STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 #LA00054070 and Complaint #LA00054083. Tag #609 and Tag #689 were cited as a result of Complaint #LA00054070. Tag #610 and Tag #689 were cited as a result of Complaint #LA00054083.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		3/4/20

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

Electronically Signed — 02/17/2020

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.

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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure all allegations of abuse/neglect were reported and/or investigated within the required timelines to the Administrator and the required reporting agency. This deficient practice was identified for 1 (Resident #1) of 8 records reviewed but had the potential to affect any of the 177 residents who reside at the facility as per the facility's Census List. Findings: Review of Resident #1's record revealed she was admitted to the facility on 11/08/19 with diagnosis of, in part, Pressure Ulcer of Buttock Stage III, Hyperlipidemia, Anemia and Chronic Congestive Heart Failure. Review of Resident #1's Nurses Notes dated 11/14/19 at 5:34pm revealed, in part, Resident #1's daughter in facility accusing nursing staff of neglect. Further review of Resident #1's Nurses notes revealed, in part, "daughter stated she knew we were abusing her mother and that she had pictures and videos to prove it." Reported Resident #1's accusations to S3Assistant Administrator and S2Director of Nursing (DON). Review of Resident #1's Physician Progress Notes dated 12/27/19 revealed, in part, Resident #1's daughter accused nursing staff of physically harming patient, daughter became physical with staff members and was asked to leave. In an interview on 01/23/2020 at 10:45am, S3Assistant Administrator stated she was notified of Resident #1's daughter's allegation of neglect on 11/14/19. S3Assistant Administrator confirmed she did not open a Statewide Incident Management System (SIMS) report for the allegation of neglect because this was a unique	F 609	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. (1) Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a)SIMS report # 17135 was opened on 1/23/2020 related to Resident #1's 11/14/2019 allegation of neglect and 12/23/2019 allegation of physical abuse. (b)The MD and the licensed nurse who documented but failed to report the allegations were inserviced by the Administrator on abuse reporting on 01/30/2020. (2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur: (a) Assistant Administrator/ designee will interview current nursing staff and attending physician staff to ensure any other allegations of abuse/neglect have been reported for investigation. Any required SIMS reports will be completed based on findings. (3) Measures put into place that will be made to ensure that deficient practices	

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F 609	Continued From page 2 situation and Resident #1's daughter had been an issue since admission. S3Assistant Administrator confirmed she was not made aware of the physician progress note dated 12/27/19 and the allegation of physical harm to Resident #1. In an interview on 01/23/2020 at 10:55am, S2DON was asked by the surveyor who was responsible to review physician progress notes. S2DON stated no one specific person was assigned the task of reviewing progress notes when they were received. S2DON confirmed she had not seen Resident #1's Physician progress note dated 12/27/19 progress note and was not aware of the allegation of abuse. S2 DON confirmed all allegations of abuse should have a SIMs report and investigation of the allegation. In an interview on 01/23/2020 at 11:49, S1Administrator stated she was not notified of Resident #1's allegations of abuse from 11/14/19 and 12/27/19. S1Administrator confirmed a SIMS report was not opened for either of the allegations. S1Administrator stated any allegation of abuse should be reported and investigated regardless of the circumstances surrounding the situation.	F 609	will not recur: (a)Administrator/designee will re-inservice the DON and the Assistant Administrators on abuse reporting timeframes. (b)DON/designee began re-inservicing facility staff on abuse reporting on 2/13/2020. (4)The facility plans to monitor performance to make sure that solutions are sustained by: (a)Assistant Administrator or Designee will interview a random mix of 20 residents and staff weekly for suspected allegations of abuse/neglect to ensure timely notification/reporting occurred if indicated. (b) DON or Designee will review Physician Progress Notes 3 x weekly for suspected allegations of abuse/neglect to ensure timely notification/reporting occurred if indicated. (c)Administrator will review results of monitoring weekly to determine effectiveness and make changes to plan if deemed necessary. Monitoring will be completed for 8 weeks and then monthly as deemed necessary. Any issues noted during monitoring will be corrected at the time of discovery. Re-education will be conducted as deemed necessary. (5)Corrective actions will be accomplished by 03/04/2020.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		3/4/20

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F 610	Continued From page 3 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review, interview, and observation the facility failed to thoroughly investigate allegations of misappropriation of property for 1 (Resident #2) of 8 records reviewed. This deficient practice was identified for 1 (Resident #2) of 8 records reviewed but had the potential to affect any of the 177 residents who reside at the facility as per the facility's Census List. Findings: Review of the facility's Abuse Investigation and Reporting policy revealed, in part, the section misappropriation of resident property and thoroughly investigated by facility management. The role of the investigator: The individual conducting the investigation will, at a minimum	F 610	(1)Corrective actions were accomplished for those residents found to have been affected by the deficient practice by the following: (a) Interviews with staff members who had contact with Resident #2 during the period of the alleged 12/16/19 and 12/27/19 misappropriation of property were documented by S3Assistant Administrator and added to appropriate SIMS investigation folders. (b) Resident #2 was provided with a key to locked dresser on 1/23/2020 by S12Assistant Administrator in presence of surveyor. (2)Other residents that have the potential	

