STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	**04/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET HARVEY, LA 70058**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to: 1. Ensure information documented on a resident's COVID-19 monitoring sheet was accurately documented and complete (Resident #2, Resident #3, and Resident #4); 2. Ensure staff signed and dated all documentation (Resident #2); and 3. Ensure documentation of a resident's respiratory infection follow-up assessment was accessible and readily available in a resident's medical record (Resident #3). This failed practice was identified for 3 of 5 sampled residents (Resident #2, Resident #3, and Resident #4). This failed practice had the potential to affect any of the 60 residents residing in the facility's [DATE] Census List. Findings: Resident #2 Review of Resident #2's [DATE] COVID-19 ([MEDICAL CONDITION] disease 19) monitoring sheet revealed Resident #2's name was handwritten on the bottom of the sheet. Further review revealed daily temperatures and monitoring for s/s (signs and symptoms) for respiratory infections was documented from [DATE] thru [DATE], which included documentation for the dates of [DATE] thru [DATE]. Review of Resident #2's Hospital Records revealed the resident was hospitalized from [DATE] to [DATE] at 2:17pm. Review of Resident #2's [DATE] COVID-19 monitoring sheet revealed no documented monitoring for COVID-19 symptoms or temperature on [DATE]-[DATE] all the areas for the information of s/s of respiratory infections and temperature had a H (hospital) in the spot for information and signature. Review of Resident #2's Hospital Records revealed the resident was hospitalized from [DATE] to [DATE], and was readmitted to the facility on In an interview on [DATE] at 1:22pm, S4Acting Director of Nursing(DON)/Infection Control Nurse was questioned about the Resident #2's [DATE] COVID-19 monitoring sheet having information documented for temperatures and monitoring of respiratory infection symptoms when the resident was actually in the hospital and S4Acting DON/Infection Control Nurse stated she thinks the form was actually for another resident and Resident #2's name was put on the form in error, which was why the name was handwritten. Review of Resident #2's [DATE] COVID-19 monitoring sheet, emailed to the surveyor on [DATE] at 2:10pm revealed H was marked for [DATE] to [DATE], however the form did have a temperature recorded and a negative sign which indicated Resident #2 did not have s/s of infection recorded for [DATE] when the resident was still admitted to the hospital. Review of Skilled Notes for [DATE] and [DATE] (emailed to the surveyor on [DATE] at 1:43pm) revealed no signature of the staff member who filled out the note, and no documented evidence of a name of the person that documented the information. In an interview on [DATE] at 4:19pm, S4Acting DON/Infection Control Nurse, after the surveyor reviewing the above information, stated the nurse completing the Skilled Nurses Notes on [DATE] and [DATE] should have signed the document. S4Acting DON/Infection Control Nurse further stated the documentation on the COVID-19 form for [DATE] was documented in error. In an interview on [DATE] at 3:46pm, S1Administrator, S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse stated the above information was documented in error and the nurse for the skilled notes should have signed the entry. They further stated the document for the COVID-19 monitoring was not accurate. Resident #3 Review of Resident #3's Face Sheet revealed Resident #3 was discharged on [DATE]. Further review revealed Resident #3 had [DIAGNOSES REDACTED]. Review of Resident #3's [DATE] COVID-19 monitoring sheet, received on [DATE] at 6:34pm, revealed staff was to monitor every shift (morning, evening, and night shifts) for s/s (signs and symptoms) of respiratory infection such as cough, sore throat, and shortness of breath and document (-) if no s/s present, or (+) if s/s present. Review revealed the only documentation of monitoring of respiratory infection s/s was documented on the following dates: morning shift on [DATE]; all three shifts on [DATE]; morning and night shift on [DATE]; morning shift on [DATE]; morning and evening shift on [DATE]; morning and night shift on [DATE]; all three shifts on [DATE]; and morning and evening shift on [DATE]. Further review revealed all other documentation area were left blank. Review of Resident #3's [DATE] COVID-19 monitoring sheet, received on [DATE] at 4:16pm, revealed monitor for s/s (signs and symptoms) of respiratory infection such as cough, sore throat, and