STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 02/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Survey # LA00050751. No deficiencies cited as a reuslt of this complaint. Complaint Survey #LA00050859. F609, F656, and F689 cited as reuslt of this complaint.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		3/25/19

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

Electronically Signed | 02/28/2019

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F 609	Continued From page 1 Based on interview and record review, the facility failed to ensure an alleged violation involving neglect was reported to the State Survey Agency when a resident who was assessed as needing extensive assistance and two person assist with bed mobility and toileting received one person assist when provided incontinent care fell out the bed and onto the floor sustaining a laceration to his head and was sent to the emergency room to be evaluated. This deficient practice was identified for 1 (Resident #1) of 9 sampled residents, and had the potential to affect any of the 176 residents who resided in the facility as documented on the Resident Census and Residents Conditions Form (CMS Form 672). Findings: Review of the facility's policy titled Reporting Abuse to Facility Management revealed in part, under 2.f Neglect id defined as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Resident #1 was admitted on 10/17/17 with diagnoses in part, of morbid obesity due to excess calories, Hemiplegia following a cerebral vascular accident affecting right dominant side, generalized muscle weakness, gastroscopy, hydrocephalus, localized edema, and stage four pressure ulcer. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 11/20/18 revealed in part, Resident #1 had a brief interview mental status score (BIMS) of 6 (severely cognitively impaired.) Further review revealed in part, Resident #1 required extensive assistance and two person assist for bed mobility, and toilet use. Further review revealed Resident	F 609	1.The facility will complete an OTIS report for Resident #1 to investigate caregiver neglect related to his fall on 02/01/19. Resident #1 no longer resides in the facility. 2.A review of Incident/Accident reports for a 4-week lookback will be completed to ensure any other suspected allegations of abuse/neglect have been reported for investigation. Any required OTIS reports will be completed based on review findings. 3. A) Administrator and administrative nursing staff will be in-serviced on regulatory requirements for investigating and reporting via online OTIS system for all allegations of abuse/neglect. B) Facility staff will be in-serviced on policy/procedure related to timely reporting of all allegations of abuse to Administer or Director of Nursing so that investigation can begin, and OTIS report submitted timely. 4.A) Asst. Administrator or designee will interview a random sample mix of 10 residents and staff per week to ensure immediate notification of Administrator and/or DON of suspected allegations of abuse/neglect and completion of required OTIS reports. Interview findings will be recorded on a QAPI monitoring tool. B) DON or designee will review Incident/Accident reports three times a week to ensure immediate notification of Administrator and/or DON of suspected allegations of abuse/neglect and completion of required OTIS report. Review results will be recorded on a QAPI monitoring tool.	

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F 609	Continued From page 2 #1 had impairment of range in motion (ROM) of one upper and one lower extremity, had an indwelling catheter, and was always incontinent of stool. Review of Resident #1's care plan revealed in part, Resident #1 was identified to have activity of daily living (ADL) self-care deficit as evidenced by needs total assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, and bathing related to a cerebral vascular accident with right hemiplegia, status post subdural hematoma with right sided hemi-craniotomy with a target date of 03/01/19. Approaches to include report changes in ADL self-performance to nurse; provide adaptive/safety equipment; provide only amount of assistance/supervision that is needed: standby, cueing/prompting, and contact guarding; Turn and reposition, shifting weight to enhance circulation; explain all procedures and purpose prior to performing a task and encourage self-performance; and utilize task segmentation as indicated to help improve ADL participation. Review of the facility's Online Tracking Incident System (OTIS) reports submitted to state office in the last 90 days revealed no OTIS reports for Resident #1. Review of the facility's incident investigation dated 02/01/19 revealed in part, Resident #1 had a fall on 02/01/19 at 10:00pm. Review under type of injury revealed a laceration. Review revealed under location, Resident's room. Further review under narrative of investigation: Certified Nursing Assistant (CNA) providing care, resident being turned to opposite side. Quarter rail not_____ (review revealed nothing else noted as to whether	F 609	Monitoring will be completed for eight weeks, then monthly as deemed necessary by QAPI team. Any issues noted during monitoring will be corrected at time of discovery. Re-education of staff will be conducted as deemed necessary. Results of monitoring will be reviewed at next scheduled QAPI meeting to determine effectiveness and make changes as deemed necessary.	

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F 609	Continued From page 3	F 609		

the rail was up or down just the word not), Resident rolled out of bed. Further review under Narrative of Investigation: On January 4th (this was the date noted written in the investigation) Social Worker at the Hospital spoke to the Administrator in regards to the resident's fall. Social worker was informed that the residents fall was contributed to him rolling him the wrong way. Administrator explained that a competency check was being put in place to assure that certified nursing assistants were using proper technique to avoid accidents.

Review of Resident #1's hospital record revealed Resident #1 was sent to the hospital on 02/01/19. Further review of Resident #1's admission summary dated 02/01/19 patient was admitted to the intensive care unit for repeat cat scan of the head and every 1 hour neuro checks.

In an interview on 2/7/19 at 09:40am Resident #1's family member indicated Resident #1 has been at the facility over a year. Resident #1's family member indicated she was called during the night and told her husband had a fall by the nurse. Resident#1's family member indicated she was told that the aide was changing the resident by herself and Resident #1 fell on the left side. Resident #1's family member further stated Resident #1 sustained a laceration to his left eye area and needed stitches and was sent to the hospital. She indicated Resident #1 is still in Intensive Care Unit for observation. Resident #1's family member stated Resident #1 was a "big man." Resident #1's family member was concerned because she did not see any bed rails on Resident #1's bed.