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F 610	Continued From page 4 interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Review of Resident #2's Minimum Data Set dated 10/01/2019 revealed a Brief Interview for Mental Status score at the highest level of 15 which represented he was cognitively intact. Review of Resident #2's Statewide Incident Management System (SIMS) report entered on 12/16/2019 revealed, in part, Resident #2 reported to the assistant administrator that someone stole $40.00 from his wallet. The resident thought it was probably his roommate. Resident #2 did not see the other resident take the money out of his wallet. Room and roommate were searched unsuccessfully. The allegation of theft was unable to be verified. Resident #2 was encouraged to secure all valuables when leaving his room. Review of another SIMS report entered on 12/27/2019 revealed, in part, Resident #2 stated $20.00 was stolen from his coat pocket that was hanging on his door. Review of the SIMS revealed the victim was interviewed by S3Assisstant Administrator and stated $20.00 was missing from his billfold. He realized the money was missing 2 nights ago. He saw the money earlier that day. The victim had been out the room for a short time, the victim stated that the billfold was in a jacket pocket which was hanging on the front of the door closet. The jacket and the room were searched, the money was not found. They were unable to verify that he had the money. The victim stated the money came from a friend at church. The victim stated that he did not see anyone take the money but it	F 610	to be affected by the deficient practice will be identified and the following will occur: (a) A review of SIMS reports will be conducted for a 3 month look back to identify any other allegations that were unable to be verified and determine if a thorough investigation was conducted. Any concerns identified will be corrected at time of discovery. (3)Measures put into place that will be made to ensure that deficient practices will not recur: (a) A new List of Possible Witnesses form was developed and implemented on 01/27/2020 by the Administrator and will be used going forward on all future SIMS investigations. (b) A new Investigative Checklist based on LA DHH Guidelines was developed and implemented by the Administrator on 01/27/2020 will be used going forward on all future SIMS investigations. (c) Both Assistant Administrators were inserviced on the use of the new forms by the Administrator on 01/27/2020. (4) The facility plans to monitor its performance and make sure solutions are sustained by: (a) Administrator or Designee will review SIMS reports prior to closing to ensure a thorough investigation was conducted. Monitoring will be completed for 8 weeks and then monthly as deemed necessary. Any issues noted during monitoring will be corrected at the time of discovery. Re-education will be conducted as	

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F 610	Continued From page 5 was "probably" his roommate. The roommate was interviewed by the assistant administrator and denied taking the money and a search revealed that the roommate did not have any money. The roommate denied seeing anyone take the money and did not see the money. It has been determined that the allegation of theft is unable to be verified. The victim was always educated on keeping his money with him and using the resident trust fund account. In an interview on 01/22/2020 at 1:25pm, S12Assistant Administrator stated Resident #2 has a lock top drawer and cabinet in his room and also has a personal funds account if he so chooses to place his money in it. In an interview on 01/22/2020 at 2:44pm, Resident #2 stated he had his money taken from him on several occasions. The facility investigated two of them and turned in an investigation report to the police. He stated that both incidents occurred when he was in another room in the facility, and he was moved to the new room about a week ago. He stated since he has been moved to his current room he does not have a key to lock up his top drawer and a cabinet as he previously was able to. He was asked why he did not lock up his money when he was in the other room, and he stated that he did not have a key to lock up his money in his room. He stated it took a while for the staff to give him the key for when he was in the other room. In an interview on 01/23/2020 at 10:15am, S3Assisstant Administrator stated the system to when a resident gets a key to lock his top drawer and cabinet it should be documented by maintenance.	F 610	deemed necessary. (5) Corrective actions will be accomplished by 03/04/2020.	

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F 610	Continued From page 6	F 610		

In an interview on 01/23/2020 at 10:17am, Resident #2 stated that he still did not have a key to his cabinets to lock up his money. He stated he had the key around his neck to the other room where he used to be.

Observation on 01/23/2020 at 10:19am, revealed S12Assistant Administrator tried the key the client had and it did not work to unlock the top drawer and cabinet in his current room.

In an interview on 01/23/2020 at 12:05pm, S3Assistant Administrator stated she did the investigations about the misisng money, and she put the grievances about the $40 and $20 dollars on the SIMS reports and that was her investigation. She stated the policy about the key was for maintenance to sign out the keys to the resident's rooms. S3Assistant Administrator stated when Resident #2 reported his money was missing he was in another room in the facility. She further stated she asked other staff what had happened per her investigation but she did not document anything about it.

In an interview on 01/23/2020 at 12:15pm, S11Social Services stated that she was the social worker for Resident #2. She stated the resident would have to ask for a key to lock his cabinets. She stated the resident was moved last week to his current room and she would look for the documentation she wrote on a piece of paper when he was moved to his current room. She was aware of the resident missing some money but was not sure about the details.

