| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195293 | A. BUILDING _____ B. WING _____ | 05/22/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| NATCHITOCHES NURSING AND REHABILITATION CENTER,LLC | 750 KEYSER AVENUE NATCHITOCHES, LA 71457 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to accurately assess a resident's urinary status after readmission from the hospital (#5), and a resident's wounds prior to hospital transfer (#6) for 2 (#5, #6) of 7 (#1, #2, #3, #4, #5, #6, #7) sampled residents. Findings: 1. Review of Resident #5's April 2020 Physician order [REDACTED]. Review of the Comprehensive Plan of Care revealed the problems included Bowel and Bladder Incontinence (Onset date 10/17/2014), and the approaches included complete assessment to determine potential for bladder training. Review of the Admission / Readmission Evaluation dated 04/27/2020 completed by S15 RN Unit Manager revealed the resident was readmitted to the facility after hospitalization , and she was assessed to be incontinent of urine and required briefs. Review of the Bladder Incontinence Evaluation dated 04/27/2020 revealed S15 RN Unit Manager initialed and signed the assessment for the evaluation of 6 criteria. Criteria #5 included the assessment of the bladder control status and it was scored 3 incontinent (inadequate control, multiple daily episodes). Review of the nurse's note dated 05/01/2020 revealed the resident had a Foley catheter present. Review of the Annual MDS assessment dated [DATE] (ARD) revealed the resident required extensive assistance of 2 people for bed mobility, dressing and toilet use and was totally dependent on 2 people for transfers. Further review revealed an indwelling urinary catheter was in use. Telephone interview on 05/15/2020 at 3:22 p.m. with S15 RN Unit Manager revealed she had completed the Admission / Readmission Evaluation for the resident on 04/27/2020 when the resident returned from the hospital and did not include the use of the Foley Catheter in the assessment of urinary status, and should have. Telephone interview on 05/18/2020 at 11:43 a.m. with S17 LPN revealed she worked with the resident on the night shift of 05/01/2020 (6:02 p.m. to 6:50 a.m. per time card) and confirmed the resident had a catheter and had recently returned from the hospital with the catheter in use. 2. Review of Resident #6's May 2020 Physician order [REDACTED]. Further review of the Physician order [REDACTED]. Review of the Quarterly MDS assessment dated [DATE] (ARD) revealed the resident had a memory problem of short and long term memory, was able to hear and understand others and had clear comprehension. Further review revealed he had clear speech and distinct intelligible words. The resident was assessed to require the extensive assistance of two people for bed mobility, transfer, toilet use, and was totally dependent on staff with a two person assist for locomotion on and off the unit. Review of the wound assessments (provided on 05/08/2020) revealed the wound assessments for the above wounds were signed off by S3 Treatment Nurse as Completed By on 05/04/2020 for the Assessment Date of 05/01/2020. Review of the above wound assessments revealed: Right Heel Diabetic Ulcer - 5 cm x 11 cm x 0.2 cm, heavy red or sanguinous exudate with no odor, full thickness ulcer with 100% granulation tissue and clearly visible wound edges; Left Lateral Ankle Stage 2 PU - 0.8 cm x 0.8 cm x 0.1 cm with 100% granulation tissue to wound bed, no exudate, no odor. Left Lateral Calf - 0.5 cm x 0.5 cm x 0.2 cm, moderate amount of red or sanguinous exudate, periwound intact, wound edges scarred, wound edges clearly visible and no assessment of tunneling was documented. Review of the time card for S3 Treatment Nurse dated 05/01/2020 revealed there were no hours for on duty entered. Telephone interview on 05/12/2020 at 3:01 p.m. with S3 Treatment Nurse confirmed she did not work on 05/01/2020 and did not complete a comprehensive wound assessment of the resident's wounds on 05/01/2020 or 05/04/2020. Review of a Nurse's Note dated 05/13/2020 provided by S3 Treatment Nurse revealed a statement for clarification for the wound care assessments dated 05/01/2020 (completed 05/04/2020) that the assessments were obtained during wound care on 04/29/2020, and the assessment should have been dated 04/29/2020. Review of the Interdisciplinary Progress Note dated 05/04/2020 provided by S3 Treatment Nurse as a late entry for 04/29/2020 revealed the wound assessments were: Right Heel Diabetic Ulcer - 5 cm x 11 cm x 0.2 cm, heavy red exudate with no odor, ulcer had full thickness with 100% granulation tissue and clearly visible wound