shortness of breath (-)= no s/s present, (+)= s/s present and requires further documentation in nursing notes and notify medical doctor. Further review revealed (+) was documented on the following dates: [DATE] the morning and night shifts; [DATE] the night shift; [DATE] the night shift; [DATE] the morning shift; [DATE] the morning and evening shifts; [DATE] the morning and evening shifts; [DATE] the morning and evening shifts; [DATE] the morning and night shifts; [DATE] the night shift; [DATE] the night shift; and [DATE] the night shift. In an interview on [DATE] at 2:17pm, S4Acting Director of Nursing (DON)/Infection Control Nurse stated to her knowledge the COVID-19 monitoring sheet was correct. S4Acting DON/Infection Control Nurse stated she was unable to locate any documentation of nurse's notes for Resident #3 for the time of [DATE] to [DATE] to follow up on the positive marks from the COVID-19 Monitoring sheet. In an interview on [DATE] at 2:57pm S4ActingDON/Infection Control Nurse stated to her knowledge after reviewing all the documentation she had available, that she thinks both sheets were correct because the facility had lost one of the monitoring sheets for a while and had started a new sheet. S4Acting DON/Infection Control Nurse stated the facility was unable to locate any further nurse's notes or other documentation from this time period, and the medical records person was out of work due to being COVID positive. S4Acting DON/Infection Control Nurse stated the nurse which would have documented the positive s/s was no longer employed and the facility did not have her phone number. In an interview on [DATE] at 3:46pm, S1Administrator, S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse were informed of the surveyor's findings. S2Administrator/Clinical Nurse Consultant and S3Clinical Nurse Consultant stated they were unable to find any nursing notes at all for Resident #3 due to the medical records staff being out ill with COVID-19. They confirmed the record was incomplete and inaccurate. Resident #4 Review of Resident #4's Nurse's Notes dated [DATE] at 5:15am revealed Resident #4 left the building per ambulance. Review of Resident #4's record revealed Resident #4 was admitted to the hospital on [DATE], and later expired at the hospital. Review of Resident #4's [DATE] COVID-19 monitoring sheet revealed documentation of monitoring for respiratory infection s/s on [DATE] and [DATE] for both the morning and evening shifts. Further review revealed temperatures were documented as having been obtained on [DATE] and [DATE] when Resident #4 was not in the facility . In an interview on [DATE] at 2:57pm, S4Acting DON/Infection Control Nurse stated after reviewing the above documentation, the staff must have charted this information in error and therefore was inaccurate documentation. In an interview on [DATE] at 3:46pm, S1Administrator, S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse were informed of the above documentation. S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse stated the documentation on [DATE] and [DATE] was an error in documentation.
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 a Certified Nursing Assistant (CNA) applied Personal Protective Equipment (PPE) in a sanitary manner (S5CNA) prior to providing care for a resident on

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) isolation (Resident #5); 2.) failed to ensure a resident who displayed respiratory infection symptoms was placed in isolation (Resident #3); and, 3.) failed to ensure the Infection Control Nurse completed individualized resident infection and antibiotic surveillance tracking forms (S4Acting Director of Nursing/Infection Control Nurse), This deficient practice was identified for 2 of 5 sampled residents (Resident #3 and Resident #5) and 2 staff members (S5CNA and S4Acting Director of Nursing/Infection Control Nurse), but had the potential to affect any of the 60 residents who reside at the facility as documented on the facility's 04/13/2020 census list. Findings: Review of the facility's Infection Control Log since March 2020, revealed 5 residents were documented as being on antibiotics for Non-Covid-19 related infections. Review of the facility's Infection Control Log since April 2020, revealed 4 residents were documented as being on antibiotics for Non-Covid-19 related infections and 10 residents were placed on [MEDICATION NAME] antibiotics due to possible exposure to Covid-19. There was no documented evidence and the facility did not present any documented evidence of having any individualized resident infection and antibiotic surveillance