In an interview on 01/23/2020 at 12:28pm, S11Social Services stated that Resident #2 was

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F 610	Continued From page 7	F 610		

moved to his current room on 01/13/2020. She stated as a social service person it would be good practice that if a resident reported that his money was missing they could lock up their valuables.

In an interview on 01/23/2020 at 12:58pm, S3Assistant Administrator stated they have no policy on the locking the residents belongings in the top drawer or cabinets. She stated residents would have to ask for a key to lock up their belongings even if they are a confused resident.

In an interview on 01/23/2020 at 2:20p, S10Licensed Practical Nurse (LPN) stated S1Administrator asked her if she would go look for the money in the resident' room where he used to reside. S10LPN further stated S1Adminstartor did not question her if she had any knowledge about the residents missing money. She stated she searched the other resident and the room and the money was not found. She stated both incidents happened on the overnight shift and the resident told her in the morning about 6:30am. She stated she remembered one incident when the resident came back from a concert and his money was missing.

In an interview on 01/23/2020 at 3:05pm, S4ADON stated that S9LPN worked the night shift when the money was reportedly missing.

In an interview on 01/23/2020 at 3:09pm, S9LPN stated that she worked the night of 12/16/2019 and she was not aware of the resident missing any money. She further stated she was not aware of the resident missing any money on 12/27/2019. She stated no one including S3Assistant Administrator did not interview her or

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question her about Resident #2 missing money.

In an interview on 01/23/2020 at 3:39pm, S4ADON stated S8Certified Nursing Assistant (CNA) worked the night shift on 12/16/2019 and 12/27/2019.

In a telephone interview on 01/23/2020 at 3:40pm, S8CNA stated she worked the night shifts and took care of the resident but she never heard the resident had missing money and no one came ask her any questions about it.

In an interview on 01/24/2020 at 10:30am, S4ADON, stated there was only one staff left to call that worked those night shifts (12/16/2020 and 12/27/2019) and that was S14CNA.

In an interview on 01/24/2020 at 10:38am, S14CNA stated she was aware of the resident had some money missing but she was not sure when it occurred. She stated she was not questioned by S3Assistant Administrator or anyone about the residents' missing money.

In an interview on 01/24/2020 at 11:15pm, S3Assistant Administrator stated there were no logs from the other maintenance person to show when the keys to resident's top drawers and cabinets were signed out. She stated the current maintenance person does not have anything to present since he was newly hired.

In an interview on 01/27/2020 at 11:30am, S1Administrator and S3Assisstant Administrator present, S1Administrator was informed about S3Assistant Administrator investigation about Resident #2's grievance of missing money and not having a key to lock up his money in his other

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room at the time. S1Adminisrtor was informed about S3Assisstant Administrator's statement that she did not document her investigation about staff interviews with the staff as part as her investigation. She was further advised Resident #2 stated that he did not have a key to his previous room when his money was stolen, and he had to keep asking for a key. S1Administrator was informed Resident #2 did not have a key to lock up his belongings at this time. S1Administrator stated he was given a key. She was informed there was no presented documentation that the resident had a key while he was in the other room.

In an interview on 01/27/2020 at 11:38am, S3Assistant Administrator brought her investigation binder and stated she had interviewed staff, a nurse, about the missing money and brought her information with her, but she stated she could not find the information. S3Asisstant Administrator then stated that it was probably documented on a nurse's note and would go look for it. She stated she did not need to look at staff because it was never known if the client had missing money or not.

In an interview on 01/27/2020 at 11:40am, S1Administrator stated the resident would have to ask for a key to his locked cabinets even if he had one before and even if he was confused as he was. She stated the Assistant administrator only did an investigation on whom she believed may have taken his money and this was enough.

In an interview on 01/27/2020 at 12:23pm, S3Assistant Administrator stated she brought her information to the surveyor, and stated she did not investigate any of the staff here because the

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F 610	Continued From page 10 resident did not have any money and presented more information. Review of notes presented revealed the following: -12/16/19 to 12/20/10, revealed, in part, investigation determined resident obtained money while outside facility, was not using resident trust account to secure money/manage money nor was he keeping money on his person at all times. During investigation, resident asked S3Assisstant Administrator for a place to lock up items in his room. S3Assisstant Administrator instructed maintenance to place lock on closet door. Lock and Key provided to resident, - 12/27/2019 resident reported missing money, SIMS report opened. - 12/27/2019 Investigation again determined resident obtained money while outside the facility, again resident not using trust account to secure money nor was he keeping his money on person at all times and again left money unsecured and unattended in his room. -01/08/2020 Resident #2 was moved from one room to another room.	F 610		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 689	(1) Corrective actions were accomplished	3/4/20

F 689 Continued From page 11

interview the facility failed to:
1. Accurately assess a resident's risk for falls (Resident #1);
2. Develop a care plan for a resident's risk for falls (Resident #1);
3. Revise a resident's care plan after a fall (Resident #1);
4. Ensure a resident was assessed for elopement/wandering risk post readmission to the facility (Resident #4);
5. Ensure a resident's care plan was updated post readmission for any new interventions (Resident #4); and
6. Ensure a resident had an increase in supervision or wanderguard system in place to prevent elopement (Resident #4).