edges; Left Lateral Ankle Stage 2 PU - 0.8 cm x 0.8 cm x 0.1 cm with 100% granulation tissue to wound bed, no exudate, no odor. Left Lateral Calf - 0.5 cm x 0.5 cm x 0.2 cm with tunneling at 12:00 o'clock of 3 cm, moderate amount of red exudate, periwound intact, wound edges scarred, and edges clearly visible. Review of the nurse's note dated 05/04/2020 at 1:02 p.m. revealed EMS was called to transport the resident to the hospital. Telephone interview on 05/13/2020 at 9:53 a.m. with S3 Treatment Nurse revealed she removed the wound vac, changed the wound dressings and observed the resident's wounds in preparation for the resident's transfer to the hospital on [DATE]. She stated the wounds had granulation tissue and had not changed in appearance since her last assessment on 04/29/2020. Review of the History and Physical (from the hospital record) dated 05/04/2020 documented at 20:42 p.m. (8:42 p.m.) revealed the resident had a large wound on his left lateral lower leg with foul smelling drainage, and required admission to ICU for evaluation of [MEDICAL CONDITION]. The Physician documented he suspected the [MEDICAL CONDITION] was Secondary [MEDICAL CONDITION] from the Lower Extremity Wounds. Review of the RN Wound assessment dated [DATE] at 9:15 a.m. of the wound to the right heel revealed it measured 4.5 cms x 9.5 cms x 0.5 cms and the general appearance was [MEDICAL CONDITION], reddened, slough tissue, boggy, irregular, ischemic, skin denuded, draining, and ecchymotic. The RN documented the greater portion of the wound was yellow, dusky, deep purple/bluish and the lesser portion of the wound was red. The RN documented the wound was unstageable. The RN documented the surrounding tissue was darkened and macerated. The RN further documented the Right Achilles Ulcer wound extended to superior heel and to lateral ankle area, mostly dusky with yellow slough tissue, and the red tissue was mostly to lateral aspect. Review of the RN Wound assessment dated [DATE] at 9:15 a.m. of the wound to the Left Lateral Lower Leg revealed Stage 4 Pressure Injury that measured 2 cms x 1.5 cms x 1 cm with 100% red granulation tissue with surrounding tissue macerated. The RN documented the wound had tracking at 12:00 o'clock - 5.5 cms, and drained [MEDICAL CONDITION] drainage on periwound palpation. Review of the RN Wound assessment dated [DATE] at 9:15 a.m. of the wound to the Left Lateral Ankle revealed the wound was an Unstageable Pressure Wound that measured 2.5 cms x 2 cms with superior aspect black and inferior aspect yellow with minimal red tissue, and dark periwound to anterior aspect. |
| F 0656<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to develop and implement the residents' plan of care by failure to monitor a resident's BP every 2 hours as ordered (#6), to provide wound care timely (#6), and to monitor and document the characteristics of a resident's urine (#5) for 2 (#5, #6) of 7 (#1, #2, #3, #4, #5, #6, #7) sampled residents. Findings: 1. Review of Resident #6's May 2020 Physician Orders revealed the resident's [DIAGNOSES REDACTED]. The Physician Orders for medications included [MEDICATION NAME] HCL 5 mg po tid, [MEDICATION NAME] 2.5 mg po q day, and [MEDICATION NAME] HCL 200 mg po q day. The Physician Orders for wound care included: Stage 2 PU Left Lateral Ankle - cleanse with wound cleanser, pat dry with gauze, and apply dressing q Monday, Wednesday and Friday; Left Lower Lateral Leg Diabetic Ulcer Grade 2 - cleanse with wound cleanser, pat dry, pack with nu gauze impregnated with [MEDICATION NAME] q Monday, Wednesday and Friday. Review of the Quarterly MDS assessment dated [DATE] (ARD) of the resident's short and long term memory revealed there was a memory |

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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| | **195293** | A. BUILDING _____ B. WING _____ | **05/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **NATCHITOCHES NURSING AND REHABILITATION CENTER,LLC** | **750 KEYSER AVENUE NATCHITOCHES, LA 71457** |

