STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195341	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE NEW ORLEANS, LA 70131**

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 failed to maintain the Centers for Disease Control (CDC) Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) by: 1.) Failing to ensure residents and staff adhered to their infection prevention and control practices of ensuring residents and/or staff wore face mask (Resident R1, Resident R2, Resident R3, Resident R4, Resident R5, Resident R6, Resident R7, Resident R8, and Resident R9, S3Dietary Staff, S4Dietary Staff); and 2.) Failing to ensure residents and/or staff maintained social distancing (Resident R7, Resident R9, S3Dietary Staff and S4Dietary Staff). This deficient practice was identified for 9 randomly observed residents (Resident R1, Resident R2, Resident R3, Resident R4, Resident R5, Resident R6, Resident R7, Resident R8, and Resident R9) and 4 staff members observed (S3Dietary Staff, S4Dietary Staff, S5Certified Nursing Assistant (CNA) Supervisor, and S7Housekeeper), but had the potential to affect any of the 171 residents as documented on the facility's Census List. Findings: Review of the CDC website for Infection Control Guidance for Healthcare Professionals (HCP) about Coronavirus (COVID-19) as of July 15, 2020 revealed in part, the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. These practices include to use facemasks to cover a person's mouth and nose. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Further review revealed patients may remove their cloth face covering when in their rooms but should put it back on when around others or leaving their room. HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. The above mentioned CDC guidance further revealed to encourage physical distancing between people of at least 6 feet apart. In interview on 07/15/2020 at 9:45am, S1Director of Nursing (DON) indicated it was the facility's policy for all staff to wear mask during their entire shift, and for residents to wear mask when not in their room. Observation on 07/15/2020 at 9:47am, with S1Director of Nursing (DON) present, revealed Resident R1 was walking down the hall without a mask to the smoker's patio. Observation on 07/15/2020 at 9:48am, with S1DON present, revealed 15 residents were on the smoker's patio area 11 of which were less than 6 feet apart from each other. Further observation revealed no staff was outside monitoring residents at this time, and numerous staff members were walking past and not assisting residents with social distancing. In interview on 07/15/2020 at 9:51am, the above was discussed with S1DON. S1DON indicated, all residents were supposed to wear a facemask when they were not in their room and the residents should be at least 6 feet apart from each other. S1DON indicated nobody was assigned to supervise the smoker's patio, and that staff were supposed to assist with residents when they make rounds, but nobody was assigned to monitor the smoker's patio or to ensure social distancing. S1DON further indicated it wouldn't matter if residents were separated, because they would just go back together anyway. Observation on 07/15/2020 at 9:54am, with S1DON present, revealed Resident R2 was in the hallway without a facemask. Further observation revealed staff walked by Resident R2 and did not remind and/or assist the resident with putting on a facemask. Observation on 07/15/2020 at 9:56am, with S1DON present, revealed Resident R3 was in the hallway without a facemask. Further observation revealed staff walked by Resident R3 and did not remind and/or assist the resident with putting on a facemask. S1DON asked Resident R3 where her facemask was, and Resident R3 stated, They didn't put one on me today. Observation on 07/15/2020 at 9:58am, with S1DON present, revealed Resident R4 was sitting in a wheelchair in the hallway and was not wearing a facemask. Further observation revealed staff walked by Resident R4 and did not remind and/or assist the resident with putting on a facemask. Resident R4 was asked where his facemask was, and Resident R4 indicated he did not know, he lost it yesterday. In interview on 07/15/2020 at 9:59am, S1DON indicated all residents are provided with facemasks. Observation on 07/15/2020 at 10:00am, with S1DON present, revealed Resident R5 was walking down the hallway without a facemask. Further observation revealed staff was walking by Resident R5 and did not remind and/or assist the resident with putting on a facemask. Observation on 07/15/2020 at 10:01am, with S1DON present, revealed Resident R6 was walking down the hallway without a facemask. Further observation revealed staff was walking by Resident R6 and did not remind and/or assist the resident with putting on a facemask. Observation on 07/15/2020 at 10:04am, revealed 8 residents were in the dining room, 3 of which did not have a facemask on, and were not eating or drinking at the time. Further observation revealed 4 residents were sitting less than 6 feet apart.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE