STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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

(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
K 000	INITIAL COMMENTS Maison De'Ville Nursing Home of Harvey is in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The facility is sprinklered, licensed for 100 beds and a census of 93 at time of survey.	K 000		
K 200 SS=C	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on visual observation, the facility failed to assure that the means of egress headroom clearance was free of obstructions or impediments to full instant use of the exit passage way. Obstructions, in the egress corridor, hinder occupant egress in emergency situations. This deficient practice could potentially affect 93 of 93 residents in the facility. Findings: During the facility tour on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was	K 200	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	1/21/21

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

Electronically Signed | 10/31/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

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K 200	Continued From page 1 observed all four corridors exit directional signage and a few of the corridors had intercom speakers that had been mounted to the ceiling and were less than the required six foot eight inches requirement. NFPA 101:19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7,unless otherwise modified by 19.2.2 through 19.2.11. NFPA 101:7.1.5.1 Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 ft 6 in. (2285 mm), with projections from the ceiling not less than 6 ft 8 in. (2030 mm) with a tolerance of -3/4 in. (-19 mm), above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not less than 7 ft (2135 mm) from the floor, with projections from the ceiling not less than 6 ft 8 in. (2030 mm) nominal above the floor. (2) Headroom in industrial equipment access areas as provided in 40.2.5.2 shall be permitted. Interview with the maintenance director revealed the facility was not aware that the headroom clearance in the corridor was not in accordance with the code requirements listed above. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 200		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits	K 271		1/21/21

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	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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

(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
K 271	Continued From page 2 Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to provide the continuation of the exit discharge to include access to the public way from all required exits. The access provides an easier transition for occupants to evacuate from all exits in the building. The deficient practice had the potential to affect 93 of 93 residents. The exit discharge was deficient for 2 of 10 exits. Findings: During the facility tour on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was observed the hall three patio exit and the dining exit had solid packed all weather surfaces. However, the solid packed all weather surface led to a confined fenced area. The egress path lacks a gate within the fenced area at the end of the solid packed all weather surface. Interview with the maintenance director revealed the facility was not aware that the exit discharge did not continue to the public way. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 271	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		1/21/21

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	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

(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
K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the fire alarm system was inspected and tested in accordance with the approved maintenance and testing program in NFPA 72. The fire alarm system gives a sense of security to offer an advance warning in fire and/or smoke emergency. This deficient practice could potentially affect 93 of 93 residents. Findings: During the facility tour on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was observed the main fire alarm system had lacked a sensitivity test within the last two years, the fire alarm was lacking a annual certification and was yellow tagged by a licensed fire alarm for zone three being disconnected. NFPA 72: 10.3.2 System components shall be installed, tested, and maintained in accordance with the manufacturer's published instructions and this Code. NFPA 72:10.4.1.2 State or local licensure regulations shall be followed to determine qualified personnel. Depending on state or local licensure regulations, qualified personnel shall	K 345	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	

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K 345	Continued From page 4 include, but not be limited to, one or more of the following: (1) Personnel who are registered, licensed, or certified by a state or local authority. LRS 40:1646 (A)(B)(C) The fire marshal is authorized to cause the inspection and testing of all life safety systems and equipment in the state, whether in public or private buildings, during installation or immediately after installation to determine compliance with applicable standards. The owner of any building containing a life safety system and equipment shall cause at a minimum an annual inspection to be made of the life safety system and equipment in that building to assure compliance with applicable safety standards and to determine whether structural changes in the building or in the contents of the building mandate alteration of a system. Life safety systems and equipment includes but is not limited to fire sprinkler, fire alarm, fire suppression, special locking systems and equipment, and portable fire extinguishers. NFPA 72: 14.4.4.3* In other than one- and two-family dwellings, sensitivity of smoke detectors shall be tested in accordance with 14.4.4.3.1 through 14.4.4.3.7. NFPA 72: 14.4.4.3.1 Sensitivity shall be checked within 1 year after installation. NFPA 72: 14.4.4.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.4.3.3. Interview with the maintenance director revealed the facility was not aware that the required inspections had not been conducted on the fire alarm system and was acknowledged by the	K 345		

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K 345	Continued From page 5 Administrator. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 345		
K 352 SS=C	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the complete, supervised, automatic sprinkler system was inspected and tested in accordance with the requirements of NFPA 13. Activation of the sprinkler system shall trigger notification of the emergency to the fire alarm system within 90 seconds, which results in protection of life and property. This deficiency has the potential to affect 63 of 63 residents. The findings include: During the facility tour on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was observed the backflow preventer located above the suspended ceiling near the hall four smoke barrier cross corridor double doors had two valves that lacked fire alarm supervision.	K 352	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	1/21/21

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K 352	Continued From page 6 NFPA 101:9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. Interview with the maintenance director revealed the facility was not aware all of the sprinkler valves including the backflow preventer valves were required to supervised via the fire alarm system. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 352		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		1/21/21

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K 353	Continued From page 7 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, records review, and interview, the facility failed to have a licensed sprinkler suppression agent complete a five year Microbiologically Influenced Corrosion inspection of the sprinkler system internal piping. The deficient practice affected 93 of 93 residents. The findings include: Records review of the facility sprinkler inspections for the year prior to the survey on October14, 2020 at 9:00 am to 2:30 pm revealed the facility did not have records of five (5) year MIC testing of internal piping of sprinkler system. NFPA 25: 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. NFPA 25: 4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25: 4.3.3* Records shall be maintained by the property owner. NFPA 25: 14.2.1 Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch	K 353	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	

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K 353	Continued From page 8 line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. NFPA 25: 14.2.1.1 Alternative nondestructive examination methods shall be permitted. NFPA 25: 14.2.1.2 Tubercules or slime, if found, shall be tested for indications of microbiologically influenced corrosion (MIC). NFPA 25: 14.2.1.3* If the presence of sufficient foreign organic or inorganic material is found to obstruct pipe or sprinklers, an obstruction investigation shall be conducted as described in Section 14.3. Interview with the maintenance director revealed the facility was unaware of the requirement for five (5) year MIC inspection for the sprinkler system internal piping.. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 353		
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	K 521		1/21/21

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K 521	Continued From page 9 This REQUIREMENT is not met as evidenced by: 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 63 of 63 residents. 4 of 4 corridor smoke compartments are deficient in being used as a return air plenum. Findings: During the facility tour on October 14, 2020 between the hours of 9:00 am to 2:30 pm it was observed the corridor was being used as a return air plenum to supply HVAC air to all resident sleeping rooms and then exhausted to the corridor. NFPA 90A: 4.3.12.1.1 Egress corridors in health care, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.2.1 through 4.3.12.1.2.4. NFPA 90A: 4.3.12.1.2 An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. NFPA 90A: 4.3.12.1.2.1 An air transfer opening(s) shall be permitted in walls or doors from toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto	K 521	A renewal waiver had been completed for the HVAC corridor being used as a return air plenum for the adjacent resident sleeping rooms.	

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K 521	Continued From page 10 the egress corridor. NFPA 90A: 4.3.12.1.2.2 Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Other Opening Protectives, air transfer caused by pressure differentials shall be permitted. NFPA 90A: 4.3.12.1.2.3 Use of egress corridors shall be permitted as part of an engineered smoke-control system. NFPA 90A: 4.3.12.1.2.4 Air transfer opening(s) shall be permitted in walls or in doors separating egress corridors from adjoining areas in detention and correctional occupancies with corridor separations of open construction (e.g., grating doors or grating partitions). Interview with the Administrator revealed the facility was aware due to the extreme age of the facility, a waiver had been approved for the HVAC system corridors to be used as a return air plenum for the resident sleeping rooms. A renewal waiver application was obtained and approved from the Administrator for waiver reapplication.	K 521		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		1/21/21

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K 712	Continued From page 11 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on visual observation and record review the facility failed to maintain documentation for fire drills conducted during each quarter on each shift. Fire drills provide training in procedures in cases of emergency. The deficient practice had the potential to affect 63 of 63 residents. 1 of 4 quarters in 2019-2020 were deficient. Findings: During the record review on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was observed the second quarter for the year 2020 was lacking completed fire drill documentation for the second and third shifts. NFPA 101:19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. Interview with the Administrator revealed the facility was not aware fire drills were not being held for each work shift of each quarter. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 712	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101	K 741		1/21/21