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| F 0656<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>problem, and that he was able to hear others, understood and had clear comprehension. Further review revealed he had clear speech and distinct intelligible words. The resident was assessed to require the extensive assistance of two people for bed mobility, transfer, toilet use, and was totally dependent on staff with a two person assist for locomotion on and off the unit. Review of the skin conditions revealed he had 1 stage 4 pressure ulcer, 3 unstageable pressure ulcers and the other skin condition of [MEDICAL CONDITION]. Review of the May 2020 MAR revealed the resident's BP 60/38 was documented with the medication [MEDICATION NAME] HCL 5 mg po tid on 05/03/2020 at 3:00 p.m. Review of the Nurse's Note dated 05/03/2020 at 7:53 p.m. completed by S4 LPN revealed the resident's BP was low (60/38) on 05/03/2020, and the Physician was notified. Further review revealed the nurse received the order to monitor the resident's BP every 2 hours and to notify the Physician of any changes. Telephone interview on 05/15/2020 at 1:40 p.m. with S4 LPN revealed she was the resident's assigned nurse on the day shift on 05/03/2020. S4 LPN confirmed the resident had experienced a low blood pressure on 05/03/2020 of 60/38, and she stated she notified the resident's Physician and informed him. She confirmed the Physician gave her the orders to check the resident's BP every 2 hours and to notify him of any changes. She stated she informed the night nurse S17 LPN of the new order, and S4 LPN stated she wrote the order down in the 24 hour report book. She stated the BPs should be documented in the nurses' notes, MAR and vital sign jot sheets. Review of the May 2020 MAR revealed the resident's BP of 129/83 was documented on 05/03/2020 at 9:00 p.m. with the medication [MEDICATION NAME]. Further review of the nurses' notes, MAR, and vital sign sheets revealed there were no further BPs documented after 9:00 p.m. on the 05/03/2020 / 05/04/2020 night shift. The next BP documented was documented on the vital sign sheet for the day shift of 05/04/2020 - 71/46. Review of additional information from jot sheet notes provided by S17 LPN revealed 2 BPs were documented for her shift on 05/03/2020 (6:11 p.m. to 6:09 a.m. per time card), and they were 99/63 and 123/87. Further review revealed there were no times documented for the BPs. Telephone interview on 05/20/2020 at 12:33 p.m. with S17 LPN confirmed she worked the night shift on 05/03/2020 and she stated she could not find documentation of additional BPs done by her after the 9:00 p.m. medications were administered. She stated she looked through her documentation for additional BPs for that night and found 2 BPs from their jot sheet notes for 05/03/2020. She stated she did not have the times that the BPs were done but they would have been done by the CNAs during the 3:00 p.m. to 11:00 p.m. shift time frame, because the CNAs did not do BP checks on the night shift. Telephone interview on 05/13/2020 at 12:00 p.m. with S18 LPN revealed she was the resident's day shift nurse on 05/04/2020, and had administered his morning medications on that day. She stated the Restorative CNA checked the resident's vitsl signs on 05/04/2020 before she gave him his 9:00 a.m. medications and gave her the BP information to use. Further interview revealed she did not recheck the resident's BP before he was transferred to the hospital on [DATE]. Review of the nurse's note dated 05/04/2020 at 1:02 p.m. revealed EMS was called to transport the resident to the hospital. Review of the History and Physical (from the hospital admission) dated 05/04/2020 documented at 20:42 p.m. (8:42 p.m.) revealed the resident was admitted to ICU for [REDACTED]. Telephone interview on 05/21/2020 at 10:25 a.m. with S2 DON confirmed they had received the order to check the resident's BP every 2 hours on 05/03/2020 and they did not have documentation that it was done every 2 hours as ordered, and should have. Review of the May 2020 TAR revealed S3 Treatment Nurse signed off for treatments of the wounds to the Stage 2 PU Left Lateral Ankle and the Left Lateral Lower Leg Diabetic Ulcer for the date of Friday 05/01/2020. Review of the time card for S3 Treatment Nurse revealed there were no hours entered as worked on the date of 05/01/2020. Telephone interview on 05/12/2020 at 3:01 p.m. with S3 Treatment Nurse revealed she did not work on 05/01/2020 and had signed the treatments off (as performed) on that day in error. Telephone interview on 05/15/2020 at 1:40 p.m. with S4 LPN revealed she was assigned as the resident's nurse on 05/01/2020 and was asked by the Administrator to do his wound care treatments on 05/01/2020. She stated they did not have a Treatment Nurse assigned for treatments on Friday 05/01/2020. She stated she was unable to perform the resident's wound care that day (05/01/2020), and had informed the Administrator. Telephone interview on 05/13/2020 at 12:11 p.m. with S2 DON confirmed the resident's wound care treatments were not done on Friday 05/01/2020 as ordered, and should have been. 2. Review of Resident #5's April 2020 Physician Orders revealed the [DIAGNOSES REDACTED]. Review of the Annual MDS assessment dated [DATE] (ARD) revealed