STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195369	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OUR LADY OF PROMPT SUCCOR NURSING FACILITY	**954 E PRUDHOMME LANE OPELOUSAS, LA 70570**

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews, S2CNA (Certified Nursing Assistant) failed to follow accepted infection control practices and transmission-based precautions to help to prevent and control the spread of an infectious communicable disease (Coronavirus 2019) as evidenced by an observation made on 6/23/2020 of S2CNA coming out of an isolation room (Resident #1) and the CNA failed to follow the facilty's policy for the correct disposal of a gown worn into an isolation room out of 9 residents in the facility who were in isolation. Findings: Resident #1. The resident was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The Departmental Notes dated 6/23/2020 at 12:31 pm reviewed and revealed the following documentation - Up in wheelchair in her room alert and verbally responsive. Calm mood. Oriented x 3 with occasional forgetfulness of time. Denies pain and discomfort at this time. Resident is aware that she's on isolation . The facility's staff assignments was reviewed and revealed the following documentation on a form labeled - Daily Assignments. The CNA assigned to obtain weights in the facility was S2CNA. On 6/23/2020 at 12:35 pm, an observation was made of S2CNA and she was observed opening the PPE cart and placed on PPE (Personal Protective Equipment) consisting of shoe covers, gloves, gown and hair covering. The sign observed of the resident's door was observed and the documentation read - Special Droplet/Contact Precautions. The door is to remain closed at ALL times. To prevent the spread of infection, anyone entering this room MUST wear Gloves, Gown, Facemask, Eye Protection. Clean hands when entering and leaving room. Wear face mask. Wear eye protection (face shield or googles), Gown and glove at door. This applies weather or not contact with the resident's environment is anticipated. S2CNA was observed picking up a disposable tray with disposable utensils and going into Resident #1's room. S2CNA was observed coming out of the room with her gown on, removing the gown, rolling it up, and then S2CNA opened the top drawer of the resident's PPE cart and placed the gown in a clear bag in the top drawer of the cart. S2CNA closed the drawer to the cart. S2CNA was observed walking off the hall, leaving the soiled gown in the top drawer of the PPE cart. An interview was conducted with the S2CNA after the above observation was made. S2CNA stated that she had placed the gown back in the top drawer because that was where she got the gown from. S2CNA stated that she usually is assigned to weigh the residents in the facility and that she was helping pass the trays on the hall. S2CNA stated that there were barrels in the resident's room to place the trash and soiled linen in and could not give a reason as to why she had not disposed of the soiled gown in the resident's room. S2CNA confirmed that she had worn the gown into the room and that she had placed the dirty gown in the top drawer of the cart in a plastic bag after coming out of the resident's room. At 12:42 pm, an interview was conducted with S1DON and she was informed by the surveyor of the observation made of S2CNA placing the soiled gown in Resident #1's PPE cart. S1DON stated that the CNA should not have placed the dirty gown in a plastic bag in the drawer. S1DON stated that the facility's policy was that S2CNA should have disposed of the gown in the resident's room and then washed her hands in the resident's bathroom sink. S1DON stated that all PPE is to be left in the room after it is used. S1DON stated that the resident was in isolation because she had gone into the emergency roiagnom on Saturday night after having a fall and was exposed to COVID-19 while in the ER. S1DON stated the facility's policy is that if residents go to the ER, they are placed in isolation upon return to the facility for 14 days. S1DON verified that another staff member could have reused the soiled gown in the PPE cart. On 6/23/2020 at 4:30 pm an interview was conducted with S1DON and she stated that she had documentation of a write up for S2CNA due to not following the facility's policy and procedure for disposable of the gown worn into the resident's room. Disciplinary Warning Checklist was provided and revealed the documentation - dated 6/23/2020, type of violation (checked off was) - Defective work - infection control, Failure to obey safety rules. Describe how violation occurred: _____ (S2CNA) failed to follow copy isolation precautions. Walked out of an isolation room and put dirty gown back into clean isolation cart. It is company policy that all PPE used in an isolation room be discarded into the proper barrels in the resident's room. Each isolation room has a barrel for trash, linen, and infectious waste (If needed). Wash hands or sanitize hands after removing PPE. Never return anything to a clean linen cart. Cart was removed from hallway immediately and desanitized. Replaced with clean isolation cart. Documentation written under employee written rebuttal: I'm aware of the procedure, panic and got nervous. Gown was supposed to go in soiled linen barrel in resident bathroom. Form is signed by S2CNAs and dated 6/23/2020 and S1DON on 6/23/2020. The facility's COVID-19 PPE Policy was reviewed and revealed the following documentation - All staff members will be issued a surgical mask or N95 masks to wear while preforming their duties in the facility. . . PPE use for residents that are suspected to have COVID-19 and/or positive for COVID-19 - For direct care to the resident, the following PPE are to be worn: Surgical mask or N95 mask, eye protection and gloves. Staff are to wear a gown. The gown and gloves are to be removed prior to leaving the residents room.

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.