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K 741	Continued From page 12 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on visual observation, the facility failed to assure that the policy on smoking required all smoking areas to be supplied with a metal, self-closing container. Cigarette butts shall be extinguished in an approved container in order to prevent accidental combustion. This deficient practice could potentially affect 93 of 93 residents. Findings:	K 741	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	

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MAISON DE'VILLE NURSING HOME OF HARVEY	**2233 EIGHTH STREET** **HARVEY, LA 70058**

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K 741	Continued From page 13 During the facility tour on October 14, 2020, between the hours of 9:00 am to 2:30 pm it was observed the smoking area was lacking a readily available noncombustible metal container. NFPA 101:19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Interview with the maintenance director revealed	K 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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

(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
K 741	Continued From page 14 the facility was not aware the containers in the smoke area did not meet the requirements.	K 741		
K 914 SS=C	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: Based on record review, the facility failed to assure that a polarity, ground and retention resident / patient room electrical receptacle test had been conducted and documented. When the correct protocols are routinely completed by qualified personnel to the resident / patient electrical receptacle outlets chances of creating a unsafe electrical event or possible fire emergency are reduced or possibly eliminated. The deficient	K 914	CMS COVID-19 emergency declaration blanket waiver effective until 60 days after the end of the emergency declaration. Wavier confirmed	1/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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

(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
K 914	Continued From page 15 practice had the potential to affect 93 of 93 residents. Findings: During the record of review on October 14, 2020 between the hours of 9:00 am to 2:30 pm revealed the resident sleeping rooms electrical receptacles lacked documentation for annual testing of polarity, ground and retention testing. NFPA 99 6.3.3.2 Receptacle Testing in Patient Care Rooms 6.3.3.2.1 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall not be less than 115 g (4oz.) Section 3-3 Section 3-3.4.3.1 A record shall be maintained of the tests required by this chapter and associated repairs of modifications. At a minimum, this record shall contain date, the rooms or areas tested and an indication of which items have met or have failed to meet the performance requirements of the chapter. Interview with the maintenance director revealed the facility was not aware that all documentation was not complete regarding the inspection/testing of the resident / patient electrical receptacles. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2020**

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

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	07/15/2020

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

(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 A COVID-19 Focused Infection control Survey was conducted on 07/15/2020. The facility was found to be in compliance with 42 CFR.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 94	F 000		

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

Electronically Signed | 08/11/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	11/18/2020

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

(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 #LA00056357, #LA00056433, and #LA00056440. No deficiencies were cited as a result of these complaints. A COVID-19 Focused Infection Control Survey was conducted on 11/18/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 96	F 000		

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

Electronically Signed | 12/11/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	12/29/2020

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

(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 #LA00056741 - No deficiencies cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 12/29/2020. The facility was found to be in compliance with 42 CRF 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents : 94	F 000		

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

Electronically Signed | 01/14/2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195403	A. BUILDING _____ B. WING _____	08/05/2020

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

(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 #LA00055706 was conducted on 08/05/2020. No deficiencies were cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 08/05/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 96	F 000		
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 providing services under a contractual arrangement based upon the facility assessment	F 880		9/5/20

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	195403	A. BUILDING _____ B. WING _____	08/05/2020

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 1	F 880		

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.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 2 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 observation, interview, and record review the facility failed to maintain the Centers for Disease Control (CDC) Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) by failing to ensure residents and staff adhered to their infection prevention and control practices of ensuring residents and staff wore a face mask covering their nose and mouth. This deficient practice was identified for 10 randomly observed residents (Resident R6, Resident R7, Resident R8, Resident R9, Resident R10, Resident R11, Resident R12, Resident R13, Resident R14 and Resident R15) and 2 staff members observed S4Certified Nursing Assistant (CNA) and S5Certified Nursing Assistant (CNA), but had the potential to affect any of the 96 residents as documented on the facility's Census List. Findings: Review of the facility's Universal Source Control and Universal Mask Use in the Facility revealed in part, every person entering the facility must wear a mask while in the facility. Review of the CDC website for Infection Control Guidance for Healthcare Professionals (HCP) about Coronavirus (COVID-19) as of July 15, 2020 revealed in part, the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part	F 880	[redacted] F880 08/05/2020 ¿¿An immediate review of F880 to mitigate the cited specific IP&C Deficient Practices: On 08/05/2020, the facility conducted an immediate review of F880 and began re-educating staff on the following to mitigate the specific IP&C Deficient Practices cited by LDH surveyors during survey exit conference: a. Proper mask usage for residents and staff. b. Wearing face masks at all times while in the facility according to CDC guidelines. ¿¿Adopt or develop a written, measurable format to objectively and routinely observe employee IP&C Performance: The facility will develop an observation tool based on CDC best practices for proper mask use by residents and staff to evaluate staff performance. Performance will be measured using a numerator, a denominator and percent performance format. a. Total number residents and employees wearing masks properly divided by Total number of resident and employee observations equals percent	

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 3 of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection. These practices include to use facemasks to cover a person's mouth and nose. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Further review revealed patients may remove their cloth face covering when in their rooms but should put it back on when around others or leaving their room. HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. During a facility tour of the facility's personal protective equipment with S2Director of Nursing (DON) an observation was made with S2DON on 08/03/2020 at 10:30AM of Resident R6 was sitting in her wheelchair in the hallway and not wearing a facial mask. In an interview on 08/03/2020 at 10:30am with S2DON confirmed Resident R6 should have a face mask on and all residents should wear a facial mask when they are out of their rooms. Observation on 08/03/2020 at 11:08AM revealed Resident R7 was propelling himself in his wheelchair to the sitting area and he did not have a face mask on. Observation on 08/03/2020 at 11:10AM revealed Resident R8 was sitting in her wheelchair near the nurse's station and did not have a face mask on.	F 880	performance. ¿¿Conduct a measurable baseline appraisal of employee IP&C work performance and employee conformance with your current IP&C system. The facility will use observation tool obtain baseline appraisal. Employee performance and conformance with current IP&C system will be measured using a numerator, a denominator and percent performance format. b. Total number residents and employees properly wearing masks properly divided by Total number of resident and employee observations equals percent performance. ¿¿Review, and revise as indicated, facility resources (Structures) including policies, procedures and your Facility Assessment. The facility will conduct a Root Causes Analysis (RCA) including a review of IP&C policies, procedures and Facility Assessment to identify factors which contributed to the noncompliance. ¿¿Design and provide in-service training for all applicable staff and their supervising staff. The facility will develop and provide in-service training based on RCA findings including a pre-test and post-test. ¿¿Conduct scheduled, measurable follow-up supervision and work performance appraisal of employee	

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 4 Observation on 08/03/2020 at 11:11AM revealed Resident R9 was sitting in his wheelchair in the hallway and did not have a face mask on. Observation on 08/03/2020 at 11:12 AM revealed Resident R10 was ambulating in the hallway and did not have a face mask on. Observation on 08/03/2020 at 11:46AM revealed Resident R9 was propelling in his wheelchair in the hallway and did not have a face mask on. Observation on 08/03/2020 at 12:10PM revealed Resident R7 was propelling himself in his wheelchair to the sitting area and he did not have a face mask on. Observation on 08/03/2020 at 1:10 PM revealed Resident R12 was sitting in her wheelchair and did not have a face mask on Observation on 08/03/2020 at 1:12 PM revealed Resident R11 was sitting in her wheelchair in the sitting area and did not have a face mask on. Observation further revealed Resident R11 coughed 6 times from 1:12PM to 1:18PM while sitting in the sitting area. In an interview on 8/3/2020 at 1:19PM, S1Administrator was notified of Resident R11 not wearing a facial mask and her coughing. Observation on 08/03/2020 at 1:20PM revealed S1Administrator and S2DON walked to the sitting where Resident R11 in her wheelchair by the exit door without a face mask on. In an interview on 08/03/2020 1:20PM, S1 Administrator and S2DON confirmed Resident R11 should have a face mask on while out of her	F 880	conformance with your IP&C system. a. 50 opportunities of proper mask usage by residents and staff will be observed weekly. (1 opportunity equals 1 resident or staff member) b. Observations will be conducted secretly and randomly by DON/Designee for 8 weeks then monthly to strive for the project to maintain the adoption of current best practices for sustainability of project goal. c. Staff observed will be provided feedback regarding their performance and provided reeducation as necessary. d. Findings of observations will be documented on observation tool developed to evaluate and measure staff performance. ¿¿Conduct an evaluation of the effectiveness and efficiency of your IP&C system. a. RCA Committee Review of data analysis from observation tool findings every 2 weeks to track and trend progress towards project goal and for opportunities for improvement. b. Conduct pre-test. Average pre-test scores to evaluate staff knowledge. 70% or greater of staff passing pre-test requires reevaluation of RCA. c. Conduct post-test. Score of below 80% indicates an opportunity for improvement and requires additional training.	