the resident required extensive assistance of 2 people for bed mobility, dressing and toilet use and was totally dependent on 2 people for transfers. Further review revealed the resident required the use of a indwelling urinary catheter. Review of the Comprehensive Plan of Care revealed the resident's problems included the Risk for UTI due to history of UTI (Problem Onset Date 11/05/2014), and the approaches included monitor urine for color/consistency and document observations. Review of the nurse's note dated 04/23/2020 at 5:53 p.m. revealed the resident was transferred to the hospital and admitted to ICU. Review of the Hospital Medical Record physician progress notes [REDACTED]. Coli (catheterized specimen). Review of the facility Admission / Readmission Evaluation dated 04/27/2020 completed by S15 RN Unit Manager revealed the resident was readmitted to the facility from the Hospital and was incontinent of urine and required briefs. Review of the Hospital Return Physician's orders dated 04/27/2020 prepared by S15 RN Unit Manager revealed there were no orders related to the use of the Foley catheter. Review of the April 2020 MAR, PRN Medication Record, Flow Sheets and nurses' notes revealed there was no documentation of the use of a Foley catheter, and there were no assessments of the characteristics of the resident's urine. Review of the nurse's note dated 05/01/2020 documented by S4 LPN revealed the resident had a Foley catheter present. Further review revealed there was no documentation concerning the assessment of the characteristics of the resident's urine. Telephone interview on 05/15/2020 at 1:40 p.m. with S4 LPN revealed she worked the day shift with the resident on 04/28/2020 and 05/01/2020 and she confirmed the resident had a Foley catheter in use. She stated the characteristics of the resident's urine should have been documented in the nurses' notes and / or the MAR. Review of the nurse's note dated 05/02/2020 at 4:40 a.m. documented by S17 LPN revealed at approximately 10:00 p.m. the resident required transfer to the hospital. Telephone interview on 05/18/2020 at 11:43 a.m. with S17 LPN revealed she worked with the resident on the night shift of 05/01/2020 (6:02 p.m. to 6:50 a.m. per time card) and confirmed the resident was readmitted to the hospital. She stated the resident had a catheter and that the resident had recently returned from the hospital with the catheter. She stated the characteristics of the urine should have been documented on the MAR Flow Sheet and / or nurses notes. She stated observations of the characteristics of the resident's urine should have been completed and added to the MAR when she returned from the hospital. Review of the ED Practitioner Record dated 05/01/2020 at 22:40 (10:40 p.m.) revealed the Physician's Clinical Impression and [DIAGNOSES REDACTED]. Review of the Urinalysis Report dated 05/02/2020 at 0025 (12:25 a.m.) revealed Cloudy, Light Yellow Urine, 1+ [MEDICATION NAME] (high), 2+ Leuk Esterase (high), 15-20 RBCs (high), 4+ Bacteria (high), and 100-120 WBCs (high), and the Urine Culture and Sensitivity Report revealed Escherichia Coli and Proteus Mirabilis were cultured. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews, observations and interviews, the facility failed to implement accepted infection control practices, and transmission-based precautions to help to prevent and control the spread of an infectious communicable disease (Coronavirus 2019) for 22 out 52 residents in the facility who had not tested positive for Covid 19. The facility failed to: 1. prevent cohorting between COVID-19 positive and negative residents 2. ensure compliance of all staff in the proper use and disposal of PPE; 3. have dedicated or disposable non-critical resident care equipment, or equipment that was disinfected between residents according to the facility's infection control policy; and Findings: COHORTING Review of the facility policy titled: Droplet Precautions revealed in part A private room is important when the source patient has poor hygiene habits, contaminating the environment or cannot assist in maintaining precautions. When a private room is not available, place resident in a room with a resident who has active infectious with the same microorganism but no other infection (cohorting) when cohorting is not achievable, maintain spatial separation of at least 3 feet between residents. Drawing the curtain between patient beds is especially important for patients in multi bed rooms with infections transmitted by the droplet route. 1. Interview on [DATE] at 12:26 p.m. with a nurse seated at the nurses' station revealed that she was an agency nurse. She stated that she was the nurse assigned to hall c where 20 residents who were COVID-19 negative and 3 residents who were COVID-19 positive resided. Further interview revealed that #R1, a COVID-19 positive resident, and #R2 a COVID-19 negative resident currently shared room b. She stated that a nurse from hall d (the hall the facility designated as the COVID-19 positive hall) was assigned to take care of #R1 and that she was assigned to take care of #R2. Observation on [DATE] at 12:30 p.m. of room b accompanied by an agency LPN, revealed that the room was occupied by #R1 (COVID-19 positive), and #R2 (COVID-19 negative). Further observation revealed that there was no curtain drawn or divider between the residents' beds. Interview on [DATE] at 12:39 p.m. with S2 DON confirmed that #R1 (COVID-19 positive) and #R2 (COVID-19 negative) currently shared a room. Interview on [DATE] at 1:40 p.m. with S3 IC Nurse confirmed that resident R1 tested positive for COVID-19 on [DATE], and that #R2 was COVID-19 negative. She further stated there were |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>rooms available on the facility's COVID-19 positive hall d on [DATE], and that #R1 was being moved to the Covid-19 hall d, on today ([DATE]); 11 days after #R1 tested positive. Interview on [DATE] at 3:15 p.m. with S1 Administrator, revealed that she was unaware of cohorting in the facility with COVID-19 positive and COVID-19 negative residents. She stated that there may have been a breakdown in communication. S1 Administrator confirmed that #R1 had resulted COVID-19 positive on [DATE]. Review of the Face Sheet for #R1 revealed that he was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of #R1's MDS Admission assessment with an ARD of [DATE], revealed #R1 had a BIMS of 12 (mild cognitive<br>impairment) and required extensive assistance for bed mobility, dressing, toileting, did not transfer and had ROM impairment on one side. Review of the Face Sheet for #R2 revealed that he was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of #R2's MDS Admission assessment with an ARD of [DATE], revealed #R2 had a BIMS of 99 (severe cognitive impairment) and required extensive assistance for bed mobility, transfers, dressing, toileting, and had bilateral lower extremity impairments in range of motion. Further review revealed the resident used a wheelchair for mobility. 2. Review of a facility census dated [DATE] revealed that residents #6 (COVID-19 positive) and #7 (COVID-19 negative) shared room [ROOM NUMBER]. Review of resident #6's Coronavirus [DIAGNOSES REDACTED]-CoV-2 testing collected on [DATE] revealed the results were, Detected, and were reported on [DATE]. Review of resident #7's Coronavirus [DIAGNOSES REDACTED]-CoV-2 testing collected on [DATE] revealed the results were, Not Detected, and were reported on [DATE]. Review of the Census List dated<br>[DATE] revealed that resident #7 was moved to another room on [DATE], 3 days after resident #6 resulted positive. 3. Interview on [DATE] at 11:00 a.m. with S3 IC Nurse revealed the facility received new COVID-19 positive lab results on 6 residents this morning, including #R4 and #R5. Interview on [DATE] at 11:05 a.m. with S2 DON revealed that #R5 (COVID-19 positive) shared a room with #R6, whose test results were pending. Interview on [DATE] at 11:09 a.m. with S1 Administrator revealed the facility had received the newly COVID-19 positive resident lab results on [DATE] at around 11:00 p.m. Interview on [DATE] at 1:45 p.m. with S1 Administrator revealed that the nurse on duty on [DATE] at 11:00 p.m. did not notify her or the DON when the results were received. She stated that the nurse who received the fax should have immediately notified her or the DON. Interview on [DATE] at 4:10 p.m. with S1 Administrator revealed had she or the DON known about the positive COVID-19 results that were received on the night of [DATE], they would have immediately moved the negative resident (#7) out of the room that #7 shared with #R4, and they would have moved the resident with pending results (#R6) out of the room with the positive resident (#R5). Interview on [DATE] at 4:06 p.m. with S2 DON revealed a room change was done on [DATE] for #R5 and #R6, after #R5 resulted positive for COVID-19 on [DATE]. Interview on [DATE] at 4:20 p.m. with S2 DON revealed had she known on [DATE] about the positive COVID-19 results she would have immediately notified the MD and separated the positive from the negative residents and the residents with pending results. Telephone interview on [DATE] at 5:15 p.m. with another agency nurse revealed she worked the night shift on [DATE], beginning at 12:00 midnight. She