Review of the nurse's note dated 02/01/19 at

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F 609	Continued From page 4	F 609		

11:16pm revealed in part, at 10:00pm the aide was providing care, called nurse to the room and the resident was on the floor. Copious amount of blood noted coming from resident's head. Laceration to head. Called 911 to transport. Resident to the emergency room for evaluation and treatment.

In an interview on 02/07/19 at 11:42am, S3 Assistant Director of Nursing (ADON) indicated she was notified by the nurse when Resident #1's fall happened. S3 ADON indicated the CNA was providing incontinent care. Resident #1 was rolled to the opposite side of the bed, the rail was down, continued to roll, and Resident #1 fell out of the bed and landed on the floor.

In an interview on 02/07/19 at 3:26pm, S2 Director of Nurses and S4 ADON present, S5 CNA indicated he was doing rounds and went into Resident#1's room to do incontinent care. S5 CNA stated he was on the left side of the bed and turned Resident #1 to the right side of the bed and "he flipped off the bed." When the surveyor questioned S5 CNA on how he knew what type of assistance was needed, he stated it in the kiosk and it was one person assist. S5 CNA further stated after the incident occurred that S6 Licensed Practical Nurse told him he should use two person assist for Resident #1.

In an interview on 02/07/19 at 4:35pm, S6 Licensed Practical Nurse (LPN) indicated the CNA called her to Resident #1's room and said the resident fell. S6 LPN further indicated she saw Resident #1 on the floor and assessed the resident. S6 LPN sated she called 911. S6 LPN indicated after the resident left, S6 LPN stated she educated S5 CNA to use two person assist

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F 609	Continued From page 5	F 609		

when providing care for Resident #1.

In an interview on 02/08/19 at 08:48am, S2 DON indicated that one person assist had been used for Resident #1 depending on who the CNA was. S2 DON further indicated the CNA's determine if they need more help and would use 2 person assist if needed.

In an interview on 02/08/19 at 2:20pm, S10 Care Plan Nurse LPN indicated when she reviewed Resident #1's care plan with the surveyor regarding Resident #1 was identified to have activity of daily living (ADL) self-care deficit as evidenced by needs total assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, and bathing related to a cerebral vascular accident with right hemiplegia, status post subdural hematoma with right sided hemi-craniotomy with a target date of 03/01/19. Approaches to include report changes in ADL self-performance to nurse; provide adaptive/safety equipment; provide only amount of assistance/supervision that is needed: standby, cueing/prompting, and contact guarding; Turn and reposition, shifting weight to enhance circulation; explain all procedures and purpose prior to performing task and encourage self-performance; and utilize task segmentation as indicated to help improve ADL participation. S10 Care plan Nurse LPN indicated total assistance does not mean one person assist or two person assist. S10 Care Plan Nurse LPN stated one staff person may need more or less depending on the staff person when caring for the resident and whether or not resident needs more help one day or less.

In an interview on 02/13/19 at 2:05pm, S1

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F 609	Continued From page 6 Administrator indicated she did not do an OTIS report due to it was not an allegation of abuse or serious harm. S1 Administrator indicated it was an incident and there was not any trend with falls for Resident #1.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/25/19

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F 656	Continued From page 7 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1.) Develop and implement a care plan for two person physical assistance for a resident who was assessed as requiring two person physical assistance; and 2.) Provide care with two person physical assistance as assessed, which resulted in a resident falling out of bed and incurring a laceration to the head. This deficient practice was identified for 1 (Resident #1) of 9 sampled residents, but had the potential to affect any of the 176 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form CMS-67 Findings: Resident #1 was admitted on 10/17/17 with diagnoses in part, of morbid obesity due to excess calories, Hemiplegia following a cerebral vascular accident affecting right dominant side, generalized muscle weakness, gastroscopy, hydrocephalus, localized edema, and stage four pressure ulcer. Review of Resident #1's Minimum Data Set	F 656	1. Resident #1 admitted to hospital on 02/01/19, did not return to facility, and was discharged on 02/08/19. 2. The facility will determine which residents require extensive and total assistance from a review of their most recent MDS Section G. The facility will then identify which extensive/total assistance residents require two-person assist through resident assessment and/or staff interviews. The facility will update the care plan of identified residents to reflect the need for two-person assist. 3. A) The DON or designee will educate the MDS/Care Planning department on ensuring care plans are developed and revised to reflect resident's ADL physical assistance needs upon completion of the MDS (Minimum Data Set). B) The DON or designee will educate CNA staff related to residents requiring two-person assist and providing two-person assistance. C) The DON or designee will complete competency checklists with CNA staff related to positioning resident in the bed	

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F 656	Continued From page 8 (MDS) with an Assessment Reference Date of 11/20/18 revealed in part, Resident #1 had a brief interview mental status score (BIMS) of 6 (severely cognitively impaired) and required extensive assistance and two person assist for bed mobility and toilet use. Further review revealed Resident #1 had a range of motion impairment of one upper and one lower extremity, had an indwelling catheter and was always incontinent of stool. Review of Resident #1's care plan revealed in part, Resident #1 was identified to have activity of daily living (ADL) self-care deficit as evidenced by needs total assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, and bathing related to a cerebral vascular accident with right hemiplegia, status post subdural hematoma with right sided hemi-craniotomy with a target date of 03/01/19. Approaches to include report changes in ADL self-performance to nurse; provide adaptive/safety equipment; provide only amount of assistance/supervision that is needed: standby, cueing/prompting, and contact guarding; Turn and reposition, shifting weight to enhance circulation; explain all procedures and purpose prior to performing task and encourage self-performance; and utilize task segmentation as indicated to help improve ADL participation. Review of the facility's incident investigation dated 02/01/19 revealed in part, Resident #1 had a fall on 02/01/19 at 10:00pm. Review under type of injury revealed a laceration. Review revealed under location, Resident's room. Further review under narrative of investigation: Certified Nursing Assistant (CNA) providing care, resident being turned to opposite side. Quarter rail not_____	F 656	and proper body mechanics. 4. A) The DON or designee will observe ADL care provided to a random 10% sample of residents identified as needing extensive/total assistance with two-person assist three times weekly to ensure physical assistance is being provided according to resident's care plan. Results of observations will be recorded on a QAPI monitoring tool. B) The DON or designee will conduct chart audits of residents requiring an MDS (Minimum Data Set) be completed to ensure the care plan is developed/revised to reflect resident's ADL physical assistance needs. Results of audits will be recorded weekly on a QAPI monitoring tool. Monitoring will be completed for eight weeks, then monthly as deemed necessary by QAPI team. Any issues noted during monitoring will be corrected at time of discovery. Re-education of staff will be conducted as deemed necessary. Results of monitoring will be reviewed at next scheduled QAPI meeting to determine effectiveness and make changes as deemed necessary.	

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F 656	Continued From page 9	F 656		

(review revealed nothing else noted as to whether the rail was up or down just the word not), Resident rolled out of bed. Further review under Narrative of Investigation: On January 4th (this was the date noted written in the investigation) Social Worker at the Hospital spoke to the administrator in regards to the resident's fall. Social worker was informed that the residents fall was contributed to him rolling Resident #1 the wrong way. Administrator explained that a competency check was being put in place to assure that certified nursing assistants were using proper technique to avoid accidents.

Review of Resident #1's hospital record revealed Resident #1 was sent to the hospital on 02/01/19. Further review of Resident #1's admission summary dated 02/01/19 revealed the patient was admitted to the intensive care unit for repeat cat scan of the head and every 1 hour neuro checks.

Review of the nurse's note dated 02/01/19 at 11:16pm revealed in part, at 10:00pm the aide was providing care, called nurse to the room and the resident was on the floor. Copious amount of blood noted coming from resident's head. Laceration to head. Called 911 to transport. Resident to the emergency room for evaluation and treatment.

In an interview on 02/07/19 at 11:42am, S3 Assistant Director of Nursing (ADON) indicated she was notified by the nurse when Resident #1's fall happened. S3 ADON indicated the CNA was providing incontinent care. When the CNA rolled Resident #1 to the opposite side of the bed, and the rail was down Resident #1 continued to roll, fell out of the bed and landed on the floor.

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F 656	Continued From page 10	F 656		

In an interview on 02/07/19 at 3:26pm, S2 Director of Nurses and S4 ADON present, S5 CNA indicated he was doing rounds and went into Resident#1's room to do incontinent care. S5 CNA stated he was on the left side of the bed and turned Resident #1 to the right side of the bed and "he flipped off the bed." When the surveyor questioned S5 CNA on how he knew what type of assistance was needed for Resident #1, he stated it was in the kiosk and it was one person assist. S5 CNA further stated after the incident occurred that S6 Licensed Practical Nurse told him he should use two person assist for Resident #1.

In an interview on 2/7/18 at 4:35pm, S6 Licensed Practical Nurse (LPN) indicated the CNA called her to Resident #1's room and said the resident fell. S6 LPN further indicated she saw Resident #1 on the floor and assessed the resident. S6 LPN stated she called 911. S6 LPN indicated after the resident left, S6 LPN educated S5 CNA to use two person assist when providing care for Resident #1.

In an interview on 02/08/19 at 08:48am, S2 DON indicated that one person assist had been used for Resident #1 depending on who the CNA was. S2 DON further indicated the CNAs determine if they need more help and would use 2 person assist if needed.

In an interview on 02/08/19 at 2:20pm, S10 Care Plan Nurse LPN indicated when she reviewed Resident #1's care plan with the surveyor regarding Resident #1 was identified to have activity of daily living (ADL) self-care deficit as evidenced by needs total assistance with bed

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F 656	Continued From page 11	F 656		

mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, and bathing related to a cerebral vascular accident with right hemiplegia, status post subdural hematoma with right sided hemi-craniotomy with a target date of 03/01/19. Approaches to include report changes in ADL self-performance to nurse; provide adaptive/safety equipment; provide only amount of assistance/supervision that is needed: standby, cueing/prompting, and contact guarding; Turn and reposition, shifting weight to enhance circulation; explain all procedures and purpose prior to performing task and encourage self-performance; and utilize task segmentation as indicated to help improve ADL participation. S10 Care plan Nurse LPN indicated total assistance does not mean one person assist or two person assist. S10 Care Plan Nurse LPN stated one staff person may need more or less depending on the staff person when caring for the resident and whether or not the resident needs more help one day or less.