tracking forms. In interview on 04/15/2020 at 3:30pm, S4Acting DON/Infection Control Nurse verified individualized tracking records for residents on antibiotics should be done as part of their infection control tracking and surveillance, but she had not completed them as required. Resident #3 Review of Resident #3's Face Sheet revealed Resident #3 was discharged on [DATE]. Further review revealed Resident #3 had [DIAGNOSES REDACTED]. Review of Resident #3's COVID-19 monitoring sheet, received on 04/14/2020 at 4:16pm, revealed monitor for s/s (signs and symptoms) of respiratory infection such as cough, sore throat, and shortness of breath (-)= no s/s present, (+)= s/s present and requires further documentation in nursing notes and notify medical doctor. Further review revealed (+) was documented on the following dates: 03/06/2020 the morning and night shifts; 03/07/2020 the night shift; 03/08/2020 the night shift; 03/09/2020 the morning shift; 03/10/2020 the morning and evening shifts; 03/12/2020 the morning and evening shifts; 03/13/2020 the morning and evening shifts; 03/15/2020 the morning and night shifts; 03/16/2020 the night shift; 03/19/2020 the night shift; and 03/20/2020 the night shift. Review of Resident #3's Physician Telephone Orders dated 03/20/2020 revealed an order to send Resident #3 to a local hospital emergency room . Review of the facility's Residents Confirmed Positive COVID-19 ([MEDICAL CONDITION] disease) Results form revealed Resident #3 was hosptalized on [DATE], and confirmed as being positive for COVID-19 on 03/24/2020. In an interview on 04/15/2020 at 2:17pm, S4Acting Director of Nursing (DON)/Infection Control Nurse stated to her knowledge the COVID-19 monitoring sheet was correct. S4Acting DON/Infection Control Nurse stated she was unable to locate any documentation of nurse's notes for Resident #3 for the time of 03/06/2020 to 03/20/2020 to review what symptoms Resident #3 would have had during this time. S4Acting DON/Infection Control Nurse stated the nurse, who documented this information, was no longer employed and the facility did not have a working phone number for her. S4Acting DON/Infection Control Nurse stated all residents during this time were to stay in their rooms; however, Resident #3 to her knowledge was not put on isolation or droplet precautions. S4Acting DON/Infection Control Nurse further stated based off just the monitoring sheet having a + documented as having signs and symptoms, if the resident had s/s of COVID she should have been placed on isolation with appropriate precautions. In an interview on 04/15/2020 at 3:46pm, S1Administrator, S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse were informed of the surveyor's findings. S2Administrator/Clinical Nurse Consultant, S3Clinical Nurse Consultant, and S4Acting DON/Infection Control Nurse further stated with just being able to review the COVID-19 monitoring sheet they would have encouraged isolation of Resident #3. Resident #5 Review of Resident #5's Face Sheet revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's Interim Care Plan revealed a problem of at risk for contracting coronavirus disease with goal date of 06/01/2020. Review revealed approaches of, in part: use of good handwashing technique before and after providing care; observe universal precautions. Further review revealed the resident required quarantine/isolation related to COVID symptoms or person under investigation dated 04/01/2020 approaches included, in part: staff will use standard universal precautions, with additional transmission based precautions as indicated by CDC (centers for disease control and prevention) guidelines. In an interview on 04/14/2020 at 4:51pm, S3Clinical Nurse Consultant stated Resident #5 had tested positive for COVID and the facility had received the results today. Observation on 04/14/2020 at 5:38pm, via visual teleconference, revealed S5Certified Nursing Assistant (CNA) prepared to provide care to Resident #5. S5CNA was wearing the appropriate mask and then performed hand hygiene with hand sanitizer. S5CNA then stated she forgot to remove her watch to her left arm; S5CNA removed her watch and then applied gloves without performing hand hygiene after removing her watch. S5CNA proceeded to apply the rest of the appropriate PPE and provide care to Resident #5. In an interview on 04/14/2020 at 5:47pm, S3Clinical Nurse Consultant (who was present during the observation), stated S5CNA should have performed hand hygiene again after removing her watch and prior to applying gloves. S3Clinical Nurse Consultant stated this action was a breach of infection control practices.