stated the COVID-19 positive test results for #R4 and #R5 came in that night. She stated she must have missed #R5's (COVID-19 positive) and #R6's (pending results) and did not move them. Telephone interview on [DATE] at 3:18 p.m. with S17 LPN revealed that she worked the night shift on [DATE] from 6:00 p.m. to 6:00 a.m. She stated she received COVID-19 test results that night and some were positive. S17 LPN further stated she did not know she was supposed to call the Administrator or DON with the positive COVID-19 test results, and confirmed she had not moved any residents that night. NON-CRITICAL RESIDENT CARE EQUIPMENT Review of the facility policy titled: Droplet Precautions revealed in part d. Resident care equipment-when possible dedicate use of non-critical care equipment to a single resident. If use of common equipment or items is unavoidable then adequately clean and disinfect before use for another resident. Interview on [DATE] at 12:47 p.m. with S7 CNA revealed that she was assigned as a floater for all halls in the facility. She stated she had obtained vital signs on all 52 residents in the facility. She further stated that she obtained vital signs on the COVID-19 negative residents first, and then the COVID-19 positive residents, and that she used the same machine. She stated that she cleaned the blood pressure cuff with alcohol based hand rub before going from negative to positive residents, but did not clean between residents. Observation on [DATE] at 1:15 p.m. revealed S6 CNA entered the staff breakroom on hall d, (where only COVID-19 positive residents resided), removed a rolling vital sign machine, and proceeded to roll the vital sign machine to hall c (where COVID-19 positive and negative residents resided). S6 CNA revealed that she was assigned to hall c. She stated there was no vital sign machine on hall c and the hall c nurse needed a resident's blood pressure checked. She further stated she did not know if the machine had been previously cleaned; if it had been used on a COVID-19 positive resident; if it had been cleaned between residents; how often the machine was supposed to be cleaned; or what the process was for cleaning the machine. S6 CNA confirmed that she was occasionally assigned to perform vital sign checks on residents. Interview on [DATE] at 1:50 p.m. with S14 CNA revealed she used the same vital sign machine for the positive hall and the negative hall. She stated the machine on the positive hall wasn't always fully charged, and she didn't want to stop what she was doing and go after another machine or charge the one she was using. Review of the CDC guidance titled: Strategies to Mitigate Healthcare Personnel Staffing Shortages revealed in part . 1. If not already done, allow HCP with suspected or confirmed COVID 19 to perform job duties where they do not interact with others, such as in telemedicine services. 2. Allow HCP with confirmed COVID 19 to provide direct care only for patients with confirmed COVID 19, preferably in a cohort setting. 3. Allow HCP with confirmed COVID 19 to provide direct care for patients with suspected COVID 19. 4. As a last resort, allow HCP with confirmed COVID 19 to provide direct care for patients without suspected or confirmed COVID 19. Interview on [DATE] at 2:48 p.m. with S2 DON revealed that 19 staff members tested positive for COVID-19, and that 9 of the 19 had returned to work. She stated that she was unaware of any staff members being retested . Further interview revealed that the facility currently had 36 positive COVID-19 resident cases and 4 COVID-19 positive residents in the hospital. She also stated that 7 residents had died that were positive for COVID-19, two of which were hospice patients. Interview on [DATE] at 2:50 p.m. with S1 Administrator revealed that she used the CDC's criteria for return to work for Healthcare Personnel with Suspected or Confirmed COVID-19, and the CDC's Strategies to Mitigate Health Care Personnel Staffing Shortages guidance to staff the facility. She stated that although she reached out to four staffing agencies, she had difficulty finding CNAs to cover some shifts. Review of the facility's shift assignments revealed the following: On [DATE] the 6:00 a.m. to 6:00 p.m. nurse for the facility's designated COVID-19 positive hall d had tested COVID-19 negative, and the 6:00 a.m. to 6:00 p.m. nurse for hall c where both COVID-19 positive and negative residents resided, had tested COVID-19 positive on [DATE]. Further review of assignments for the 7:00 a.m. to 3:00 p.m. shift on [DATE] revealed that 2 CNAs assigned to hall c were COVID-19 positive as of [DATE], and 2 CNAs on hall d were COVID-19 negative. On [DATE] the 3:00 p.m.