STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195632	A. BUILDING _____ B. WING _____	04/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAFON NURSING FACILITY OF THE HOLY FAMILY	6900 CHEF MENTEUR HWY NEW ORLEANS, LA 70126

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility: 1.) failed to ensure staff (S5Certified Nursing Assistant (CNA) and S6CNA performed incontinence care for a resident in isolation in a sanitary manner (Resident #5); 2.) failed to ensure a nurse (S4Licensed Practical Nurse (LPN) cleaned equipment in a sanitary manner after being used on a resident in isolation. (Resident #4); 3.) failed to ensure staff removed Personal Protective Equipment (PPE) in a sanitary manner (S5CNA); 4.) failed to ensure staff used PPE appropriately (S8CNA and S9Laundry); 5.) failed to ensure staff (S6CNA) changed gloves and/or washed hands after assisting a resident on isolation with washing her face and hands (Resident #5); 6.) failed to ensure staff maintained social distancing of at least 6 feet between residents (Unit A); and 7.) failed to ensure the Infection Control Nurse completed individualized resident infection and antibiotic surveillance tracking forms. This deficient practice was identified for 2 of 5 sampled residents (Resident #4 and Resident #5), one randomly sampled resident (Resident #R1), 5 staff members (S4LPN, S5CNA, S6CNA, S8CNA, and S9Landry) and 1 of 4 units, but had the potential to affect any of the 110 residents who reside at the facility as documented on the facility's census report. Findings: Resident #4: Observation on 04/21/2020 at 8:05am, via face time revealed Resident #4 was on isolation. Further observation revealed S4Licensed Practical Nurse (LPN) put a blood pressure machine on Resident #4's personal bedside table, then proceeded to take Resident #4's blood pressure on her right arm. S4LPN then felt Resident #4's thrill (palpable vibration to assess vascular access for [MEDICAL TREATMENT] patients) and listened to Resident #4's bruit with her stethoscope on her left arm (sound heard to assess vascular access for [MEDICAL TREATMENT] patients). S4LPN then moved her stethoscope and blood pressure machine to another table in Resident #4's room, proceeded to remove her gloves and protective gown, then proceeded to wash her hands. S4LPN then removed the stethoscope and blood pressure machine from Resident #4's room with her ungloved hands and placed the above mentioned equipment on top of the sheet that covered the PPE cart outside of Resident #4's room. S4LPN took a paper towel, went to a sanitizer dispenser hanging on the wall, and pulled the dispenser 3 times to disperse the sanitizer on the paper towel. The paper towel was not entirely wet/saturated as the entire paper towel did not entirely change color and appeared dry and stiff on most of the paper towel. S4LPN then proceeded to wipe the above mentioned equipment with ungloved hands with the paper towel. In interview on 04/21/2020 at 8:21am, S4LPN was asked why was she using the paper towel with hand sanitizer to clean the equipment instead of a disinfectant bactericidal virucidal wipe, and S4LPN indicated she should be using the wipes, but was not because she didn't have any by her. S2Director of Nurses (DON) had staff obtain disinfectant bactericidal virucidal wipes. S4LPN then proceeded to clean equipment with ungloved hands and the disinfectant wipes, at which time S2DON told S4LPN to put some gloves on. S4LPN proceeded to put gloves on without washing hands, and wiped down the equipment. Resident #5: Observation on 04/21/2020 at 9:06am revealed Resident #5 was in isolation. Further observation revealed S6CNA provided personal care to resident's vaginal area, then without changing gloves touched the cleansing wipes package and skin barrier tube. S6CNA then applied skin barrier cream to Resident #5's external genital area using the same pair of gloves that used for incontinence care. S6CNA then assisted with putting on one side of a clean adult brief and touched the resident's bedding using the same pair of gloves. Observation on 04/21/2020 at 9:11am, revealed Resident #5 was turned on her side, and S5CNA provided personal care to resident's buttocks. S5CNA touched the cleansing wipes package, skin barrier tube, and applied skin barrier cream to Resident #5's buttocks using the same pair of gloves used for personal care. With the same pair of gloves, S5CNA assisted with putting on the other half of a clean adult brief and then touched Resident #5's bedding. Observation on 04/21/2020 at 9:16am, revealed S6CNA removed her gloves, washed hands, put on new gloves, took a clean towel out of a drawer, wet the towel with water, and assisted Resident #5 with cleaning her face. S6CNA then took the soiled towel and disposed of it, and without changing gloves, opened the