The deficient practice was identified for 1 of 5 residents reviewed for incidents/accidents and fall risk (Resident #1) and 1 of 8 residents reviewed for wandering/elopement risks (Resident #4) in a total sample of 8. This failed practice had the potential to affect any of the 177 residents residing in the facility who may experience a fall as documented on the facility's Census list and any of the 17 residents assessed as being a wandering risk as documented on the facility's Physician's Orders List for Wanderguard, Elopement.

Findings:

Resident #1
Review of Resident #1's record revealed Resident #1 was admitted to the facility on 11/08/19 with diagnoses of, in part, Hyperlipidemia, Anemia and Chronic Congestive Heart Failure.

Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date

F 689

for those residents found to have been affected by the deficient practice by the following:
(a) Resident #1 was assessed for fall risk on 11/14/19.
(b) A fall risk care plan has been developed for Resident #1.
(c) Resident #1's care plan was revised to reflect 12/13/2019 fall.
Per facility's QAPI Plan implemented on 12/31/19, the following corrective actions were accomplished:
(d) Resident #4 was assessed for risk of elopement on 12/31/19.
(e) A Baseline Care Plan was completed on 12/31/19 to reflect Resident #4's risk for elopement and interventions to prevent elopement. Resident #4's comprehensive care plan revised to reflect 12/31/19 interventions to prevent elopement.
(f)On 12/31/2019, a new wanderguard bracelet placed on Resident #4.

(2) Other residents that have the potential to be affected by the deficient practice will be identified and the following will occur:
(a) An audit of medical records will be completed to identify residents who admitted/readmitted in the past 30 days to ensure their fall risk was assessed.
(b) An audit of medical records will be completed to identify residents who admitted/readmitted in the past 30 days to ensure a care plan was developed related to any identified risk for falls.
(c) An audit of Incident/Accident reports will be completed to identify residents who experienced a fall in the past 30 days to ensure their care plan was revised after a

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	195174	A. BUILDING ______ B. WING ______	C 01/24/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 (ARD) of 11/14/19 revealed, in part, required extensive assistance of staff with bed mobility, transfers and dressing. Review of Resident #1's Physical Therapy Plan of Care dated 11/11/19 and completed by S7Physical Therapist (PT) revealed, in part, precautions for fall risk. Review of Resident #1's Occupational Therapy Plan of Care dated 11/11/19 revealed, in part, precautions for fall risk. Review of the facility's policy titled Falls and Fall Risk, Managing revealed, in part, based on previous evaluations and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of Resident #1's record revealed a fall risk assessment was not completed upon admission to the facility. Review of Resident #1's Physician progress note dated 12/13/19 revealed, in part, Resident #1 was seen and examined in her room today. Further review of Resident #1's Physician Progress note revealed the provider walked in Resident #1's room and she was on the floor laying with her head on a pillow. Resident #1 reported that she slipped. Resident #1 was placed in a wheelchair with help of nursing staff. In an interview on 01/23/2020 at 2:23pm, S13Registered Nurse (RN)/Assistant Director of Nursing (ADON) reviewed Resident #1's record and confirmed a fall risk assessment was not	F 689	fall. (d) An audit of medical records will be completed to identify residents who admitted/readmitted in the past 30 days to ensure their risk for elopement was assessed. (e) An audit of medical records will be completed to identify residents who admitted/readmitted in the past 30 days to ensure a care plan was developed/revised related to any identified risk for elopement. (f) An audit will be completed to ensure residents assessed as at risk for elopement have wanderguard system in place to prevent elopement. (3)Measures put into place that will be made to ensure that deficient practices will not recur: (a) The DON began inservicing Nursing staff on admission/readmission procedures, including assessment of resident's risk of falls and elopement, on 01/14/2020. (b) MDS/Care Plan staff will be inserviced by the DON/designee on the development/revision of care plan related to fall/elopement risk upon admission/readmission and the revision of care plan after resident experiences a fall. (4)The facility plans to monitor its performance and make sure solutions are sustained: (a) The DON or Designee will conduct a chart audit on residents who admit/readmit to ensure they are assessed for fall/elopement risk and a	

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completed upon admission to the facility. S13RN/ADON reviewed the record and confirmed a care plan was not developed nor fall risk nor was a care plan developed after the 12/13/19 fall. S13RN/ADON was unable to determine what fall risk precautions were implemented for Resident #1.

In an interview on 01/23/2020 at 2:40pm, S5LicensedPracticalNurse (LPN) stated she was responsible to complete a fall risk assessment for Resident #1 upon admission to the facility; however, she failed to complete an assessment. S5LPN reviewed the current care plan and confirmed falls were not addressed on the care plan and stated without a fall risk assessment she would not have known what to address in the care plan.

In an interview on 01/24/2020 at 10:13am, S6LPN stated she was the assigned nurse for Resident #1 on 12/13/19. S6LPN stated the Physician notified her that he found Resident #1 on the floor of her room. S6LPN stated any change in a resident condition, such as a fall, should be documented on the 24 hour report / change of condition report to ensure all staff were aware of the change in status.

Review of the 24 hour report / change of condition report dated 12/13/19 for the hall where Resident #1 resided was presented to the surveyor by S4LPN/ADON. Review of the 24 hour report revealed no documentation for Resident #1 in regards to the fall that was documented by her physician and confirmed by S6LPN.

In an interview on 01/24/2020 at 10:40am,

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care plan is developed/revised related to any identified risk.
(b) The DON or Designee will review incident reports 3 x weekly and conduct chart audits on residents who experience a fall to ensure care plan is revised after a fall.
(c) The DON or Designee will conduct audits on residents identified at risk for elopement 3 x weekly to ensure wanderguard system in place to prevent elopement.

Monitoring will be completed for 8 weeks and then monthly as deemed necessary. Any issues noted during monitoring will be corrected at time of discovery. Re-education will be conducted as deemed necessary.

(5) Corrective Actions will be accomplished by 03/04/2020.

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S4LPN/ADON stated she reviewed the 24 hour reports daily to be aware of what had happened with the residents. S4LPN/ADON stated she attended all daily morning meetings and all nursing issues were discussed. S4LPN/ADON stated on Monday 12/16/19 she attended the facility's daily Quality Assurance and Medicare Meeting and nursing issues were discussed but Resident #1's fall was not mentioned. S4LPN/ADON confirmed she had no knowledge Resident #1 had a fall on 12/13/19. Review of the minutes from the 12/16/19 Quality Assurance and Medicare Meeting revealed no documentation of a fall for Resident #1 on 12/13/19.

In an interview on 01/24/2020 at 11:00am, S7Physical Therapist stated she assessed Resident #1 upon admission and determined she was a fall risk. S7Physical Therapist stated the facility should have put interventions in place to decrease the fall risk. S7Physical Therapist stated she was not aware Resident #1 fell on 12/13/19. S7PT further stated a rehab representative attended the daily Quality Assurance and Medicare Meeting and that is how the rehab department finds out what residents had incidents or accidents. S7PT stated Resident #1 remained at risk falls and should have fall interventions in place.

Resident #4
Review of the facility's Elopement Prevention System Policy and Procedure revealed, in part: based on resident's assessment and history, determination will be made for wanderguard device to be used on resident.

Review of the facility's Wandering, Unsafe Resident Policy and Procedure revealed, in part,

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F 689	Continued From page 15 the staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at-risk individuals for potentially correctible factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Further review revealed interventions to try to maintain safety, such as a detailed monitoring plan will be included. Review of Resident #4's record revealed the resident was admitted to the facility on 07/23/19 with diagnoses of, in part: paranoid schizophrenia, bipolar disorder, arthritis, lack of coordination, muscle weakness, major depressive disorder, and suicidal ideations. Review of Resident #4's MDS (Minimum Data Set) with ARD (Assessment Reference Date) 10/29/2019 revealed, in part: the resident had a BIMS (Brief Interview for Mental Status) score of 09 (score of 08-12 indicated moderately impaired cognition). Resident #4 required supervision with setup assistance only for walking and locomotion on and off the unit. Review of Resident #4's Risk of Elopement and/or Wandering Review dated 10/29/2019 revealed Resident #4 was assessed as being at risk for wandering/elopement as evidenced by mental illness with orders for interventions having been last obtained on 07/23/2019. Review of Resident #4's Care Plan revealed a problem of at risk for elopement with goal date of 10/23/2019 with approaches of, in part: complete elopement risk assessment per facility protocol; assess/record/report to physician risk factors for	F 689		

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F 689	Continued From page 16	F 689		

potential elopement; and apply wander guard system such as a wanderguard to reduce risk of elopement.

Review of Resident #4's Hospital discharge paperwork dated 12/20/2019 revealed no documented evidence of any orders for a locked unit or any type of assistive device to prevent the resident from leaving the facility.

Review of Resident #4's Admission Evaluation and Interim Care Plan dated 12/21/2019 revealed Resident #4 was assessed as alert and anxious. Further review revealed the section of behavioral factors, which included a check box for wanders was not completed.

Review of Resident #4's record revealed no documented evidence of Resident #4 having been reassessed for elopement risk or orders for wanderguard having been obtained after being readmitted on 11/25/2019 or 12/20/2019, or Risk of Elopement and/or Wandering Review having been completed on 11/25/2019 or 12/20/2019. Further review revealed no documented evidence of the careplan having been updated with Resident #4's hospitalizations on 11/14/2019 to 11/25/2019, and 12/10/2019 to 12/20/2019.

Review of Resident #4's Physician Orders from 12/20/2019 to 12/28/2019 revealed no documented evidence of a wanderguard having been ordered for the resident.

Review of Resident #4's Release of Responsibility for Leave from Building revealed Resident #4 signed himself out of the building on 12/28/2019 at 3:36pm.

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F 689	Continued From page 17 Review of Resident #4's Record revealed the resident returned to the facility on 12/31/2019. In an interview on 01/24/2020 at 2:04pm, S2DON (Director of Nursing) stated from 12/20/2019 to 12/28/2019 the facility did not have any documented evidence of Resident #4 having a wander guard present. S2DON stated the facility was unable to locate any elopement/wander risk assessment having been completed. S13ADON (Assistant Director of Nursing) joined the interview and stated she interviewed S15Weekend Supervisor and she (S15Weekend Supervisor) did not think the resident was a wander guard risk. S2DON and S13ADON stated the facility had no documented evidence of the assessment having been completed and/or the careplan having been updated on 12/20/2019 when the resident arrived back from the hospital with his current elopement/wander risk status. In an interview on 01/27/2020 at 2:11pm, S16LPN (Licensed Practical Nurse) stated she was one of the nurses which provided care to Resident #4 after he returned from the hospital on 12/20/2019. S16LPN stated we, the staff, were not told to do anything different when the resident came back. S16LPN stated they were not told to increase supervision, not instructed to complete an elopement assessment for wanderguard placement, or instructed if Resident #4 was allowed to leave the building. S16LPN stated when a resident was readmitted to the facility the admitting nurse was to do assessments like elopement risk assessment and the admitting nurse was to do a baseline careplan. S16LPN stated she did not realize Resident #4 did not have a wanderguard in place.	F 689		

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E 000	Initial Comments E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 20, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Total residents: 142 F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 20, 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: 142	E 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS A desk review was conducted for previous deficiencies cited on 01/24/2020. All deficiencies were cleared. Complaint Survey #LA00054070 and Complaint #LA00054083. Tag #609 and Tag #689 were cited as a result of Complaint #LA00054070. Tag #610 and Tag #689 were cited as a result of Complaint #LA00054083.	{F 000}		

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

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	195174	A. BUILDING ______ B. WING ______	06/03/2020

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 06/03/2020. 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 Contol and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 175	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/13/2020

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 08/13/2020. 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: 170	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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		9/27/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/24/2020