-11:00 p.m. shift assignment revealed that a COVID-19 negative CNA was assigned to hall d, (positive hall) and a CNA that tested COVID-19 positive on [DATE] was assigned to hall c (where 20 COVID negative and 3 COVID positive residents resided). On [DATE] the 11:00 p.m.-7:00 a.m. shift assignment revealed that the CNA on d was COVID-19 negative, and the CNA assigned to hall c tested COVID-19 positive on [DATE], and continued to work from 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. On [DATE] the 3:00 p.m.-11:00 p.m. shift assignment revealed that all 3 CNAs assigned to hall d were COVID-19 negative, and the CNA assigned to hall c tested COVID-19 positive on [DATE]. On [DATE] the 7:00 a.m. -3:00 p.m. shift assignment revealed that 2 CNAs assigned to hall d were COVID-19 negative, and a CNA who tested positive for COVID-19 on [DATE] was assigned to hall c. Interview on [DATE] at 12:40 p.m. with S4 LPN revealed S8 (COVID-19 negative), S12 (COVID-19 positive), and S13 (COVID-19 negative) CNAs were the CNAs assigned to hall d on the 7:00 a.m. to 3:00 p.m. on [DATE]. Review of documentation provided by S2 DON revealed that S6 CNA tested positive for COVID-19 on [DATE]. Interview on [DATE] at 4:52 p.m. with S1 Administrator revealed the Strategies to Mitigate HCP staffing shortages indicated that COVID-19 positive employees could be assigned to care for COVID-19 negative residents as a last resort. S1 Administrator stated hall d was the facility's designated hall for COVID-19 positive residents, and that halls e and c housed predominantly COVID-19 negative residents. S1 Administrator confirmed that COVID-19 positive staff members had been assigned to care for COVID-19 negative residents. She stated that employees should have been switched out and COVID-19 positive staff should have been assigned to work the facility's COVID-19 designated hall d with COVID-19 positive residents. PPE Review of the facility's policy titled: Protocol for PPE Optimization revealed in part: Goggle/Faceshield Optimization: Disinfect upon leaving care area of a patient in contact or droplet precautions. Gown Optimization: The following pieces of clothing can be considered as a last resort for patients as single use: Reusable (washable) laboratory coats Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available. Open back gowns, with long sleeve patient gowns or laboratory coats. Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles. Open back gowns, with long sleeve patient gowns or laboratory coats. Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles. Review of an additional facility policy titled: Droplet Precautions revealed in part |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **195293** | A. BUILDING _____ B. WING _____ | **05/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **NATCHITOCHES NURSING AND REHABILITATION CENTER,LLC** | **750 KEYSER AVENUE NATCHITOCHES, LA 71457** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>c. Gowns-apply gown before entering the room if it is anticipated that your clothing will come in contact with infected materials. Remove the gown before leaving the room, place in plastic bag. Observation on [DATE] at 1:19 p.m. of the d hall (COVID-19 positive) breakroom revealed that it was occupied by S7 CNA, S8 CNA, and S13 CNA. S7 CNA and S8 CNA were wearing<br>washable lab jackets, and S13 CNA was wearing a disposable gown. Interview with the CNAs at that time revealed that they wore washable, short sleeve resident gowns over either a washable lab jacket, or disposable isolation gown to perform direct care, and removed the washable resident gown before leaving hall d. Further interview with the CNAs revealed that the sleeves of both the jackets and disposable gown they were wearing at the time of the interview remained exposed during direct care. S7, S8, and S13 CNAs confirmed the sleeves of the lab jackets and disposable gowns could be contaminated during direct care and should be removed when leaving a resident's room. Observation on [DATE] at 1:22 p.m. revealed S9 COTA exited a COVID-19 positive resident's room on hall d, wearing a long sleeve washable lab jacket and face shield. S9 COTA was observed to flip her face shield into an upward position, exited hall d, walk around the nurse's station onto hall c, and enter the therapy department office. Interview on [DATE] at 1:23 p.m. with S9 COTA revealed that her lab jacket was part of her PPE and that she had been told that she did not have to take the lab jacket off before she left the room of a COVID-19 positive resident. She further stated she had been told to remove her PPE once she got to her