In an interview on 02/08/19 at approximately 4:22pm, S7 Corporate Nurse indicated the process for CNAs to find out what type of assistance is needed for a particular resident would be if the resident was new then they would communicate with the nurse to see what type of assistance was needed. S7 Corporate Nurse further indicated if the CNAs have cared for the resident before then they use their judgement and training to assess if more help is needed and report it to the nurse who can communicate changes. S7 Corporate Nurse indicated the CNAs can review the completed care to see what type of care was given previously but it was not used to tell them the type of care that was required. When the surveyor questioned S7 Corporate

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MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

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F 656	Continued From page 12 Nurse on Resident #1's last MDS assessment for toileting required extensive assistance and two person assist, she indicated it was a 7 day look back period and showed what the resident required previously but could change depending on the staff or the resident. When the surveyor questioned the S7 Corporate Nurse regarding Resident #1's being care plan for self-care deficit, and needing total assistance and approach to provide only amount of assistance/supervision that is needed: standby; cueing/prompting; contact guarding; weight bearing, she indicated the staff uses only the amount of care that is needed whether one person assist or two person assist depending on staff person and the resident.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a resident from falling out of bed, which resulted in a head laceration and hospitalization. This deficient practice was identified for 1(Resident #1) of 9 sampled residents but had the potential to affect any of the 176 residents who resided in the facility as documented on the Resident Census and Conditions of Resident's form CMS-672.	F 689	1. Resident #1 admitted to hospital on 02/01/19, did not return to facility, and was discharged on 02/08/19. At the time of the 02/01/19 fall, a Resident Incident Report was completed and investigation into cause of fall began. Immediate Post-Incident Action on 02/01/19 Resident Incident Report is “2 PERSON ASSIST”. On 02/04/19, prior to survey entrance, the	3/25/19

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F 689	Continued From page 13 Findings: Resident #1 was admitted on 10/17/17 with diagnoses in part, of morbid obesity due to excess calories, Hemiplegia following a cerebral vascular accident affecting right dominant side, generalized muscle weakness, gastroscopy, hydrocephalus, localized edema, and stage four pressure ulcer. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 11/20/18 revealed in part, Resident #1 had a brief interview mental status score (BIMS) of 6 (severely cognitively impaired) and required extensive assistance and two person assist for bed mobility and toilet use. Further review revealed Resident #1 had a range of motion impairment of one upper and one lower extremity, had an indwelling catheter and was always incontinent of stool. Review of Resident #1's care plan revealed in part, Resident #1 was identified to have activity of daily living (ADL) self-care deficit as evidenced by needs total assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, and bathing related to a cerebral vascular accident with right hemiplegia, status post subdural hematoma with right sided hemi-craniotomy with a target date of 03/01/19. Approaches to include report changes in ADL self-performance to nurse; provide adaptive/safety equipment; provide only amount of assistance/supervision that is needed: standby, cueing/prompting, and contact guarding; Turn and reposition, shifting weight to enhance circulation; explain all procedures and purpose prior to performing task and encourage	F 689	facility developed and began implementing a QAPI plan related to Resident #1's fall. QAPI plan includes in part, identifying residents who require extensive and total assistance, updating care plans to reflect need for two person assistance, educate staff on residents who require two person assistance, and random monitoring of adl care for residents requiring two person assist. Above mentioned Resident Incident Report and QAPI plan with supportive evidence of implementation were provided to survey team during survey process. 2. A) The facility will determine which residents require extensive and total assistance from a review of their most recent MDS Section G. The facility will then identify which extensive/total assistance residents require two person assist through resident assessment and/or staff interviews. The facility will update the care plan of identified residents to reflect the need for two person assist. B) The facility will continue to implement the QAPI plan developed on 02/04/19 and revise plan as needed based on monitoring findings. 3. A) The DON or designee will educate CNA staff related to residents requiring 2 person assist and providing 2 person assistance. B) The DON or designee will complete competency checklists with CNA staff related to positioning resident in the bed and proper body mechanics. 4. A) The DON or designee will observe ADL care provided to a random 10%	

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F 689	Continued From page 14 self-performance; and utilize task segmentation as indicated to help improve ADL participation. Review of the facility's incident investigation dated 02/01/19 revealed in part, Resident #1 had a fall on 02/01/19 at 10:00pm. Review under type of injury revealed a laceration. Review revealed under location, Resident's room. Further review under narrative of investigation: Certified Nursing Assistant (CNA) providing care, resident being turned to opposite side. Quarter rail not_____ (review revealed nothing else noted as to whether the rail was up or down just the word not), Resident rolled out of bed. Further review under Narrative of Investigation: On January 4th (this was the date noted written in the investigation) Social Worker at the Hospital spoke to the administrator in regards to the resident's fall. Social worker was informed that the residents fall was contributed to him rolling Resident #1 the wrong way. Administrator explained that a competency check was being put in place to assure that certified nursing assistants were using proper technique to avoid accidents. Review of Resident #1's hospital record revealed Resident #1 was sent to the hospital on 02/01/19. Further review of Resident #1's admission summary dated 02/01/19 revealed the patient was admitted to the intensive care unit for repeat cat scan of the head and every 1 hour neuro checks. Review of the nurse's note dated 02/01/19 at 11:16pm revealed in part, at 10:00pm the aide was providing care, called nurse to the room and the resident was on the floor. Copious amount of blood noted coming from resident's head. Laceration to head. Called 911 to transport.	F 689	sample of residents identified as needing extensive/total assistance with two person assist three times weekly to ensure needed physical assistance is being provided. Results of observations will be recorded on a QAPI monitoring tool. B) The DON or designee will review Incident/Accident reports three times weekly to ensure the needed physical assistance was available/provided according to resident's care plan. The resident's assistance needs will be adjusted as needed and care plan revised based on review findings. Results of reviews will be recorded on a QAPI monitoring tool. Monitoring will be completed for eight weeks, then monthly as deemed necessary by QAPI team. Any issues noted during monitoring will be corrected at time of discovery. Re-education of staff will be conducted as deemed necessary. Results of monitoring will be reviewed at next scheduled QAPI meeting to determine effectiveness and make changes as deemed necessary.	