drawer to obtain another clean towel, wet the towel with water, then gave it to Resident #5 to wash her hands. Observation on 04/21/2020 at 9:19am, S5CNA was observed taking her gloved hand and then moved her yellow PPE gown to the side, and reached in the pocket of her scrubs to retrieve a trash bag. S5CNA removed and disposed of her gloves then removed her yellow PPE gown with ungloved hands and rolled the gown up against her right leg with ungloved hands. In interview on 04/21/2020 at 9:28am, S2Director of Nurses (DON) verified the above findings and indicated she was present for Resident #4 and Resident #5's observations as well, and there were breeches in infection control. S2DON further indicated S4LPN should have used the appropriate wipes to clean the equipment and that even though she does constant in-services and education, she still sees staff not adhering to infection control guidelines. Unit A: Observation on 04/21/2020 at 12:20pm, of Unit A revealed 13 residents were present without masks in the dining room with 3 staff members present. Further observation revealed of the 13 residents: 3 residents were sitting at a table (table was 4 foot by 4 foot) near the windows to the right of the dining room with the 3 residents sitting 3 feet apart from each other (2 of the residents were facing each other and the other resident was on the left of the table); and 9 residents were sitting at a long table with three staff members present assisting residents, which was 4 (4 foot by 4 foot) tables placed together. The residents were sitting 2 feet apart shoulder to shoulder. In an interview on 04/21/2020 at 12:32pm, S7LPN (Licensed Practical Nurse) stated it is hard to feed the residents separate because once the residents smell food they all go to the dining room. S7LPN stated would try to separate them between the day room and the dining room but don't know how well that will work because once they smell food they go to the dining room. S7LPN stated they had not tried separate dining times or separate areas as of this time. In an interview on 04/21/2020 at 12:34pm, S2DON (Director of Nursing) stated the residents should be 6 feet apart at all times per CDC (Centers for Disease Control) guidelines for COVID-19 ([MEDICAL CONDITION] disease 19) prevention measures. Resident #R1: Observation on 04/21/2020 at 12:32pm, revealed Resident #R1 with isolation cart outside of the room. S2DON stated the resident was on isolation due to a recent hospitalization . S8CNA (Certified Nursing Assistant) was in the room assisting Resident #R1 with positioning wearing only a hair cover and mask for PPE (personal protective equipment). Observation revealed S8CNA did not have on gloves or isolation gown. S2DON requested she leave the room immediately and apply the correct PPE. During the observation the surveyor then asked S8CNA what PPE she should be wearing and S8CNA looked at the cart and stated, she should have put on a isolation gown, gloves, mask, and hair covering prior to entering the room. S8CNA stated there was no reason for not having the correct PPE in place, other than she was rushing and forgot to put these items on. In an interview on 04/21/2020 at 12:34pm, S2DON stated the staff had been trained and information was on the carts on what PPE to apply. S2DON stated the CNA should have applied the correct PPE prior to entering the room. Observation on 04/21/2020 at 12:51pm, revealed S9Laundry was pushing a clean laundry rack down the hall with gloves on while in the hallways. S2DON stopped the staff member and stated she was not to wear gloves in the hallway. In an interview on 04/21/2020 at 12:52am, S2DON stated staff have been educated on not wearing gloves in general areas and proper use of gloves, therefore the laundry personnel should not have been wearing gloves in the hallway. Review of the facility's Infection Control Tracking and Trending revealed the facility was tracking: the location of resident infections (resident room numbers), types of infections, if cultures were obtained the type of organism, and evidence all the medication for the treatment of [REDACTED]. In an interview on 04/21/2020 at 1:55pm, S3Infection Control Nurse stated she

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) was not completing individual resident infection control reports and the nurses on the floor did not complete individual resident infection control reports either. S3Infection Control Nurse stated the nurses document the resident's symptoms in the nurse's notes when notifying the physician of the symptoms, and are responsible for monitoring the resident but do not compile the data, which was used for tracking, and trending infections. In an interview on 04/21/2020 at 1:57pm, S2DON stated the facility did not have any further information on the tracking and trending of infections.