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 5	F 880		

room. S1Administrator and S2DON further confirmed all residents should be wearing a face mask when out of their rooms.

Observation on 08/04/2020 at 12:10PM revealed Resident R13 was propelling himself in his wheelchair to the sitting area and his face mask was below his chin not covering his nose and mouth.

Observation on 08/04/2020 at12:10PM revealed Resident R14 was propelling himself in his wheelchair to the sitting area and he did not have a face mask on.

Observation on 08/05/2020 at12:10PM revealed Resident R15 was propelling himself in his wheelchair to the sitting area and his face mask below his chin.

Observation on 08/05/2020 at 9:24AM revealed Resident R9 was sitting in his wheelchair near the nurse's station and did not have a face mask on.

Observation on 08/05/2020 at 9:27AM Resident R10 was ambulating in the hallway and did not have a face mask on.

Observation on 08/05/2020 at 11:17AM revealed S4CNA standing in the hallway without a face mask speaking to S7CNA.

In an interview on 08/05/2020 at 11:17AM, S4CNA was asked if she should have a face mask on and she indicated yes.

Observation on 08/05/2020 at 11:18AM revealed S5CNA walking in hallway with her facial mask on her chin and her nose and mouth were not

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

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F 880	Continued From page 6 covered. In an interview on 8/5/2020 at 12:35PM S1Administrator and S6Regional Director of Quality Measures were notified of S4CNA not wearing a mask and S5CNA wearing a facial mask on her chin and not covering her mouth and nose. Both the Administrator and Regional Director of Quality Measures confirmed the CNAs should be wearing facial masks and the mask should cover their nose and mouth. .	F 880		

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	195403	A. BUILDING _____ B. WING _____	10/16/2020

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F 000	INITIAL COMMENTS Recertification Survey A COVID-19 Focused Infection Control Survey was conducted on 10/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 91	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		11/13/20

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

Electronically Signed | 10/30/2020

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain ceiling tiles in good repair in a room and working light fixtures in a hallway. This deficient practice had the potential to affect any of the 91 residents who reside at the facility as documented on the facility's CMS Form-672 Resident Census and Condition of Residents. Findings: The facility's Policy and Practices entitled Infection Control revealed in part, the objectives of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public. An observation on 10/12/2020 at 7:35AM of Room "a" revealed to the left of the entrance of room "a" two missing ceiling tiles. Further observation of the ceiling where the ceiling tiles were missing revealed it was open to the attic,	F 584	1. Corrective action taken to correct deficient practices for resident #72 was accomplished by replacing the missing ceiling tile located in the dining room and above the resident□s table. All hallway lights were inspected and any not in working ordered were replaced. 2. All residents have the potential to be affected by the deficient practices. Ceiling tiles throughout the facility were inspected and replaced where appropriate. All light fixtures in hallways, resident rooms, and bathroom were inspected and deemed to be in working order. 3. Measures taken to eliminate the deficient practices are as follows: A. Facility staff were in-serviced on how to report maintenance issues.	

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F 584	Continued From page 2 wires were noted, and pipes were exposed. Upon further observation, Resident #72 was sitting in his wheelchair beneath the missing tiles while waiting for breakfast. Observation on 10/16/2020 at 09:50am with S2Director of Nursing (DON) of Room "a" revealed missing ceiling tiles. In an interview on 10/16/2020 at 09:50am, S2DON acknowledged room 'a" was not maintained in a clean and sanitary/safe environment with the hole in the ceiling. Observation on 10/16/2020 at 10:40AM with S5Maintenance Housekeeping Supervisor revealed missing ceiling tiles in room "a." In an interview on 10/16/2020 at 10:40AM, S5Maintenance Housekeeping Supervisor he acknowledged the tiles were not maintained and did not provide a clean and sanitary environment in room "a" where residents ate their meals or took part in activities. An observation on 10/12/2020 at 7:40AM of hallway "g" revealed one light fixture off of the ceiling with wires exposed and two other light fixtures with lights not working. Further observation revealed 2 Licensed Practical Nurses, S8LPN and S11LPN preparing medications at their carts. In interview on 10/12/2020 at 7:40AM, S11LPN indicated she had been employed at the facility since July, 2020 and the lights have not worked since that time. In interview on 10/12/2020 at 7:41AM, S8LPN indicated she used the light coming in from the	F 584	B. Maintenance staff were in-serviced on timeliness response to issues and ensuring maintenance log is checked multiple times daily. 4. The facility plans to ensure compliance using the following strategies: A. Maintenance log will be reviewed and initialed daily by NFA and maintenance director in morning QA meeting to ensure issues are addressed in a timely manner. B. NFA will inspect ceiling tiles and light fixtures twice weekly to ensure all are in working condition. Results will be recorded on monitoring tool and discussed in morning QA meeting. C. Failure to inspect, repair, and maintain the physical plant will result in a personal in-service and progressive discipline up to and including termination. 5. Compliance will be accomplished by November 13, 2020.	

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F 584	Continued From page 3 window to prepare the medications for administration.	F 584		
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. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		11/13/20

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F 656	Continued From page 4 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 observation, interview, and record review the facility failed to implement a resident's plan of care by failing to discontinue hospice services on the care plan after the Resident (Resident #26) was discharged from hospice, and failing to include isolation precautions on the care plan (Resident #251). This deficient practice was identified for 2 (Resident #26 and Resident #251) of 21 sampled residents but had the potential to affect any of the 91 residents who resided at the facility as documented on the facility's CMS Form-672 Resident Census and Condition of Residents. Findings: Resident #26 Review of Resident #26's clinical record revealed that he was admitted to the facility on 12/27/2019 with diagnoses of in part, Pulmonary Embolism, Alcohol Abuse, Encephalopathy, Morbid Obesity, Shortness of Breath, Long term use of anticoagulants, and Pleural Effusion. Review of Resident #26's physician's orders revealed in part, on 12/30/2019 Resident #26 was admitted to hospice with a diagnosis of Cirrhosis of the Liver. Subsequently, the clinical record indicated on July 22, 2020 Resident #26 was discharged from hospice care because he was no longer terminally ill.	F 656	1. Corrective action was accomplished for resident #26 by updating the resident□s entire care plan to assure all needs were care planned. Corrective action was accomplished for resident #251 by reviewing the resident□s clinical record and ensuring that the isolation order, and isolation care plan were both present in the resident□s clinical record. 2. Residents with orders for hospice and with the need for isolation were identified through chart audit for the past 30 days. Care plans for those residents were updated as needed and where appropriate. 3. Measures taken to eliminate the alleged deficient practice are as follows: Re-education of the Care plan nurse was completed. 4. The facility plans to ensure compliance using the following strategies: a. DON or designee will audit 25% of the clinical records based on the MDS schedule 3 times a week for 6 weeks to ensure the care plans are complete, appropriate, and up to date. using a	

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F 656	Continued From page 5 Review of the care plan revealed Resident #26 was admitted to hospice with a focus on providing collaborative care between the hospice agency and the facility with a goal of keeping the hospice facility up to date with his plan of care through 12/24/2020. Further review revealed the care plan was updated on 4/7/2020, 6/30/2020, 7/7/2020, 7/30/2020, and 8/24/2020 with an update scheduled for12/24/2020. Further review revealed hospice care was discontinued on 7/22/2020 and the care plan was not accurately updated to reflect the modification of care. In an interview on 10/14/2020 at 10:45AM, S6Licensed Practical Nurse (LPN) indicated the Resident #26 was no longer on hospice and had been discharged because he was no longer terminally ill. In an interview on 10/15/2020 at 10:40AM, S7Certified Nursing Assistant (CNA) indicated she has not witnessed anyone from Hospice caring for Resident #26 and that she provided him with baths/showers, activities of daily living care and assistance as needed. There was no documented evidence and the facility did not present any documented evidence that the care plan had been revised to reflect the current plan of care related to hospice care for Resident #26. Resident #251 Review of Resident #251's clinical record revealed in Resident #251 was admitted to the facility on 10/02/2020 with diagnosis in part of Cerebral Vascular Accident, Diabetes Mellitus, Hypertension and Aphasia.	F 656	monitoring tool b. Results will be reviewed weekly in the QA meeting. QAPI team will determine the need to extend the monitoring process as deemed appropriate. If any issues identified during the review period will be corrected at that time 5. Compliance will be accomplished by November 13, 2020.	