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Resident to the emergency room for evaluation and treatment.

In an interview on 02/07/19 at 11:42am, S3 Assistant Director of Nursing (ADON) indicated she was notified by the nurse when Resident #1's fall happened. S3 ADON indicated the CNA was providing incontinent care. When the CNA rolled Resident #1 to the opposite side of the bed, and the rail was down Resident #1 continued to roll, fell out of the bed and landed on the floor.

In an interview on 02/07/19 at 3:26pm, S2 Director of Nurses and S4 ADON present, S5 CNA indicated he was doing rounds and went into Resident#1's room to do incontinent care. S5 CNA stated he was on the left side of the bed and turned Resident #1 to the right side of the bed and "he flipped off the bed." When the surveyor questioned S5 CNA on how he knew what type of assistance was needed for Resident #1, S5 CNA stated it was in the kiosk and it was one person assist. S5 CNA further stated after the incident occurred that S6 Licensed Practical Nurse told him he should use two person assist for Resident #1.

In an interview on 2/7/19 at 4:35pm, S6 Licensed Practical Nurse (LPN) indicated the CNA called her to Resident #1's room and said the resident fell. S6 LPN further indicated she saw Resident #1 on the floor and assessed the resident. S6 LPN stated she called 911. S6 LPN indicated after the resident left, S6 LPN educated S5 CNA to use two person assist when providing care for Resident #1.

In an interview on 02/08/19 at 08:48am, S2 DON indicated that one person assist had been used

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F 689	Continued From page 16	F 689		

for Resident #1 depending on who the CNA was. S2 DON further indicated the CNAs determine if they need more help and would use 2 person assist if needed.

In an interview on 02/08/19 at approximately 4:22pm, S7 Corporate Nurse indicated the process for CNAs to find out what type of assistance is needed for a particular resident would be if the resident was new then they would communicate with the nurse to see what type of assistance was needed. S7 Corporate Nurse further indicated if the CNAs have cared for the resident before then they use their judgement and training to assess if more help is needed and report it to the nurse who can communicate changes. S7 Corporate Nurse indicated the CNAs can review the completed care to see what type of care was given previously but it was not used to tell them the type of care that was required. When the surveyor questioned S7 Corporate Nurse on Resident #1's last MDS assessment for toileting required extensive assistance and two person assist, she indicated it was a 7 day look back period and showed what the resident required previously but could change depending on the staff or the resident. When the surveyor questioned the S7 Corporate Nurse regarding Resident #1's being care plan for self-care deficit, and needing total assistance and approach to provide only amount of assistance/supervision that is needed: standby; cueing/prompting; contact guarding; weight bearing, she indicated the staff uses only the amount of care that is needed whether one person assist or two person assist depending on staff person and the resident.

In an interview on 02/11/19 at 09:40am, S8 CNA

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F 689	Continued From page 17 indicated she used two person assist for Resident #1 when doing a diaper change. In an interview on 02/11/19 at 09:45am, S9 CNA indicated she used two person assist for Resident #1 when turning and changing Resident #1 due to his weight. Review of Resident #1's record revealed Resident #1 weight on 1/10/19 was 277 pounds.	F 689		

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F 000	INITIAL COMMENTS An onsite visit was conducted for all previous deficiencies cited on 02/11/2019. All deficiencies from this survey have been corrected.	F 000		

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 000	INITIAL COMMENTS Complaint Survey #LA00051835. No deficiencies cited as a result of this complaint.	F 000		

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

Electronically Signed | 06/20/2019

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F 000	INITIAL COMMENTS Complaint #LA00052178. No deficiencies were cited as a result of the complaint allegations. However, an unrelated tag, F-0609 was citedas a result of the complaint survey investigation.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		8/10/19

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Electronically Signed		07/25/2019

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F 609	Continued From page 1 Based on record review and interview, the facility failed to report an allegation of abuse for 1 (Resident #5) of 5 sampled residents to the State Agency within 2 hours of the incident. This deficient practice had the potential to affect any of the 179 residents residing in the facility as documented on the facility's Census & Conditions of Residents form (CMS 672). Findings: Review of Resident #5's electronic nurse's note dated 04/19/19 at 10:47am revealed, in part, Resident #5 was seen exposing himself to a female resident. Resident #5 made the female resident touch his penis. S2DON (Director of Nurses) and S6SW (Social Worker) notified. Nurse's note was signed by S5LPN (Licensed Practical Nurse). Review of the Online Tracking Incident System (OTIS) dated 04/23/19 at 01:14pm revealed in part, the report was generated as a result of the facility's Quality Assurance (QA), Performance Improvement (PI) plan. On 04/19/19, the nurse on duty was informed by a staff nurse that Resident #5 exposed his penis to another resident. The OTIS report also revealed Resident #5's Brief Interview for Mental Status (BIMS) score was 14, which indicated Resident #5 was cognitively intact. Further review revealed the female resident had a BIMS score of 0, which indicated the resident had significant cognitive impairment. In an interview on 07/03/19 at 11:53am, S1Administrator indicated she did not know an OTIS report had not been entered at the time of incident on 04/18/19. S1Administrator indicated S3Assistant Administrator conducted a QAPI on	F 609	1. Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: The Facility completed an OTIS report related to the alleged resident to resident altercation reported in Resident #5□s 04/19/19 Incident Report. 2. Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: A review of incident reports will be conducted for a 3 month look back to determine if there were any other allegations of abuse/neglect and if reporting requirements were met and in compliance. If not, corrective actions will be taken. 3. Measures put into place that will be made to ensure that deficient practice will not recur: Inservice with S2DON, S6SW, S1Administrator, and S3Assistant Administrator was conducted on 07/24/19 on required timeframes for reporting alleged violations to State Agency: (a) no later than 2 hours after allegation is made if events involve abuse or result in serious bodily injury. (b) no later than 24 hours after allegation is made if the events do not involve abuse and do not result in serious bodily injury.	

