit) indicating the required PPE to don before entering the area.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE