

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 195249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2020
NAME OF PROVIDER OF SUPPLIER WOODS HAVEN SR CITIZENS HOME		STREET ADDRESS, CITY, STATE, ZIP 8275 HIGHWAY 165 POLLOCK, LA 71467	
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 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Provide and implement an infection prevention and control program.</p> <p>Based on interview and record review the facility failed to develop and implement an Infection Prevention and Control Program that included standards, policies and procedures for the cleaning and disinfecting of isolation rooms and handling of isolation laundry. The facility failed to ensure employees were screened for signs and symptoms of COVID-19 at the beginning of their shifts. The facility failed to ensure staff properly donned personal protective equipment and performed hand hygiene as required. Findings: Interview with S12 Housekeeping Supervisor on 07/30/2020 at 9:35 a.m. revealed that isolation rooms were cleaned by the CNA who was assigned to the resident and not by housekeeping staff. Interview with S3 CNA on 07/30/2020 at 9:40 a.m. revealed she worked the 6:00 a.m. - 2:00 p.m. shift. She stated she checked her own temperature at the nurses' station when she arrived to work and wrote it on a daily log sheet. She further stated she did not complete any screening questions regarding COVID-19 and was not asked any questions about signs, symptoms, or exposure to COVID by another staff member. Observation of and interview with S8 Laundry employee on 07/30/2020 at 12:05 p.m. revealed she was working alone in the laundry facility. She was noted to don a surgical mask positioned below her chin, with her mouth and nose uncovered throughout the interview. She stated she identified soiled laundry from isolation rooms by their being contained in a dissolvable laundry bag. She stated she brought all soiled laundry receptacles into the dirty side of the laundry room at one time, then washed the laundry from the isolation rooms last. She stated she received no instructions for handling laundry of residents with COVID-19, other than to wash it in the dissolvable bags. She stated she wore gloves when she handled the dissolvable bags. Observation of S4 CNA on 07/30/2020 at 12:40 p.m. revealed she was wearing a surgical mask positioned below her nose. She removed her eyeglasses and surgical mask and donned PPE to enter an isolation room. She donned gloves, then a cloth gown, goggles, and an N95 mask prior to entering the room. She exited the room after doffing the gown in the resident's room, then doffed her goggles, N95 masks, and finally, her gloves. She stated she would store her goggles and N95 mask in a ziplock bag on the cart outside the resident's door. She stated she could not recall if she had attended an in-service on donning and doffing PPE. Interview with Resident #1 on 07/30/2020 at 9:38 a.m. revealed she had been on Isolation precautions after testing positive for COVID-19 on 07/25/2020. She stated she had a private room and had been confined to her room after receiving a positive test result. She stated a CNA wiped her bedside table, rolling tray, and other surfaces in her room every day, but no one had mopped her room since she tested positive for COVID. Observation of S4 CNA on 07/30/2020 at 1:30 p.m. revealed she exited a resident's room carrying a small garbage bag with a gloved hand. She disposed of the bag, removed her glove, and approached a resident seated in his wheelchair in the hall. The resident's mask was observed suspended from one ear by one of the loops. S4 CNA affixed the resident's mask appropriately, then wheeled him back into his room. She did not utilize hand sanitizer. Interview with S13 PTA on 07/31/2020 at 8:30 a.m. revealed she worked Monday through Friday 9:00 a.m. - 3:00 p.m. She stated she checked her own temperature at the nurses' station after she entered the facility and recorded it on a daily log sheet. She further stated she completed no screening on signs, symptoms, or exposure to COVID-19. Interview on 07/31/2020 at 9:36 a.m. with S11 Housekeeper revealed he always wore a mask and asked for a new mask when his became dirty or messed up. He stated he arrived at work usually around 5:45 a.m. and checked his own temperature before starting work. He stated he was not sure what his temperature had to be in order to work and that no one asked him any questions about his health before clocking in. He stated he did not know if residents were positive for COVID-19 or not before cleaning the rooms, and he wasn't sure how to tell if a resident had tested positive or not. He further stated he was not sure if he needed to wear anything special to clean a COVID positive resident's room. Observation of S4 CNA on 07/31/2020 at 9:50 a.m. revealed she exited a resident's room and propelled a Hoyer lift down the hall to a nook near the smoking exit door. She left the Hoyer lift and walked away. Her surgical mask was positioned below her nose. Interview with S4 CNA at 9:53 a.m. revealed she normally did not clean or sanitize equipment used in the rooms of residents who were not on isolation and did not think she was required to do so. Interview with S2 DON on 07/31/2020 at 9:55 a.m. revealed that Hoyer lifts, along with any equipment that came into contact with residents, should be cleaned and sanitized after each use. She was unable to produce a policy on routine cleaning of facility equipment. Interview on 07/31/2020 at 10:03 a.m. with S6 CNA revealed she was assigned to the facility C- hall. She stated that she checked her own temperature when she got to work, thought it had to be under 100 degrees to be able to work, and stated no one asked her about experiencing signs and symptoms of COVID-19 prior to her shifts. She stated she had received information on handwashing and signs and symptoms of COVID-19, but was not sure what the process was or who was responsible for taking out the laundry in the barrels in the COVID positive resident rooms. Observation of S7 LPN on 07/31/2020 at 10:10 a.m. as she prepared to enter an isolation room revealed she removed an isolation gown from a plastic overwrap, and it fell on to the floor. She picked it up, donned the gown, and tied the bottom ties behind her waist. She left the neck ties untied exposing all of her neck, upper chest, and back. All of her back side was uncovered. She proceeded to don her N95 mask, face shield, and gloves. Interview with S5 CNA on 07/31/2020 at 11:00 a.m. revealed she worked 6:00 a.m. - 2:00 p.m. She stated she had been assigned to Resident #1 since she had been placed on isolation for a positive COVID-19 test. She stated she wiped all surfaces in her room with a spray cleaner, but did not know the kill time of the cleaner. She further stated she had not mopped Resident #1's room since she had been placed in isolation. She stated she had received no specific instructions for cleaning isolation rooms. On 07/31/2020 at 11:30 a.m., S4 CNA and S6 CNA were observed as they fed lunch to two residents who shared a room. S4 CNA was observed to wear her surgical mask below her nose. Both CNAs stated they were responsible for cleaning isolation rooms when assigned to residents in isolation. S4 CNA stated she used a spray cleaner and wiped it off afterwards. She was unaware of the kill time. S6 CNA stated she, too, was unaware of the cleaning spray's kill time, but usually cleaned with a disinfectant wipe. Both CNAs stated they mopped the rooms of isolation residents, but not every day. Both stated they had not received any specific instructions for cleaning rooms of residents' with COVID-19. Interview on 07/31/2020 at 11:48 a.m. with S9 LPN revealed that she sanitized her hands and checked her temperature before each shift. She stated that no one asked her any questions regarding signs and symptoms of COVID-19 before her shifts, nor did she have to fill out a screening tool. She also stated that the CNA's on the halls were responsible for cleaning the isolation rooms and she was not sure what they used or what the process was. Interview with S2 DON on 07/31/2020 at 12:15 p.m. revealed she had no policy for routine or terminal cleaning of isolation or COVID-19 rooms, no documentation of CNAs being instructed on cleaning isolation rooms, and no employee screening log. She stated all staff should don surgical masks while in the facility and N95 masks when caring for residents with COVID-19. She stated her COVID-19 policy had not been updated since 03/09/2020 to include this information.</p>		

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.