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F 880	Continued From page 1 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 infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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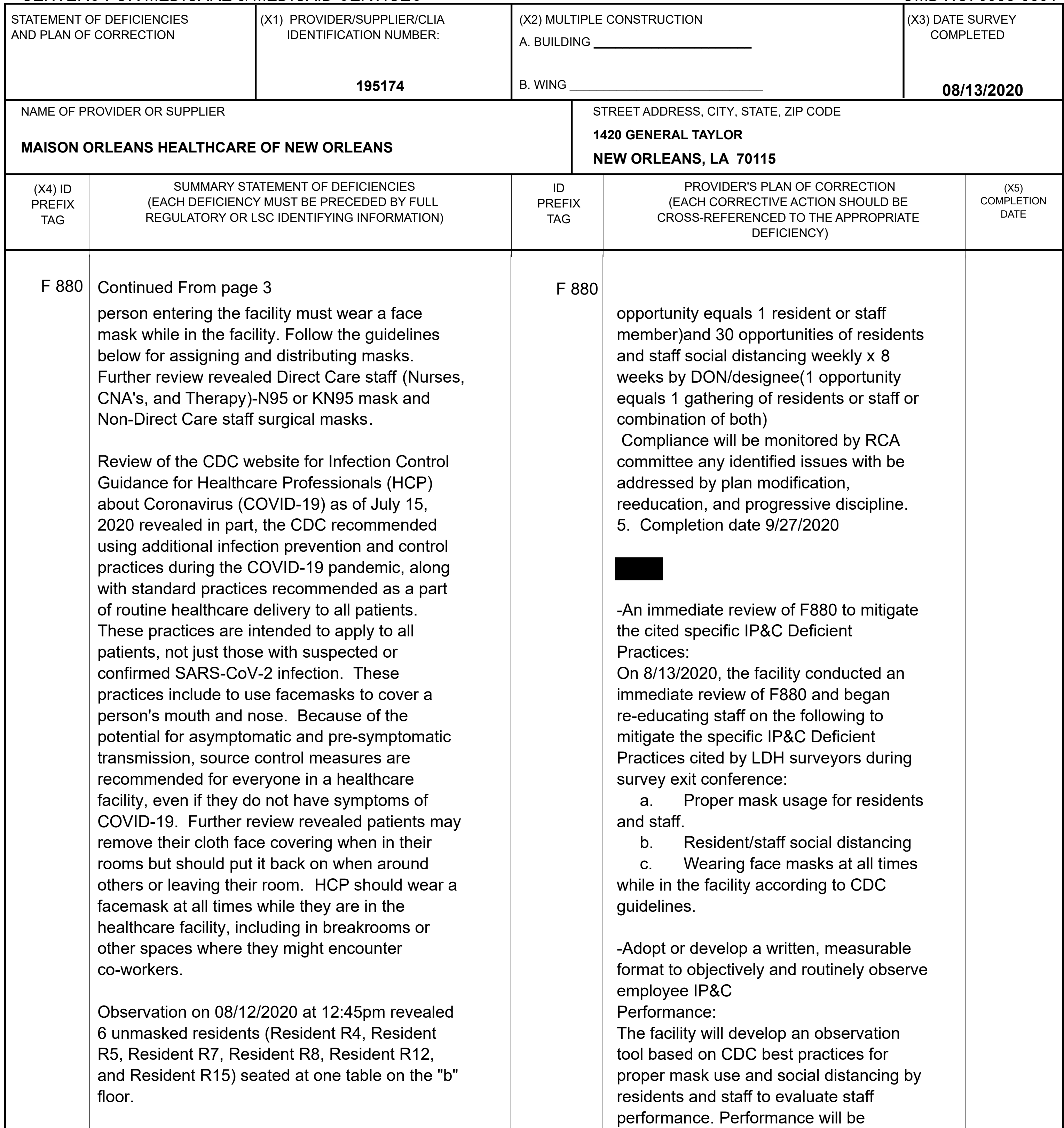
F 880	Continued From page 2 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the Center for Disease Control Guidance for Healthcare Professionals about the Coronavirus (COVID-19) by: 1.Failing to ensure residents and staff adhered to their infection control practices of ensuring residents and/or staff wore a face mask (Resident R4,Resident R5, Resident R6, Resident R7, Resident R8, Resident R10, Resident R11, Resident R12, Resident R13 Resident R14, Resident R15, Resident R16, Resident R17, S5Certified Nursing Assistant (CNA), S6Dietary Staff, S7CNA, S8Housekeeping, S9Licensed Practical Nurse (LPN), S11Ward Clerk); and 2.Failing to ensure residents and/or staff maintained social distancing (Resident R1, Resident R2, Resident R3, Resident R4, Resident R5, Resident R7, Resident R8, Resident R15, S10LPN, and S11Ward Clerk.) This deficient practice was identified for 16 randomly observed residents (Resident R1 Resident R2, Resident R3, Resident R4, Resident R5, Resident R6, Resident R7, Resident R8, Resident R10, Resident R11, Resident R12, Resident R13, Resident R14, Resident R15, Resident R16, Resident R17) and 7 staff members observed (S5 CNA, S6Dietary Staff, S7CNA, S8Housekeeping, S9LPN, S10LPN, S11Ward Clerk) but had the potential to affect any of the 170 residents as documented on the facility's Census list. Findings: Review of the Facility's policy with the title of Universal Source Control revealed in part, every	F 880	MOH POC FOR F 880 1. Corrective action was obtained for residents identified to be affected by alleged practice by conducting a re education on proper mask use & social distancing with the staff. Ensured masks were available to all who needed one. Additional signage placed throughout facility reminding residents of need to wear masks when out of room & to practice social distancing. Areas for social distancing re-marked in halls and on patio. 2. All residents have the potential to be affected. Corrective action was obtained for residents identified to be affected by alleged practice by conducting a reeducation on proper mask use with the staff and ensured masks were available to all who needed one. Corrective action was obtained for residents identified to be affected by alleged practice by conducting a reeducation on social distancing with the staff. 3. Measures put in place to address the deficient practice are a) Conduct root cause analysis b) Develop and implement training or other corrective action based on root cause analysis as outlined in the submitted D POC 4. Monitoring for compliance will be conducted as outlined in submitted D POC using 50 opportunities of proper mask usage by residents and staff weekly x 8 weeks by DON/designee (1	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195174	A. BUILDING ______ B. WING ______	08/13/2020

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

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F 880	Continued From page 3 person entering the facility must wear a face mask while in the facility. Follow the guidelines below for assigning and distributing masks. Further review revealed Direct Care staff (Nurses, CNA's, and Therapy)-N95 or KN95 mask and Non-Direct Care staff surgical masks. Review of the CDC website for Infection Control Guidance for Healthcare Professionals (HCP) about Coronavirus (COVID-19) as of July 15, 2020 revealed in part, the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed 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. Observation on 08/12/2020 at 12:45pm revealed 6 unmasked residents (Resident R4, Resident R5, Resident R7, Resident R8, Resident R12, and Resident R15) seated at one table on the "b" floor.	F 880	opportunity equals 1 resident or staff member)and 30 opportunities of residents and staff social distancing weekly x 8 weeks by DON/designee(1 opportunity equals 1 gathering of residents or staff or combination of both) Compliance will be monitored by RCA committee any identified issues with be addressed by plan modification, reeducation, and progressive discipline. 5. Completion date 9/27/2020 -An immediate review of F880 to mitigate the cited specific IP&C Deficient Practices: On 8/13/2020, 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. Resident/staff social distancing c. 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 and social distancing by residents and staff to evaluate staff performance. Performance will be	

