STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195382	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STERLING PLACE	**3888 NORTH BLVD. BATON ROUGE, LA 70806**

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 and interviews the facility failed to ensure CDC recommended guidelines for COVID-19 prevention were implemented. This deficient practice was evidenced by failing to: 1. Ensure 7 (S4N, S5N, S6N, S7A, S8A, S9A, and S10C) staff members properly implemented universal use of facemasks while in the facility; and 2. Ensure bio-waste containers for discarded PPE were stored inside resident isolation rooms. Findings: 1. On 06/15/2020 at 12:35 p.m., an observation was made of S5N sitting at the nurse's station directly across from resident/staff elevators. S5N was wearing a mask improperly placed under the nose with nares exposed. S5N adjusted the mask into proper position upon realizing the observation had been made. S5N did not perform hand hygiene. S5N continued to use a writing tool to transcribe documentation onto paper. On 06/15/2020 at 12:36 p.m., an interview was conducted with S5N. S5N stated the mask was improperly placed under the nose because she had to blow her nose. S5N stated the mask was not replaced to the proper position because it was hot. S5N did not provide a response when asked about performing hand hygiene after the mask was adjusted. On 06/15/2020 at 12:50 p.m., an observation was made of a nurse's station on a different floor. The nurse's station was located directly across from resident/staff elevators. S4N and S6N were sitting behind the nurses station with masks improperly placed. S4N had one ear loop attached to the ear while the remaining ear loop was free. S4N's mask dangled from the attached ear loop and the face and mouth were exposed. S6N's mask was attached to two buttons on a headband. S6N's mask was elevated to the headband and the nose and mouth were exposed. S4N placed the free ear loop on the remaining ear and S6N lowered the mask to cover the nose and mouth upon realizing the observation had been made. On 06/15/2020 at 12:55 p.m., S4N and S6N were interviewed. S4N stated the mask was improperly placed due to having consumed water. S6N stated the mask was improperly placed due to consumption of a parfait. S6N stated they were eating/drinking at the nurse's station because there was no designated place to do so. On 06/15/2020 at 1:03 p.m., an interview was conducted with S3N. S3N stated staff should be properly worn at all times in the facility. On 06/15/2020 at 2:30 p.m., an observation was made of S4N sitting behind a nurse's station directly across from the resident/staff elevators. S4N had a mask improperly placed with one ear loop attached to the ear while the remaining ear loop was free. S4N's mask dangled from the attached ear loop and the mouth and nose were exposed. S4N stated the mask was improperly placed due to consumption of water. S4N raised a disposable plastic bottle of water, consumed the liquid, and properly placed the mask over the mouth and nose. Hand hygiene was not observed. On 06/16/2020 at 8:40 a.m., an observation was made of S8A disinfecting a meal cart near the kitchen entrance. S8A was observed to wear a mask improperly placed under the nose with nares exposed. S8A stated masks were to be properly worn over the nose while in the facility. S8A stated the mask was improperly placed under the nose because the kitchen was hot. S8A did not adjust the mask into proper position. On 06/16/2020 at 8:50 a.m., an observation was made of S7A rinsing flatware prior to placing them in the dishwasher. S7A was observed to wear a mask improperly placed under the nose with nares exposed. On 6/16/2020 at 8:51 a.m., an observation was made of S10C carrying an open carton of eggs through the kitchen. S10C was not wearing a mask. On 06/16/2020 at 8:54 a.m., an observation was made of S10C labeling non-perishable food items with a marker. S10C was not wearing a mask. On 06/16/2020 at 8:55 a.m., an interview was conducted with S10C. S10C stated masks are to be worn at all times in the facility. S10C stated she was not wearing a mask due to being overheated from the steam in the kitchen. S10C stated staff could go outside to remove the masks if needed. S10C removed a mask from a pocket and properly placed it. On 06/16/2020 at 9:00 a.m., an observation was made of S7A rinsing dishes. S7A had a mask improperly wore under the nose with nares exposed. S7A stated the mask was improperly placed due to heat in the kitchen. On 06/16/2020 at 9:04 a.m., an observation was made of the laundry room. S9A was observed standing on the clean laundry side without a mask. S9A realized an observation was made and retrieved a mask from a storage shelf. S9A placed the mask properly on the face. On 06/16/2020 at 9:05 a.m., an interview was conducted with S9A. S9A stated she was not wearing a mask because she had stepped outside for a moment. S9A stated the mask was about to be placed prior to the observation. On 06/16/2020 at 10:47 a.m., an observation was made of S4N sitting behind a nurse's station directly across from the resident/staff elevators. S4N was observed to have a mask hanging from her left ear. S4N's mouth and nose were exposed. S4N placed the mask over her nose and mouth. Hand hygiene was not observed. On 06/16/2020 at 12:23 p.m., an interview was conducted with S3N. S3N was notified of the above observations. S3N stated staff should wear masks properly while in the facility. S3N stated staff should not eat or drink while at the nurse's stations. S3N stated staff should consume meals/beverages in the breakrooms, the dining area, or conference room. On 06/19/2020 at 9:00 a.m., an interview was conducted with S1AD. S1AD was informed of the observations made of absent/improperly placed masks. S1AD confirmed staff should properly wear masks while inside the facility. 2. On 06/15/2020 at 12:38 p.m., an observation was made of 2 cardboard boxes outside of isolation rooms on a residential hallway. The 2 cardboard boxes were marked with a biohazard emblem and lined with a red plastic. Both boxes were open and the contents were visible. One box contained a discarded isolation gown, disposable plastic cups, and a metal and black plastic clothing hanger. The other box contained discarded gloves and a small packet resembling an alcohol swab. On 06/15/2020 at 12:43 p.m., an interview was conducted with S2AA. S2AA observed the 2 cardboard boxes on the residential hallway. S2AA confirmed the boxes were used to collect bio-waste from the isolation rooms. S2AA stated the bio-waste boxes should not be on the residential hallway. S2AA stated PPE used for isolated residents should be removed and discarded inside the room. S2AA stated it would have to be assumed the PPE in the boxes was removed and discarded in the residential hallway. On 06/18/2020 at 3:03 p.m., an interview was conducted with S1AD. S1AD was notified of the observation of bio-waste boxes in a residential hallway. S1AD confirmed the bio-waste boxes should not have been on the residential hallway.

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.