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F 656	Continued From page 6	F 656		

Observation on 10/12/2020 at 7:00AM of Resident #251's door revealed signage for isolation precautions.

In an interview on 10/12/02020 at 7:00am, S12LPN indicated Resident #251 was on isolation because she was newly admitted. She further indicated she did not know why Resident #251 was in a room with other residents when Resident #251 was on isolation precautions.

Review of Resident #251's physician's orders revealed in part, there was no order for isolation from date of admit on 10/02/2020 through 10/12/2020.

Review of the policy and procedure entitled Coronavirus Disease (COVID 19) - Identification and Management of Ill Residents dated August 2020 Procedure for Accepting Admissions from Hospitals revealed in part:
For patients/residents who are tested prior to hospital discharge and are COVID 19 negative, ADMIT and-
a. Place resident in isolation and care for using all recommended COVID-19 PPE for 14 days;
b. Monitor resident for symptoms consistent with COVID 19 every shift; and
c. Increase monitoring of resident's vital signs (temperature twice daily, pulse ox twice daily, and blood pressure, pulse, respirations daily) for 14 days.

In an interview on 10/15/2020 at 10:47AM, S6LPN indicated the Resident #251 was admitted to the facility with no signs or symptoms of COVID-19 and that Resident #251 was placed on precautions for 14 days because she was newly

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F 656	Continued From page 7 admitted. In an interview on 10/15/2020 at 2:33PM, S4 Registered Nurse Corporate Nurse indicated Resident #251 never tested positive for COVID 19. S4RN Corporate Nurse further stated upon Resident #251's admission there were no private rooms available so the facility staff put her in a room with other residents who had previously tested positive for COVID 19. S4RN Corporate Nurse further stated that sometimes you do the best that you can and because the residents were residing with other residents who had previously tested positive, they thought this was the best option for this resident. S4 RN Corporate Nurse indicated this procedure is in the plan of care for all newly admitted residents. Review of Resident #251's care plan revealed Resident #251 was not care planned for isolation. There was no documented evidence and the facility did not present any documented evidence that Resident #251 was care planned to be on isolation precautions.	F 656		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		11/13/20

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F 761	Continued From page 8 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure drugs in the medication storage room did not have expired medications available for use. This deficient practice had the potential to affect any of the 91 residents who reside in the facility as documented on the facility's CMS Form-672 Resident Census and Conditions of Residents. Findings: Observation on 10/15/2020 at 2:00 p.m., of the facility's (b) revealed the following: 1. (7) Major Fish Oil 500 mg expiration date 9/20/2020 and available for use, 2. (7) Good Sense Antacid expiration date 8/20/2020 and available for use, 3. (12) Good Sense Bisacoyl 5mg tablets expiration date 8/20/2020 and available for use, 4. (24) Geri care Thera tab Multivitamin expiration date 7/20/2020 and available for use, 5. (2) Gericare Simethacone 80mg tablets expiration date 8/20/2020, and available for	F 761	1. Corrective action was accomplished for the proper labeling and storage of drugs and biologicals by disposing of all expired over the medications, nasal cannula tubing, syringes, catheters, catheter kits, Ensure, Nepro, and enteral feedings. 2. All residents who use medications have the potential to be affected. All expired medications and supplies have been discarded. 3. Nurses and central supply clerk will be reeducated on checking for expired medications and supplies and removing those items when discovered. 4. DON or designee will monitor expiration dates of medications and supplies weekly x 6 weeks using a monitoring tool. Expired items will be removed from stock at time pf discovery.	

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F 761	Continued From page 9 6. (24) Gericare Vitamin E 400IU capsules expiration date 7/20/2020, and available for use 7. (8) Abbott Osmolite 1.5 calorie therapeutic nutrition expiration date 5/20/20 and available for use, 8. (4) Milk of Magnesia expiration date 3/20/2020, and available for use, 9. (33)Suplena therapeutic nutrition expiration date 12/18/2018 and available for use In an interview on 10/15/2020 at 2:00pm with S5Director of Nursing (DON), S2LPN (Licensed Practical Nurse) verified the expiration dates on the items listed above. S2LPN and S5DON further indicated and acknowledged "b" had not been audited and expired medications were not discarded by the dates of expiration listed above and available for use.	F 761	Results of the audit will be discussed in the weekly QA meeting with changes to the action plan as indicated. 5. Completion date Nov 13, 2020	
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,	F 880		11/13/20

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F 880	Continued From page 10 staff, volunteers, visitors, and other individuals 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.	F 880		

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F 880	Continued From page 11 §483.80(e) Linens. 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 review, and interviews, the facility failed to maintain a safe and sanitary environment by: 1) Failing to ensure hand soap was in the dispenser, toilet paper was available for use, (Room "c"); 2) Failing to ensure paper towels, toilet paper and a dead roach were not on the bathroom floor (Room "d"); 3) Failing to ensure a brown crusted like substance was not on the garbage bin, no chipped paint was on the wall by the faucet, and a shower head was not laying on the floor (Room "e"); and 4.) Failing to ensure there were no chipped and missing tiles on the bathroom floor and no black like substance on the air conditioner vent. (Room "f") This deficient practice had the potential to affect any of the 91 residents who reside at the facility as documented on the facility's CMS Form-672 Resident Census and Condition of Residents. Findings: Review of the Facility Policy and Procedure - Infection Control revealed in part, "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent	F 880	1. All residents within the facility have the potential to be affected by the alleged deficient practices. 2. Maintenance staff replaced all missing ceiling tiles and non-working light bulbs and repaired facility floors where tiles were noted as missing. In addition, every air conditioning vent in the facility was sanitized, pressure washed, and repainted. Housekeeping staff performed a deep cleaning on all shower rooms and public bathrooms and all bathroom and washrooms were inspected and the appropriate sanitizing and toiletry items were replaced if missing. 3. The following steps were accomplished to improve facility compliance with the alleged deficient practices A. Housekeeping and maintenance personnel were educated on ensuring the appropriate sanitation products are available in all bathrooms and washrooms throughout the facility. B. Maintenance staff was in serviced on checking the maintenance log to address resident and staff reported issues. C. A facility wide in-service was	

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	195403	A. BUILDING _____ B. WING _____	10/16/2020

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

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F 880	Continued From page 12 and manage transmission of diseases and infections. Furthermore, the objectives of our infection control policies and practices are to: b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public." Observation on 10/12/2020 at 6:40AM of Room "c" revealed in the bathroom closet, mini blinds pulled half way up at an angle with some of the blinds sticking out towards the front, with the toilet running and no toilet tissue available. Further observation revealed no hand soap in the soap dispenser near the sink. Further observation revealed the outer portion of the sink base was peeling and the microfiber board was exposed. Observation above and to the left of the sink revealed a raw piece of wood nailed to the wall. An interview on 10/12/2020 at 6:40AM with S9Licensed Practical Nurse (LPN) who stated that room "c" was currently used for resident care. An interview on 10/16/2020 at 10:00AM with S2/Director of Nursing (DON) who observed room "c" in disrepair and agreed the area was not maintained and the surfaces could not be properly cleaned and sanitized. Observation on 10/12/2020 at 6:43AM of room "d" revealed paper towels on the floor by the trash can, toilet paper on the floor by the toilet and in the corner of the room upon entry. Further observation revealed a large, dead roach on the floor in the corner near the entry of room "d". An interview on 10/16/2020 at 10:00AM with S2DON who indicated the room "d" was used by	F 880	completed on how to report maintenance issues and the appropriate escalation to remedy immediate concerns. 4. NFA will ensure compliance with IP&C guidelines as it pertains to maintenance and house keeping issues by inspecting facility, in-particular the problem areas pointed out during survey, twice a week for 8 weeks. Any issues will be recorded in the Housekeeping and Maintenance logs which will be reviewed and signed in morning meeting by NFA. [redacted] 1. Review of F880 and mitigation for the cited IP&C deficient practices: On 10/23/2020, the facility conducted an immediate review of F880 and began re-educating staff on the following to mitigate the specific IP&C Deficient Practices cited by LDH surveyors during survey exit conference: a. Proper maintenance of facility physical plant. b. Ensuring needed materials are available and properly stored/displayed for easy access by staff and residents. 2. Employee IP&C evaluation format: a. 50 opportunities of bathroom and washroom inspection will be completed weekly with staff provided feedback on competency/adherence to ensure compliance maintained. 3. Summary of baseline, measured employee evaluations. a. Total number of facility areas inspected that were in compliance/ Total	

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F 880	Continued From page 13 residents and staff. Observation on 10/12/2020 at 6:47AM of room "e" revealed the side of the sink base peeling off with microfiber compressed wood exposed and not able to be properly cleaned. Further observation revealed a small plastic garbage bin located near the farthest wall with brown crusted substance noted ¾ up the plastic bin. Further observation revealed the shower stall closest to the door with chipped pain where the faucet comes out of the wall; the second shower stall with shower head hanging to the floor and not suspended from the holder in a sanitary manner. An interview on 10/12/2020 at 6:55AM with S10/Transportation Aide who indicated room "e" was currently used for resident care. Observation on 10/12/2020 at 7:43AM of room "f" revealed 15 tiles on the bathroom floor chipped or missing. Further observation revealed there was one tile above the sink broken with a rough edge. Further observation revealed an air conditioner vent located above the toilet missing part of the ventilator pieces and filled with a black substance. An interview on 10/16/2020 at 10:02AM with S2/Director of Nursing (DON) who observed the tiles broken in room "f" and agreed that they could not be properly cleaned. An interview on 10/16/2020 at 10:43AM with S5/Maintenance Housekeeping Supervisor indicated upon observation of room "f", he agreed the surface could not be properly cleaned.	F 880	number of facility areas inspected observations= Baseline % 4. List of facility procedures to be reviewed. a. New Employee orientation i. Orientation on skill and facility policies b. Ongoing In-service Training i. Education on facility policies a. Maintenance Service A. IP&C ii. Reporting maintenance issues (staff and residents) 5. Summary of RCA conclusions, fishbone, 5 Why's and other RCA techniques a. Fishbone b. 5 Whys 6. List of improvements necessitated by the RCA. a. Orientation. b. Ongoing In-servicing c. Proficiency Check-offs 7. Syllabus, outline, or agenda. a. Training Leader i. Identify employees for training ii. Issue pre-test iii. Discuss Educational Handout with employees iv. Skills Proficiency Check-off v. Employee Feedback regarding their performance vi. Repeat training where necessary vii. Issue Post-Test	

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F 000	INITIAL COMMENTS Complaint Survey LA00053881.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident was not left soiled in urine and feces for over an hour by failing to provide incontinent care in a timely manner. This deficient practice was identified for 1 (Random Resident #11) of 6 sampled and 12 random residents, and had the potential to affect any of the 94 residents who resided in the facility as documented on the Alphabetical Resident Census as submitted by the facility. Findings: Review of the record revealed R#11 was admitted to the facility on 05/05/17 with diagnoses of Hypertension, Diabetes, Anxiety Disorder, Bipolar Disorder, Schizophrenia, Muscle Weakness, and	F 600	1. Corrective actions were accomplished for resident #11 found to be affected by the alleged deficient practice by ensuring resident was clean and S5CNA was re-educated on abuse and neglect. 2. Other residents that have the potential to be affected by the alleged deficient practice were identified by: a. Assessments were completed on all current residents to ensure no negative outcomes related to the alleged deficient practice. b. Any identified issues were addressed by investigation and reporting as indicated.	2/24/20

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

Electronically Signed | 01/24/2020

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F 600	Continued From page 1 Morbid Obesity. Minimum Data Set (MDS) with an Assessment Reference Data Set (ARD) with a date of 10/30/19 revealed R#11 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 13-15 indicates the resident was intact cognitively. Under Section G- Functional Status revealed R#11 required limited assistance for toilet use and needed one person physical assist for toilet use support. Under Section H- Bowel and Bladder: urinary incontinence, R#11 was assessed as frequently incontinent and was occasionally incontinent of bowels. There was no indication of a Bowel Training Program Being used. In an interview on 1/10/2020 at 10:10am R#11indicated that the staff doesn't answer the call light when she calls to be changed if she's wet. The staff will say their coming but they don't. R#11 stated that she asked S5CNA Certified Nursing Assistant (CNA) the previous week to assist her with cleaning her after she had a bowel movement on herself. R#11 indicated S5CNAtold her she doesn't do showers. Resident R-11 indicated she replied I don't want a shower I just need help with being cleaned. R#11 further indicated that she told the S5CNA "you helped my roommate." R#11 indicated that S5CNA didn't answer and just walked out the room. R#11 further indicated that she cleaned herself as best she could and changed her pants. R#11 indicated she didn't get cleaned thoroughly until morning when the next shift came on and she got a shower. In an interview on 01/10/2020 at 12:25pm S2DON Director of Nursing (DON) was asked if she was aware of R#11's complaint about S5CNA refusing to clean R#11 fter she soiled herself one	F 600	3. The measures put in place to ensure the deficient practice does not recur was an in-service with nursing staff on abuse and neglect. 4. The facility plans to monitor its performance to make sure solutions are sustained by: a. The Administrator/Designee will conduct interviews with at least 10% of facility residents weekly to identify any allegations of abuse/neglect and ensure any allegations are investigated and reported within required timelines. b. Effectiveness of plan and results of monitoring/audits will be reported weekly in QA meetings and any issues will be addressed as appropriate with revision, reeducation, and progressive discipline.	

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F 600	Continued From page 2	F 600		

day last week. The S2DON indicated that R#11 had not informed her of this incident and that she talks to her all the time.

In an interview on 1/10/2020 at 2:25pm S5CNA indicated that she recalled the day Resident R#11 was referring to. S5CNA indicated R#11 asked her to assist her with cleaning her bottom. S5CNA revealed that she explained to R#11 that she was passing out the supper trays and didn't want to cross contaminate and informed the resident that she would be back as soon as she could. S5CNA further indicated that when she returned to clean R#11 she refused, and S5CNA stated she reported this to the nurse on duty of R#11's refusal to be cleaned because R#11 was angry with S5CNA as she didn't come back right away to clean her,

In an interview on 1/10/2020 at 4:40pm S5CNA indicated that it was approximately an hour after passing the dinner trays and cleaning the dining room before she went to assist R#11 with cleaning her bottom.
In an interview on 1/10/2020 at 5:20pm The S2DON indicated that it was inappropriate for S5CNA to clean the dining room after passing the trays before returning to offer assistance with cleaning R#11. The S2DON further indicated the S5CNA should have returned to clean the resident after trays were passed.

In an interview on 1/10/2020 at 5:25pm R#11 indicated that when S5CNA refused to clean her it made her feel rejected, like she was not worth the headache or the trouble. R#11 further indicated that it made her feel like her mother made her feel when she was abandoned by her mother as a child.

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were investigated as per the stablished policy and procedure to investigate any such allegation. This deficient practice was identified for 1 (Resident #6) of 6 sampled residents and had the potential to affect any of the 94 residents who resided in the facility as documented on the CMS Form 672 Census and Conditions of Residents. Record review revealed Resident #6 was admitted to the facility on 6/18/19 and readmitted on 10/28/19 with diagnoses in part, Quadriplegia, Hypomagnesaemia, Hyperlipidemia, Post Traumatic Stress Disorder, Major Depressive Disorder, Anxiety Disorder and Personal History of Traumatic Brain Injury. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/19	F 607	1. Corrective action was obtained for the resident identified to be affected by the alleged deficient practice by reporting the allegation via SIMS (#___15228_____) for Resident #6 and completing an investigation as per the established policy and procedure. 2. Other residents that have the potential to be affected by the alleged deficient practice were identified by: a. Assessments were completed on all current residents to ensure no negative outcomes related to the alleged deficient practice. d. Any identified issues were addressed by investigation and reporting as indicated per established policy and procedure. 3. The measures put in place to ensure that the alleged deficient practice does not recur are:	2/24/20

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F 607	Continued From page 4 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) and a score of 15 indicating Resident #6 was cognitively intact. Findings: Review of the facility's policy Abuse Investigation and Reporting revealed in part all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin shall be promptly reported to local, state and federal agencies as defined by current regulations and thoroughly investigated by facility management. Further, the policy revealed all alleged allegations of abuse or neglect must be reported within 2 hours to the State Survey Agency, Adult Protective Services (where law provides for jurisdiction in long term care facilities) and local law enforcement. Further review revealed an alleged violation of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury or twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Review of the facility's Grievance/Complaint reports for October, November and December 2019 revealed there were no incidents, grievances or complaints documented for Resident #6. In an interview on 1/6/20 at 1:55PM Resident #6 made an allegation of physical abuse. Resident #6 stated the allegation of abuse occurred a while ago, but could not recall the date. Resident #6	F 607	a. Conduction of an in-service with staff on established Abuse/Neglect Policy and Procedure. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. The Administrator/Designee will conduct interviews with at least 10% of facility residents weekly to identify any allegations of abuse/neglect and ensure any allegations are addressed per Abuse/Neglect Policy. b. Effectiveness of plan and results of monitoring/audits will be reported weekly in QA meetings and any issues will be addressed as appropriate with revision, reeducation, and progressive discipline.	

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F 607	Continued From page 5	F 607		

stated the allegation of abuse occurred in the shower room when 2 shower aides were giving him a shower. Resident #6 stated he needed to have a bowel movement and stated that when he has a diaper on it restricted his ability to have a bowel movement. Resident #6 indicated he asked the aides to leave his diaper off so that he could have a bowel movement. Resident #6 stated the shower aides then called S4 LPN/Charge Nurse into the shower room. Resident #6 indicated S4 LPN/Charge Nurse came into the shower room and told the shower aides to throw him in his chair and put him in the bed so that he could have a bowel movement. Resident #6 said the shower aides took her word literally and threw him into his wheelchair. Resident #6 stated that his hands wound up behind him and he sustained injuries to both his left and right forearms. Resident #6 asked S3Counselor to take pictures of the injuries. Resident #6 stated S3Counselor then showed the pictures to S2DON (Director of Nursing) and S1 Administrator.

An observation on 1/6/2020 at 1:55PM revealed, Resident #6 had brown, scabbed areas approximately 1"length 0.5"width on the right wrist and approximately1"length x 0.5"width on the left side of his arm.

An observation on 01/06/19 at 2:30PM of a meeting with the S2DON, S1Administrator and Resident #6 in Resident #6's room-a. During the meeting, S2DON stated the resident did report the allegation of physical abuse directly to her. Furthermore, the S2DON reported that she saw the pictures on the counselor's phone and let S1Administrator know the resident made allegations of physical abuse. The S2DON

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further stated when the resident complained of the allegation of abuse, she assessed his body and saw no signs of abuse on his torso, back, or legs. S2DON indicated she observed scabbed areas on his forearms and the scabbed areas appeared older. S2DON indicated she had not documented the assessment.

In an interview with S1Administrator on 1/6/2020 at 2:45PM, S1Administrator stated this is the first time he heard about the allegation of physical abuse.

Review of the Statewide Incident Management System (SIMS) reports on 01/06/2020 at 2:49PM for 10/29/19 through 01/06/20 revealed no SIMS report filed on behalf of Resident #6 related to physical abuse.

In an interview with S2DON on 01/06/2020 at 2:51PM, S2DON stated the resident told the S2 DON he was physically abused. S2DON reported she assessed Resident #6 and found no evidence of abuse. S2DON stated she reported the allegation of abuse to the administrator.

In a telephone interview on 01/10/20 at 3:00PM, S3Counselor stated Resident #6 told her about two weeks ago, the staff pushed him in his wheelchair and roughed him up. She went on to say Resident #6 asked her to take pictures of his forearms. S3Counselor took the pictures with her cell phone and showed the pictures to the S2DON and the S1Administrator in Administrator's office.

Review of the Health Standards Incident Report was entered into the system on 01/06/2020 at 2:58PM.

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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: Based on interview and record review, the facility failed to ensure an allegation of abuse was reported immediately in accordance with State law through established procedures. This deficient practice was identified for 1 (Resident #6) of 6 sampled residents and had the potential to affect any of the 94 residents who resided in	F 609	1. Corrective action was obtained for the resident identified to be affected by the alleged deficient practice by reporting the allegation via SIMS (#_____15228_____) for Resident #6 and completing an investigation.	2/24/20

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F 609	Continued From page 8 the facility as documented on the CMS Form 672 Census and Conditions of Residents. Findings: Record review revealed Resident #6 was admitted to the facility on 6/18/19 and readmitted on 10/28/19 with diagnoses in part, Quadriplegia, Hypomagnesaemia, Hyperlipidemia, Post Traumatic Stress Disorder, Major Depressive Disorder, Anxiety Disorder and Personal History of Traumatic Brain Injury. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/19 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) and a score of 15 indicating Resident #6 was cognitively intact. Review of the facility's policy Abuse Investigation and Reporting revealed in part all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin shall be promptly reported to local, state and federal agencies as defined by current regulations and thoroughly investigated by facility management. Further, the policy revealed all alleged allegations of abuse or neglect must be reported within 2 hours to the State Survey Agency, Adult Protective Services (where law provides for jurisdiction in long term care facilities) and local law enforcement. Further review revealed an alleged violation of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury or twenty-four (24) hours if the	F 609	2. Other residents that have the potential to be affected by the alleged deficient practice were identified by: a. Assessments were completed on all current residents to ensure no negative outcomes related to the alleged deficient practice. d. Any identified issues were addressed by investigation and reporting as indicated. 3. The measures put in place to ensure that the alleged deficient practice does not recur are: a. Conduction of an in-service with staff on reporting accusations of abuse/neglect to the Administrator/DON immediately. b. An in-service with the Administrator and DON was completed on conducting investigations and reporting allegation of abuse/neglect within the required timelines. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. The Administrator/Designee will conduct interviews with at least 10% of facility residents weekly to identify any allegations of abuse/neglect and ensure any allegations are investigated and reported within required timelines. b. Effectiveness of plan and results of monitoring/audits will be reported weekly in QA meetings and any issues will be addressed as appropriate with revision, reeducation, and progressive discipline.	

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alleged violation does not involve abuse and has not resulted in serious bodily injury.

In an interview on 1/6/20 at 1:55PM Resident #6 made an allegation of physical abuse. Resident #6 stated the allegation of abuse occurred a while ago, but could not recall the date. Resident #6 stated the allegation of abuse occurred in the shower room. Resident #6 indicated S4 Licensed Practical Nurse (LPN)/Charge Nurse came into the shower room and told the shower aides to throw him in his chair and put him in the bed so that he could have a bowel movement. Resident #6 said the shower aides threw him into his wheelchair and stated his hands wound up behind him and he sustained injuries to both his left and right forearms. At an unknown date, Resident #6 stated he asked S3Counselor to take pictures of the injuries. Resident #6 stated S3Counselor then showed the pictures to S2Director of Nursing and S1Administrator.

An observation on 1/6/2020 at 1:55PM revealed, Resident #6 had brown, scabbed areas approximately 1"length x 0.5"width on the right wrist and approximately1"length x 0.5"width on the left side of his arm.

An observation on 01/06/19 at 2:30PM of a meeting with the S2Director of Nursing (DON), S1 Administrator and Resident #6 in Resident #6's room - a. In an interview at that time, S2DON stated the resident had previously reported the allegation of physical abuse directly to her. Interview further revealed, S2DON reported that she saw the pictures on the counselor's phone and informed the Administrator of allegations of physical abuse. S2DON further stated when Resident #6 complained of the allegation of

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abuse, she assessed his body and saw no signs of abuse on his torso, back, or legs. S2DON indicated she observed scabbed areas on his forearms and the scabbed areas appeared older. S2DON indicated she had not documented the assessment.
In an interview with S1Administrator on 1/6/2020 at 2:45PM, S1Administrator stated this is the first time he heard about the allegation of physical abuse.

Review of the Statewide Incident Management System (SIMS) reports on 01/06/2020 at 2:49PM for 10/29/19 through 01/06/20 revealed no SIMS report filed on behalf of Resident #6 related to physical abuse.
In an interview with S2DON, on 01/06/2020 at 2:51PM, S2DON stated the resident told the S2DON he was physically abused. S2DON reported she assessed Resident #6 and found no evidence of abuse. S2 DON stated she reported the allegation of abuse to S1Administrator.

In a telephone interview on 01/10/20 at 3:00PM, S3Counselor stated Resident #6 told her about two weeks ago, the staff pushed him in his wheelchair and roughed him up. S3Counselor went on to say Resident #6 asked her to take pictures of his forearms. S3Counselor took the pictures with her cell phone and showed the pictures to the S2DON and the S1Administrator in Administrator's office.

There was no documented evidence and the facility presented no documented evidence that the allegation of abuse regarding Resident #6 was reported promptly to facility administrative staff and/or to other officials including to the State Survey Agency.

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F 000	INITIAL COMMENTS Complaint Survey #LA00054760-CV A COVID-19 Focused Infection Control Survey was conducted on 04/21/2020.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		6/1/20

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

Electronically Signed | 07/20/2020

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F 842	Continued From page 1 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to: 1. Ensure information documented on a resident's COVID-19 monitoring sheet was accurately	F 842	1. Corrective action was accomplished for resident #2,who was both found to be affected by the alleged deficient practices, was assessed by nursing staff and	

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F 842	Continued From page 2 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 04/13/2020 Census List. Findings: Resident #2 Review of Resident #2's March 2020 COVID-19 (corona virus 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 03/14/2020 thru 03/31/2020, which included documentation for the dates of 03/18/2020 thru 03/23/2020. Review of Resident #2's Hospital Records revealed the resident was hospitalized from 03/18/2020 to 03/23/2020 at 2:17pm. Review of Resident #2's April 2020 COVID-19 monitoring sheet revealed no documented monitoring for COVID-19 symptoms or temperature on 04/10/2020-04/12/2020 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	F 842	assessment added to residents charts. Resident #3 and # 4 are out of the facility, no corrective action needed. 2. Other residents that could be affected by the alleged deficient practice are any residents that are being monitored for COVID-19 related symptoms and that are on isolation. A. All residents were assessed for COVID-19 symptoms to ensure no negative outcomes. 3. Measures taken to eliminate the alleged deficient practice are as follows: A. Re-education of all nursing staff on proper charting for COVID-19 monitoring sheet and maintaining complete/accurate clinical records. 4. The facility plans to ensure compliance with the following steps: A. DON or designee will audit 25% of charts 3 times a week for 6 weeks to ensure documentation is completed correctly. B. Results will be reviewed weekly in QA meeting. QAPI team will extend monitoring as deemed necessary. Any issues will result in personal in-service for staff, progressive discipline, and plan modification where appropriate. 5. Compliance will be achieved by June 1, 2020.	

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revealed the resident was hospitalized from 04/06/2020 to 04/10/2020, and was readmitted to the facility on

In an interview on 04/15/2020 at 1:22pm, S4Acting Director of Nursing(DON)/Infection Control Nurse was questioned about the Resident #2's March 2020 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 March 2020 COVID-19 monitoring sheet, emailed to the surveyor on 04/15/2020 at 2:10pm revealed "H" was marked for 03/18/2020 to 03/21/2020, 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 03/22/2020 when the resident was still admitted to the hospital.

Review of Skilled Notes for 04/10/2020 and 04/11/2020 (emailed to the surveyor on 04/15/2020 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 04/15/2020 at 4:19pm, S4Acting DON/Infection Control Nurse, after the surveyor reviewing the above information, stated the nurse completing the Skilled Nurses Notes on 04/10/2020 and 04/11/2020 should have signed the document. S4Acting DON/Infection Control Nurse further stated the documentation on the

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COVID-19 form for March 22, 2020 was documented in error.

In an interview on 04/15/2020 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 03/20/2020. Further review revealed Resident #3 had diagnoses of in part: hypoxemia, COPD (Chronic Obstructive Pulmonary Disease/lung disorder), and Chronic respiratory failure with hypoxia.

Review of Resident #3's March 2020 COVID-19 monitoring sheet, received on 04/14/2020 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 03/13/2020; all three shifts on 03/14/2020; morning and night shift on 03/15/2020; morning shift on 03/16/2020; morning and evening shift on 03/17/2020; morning and night shift on 03/18/2020; all three shifts on 03/19/2020; and morning and evening shift on 03/20/2020. Further review revealed all other documentation area were left blank.

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Review of Resident #3's March 2020 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.

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 follow up on the positive marks from the COVID-19 Monitoring sheet.

In an interview on 04/15/2020 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

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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 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 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 04/04/2020 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 04/04/2020, and later expired at the hospital.

Review of Resident #4's April 2020 COVID-19 monitoring sheet revealed documentation of monitoring for respiratory infection s/s on 04/04/2020 and 04/05/2020 for both the morning and evening shifts. Further review revealed temperatures were documented as having been obtained on 04/04/2020 and 04/05/2020 when Resident #4 was not in the facility .

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F 842	Continued From page 7 In an interview on 04/15/2020 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 04/15/2020 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 04/04/2020 and 04/05/2020 was an error in documentation.	F 842		
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		6/1/20

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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.

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MAISON DE'VILLE NURSING HOME OF HARVEY	2233 EIGHTH STREET HARVEY, LA 70058

(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 880	Continued From page 9 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 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 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	F 880	1. Corrective actions for alleged deficient practices for resident 3 and resident 5 are not required as both residents are no longer within the facility. 2. Other residents that could be affected by the alleged deficient practice are any residents that are being monitored for COVID-19 related symptoms and that are on isolation. A. All residents were assessed for COVID-19 symptoms to ensure no negative outcomes. 3. Measures taken to eliminate the alleged deficient practices are as follows: A. In-service of all staff with demonstration of donning/doffing of Personal Protective Equipment. B. Corporate nursing staff will in-service Director of Nursing on proper and accurate completion of antibiotic surveillance sheets. 4. The facility plans to ensure compliance with the following steps:	

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F 880	Continued From page 10 Non-Covid-19 related infections and 10 residents were placed on prophylactic 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 03/20/2020. Further review revealed Resident #3 had diagnoses of in part: hypertension, hypoxemia, COPD (Chronic Obstructive Pulmonary Disease/lung disorder), and Chronic respiratory failure with hypoxia. 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;	F 880	A. Weekly audit of 25% COVID-19 monitoring sheets 3 times a week for 6 weeks to ensure symptomatic residents have been reported and treated. B. DON or designee will perform inspection of PPE application by staff and will record results of performance 5 times a week for 6 weeks. C. Administrator will review antibiotic surveillance sheets 2 times a week for 6 weeks to ensure compliance will be met. D. Results will be reviewed weekly in QA meeting. QAPI team will extend monitoring as deemed necessary. Any issues will result in personal in-service for staff, progressive discipline, and plan modification where appropriate. 5. Compliance will be achieved by June 1, 2020.	

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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 (corona virus disease) Results form revealed Resident #3 was hospitalized on 03/20/2020, 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.

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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 03/31/2020 with diagnoses of, in part: osteomyelitis (bone infection), pressure ulcer (bed sore) of unspecified site, diabetes mellitus type II, and hypertension (high blood pressure).

