

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>195499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/03/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>ST FRANCES NSG &amp; REHAB CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>417 INDUSTRIAL DRIVE OBERLIN, LA 70655</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide and implement an infection prevention and control program.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and review of the facility policy and procedures, the facility failed to ensure resident care equipment was thoroughly disinfected before reuse by another resident. Total facility census was 73 as of 07/30/2020. Findings: Review of the facility policy and procedure titled Isolation Techniques revealed the following: All reusable resident care equipment shall be thoroughly cleaned, disinfected and sterilized before reuse. Observation on 07/31/2020 at 9:56 a.m. revealed S2 CNA had taken a resident's vital signs using a digital wrist blood pressure meter and monitor device, a finger pulse oxygen saturation monitor and a [MEDICATION NAME] forehead infrared thermometer. S2 CNA then proceeded to take the resident's roommates vital signs without sanitizing the equipment. Interview on 07/31/2020 at 10:00 a.m. with S2 CNA revealed she was using hand sanitizer on her hands and then wiping the equipment with the hand sanitizer from her hands. She confirmed that she should be using sanitizing wipes to sanitize the equipment before reusing on another resident. Interview on 07/31/2020 at 12:25 p.m. with S1 Administrator confirmed staff should be using sanitizing wipes on resident care equipment between each resident use.		

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.