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F 880	Continued From page 4 Observation on 08/12/2020 at 1:00pm near "b" floor nursing station revealed S7CNA with her face mask below her mouth, and she pulled up her face mask when she saw the surveyor. S7CNA accompanied surveyor to the table and further observations along the way from the nursing station revealed Resident R17 without a face mask seated in wheelchair, Resident R12 was ambulating without a face mask. Further observation revealed Resident R4, Resident R5, Resident R7, Resident R8, Resident R15 were seated adjacent to each other at a table all without face masks. Further observation of the table size revealed it was five and one-half feet by three and one-half feet. Further observation revealed Resident R10, Resident R11, Resident R13, and Resident R14 were seated on "b" floor enclosed balcony without face masks. Still further observations revealed Resident R6 and Resident R16 seated in wheelchairs next to each other without face masks. Observation on 08/12/2020 at 2:05pm revealed S6Dietary staff walking down the hallway with her face mask below her nose. In an interview on 08/12/2020 at 2:35pm, when the surveyor asked the S2Assistant Administrator about S6Dietary staff observed to have her face mask below her nose, he stated "they know better." Observation on 08/13/2020 at 10:00am on "a" floor revealed S8Housekeeper without a face mask on her face and she pulled her mask on her face when she saw the surveyor. S8Housekeeper stated she should have kept her face mask on at all times.	F 880	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 performance. b. Total number of observations with maintained socially distancing by residents and staff divided by Total number of opportunities observations percent 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. a. Total number residents and employees properly wearing masks properly divided by Total number of resident and employee observations equals percent performance. b. Total number of observations with maintained socially distancing by residents and staff divided by Total number of opportunities observations percent performance. -Review, and revise as indicated, facility resources (Structures) including policies, procedures and your Facility Assessment.	

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F 880 Continued From page 5

Observation on 08/13/2020 at 10:05am revealed Resident R1, Resident R2, and Resident R3 on the "a" floor enclosed balcony talking. Further observation revealed they were not socially distanced 6 feet apart and in close proximity of each other. No staff made any attempt to encourage, prompt, or assist any of these residents with social distancing.

In an interview on 08/13/2020 at 10:07am, S4LPN acknowledged Resident R1, Resident R2, and Resident R3 should be 6 feet apart from one another.

Observation on 08/13/2020 at 10:10am revealed S5CNA walking past the "a" floor nursing station then walking past the surveyor with her face mask below her nose.

In an interview on 08/13/2020 at 10:10am, when the surveyor questioned S5CNA about her mask being below her nose, she then placed the face mask over her nose.

Observation on 08/13/2020 at 10:15am on "a" floor revealed S9LPN without a face mask on and she pulled her mask on when she saw the surveyor. S9LPN stated she should have kept her face mask on at all times.

Observation on 08/13/2020 at 10:19am on "b" floor revealed S10LPN with her face mask hung from her ear, and S11Ward Clerk with her face mask below her nose. S10LPN and S11Ward Clerk were seated within 3 feet of each other.

Observation on 08/13/2020 at 10:25am on "b" floor revealed Resident R4, Resident R5, Resident R6, Resident R7, and Resident R8

F 880

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 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. 30 opportunities of residents and staff social distancing will be observed weekly. (1 opportunity equals 1 gathering of residents or staff or combination of both)
c. 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.
d. Staff observed will be provided feedback regarding their performance and provided reeducation as necessary.
e. Findings of observations will be documented on observation tool developed to evaluate and measure staff performance.

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	195174	A. BUILDING ______ B. WING ______	08/13/2020

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

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F 880	Continued From page 6 without face masks and seated next to each other at a table. Further observation revealed Resident R12 without a face mask while Resident R12 ambulated past the nursing station. No staff made any attempt to encourage, prompt, or assist any of these residents with mask placement. Observation with S2Assistant Administrator on 08/13/2020 at 10:35am on "b" floor revealed Resident R4, Resident R5, Resident R6, Resident R7, and Resident R8 without face masks and seated next to each other at a table. In an interview on 08/13/2020 at 10:36am, S2Assistant Administrator acknowledged the residents were not wearing masks and were not socially distanced.	F 880	-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.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	195174	A. BUILDING ______ B. WING ______	R 09/29/2020

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

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{F 000}	INITIAL COMMENTS A review/approval of the facility's Directed Plan of Correction for the COVID-19 Infection control survey and deficiency cited on 08/13/2020 have been completed. The deficiency was cleared. A COVID-19 Focused Infection Control Survey was conducted on 08/13/2020. 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: 170	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	195174	A. BUILDING ______ B. WING ______	C 11/13/2020

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F 000	INITIAL COMMENTS Complaints #LA00054884, #LA00055311, #LA00055319, #LA00055324, LA00056024 and #LA00056428 - there were no deficiencies cited as a result of these complaints. A COVID-19 Focused Infection Control Survey was conducted on 11/10/2020. 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 : 173	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/09/2020

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.

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	195174	A. BUILDING ______ B. WING ______	12/07/2020

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 12/07/2020. 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: 171	F 000		

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

Electronically Signed — 12/16/2020

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.