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F 609	Continued From page 2 04/23/19 and discovered an OTIS had not been entered, and S3Assistant Administrator entered the OTIS into the system at that time. In an interview on 07/03/19 at 11:55am, S2DON indicated she could not recall if she was notified at the time of incident on 04/19/19. Surveyor reviewed the nurse's note dated 04/19/19 at 10:47am with S2DON, which revealed documentation that the nurse had notified S2DON and S6SW. In an interview on 07/03/19 at 12:00pm, S4Corporate Nurse confirmed the incident on 04/19/19, which involved allegations of abuse, was not reported to the state in a timely manner. S4Corporate Nurse agreed the incident should have been reported within 2 hours after the incident was reported to the administrative staff.	F 609	4. The facility plans to monitor performance to make sure that solutions are sustained by: (a) DON or Designee will review Incident/Accident reports daily x 7 days then 5 x weekly for suspected allegations of abuse/neglect to ensure timely notification/reporting occurred if indicated. (b) Assistant Administrator or Designee will interview a random mix of 20 residents and staff daily x 7 days then weekly for suspected allegations of abuse/neglect to ensure timely notification/reporting occurred if indicated. (c) Administrator will review results of monitoring weekly to determine effectiveness and make changes to plan if deemed necessary. Monitoring will be completed for 8 weeks and then monthly as deemed necessary. Any issues noted during monitoring will be corrected at time of discovery. Re-education will be conducted as deemed necessary.	

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{F 000}	INITIAL COMMENTS An evidence review was conduced for all previous deficiencies cited on 07/03/19. All deficiencies from this survey have been corrected.	{F 000}		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR NEW ORLEANS, LA 70115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #LA00053001. No deficiencies cited as a result of this complaint	F 000		

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	195174	A. BUILDING **01** B. WING _____	C **10/31/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

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K 000	INITIAL COMMENTS Maison Orleans Healthcare of New Orleans Is not in compliance with the requirements of Title 42 Code of Federal Regulations , Part 483.70(a) (Life Safety Code) as the following deficiencies will demonstrate. The Facility is sprinkled , licensed for 200 beds and a census of 173 .	K 000		
K 521 SS=C	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: K521 HVAC Based on visual observation the facility failed to assure that the heating, ventilation and air conditioning system was installed in accordance with NFPA 90A. The system could re-circulate smoke originating from one part of the building into other parts of the building otherwise unaffected. The deficient practice had the potential to affect 176 of 176 residents. 6 of 6 corridors are deficient in being used as a return air plenum. Findings:	K 521	Waiver applied for on 10/31/2019	12/16/19

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

Electronically Signed | 11/14/2019

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K 521	Continued From page 1 During the facility tour, between the hours of 9:00 AM and 4:30 PM on 10-31-2019 it was observed that the corridors are being used as return air plenums. The Facility is requesting a continuation of a waiver.	K 521		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: K914 Electrical Systems - Maintenance and Testing Based on visual observation and record review, the facility failed to maintain electrical receptacles in patient areas NFPA 99 requires non-hospital grade electrical receptacles to be tested for	K 914	DISCLAIMER: This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists	12/16/19

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K 914	Continued From page 2 physical intercity , continuity of grounding circuit , polarity , and retention force of grounding blade.. The deficient practice had the potential to affect 176 of 176 residents. Findings: During the record review, between the hours of 9:00 AM and 4:30 PM on 11-31-2019 revealed non-hospital grade electrical receptacles located in resident areas throughout the facility did not have annual retention testing documentation. Interview with Maintenance director revealed the facility was not aware that continuity , polarity , and retention testing was required on the electrical receptacles .	K 914	or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. K-914 (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) Nonhospital grade receptacle testing in resident areas initiated on 11/4/2019. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) All current residents had the potential to be affected by the deficient practice (b) All Nonhospital grade receptacles in resident areas will have annual retention testing documented. (3) Measures put into place that will be made to ensure that deficient practices will not recur: (a) The Assistant Administrator presented an inservice on 11/5/2019 to Maintenance Supervisor and Maintenance worker regarding Annual Testing of non hospital grade receptacles and demonstrated proper testing procedure. (b) Any receptacles noted to fail testing will be locked out/ tagged out and a contracted electrician contacted for repairs (4) The facility plans to monitor its performance and make sure solutions are sustained by randomly testing a non hospital grade receptacle in a resident area on each resident floor weekly for 6 weeks then monthly thereafter as deemed	

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K 914	Continued From page 3	K 914	necessary by the QAPI committee. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (5) Corrective actions will be accomplished by December 16, 2019.	

