STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195510	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RUSTON NURSING AND REHABILITATION CENTER,LLC	3720 HWY 80 EAST RUSTON, LA 71270

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview the facility failed to ensure staff practices were consistent with current infection control principles and practices to prevent the spread of infection by failing to properly don PPE (personal protective equipment) before entry to residents' room on isolation and transmission based precautions. Findings: Observation on 7/14/2020 at 11:50AM revealed residents' room [ROOM NUMBER] on A Hall in the facility with PPE cart outside door and signage on door: 1. Contact Precautions WEAR KN95 MASK written and included in instructions. 2. PPE Must Be Worn When Entering - Gowns, Gloves, Facemask (on orange paper) Further observation revealed S4 CNA (certified nursing assistant) entered room [ROOM NUMBER] with meal tray and failed to put on gown and gloves before entry. S4 CNA then exited room [ROOM NUMBER], grabbed another meal tray from cart and re-entered room [ROOM NUMBER], again without gown and gloves. During an interview on 7/14/2020 at 11:55AM S4 CNA was asked by surveyor the isolation status of residents in room [ROOM NUMBER]. S4 CNA opened the door to room [ROOM NUMBER], looked inside, closed the door, and then stated there is nothing wrong with them. During an interview on 7/14/2020 at 2:24PM S5 SSD (scheduling and staff development), confirmed room [ROOM NUMBER] on A Hall was shared by two residents on isolation and transmission based precautions. S5 SSD reported S4 CNA was trained on proper use of PPE and infection control practices. S5 SSD confirmed infection control practices and facility policy was not followed when S4 CNA failed to don appropriate PPE prior to entry to room [ROOM NUMBER].
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review and interviews the facility failed to ensure the notification of the facility's COVID-19 status to all residents' representatives and families. The facility failed to ensure all residents with a responsible party (RP), emergency contact or POA (power of attorney) were notified of confirmed positive COVID-19 cases in the facility by the next calendar day at 5:00 PM. Findings: Review of the facility policy entitled Coronavirus/COVID-19 revealed in part: Section: Communication 2. Notify the resident, resident representative and family of confirmed infection of COVID-19 or when 3 or more resident's or staff with new-onset of respiratory symptoms occurring within 72 hours of each other by 5pm the next day. During an interview on 7/14/2020 at 9:36am S2 Corporate nurse reported the facility utilized a Hotline phone line that was updated as needed and available for residents' families to call to obtain facility updates in regards to the COVID-19 status in the facility. S2 Corporate nurse further reported each family received a letter from the facility in May 2020 that informed them of the Hotline and the phone number to call. S2 Corporate nurse reported the facility administrator called the family/RP of 4 newly confirmed COVID-19 residents last week to notify them of their resident's positive COVID-19 status and that no other residents' families/RPs were notified. During an interview on 7/14/2020 at 3:05pm S3 Social Services reported she received a telephone call from the daughter-in-law of Resident #4 on 7/13/2020 inquiring about positive COVID-19 cases in the facility. S3 Social Services further reported the daughter-in-law indicated she had not been notified by the facility and only had knowledge of the positive COVID-19 cases in the facility by calling the Hotline. During a telephone interview on 7/14/2020 at 3:50pm S1 Administrator reported if a resident tested positive for COVID-19 only that resident's family/RP would be notified by telephone call and not all residents' families/RPs would be notified of the positive COVID-19 case. When asked by the surveyor if it was the residents' families/RPs responsibility to call the Hotline in order to obtain the facility's status of COVID-19 within the facility, S1 Administrator affirmed that it was. When asked by the surveyor how often the Hotline was accessed by residents' families/RPs, S1 Administrator indicated this was an unknown number. When asked by the surveyor if there was a possibility that some residents' families/RPs may not be aware of positive COVID-19 cases currently in the facility, S1 Administrator responded that it was a possibility if they had not called into the Hotline. S1 Administrator confirmed the families/RPs were notified for the 4 residents that tested positive for COVID-19 last week but no other residents' families/RPs were notified by the facility of the COVID-19 status in the facility. During a telephone interview on 7/14/2020 at 4:10pm the niece, POA and resident contact of Resident #1 reported she had not received any telephone calls or letters from the facility for notification of positive COVID-19 cases in the facility nor was the niece aware of the facility Hotline phone line that she could call to get information on her own. The niece reported she received information from her uncle (Resident #1) there were positive COVID-19 cases in the facility and not from the facility. During a telephone interview on 7/14/2020 at 4:27pm the wife of Resident #2 reported she had not received any telephone calls or letters from the facility for notification of positive COVID-19 cases in the facility nor was the wife aware of the facility Hotline phone line that she could call to get information on her own. The wife further reported she called a staff member today to check on the status of her husband (Resident #2 was on Hospice, [MEDICAL CONDITION] and Alzheimers) and was informed by this staff member that there were positive COVID-19 cases currently in the facility. During a telephone interview on 7/14/2020 at 4:36pm the daughter of Resident #3 reported she had not received any telephone calls or letters from the facility for notification of positive COVID-19 cases in the facility nor was the daughter aware of the facility Hotline phone line that she could call to get information on her own. The daughter reported she found out about the positive COVID-19 cases in the facility through a text message from a friend that resided on the same hallway as her father (Resident #3) and not from the facility.

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.