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

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F 880	Continued From page 13 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.	F 880		

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F 000	INITIAL COMMENTS Complaint # LA00055595. F600 was cited as a result of this complaint. COVID-19 Focused Infection Control Survey was conducted on 07/22/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 90	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure a resident was free from neglect by: 1.) failing to notify the Physician when a resident had a change in skin condition; 2.) failing to follow a physician order to obtain a	F 600	1. Corrective actions were not needed for the affected resident as the resident has not returned to the facility. 2. Other residents that could be affected by the alleged deficient practices are any	9/1/20

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

Electronically Signed | 08/05/2020

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F 600	Continued From page 1 complete white blood cell count; and 2.) failing to notify the physician of an abnormal lab result. This deficient practice was evidenced in 1 (Resident #1) of 5 sampled resident, but had the potential to affect any of the 90 residents residing in the facility as documented on the facility's current census list. Findings: Review of Resident #1's record revealed an admit date of 05/06/2020 with diagnoses in part, Paraplegia, Diabetes Mellitus, and Hepatitis C. Review of Resident #1's record revealed, in part, a clinic visit note dated 07/07/2020 from S5Infectious Disease Physician, along with laboratory results from the 07/07/2020 visit. Further review of the laboratory results dated 07/07/2020 revealed Resident #1 had a white blood cell count of 34.5 (H- high level). Review of the clinic visit note revealed it was printed at S5Infectious Disease Physician clinic on 07/09/2020 at 4:36pm and faxed to the facility on 07/09/2020 at 4:58pm. Further review of Resident #1's record revealed Resident #1 was transferred to the hospital for tachycardia on 07/10/2020. Review of Resident #1's hospital Emergency Room records dated 07/10/2020 at 8:56pm revealed, in part, Resident #1 had tachycardia and fever today and had a small knot to left groin one week ago and "busted" on Wednesday (07/08/2020) with worsened swelling since that time; vital signs were documented as follows: blood pressure was 117/68, heart rate was 133, and his temperature was 102.6 Fahrenheit.	F 600	residents with a reportable change in condition, with an order for a lab, or that has an abnormal result from a lab that would require physician notification. A. All residents were assessed via skin audits to ensure changes have been documented and any identified areas were reported to the physician. B. Review of all physician ordered for last 30days to assure completion C. Lab results for the last 14 days were reviewed to ensure physician notification was accomplished for abnormal labs. 3. Measures taken to eliminate the alleged deficient practice are as follows: A. Re education of all LPN and RN nursing staff on physician notification for abnormal labs, physician notifications for changes in condition of a resident, and proper documentation and execution of physician orders. 4. The facility plans to ensure compliance with the following steps: A. DON or designee will audit 25% of the charts twice a week for 6 weeks to ensure completion of physician orders and reporting of abnormal labs when appropriate. B.DON will review 100% of the weekly body audits to ensure completion and the reporting of change in condition noted during the audit. Results will be reviewed in the weekly QA meeting. QAPI team will extend monitoring as deemed necessary. Any issues will result in a personal in-service	

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Further review of the Emergency Room records revealed upon physical exam Resident #1 had left inguinal swelling, indurated with purulent drainage. Review of Resident #1's Computerized Tomography (CT) scan (an X-ray that gives doctors a much better picture of what's going on inside the body) dated 07/10/2020 revealed left inguinal cellulitis with soft tissue emphysema and no drainable abscess. Further review of the CT scan clinical impression revealed Sepsis and Left Cellulitis of Groin.

Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 05/12/2020 revealed, in part, a Brief Interview for Mental Status score of 15 (score of 13-15 was cognitively intact), no rejection of care and a mood severity score of 0. Further review of the MDS revealed his functional status required a limited one person assistance for bed mobility, transfers, and activities of daily living and had an impairment to bilateral lower extremities. A urinary catheter was present and he was frequently incontinent of bowels and was at risk for developing pressure ulcers and had no pressure ulcers present.

Review of Resident #1's care plan revealed, in part, a problem identified for a potential for skin breakdown with approaches, in part to perform a skin assessment as scheduled and as needed and report redness, sores, openings, area of concerns immediately to nurse.

Review of Resident #1's weekly skin integrity review dated 06/26/2020 revealed documentation of a rash and redness to groin area. Further review of Resident #1's weekly skin integrity review dated 06/30/2020 revealed redness to

for staff, progressive discipline and plan modification where appropriate.

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groin area.

Review of Resident #1's Nurse's Notes for June 2020 revealed no documentation of the physician being notified of the change in skin condition for Resident #1 on 06/26/2020 and 06/30/2020.

Review of Resident #1's physician orders dated 07/07/2020 revealed, in part, an order for a STAT complete white blood cell count (CBC). Further review of Resident #1's orders revealed an order for a CBC on 07/08/2020.

Review of Resident #1's laboratory results dated 07/07/2020 revealed the CBC was rejected with no result due to the specimen was grossly hemolyzed (the blood was clotted). Further review revealed S4Licensed Practical Nurse was notified on 07/07/2020 at 3:22pm of hemolyzed CBC specimen.

Further review of Resident #1's laboratory results revealed no documentation of a CBC result from 07/08/2020.
Review of Resident #1's July 2020 Nurse's Notes revealed no documentation of the Nurse Practitioner or the Physician being notified of Resident #1's hemolyzed blood sample drawn on 07/07/2020.

Further review of Resident #1's Nurse's Notes revealed no documentation of the Physician being notified of Resident #1's white blood cell count from his Infectious Disease clinic visit on 07/07/2020. Further review of Resident #1's July 2020 Nurse's Notes revealed no documentation of the physician being notified of the CBC results ordered on 07/08/2020.

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In a telephone interview on 07/22/2020 at 11:30am, S5Infectious Disease Physician stated she normally completes a genitourinary (GU) exam on all her patients, but if she did not document in her note then she did not do a GU exam. S5Infectious Disease Physician stated she did not see Resident #1's lab results that she ordered on 07/07/2020 and if she would have seen a white blood cell count (WBC) of 34.5, she would have thought it was an error and ordered a re-draw. S5Infectious Disease Physician confirmed her clinic staff would fax the clinic notes to the facility after the visit and she did not forward her notes or laboratory results to the facility Physician.

In a telephone interview on 07/20/2020 at 12:30pm, S6Family Nurse Practitioner (FNP) stated she recalled being called concerning Resident #1 having a temperature of 102.9 Fahrenheit on 07/07/2020 and she gave orders for a STAT CBC and to check Resident #1's COVID status and recheck his vital signs. S6FNP stated she received a call back with his COVID status being negative, as of 07/07/2020, and his temperature was in a normal range. S6FNP stated she did not recall getting another call concerning Resident #1's hemolyzed CBC blood sample.

In a telephone interview on 07/21/2020 at 12:16pm, S7Physician stated he recalled seeing Resident #1 on 07/08/2020 and he did not recall getting the results of Resident #1's CBC that was ordered on 07/08/2020. S7Physician stated he did not have access to the lab work from S5Infectious Disease Physician that was drawn on 07/07/2020. S7Physician stated if S5Infectious Disease Physician drew labs and

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Resident #1 had a WBC of 34.5, then he should have been admitted to the hospital on 07/07/2020.

In an interview on 07/22/2020 at 11:50am, S2Director of Nursing (DON) stated the staff nurse should review the notes from the facility Physician visits and any consulting physician visit notes for any new orders. S2DON stated any laboratory results that are faxed to the facility should have an initial of the nurse that reviewed the laboratory results. S2DON stated the nurse should then document on the lab sheet that the results were faxed to S7Physician. S2DON confirmed there was no initials on Resident #1's laboratory results from S5Infectious Disease Physician visit on 07/07/2020. S2DON confirmed S8Licensed Practical Nurse/Wound Care Nurse should have communicated the change in skin condition to the physician on 06/26/2020 and 06/30/2020 and she had no documentation that she notified the Physician of the change.

In an interview on 07/21/2020 at 1:00pm, S1Administrator confirmed there was no documentation of the Physician being notified of Resident #1's rash and redness to his groin area documented on 06/26/2020 and 06/30/2020, no documented evidence of a CBC result from 07/08/2020, and no documentation of S7Physician being notified of Resident #1's elevated WBC from 07/07/2020 ordered by S5Infectious Disease Physician. S1Administrator confirmed there was a delay in care for Resident #1.