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F 000	INITIAL COMMENTS Recertification survey and Complaint survey LA00053227. No deficiencies cited for Complaint survey.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		12/16/19

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F 656	Continued From page 1 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents or responsible party were invited to care plan meetings for 1 (Resident #122) of 68 sampled residents but had the potential to affect any of the 180 residents as documented on the facility's Resident Census and Conditions of Residents. (CMS 672) Findings: Review of the Minimal Data Set (MDS) dated 09/19/19 revealed Resident #122 had a Brief Interview for Mental Status (BIMS) of 13 BIMS score which indicated Resident #122 was cognitively intact. In an interview on 10/28/19 at 11:54am, Resident #122 indicated she had never been invited to or participated in a care plan meeting. In an interview on 11/01/19 at 02:35pm, S8Social Worker (SW), revealed he did not have a care plan meeting with Resident #122 because the resident did not request one. S8SW disclosed he only had care plan meetings with residents if the family requested them. S8SW stated he was not aware that he had to invite all residents to their individual care plan meetings. Interview an on 11/01/19 at 2:45pm, S6Regional	F 656	DISCLAIMER: This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Tag F656 (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) RI #122 was invited to a care plan meeting on 11/7/2019. She is self responsible. (b) Meeting to be held on 11/27/19. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) All current residents had the potential to be affected by the deficient practice (b) All residents and responsible parties if one exists will be invited to care plan meetings quarterly at the time of their next	

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F 656	Continued From page 2 Administrator, revealed the Care Plan meetings should be done quarterly with family and or resident.	F 656	MDS assessment according to the MDS Schedule beginning 11/7/2019. (3) Measures put into place that will be made to ensure that deficient practices will not recur: (a) The Administrator presented an inservice on 11/7/2019 to Administration, Nursing Administration, Therapy, MDS, Social Services, Dietary and Activity Departments on Ensuring Residents and Responsible Party are invited to Care Plan Meetings. (b) The Social Worker will invite residents and responsible party if one exists to care plan meetings weekly beginning on 11/7/2019 in writing. Notice to be given/ sent at least 2 weeks in advance of meeting. (4) The facility plans to monitor its performance and make sure solutions are sustained by auditing the CP invitations weekly for 6 weeks then monthly thereafter as deemed necessary by the QAPI committee. Care Conference attendance will also be documented on the Care Plan Conference Summary and placed on the resident medical record. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (5) Corrective actions will be accomplished by December 16, 2019.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/16/19

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F 812	Continued From page 3 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions. This deficient practice was evidenced by the facility failing to ensure the three compartment sink was being used properly and monitored for proper functioning. This deficient practice had the potential to affect any of the residents in the facility who received food from the facility's kitchen. Findings: During initial tour of the kitchen on 10/28/19 at 9:50am S11DietaryManager and S5DietarySupervisor were present and on observation of three compartment sink, female employee observed cleaning dirty plastic bowls in the wash compartment and dirty pans with reddish color resembling tomato sauce color residue in the rinse compartment. The sanitizer compartment was empty without any water	F 812	Tag F812 (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) The female dietary employee was counseled by the Dietary Supervisor on 10/28/2019. (b) AutoChlor representative was contacted via phone for service on 10/28/19. (c) The reddish ring noted in the center of the sink in the sanitizer compartment was removed by the Dietary manager on 10/28/19. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) All current residents had the potential to be affected by the deficient practice (b) AutoChlor representative serviced	

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F 812	Continued From page 4 present. S5DietarySupervisor counseled female employee and S5DietarySupervisor let out the dirty water from the rinse compartment to properly fill the sinks. Observation on 10/31/19 at 8:40am with S11Dietary Manager present, the three compartment sink contained dirty dishes. Observation further revealed S12Dishwasher filled the rinse compartment and sanitizer compartment which revealed a reddish ring noted to the center of sink in the sanitizer compartment and a reddish color noted to the suds and the edges of the sink. In an interview 10/31/19 at 8:45am S12Dishwasher verbalized that's the color of the sanitizer and it always had that color in it. S12Dishwasher drained the sanitizer and water out and refilled the sink with water and sanitizer and revealed the same results of the reddish film. In an interview 10/31/19 at 8:47am S11DietaryManager acknowledged a reddish ring in the center of the sink that appeared to be dirt scum. S11DietaryManager further verbalized that she's never noticed any reddish color film in the suds for a sanitizer and that the film was not normal. In an interview 10/31/19 at 9:11am S11DietaryManager verbalized contacting Auto-Chlor Representative and that they were sending someone out to check the line due to the reddish film not clearing out the lines properly even after cleaning the sink of the reddish residue.	F 812	sanitizer dispenser on 10/31/2019 (3) Measures put into place that will be made to ensure that deficient practices will not recur: (a) The Dietary Manager/ Supervisor presented an inservice on 10/31/2019 and 11/6/2019 to the Dietary Staff on proper use and monitoring for proper functioning of the 3 compartment sink. (4) The facility plans to monitor its performance and make sure solutions are sustained by auditing the 3 Compartment sink 3 x week for 6 weeks then monthly thereafter as deemed necessary by the QAPI committee. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (5) Corrective actions will be accomplished by December 16, 2019.	
F 814 SS=E	Dispose Garbage and Refuse Properly	F 814		12/16/19

