

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 195596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2020
NAME OF PROVIDER OF SUPPLIER MARY GOSS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP 3300 WHITE STREET MONROE, LA 71203	
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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the COVID - 19 Positive Residents and Positive Staff reports and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable disease and infections. The facility failed to notify the Office of Public Health when staff and/or residents were suspected to have COVID-19. Findings: Review of the COVID - 19 Positive Residents report, which was presented to the surveyors by S2Director of Nursing dated 06/05/2020 - 06/21/2020 revealed there were 14 residents named on the report. Further review of the report revealed dates of when the 14 residents first started having symptoms. Review of the COVID - 19 Positive Staff report, which was presented to the surveyors by S2Director of Nursing dated 03/25/2020 - 06/24/2020 revealed 14 staff members were named on the report. Further review of the report revealed dates of when 8 of the 14 listed staff members first started having symptoms of the COVID-19 virus. On 06/29/2020 at 8:40AM, an interview with S2Director of Nursing revealed they had not been reporting any resident and/or staff suspected cases of the COVID-19 until after a resident and/or staff member was identified as being positive for [MEDICAL CONDITION]. On 06/30/2020 at 12:35PM, telephone interview with S1Administrator confirmed they were not reporting the staff and/or residents with suspected cases of COVID-19 until after a resident and/or a staff member was identified as being positive for the COVID-19 virus.		

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.