STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455551	A. BUILDING _____ B. WING _____	**04/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAINVIEW HEALTHCARE CENTER	**2510 W 24TH ST PLAINVIEW, TX 79072**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview and record review; it was determined the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for 1 of 2 medication carts reviewed for medication storage. RN A failed to close and lock a drawer containing numerous medications when she left the medication cart unattended to provide resident care. RN A failed to place numerous medication blister packs and a medication dispensing cup containing several medications in the medication cart when she left the medication cart unattended to provide resident care. The facility's failure to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access places residents at risk for drug diversion, accidental or intention overdose on medication, accidental ingestion of toxic or caustic substances, and exposure to toxic or caustic substances. Findings include: During an observation on Initial Tour on 4/20/20 at 9:14 AM, RN A entered a Resident's room and left the Hall 100 medication cart unattended. No staff was visible in hall, and one medication cart drawer was open with numerous medication cards visible. Approximately 7 medication cards with medication in the blister packs and a medication cup with several pills were sitting on the medication cart. While standing at the medication cart, no staff could be visualized. After approximately 1 minute, RN A emerged from the resident room. When asked whether medication was to be left unattended on the medication cart and the medication drawer open, RN A closed the drawer, locked the cart, and stated, No, but I just stepped in the room real quick. When asked if she was attending to an emergency that required leaving the medication on the cart and the medication drawer open, RN A stated, No. During an interview on 4/20/20 at 10:50 AM, when asked whether medications should be left on the medication cart or the medication cart drawers should be left open while the medication cart is unattended, DON stated, No, that's not supposed to happen. When asked what the risks of leaving medication unattended were, DON stated, Another resident can take them. Record Review of the facility's Policy for Storage of Medication, dated 4/2007, it stated: Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation 7. Compartments (including, but not limited to, drawers cabinets, rooms, refrigerators, carts, boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to 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 for 4 of 4 common areas (Dining Room, Therapy Room, North Hall and South Hall) reviewed for infection control. RN A failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic. SW failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic. Transport failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic. CNA B failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic. CNA C failed to always wear a face mask in the facility as mandated during the COVID-19 Pandemic. This failure has the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections, particularly COVID-19. Findings include: During an observation on Initial Tour on 4/20/20 at 9:00 AM, the facility was locked to outside visitors. Upon knocking on the door, SW approached the door without a face mask in place. SW allowed Surveyor entry to the facility and spoke with Surveyor without a face mask in place. SW failed to maintain at least 6 feet of social distancing while speaking with Surveyor. During an observation on Initial Tour on 4/20/20 at 9:02 AM, CNA B was on South Hall in a resident's room assisting her with resident care. CNA B's face mask only covered her mouth, and her nose was outside the mask. During a simultaneous observation, RN A was not wearing a mask while passing medications. During an observation on Initial Tour on 4/20/20 at 9:06 AM, CNA C left a resident's room on the North Hall. CNA C's mask only covered her mouth, and her nose was outside mask. When asked when staff are to wear face masks, CNA C stated, All the time. Whenever we are in the building. When asked whether she was instructed on the proper way to ensure a mask is fitted, CNA C stated, Yes. During an interview on 4/20/20 at 9:08 AM, DON confirmed two residents were tested for COVID-19 and admitted to hospital for respiratory illnesses. DON confirmed two staff members were tested for COVID-19 due to positive signs and symptoms of respiratory illnesses. DON confirmed interventions to mitigate the When asked when staff were to wear face masks, DON stated, anytime they are in the building. When informed numerous staff throughout the building were not wearing masks during initial tour, DON stated, They should have been. DON confirmed the mandatory wearing of face masks was to prevent the spread of and possible COVID-19 infection. During an observation on Initial Tour on 4/20/20 at 9:10 AM, Transport was speaking with kitchen staff in the dining area. Several residents were in the dining area. Transport's face mask only covered her mouth, and her nose remained outside face mask. When asked when staff are to wear their face masks, Transport stated, All the time if we are in the building. When asked whether she was instructed how to ensure a face mask is fitted properly, Transport stated, Yes. Transport confirmed does all the resident transports for the facility. During an observation on Initial Tour on 4/20/20 at 9:13 AM, SW was talking to Transport in therapy room. Multiple residents were also in the room. SW now had a face mask in place; however, SW's face mask only covered her mouth. SW's nose remained outside the face mask. When asked when staff are to wear their face masks, SW and Transport stated, All the time. Whenever we are in the building. Transport placed her face mask over her nose as she made statement. When asked whether she was instructed on the proper way to ensure a mask is fitted, Transport stated, Yes. SW placed mask over her nose when asked about education for proper fitting of the face mask. During an observation on 4/20/20 at 9:14 AM, RN A was now wearing a face mask. RN A confirmed she was not wearing a face mask during initial tour. When asked when face masks should be worn, RN A stated, Whenever we are in the building. When asked why she was not wearing a face mask, RN A stated, I didn't have one. I had to wait until someone got here that could get me one. During an interview on 4/20/20 at 10:35 AM, when asked when staff should be wearing face masks, ADM stated, all staff should be wearing masks any time they are in the building. When informed numerous staff were not wearing face masks while performing resident care, ADM stated, They know better. We have done so many in-services. If we were to get a positive case, and they are doing that, we would be like the outbreaks in some of the (other) nursing homes. Record Review of the facility-provided COVID-19 Committee Meeting minutes revealed: 4/16/20: -Continue with current plan; -Do have 2 residents in hospital with respiratory issues but neither are positive for COVID-19. 3/25/20: -Continue with current plan -Facility is still on lockdown to outside visitors. Limit on other agency personnel; -Outside agency personnel

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) will have to also wear a mask when in facility. Although requested, no policies related to wearing face mask were provided.