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F 814	Continued From page 5 CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure garbage and refuse were disposed of properly. This deficient practice had the potential to affect all 180 residents who resided in the facility as per the facility's Resident Census and Conditions of Resident Form. Findings: An observation of the facility's garbage dumpsters was conducted with S13HousekeepingSupervisor on 10/28/19 at 9:42am. During the observation two large garbage dumpsters were noted and both of the dumpster's tops were open. Further observation of the open dumpsters revealed a trash bag filled with trash of trash on top of each dumpster lid. Further observation of the ground in between the dumpsters were at least three trash bags of trash, soiled diapers on the ground, as well as other trash outside of the trash bags. Both dumpsters with ample amount of room inside of dumpster whereas trash and bags could have been properly disposed of. On 10/28/19 at 9:45am an interview was conducted with S13HousekeepingSupervisor. During the interview S13Housekeeping Supervisor acknowledged that the dumpster's top should have been closed and the side doors are accessible if trash wasn't impeding walk space in between dumpsters.	F 814	Tag F814 (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) The trash noted on top of the dumpster lids was placed inside the dumpster by Housekeeping personnel on 10/28/2019. (b) The 3 trash bags noted on the ground as well as the diapers and other trash was picked up and placed inside the dumpster by Housekeeping personnel on 10/28/19. (c) The lids to both dumpsters were properly closed by Housekeeping personnel on 10/28/19. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) All current residents had the potential to be affected by the deficient practice. (b) Reminder signs were placed on the Dumpster Enclosure by the Assistant Administrator on 11/7/2019. (3) Measures put into place that will be made to ensure that deficient practices will not recur: (a) The Housekeeping Supervisor presented an inservice on 11/13/19 to the Housekeeping Staff on Disposing Garbage and Refuge Properly. (b) The DON/ designee presented an inservice on 11/6/2019 to the Nursing	

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F 814	Continued From page 6	F 814	Staff on Disposing Garbage and Refuge Properly. (c) The Dietary Manager/ Supervisor presented an inservice on 10/31/19 and 11/6/2019 to the Dietary Staff on Disposing Garbage and Refuge Properly. (4) The facility plans to monitor its performance and make sure solutions are sustained by auditing the Dumpster at least 5 x week for 6 weeks then monthly thereafter as deemed necessary by the QAPI committee. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (5) Corrective actions will be accomplished by December 16, 2019.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		12/16/19

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F 880	Continued From page 7	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	1420 GENERAL TAYLOR NEW ORLEANS, LA 70115

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F 880	Continued From page 8 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain an effective infection prevention and control program by failing to and ensure staff washed and/or sanitized their hands during care of 1 (Resident #208); and failed to ensure staff followed standard precautions during administration of dietary supplement for 1 (Resident #11) of 68 sampled residents in the investigative stage of the annual survey. This failed practice had the potential to affect all of the residents in the facility. The total census was 180. Findings: Resident #208 Observation on 10/30/19 at11:45am, revealed S10Certified Nursing Assistant(CNA) was observed coming out of a Resident #208's room with a pair of blue gloves on. S10CNA was asked if he knew that Resident #208 was on contact precautions for Clostridium-Difficile (C-Diff) and if he should have washed his hands after removing his gloves. S10CNA indicated yes. In an interview on 10/30/19 at 12:05pm, S7Licensed Practical Nurse(LPN) was informed of S10CNA coming out of Resident #208's room with gloves on. S7LPN stated S10CNA should not have had gloves on in the hallway and should	F 880	Tag F880 (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) The DON/designee educated S10 CNA on effective infection prevention techniques including removing gloves and washing hands before exiting residents room on 10/30/2019. (b) The DON/designee educated S9 LPN on effective infection prevention techniques including discarding containers if cap becomes contaminated ie contact with the floor on 10/31/2019. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) All current residents had the potential to be affected by the deficient practice (b) The facility will maintain an effective infection prevention program (3) Measures put into place that will be made to ensure that deficient practices will not recur: The DON/designee will Inservice Nursing and CNA staff on (a) Handwashing (b) Proper use of gloves (Not in hallway) (c) Proper removal and disposal of	

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F 880	Continued From page 9 have removed his gloves in the room and washed his hands before leaving Resident #208's room. Record review of Resident #208's electronic lab report dated 10/23/19 indicated Resident #208 was positive for (C-Diff). In an interview on 10/30/19 at 01:15pm, S2Director of Nursing(DON) agreed S10CNA should not have come out the room with the gloves on, and he should have washed his hands prior to leaving the room. Resident # 11 Observation on 10/30/19 at 09:25am, revealed S9Licensed Practical Nurse(LPN) dropped the cap to the supplement container on the floor. S9LPN picked the cap up off the floor and replaced the cap on the supplement container. In an interview on 10/30/19 at 10:10am, S2Director of Nursing(DON) was made aware of S9LPN dropping the cap to a container of supplement on the floor and replacing it on the supplement container. S2DON stated agreed that S9LPN should have discarded the container after replacing the cap on the container.	F 880	gloves in resident rooms (d) Proper Handwashing Related to glove use (Washing hands after removing gloves) (e) Discarding containers or disposable equipment immediately if it or it□s cap or lid becomes contaminated □ ie contact with the floor or another non clean surface. (4) The facility plans to monitor its performance and make sure solutions are sustained by (a) DON/designee will perform visual observations of resident care on ten residents per unit three times a week for 6 weeks then monthly thereafter as deemed necessary by the QAPI committee to ensure proper removal of gloves and handwashing by staff. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (b) DON/designee will perform visual observations of random medication/supplement administrations on one nurse per unit three times a week for 6 weeks then monthly thereafter as deemed necessary by the QAPI committee to ensure proper infection control technique maintained. Any issues noted will be corrected at time of monitoring. Follow up re-education with staff as needed based on results of audit. (5) Corrective actions will be accomplished by December 16, 2019.	

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	195174	A. BUILDING **01** B. WING _____	R **12/18/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAISON ORLEANS HEALTHCARE OF NEW ORLEANS	**1420 GENERAL TAYLOR** **NEW ORLEANS, LA 70115**

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{K 000}	INITIAL COMMENTS	{K 000}		

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 000	INITIAL COMMENTS A follow up to the Recertification Survey was conducted onsite for the previous deficiencies cited on 11/1/19. The deficiencies from this survey have been corrected.	F 000		

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.