STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195500	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIOGA COMMUNITY CARE CENTER	**5201 SHREVEPORT HWY PINEVILLE, LA 71360**

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** - Some	**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 interview and record review, the facility failed to implement/maintain a comprehensive person-centered care plan that included a re-admission medication review and reconciliation for 1 (#1) of 5 sampled residents. Findings: Review of the facility's policy for Reconciliation of Medications on Admission revealed, in part: 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. 2. Using an approved form or other method, list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders. 3. Review the list carefully to determine discrepancies/conflicts, such as, the dosage on the discharge summary does not match the dosage from the resident's previous MAR. 4. If there is a discrepancy or conflict in medications, does, route, or frequency, determine the most appropriate action to resolve the discrepancy, such as contacting the physician from the referring facility or the admitting or Attending Physician. Review of Resident #1's physician's orders [REDACTED].#1's eMARs from March 9, 2020 through July 23, 2020 revealed both strengths of the [MEDICATION NAME] were listed for prn use. Review of nursing progress notes dated 03/08/2020 revealed the resident was transferred to a local emergency department for c/o abdominal and chest pain. She returned to the facility with a new order for [MEDICATION NAME] 4 mg po q 8 hrs prn nausea/vomiting. Both orders remained on the eMAR. On 03/11/2020, she received [MEDICATION NAME] 4mg at 11:02 a.m. and 8 mg at 3:48 p.m. On 03/13/2020, the resident's physician visited and ordered [MEDICATION NAME] 8 mg q 8 hrs prn nausea/vomiting. Both orders for [MEDICATION NAME] remained on the eMAR. On 03/14/2020, [MEDICATION NAME] 4 mg was administered at 8:10 p.m., and [MEDICATION NAME] 8 mg administered at 11:57 p.m. Interview with S5 LPN revealed she was assigned to Resident #1. She verified that two different strengths of [MEDICATION NAME] were listed on the eMAR, with no parameters to differentiate when the lower or higher dose should be given. She stated she would have to contact the nurse practitioner or doctor to determine which dose should be administered. She confirmed that she was the nurse on duty when the resident returned from the 03/08/2020 hospitalization , and she failed to reconcile the 2 different doses of [MEDICATION NAME]. She stated she should have removed the 8 mg po q 8 hrs PRN order for [MEDICATION NAME] when the resident returned with an order for [REDACTED]. Telephone interview with S6 LPN revealed she was the medical records nurse who completed medication reconciliations every 24 hours on records of residents with medication holds, discontinued medications, and new orders. She stated the reconciliation list was reviewed at the morning meeting daily, Monday through Friday. She stated the nurse who received the resident from the hospital should have notified the MD or NP for order clarification for the [MEDICATION NAME]. She further stated that she failed to identify the two different [MEDICATION NAME] orders on 03/09/2020 and on 03/13/2020 and should have called the MD/NP to clarify the order.
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 an infection control program designed to prevent the development and transmission of communicable diseases and infections (COVID-19) by failing to ensure that staff utilized PPE according to facility policy. The facility census was 84, with 17 COVID-19 positive residents in the COVID-19 isolation unit. Findings: Review of the facility's Infection Control Interim Policy for Coronavirus revealed, in part: 1. For the duration of the emergency, all staff should wear a mask while in the facility. 2. Employees must wear no less than ear loop masks, if PPE is available. Observation of S3 OT on 07/22/2020 at 8:30 a.m. revealed she was seated on a chair in the hallway of the facility's secured COVID-19 isolation unit, talking on a cellular phone. She was not wearing a mask or face shield. Interview with S4 Ward Clerk on 07/22/2020 at 8:35 a.m. revealed she arrived to work at 7:00 a.m. and had not screened S3 OT. She stated S3 OT must have entered the unit prior to 7:00 a.m. She observed S3 OT seated in the hallway of the unit and confirmed that she was not wearing any PPE. Interview with S3 OT on 07/22/2020 at 8:40 a.m. revealed she was not wearing a mask because the resident with whom she was conducting the Face time call could not understand her with a mask on. She stated she was being bad and should have had her mask on. She further stated she was issued a package of isolation gowns, gloves, an N95 mask, a face shield, and shoe covers on the afternoon of 07/21/2020, when she was oriented to the COVID unit by S5 RSD (Rehabilitation Services Director) at the facility. She stated she did not think she had to wear the gown until she entered a resident's room, but should have donned a mask and face shield prior to entering the unit. Interview with S1 Administrator on 07/22/2020 at 9:15 a.m. revealed that therapy staff attended facility-specific orientation, performed by Nursing Administrative staff. She stated they received daily updates related to COVID-19 and were monitored for competencies via skills checklists performed by nursing personnel. She further stated S3 OT had received PPE training and should have donned an N95 mask and face shield while in the COVID unit.

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.