office and the washable lab jacket was supposed to be sent to laundry at the end of the day. S9 COTA confirmed that the sleeves of her jacket could possibly be contaminated as well as her face shield. Interview on [DATE] at 1:25 p.m. with S11 DOR, revealed that she had been instructed to wear an outer layer of PPE, such as a jacket or gown, in the COVID-19 positive resident rooms, and that she could return to the therapy office located hall c to disrobe. She further stated that jackets and gowns used by therapy staff were sent to laundry at the end of the day and not changed between residents. Interview on [DATE] at 3:25 p.m. with S3 IC Nurse, revealed that she was the facility's Infection Preventionist and Wound Care nurse. She stated there was no shortage of PPE in the facility and that all COVID-19 positive residents were on droplet precautions. She confirmed that staff was wearing washable lab jackets into the rooms on hall d and then onto other halls. She stated that she did not know what the directive was for washable jackets being used as PPE, but that she thought they should be changed between residents and removed before leaving the hall with COVID-19 positive residents. Observation on [DATE] at 3:52 p.m. revealed S4 LPN sitting at the nurse's station wearing a disposable gown. Interview with S4 LPN at that time revealed that she was the nurse assigned to the COVID-19 positive hall d, and that she changed her disposable gown a couple times a day, but not every time she came out of a COVID-19 positive resident's room, and that she probably should. Observation on [DATE] at 11:07 a.m. revealed S10 Admissions Coordinator exited a COVID-19 positive resident's room on hall d, wearing a washable lab jacket, and approached a CNA standing near the nurses station. Interview with S10 Admissions Coordinator at the time revealed that she should have removed the lab jacket outside of the resident's room. Observation of hall d on [DATE] at 11:10 a.m. revealed S12 CNA exited the room of a COVID-19 positive resident on hall d (room a), wearing a washable resident gown and gloves. Further observation revealed S12 CNA walked to the clean linen cart, removed sheets, then returned to room a and closed the door. Interview on [DATE] at 11:11 a.m. with S4 LPN confirmed that both residents in room a were COVID-19 positive. Interview on [DATE] at 11:13 a.m. with S12 CNA revealed that she should have removed the gown and gloves prior to exiting room a, washed her hands, and then retrieved the clean linen. Review of a facility Educational In-Service record dated [DATE] titled: PPE with COVID positive residents revealed in part . Each positive resident will have a designated hook on the back of their room door where staff's second layer of PPE will be hanging for use. When entering room, staff should already have 1 layer of PPE (gown/jacket/etc). Once in room, obtain second layer of PPE and don. After completing care, hang second layer of PPE back on hook on door. If soiled, place in soiled linen barrel and obtain a replacement. When leaving designated unit; remove all layers of PPE. Further review revealed that the in-service record had been signed by S12 CNA and S4 LPN. Interview on [DATE] at 11:00 a.m. with S19 OT revealed that she was instructed this morning to spray her face shield with vindicator and leave it on hall d, double glove, and that a washable gown had been placed in each resident's room to wear while providing care. She stated the gown was to be placed back on the hook in the resident's room after use. Observations of a COVID-19 positive room on hall d on [DATE] at 11:35 a.m. revealed S15 RN Unit Manager was standing at the resident's bedside, and wearing a face shield, face mask, gloves and a disposable gown. The gown was not tied and the left arm sleeve was hanging down to her wrist as she changed a patch on the residents' chest. The bottom of the gown was hanging and touched the floor as S15 RN Unit Manager moved about during the patch change. Upon completion of the patch change, S15 RN Unit Manager exited the resident's room with her PPE on, looked in a yellow barrel that was just outside the door, turned and went back in the room and disposed of the old patch and her gloves and gown in a waste receptacle. Interview on [DATE] at 1:30 p.m. with S15 RN Unit Manager confirmed she did not tie her gown to secure it and she should have. She confirmed that the left sleeve of the gown was hanging down to her wrist and that the bottom of her gown was hanging and touching the floor as she changed the resident's patch. S15 RN Unit Manager confirmed the resident was COVID-19 positive according to his lab results. |