STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675680	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRENTWOOD PLACE ONE	3505 S BUCKNER BLVD BLDG 2 DALLAS, TX 75227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program that included a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility and a system based on national standards for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for six (Hall 100, Hall 200, Hall 300, Hall 400, Hall 500, and Hall 600) of six halls reviewed for infection control, impacting 99 residents in the facility. 1. The facility failed to implement and maintain contact precautions and ensure staff utilized Personal Protective Equipment (PPE) appropriately to prevent cross contamination between residents positive with COVID-19 and residents who were not positive for [MEDICAL CONDITION]. 2. The facility failed to ensure residents, especially those residents positive for COVID-19, were [MEDICATION NAME] social distancing to help prevent the spread of COVID-19. 3. The facility failed to track and trend infections of COVID-19 to prevent the spread of infection. An Immediate Jeopardy/Immediate Threat was identified on 04/28/20. While the Immediate Jeopardy was removed on 05/03/20, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm that is not Immediate Jeopardy, due to facility continuation of in-servicing and monitoring the plan of removal. The facility was provided the Immediate Jeopardy template on 04/28/20. Findings included: An interview with the Administrator, DON, and Nurse Consultant on 04/28/20 at 1:35 PM revealed Resident #1 was the first person in the facility diagnosed with [REDACTED]. The resident passed away at the hospital. Review of the facility line listing (list of residents with dates of diagnosis), dated 04/30/20 revealed 11 residents (Resident #1-#11) passed away after developing COVID-19 in the facility. Thirty-six residents tested positive between 04/01/20-04/06/20. Three of the total 11 residents who passed away were diagnosed on [DATE] and 04/13/20. Twenty-one residents tested positive between 04/11/20-04/16/20. Twelve residents tested positive between 04/28/20-05/01/20. An interview on 04/30/20 at 12:30 PM with the Administrator and Nurse Consultant revealed the facility did not track and trend infections of COVID-19 to prevent the spread of infection through the facility. They said they did not review the dates of [DIAGNOSES REDACTED]. The Nurse Consultant reported she had not had time to do this and the DON was out for two weeks with [MEDICAL CONDITION]. They said they did not know if residents who had tested positive with one negative test could move to non-isolation halls and would have to look up the CDC guidelines to find out. Observations on 04/28/20 at 2:45 PM and 3:20 PM revealed the facility was structured like a wagon wheel with the nurse's station in the center. Observations of the hallways revealed: Hall 100, identified as an isolation unit, had the double doors closed. Isolation signs were posted. There were no PPE supplies available prior to entering the unit or an area with a hazard box to doff PPE prior to leaving the unit. Hall 200, identified as an isolation unit, had the double doors closed. Isolation signs were posted. There were no PPE supplies available prior to entering the unit or an area with a hazard box to doff PPE prior to leaving the unit. Hall 300, identified as an isolation unit, had the double doors closed. Isolation signs were posted. There were no PPE supplies available prior to entering the unit or an area with a hazard box to doff PPE prior to leaving the unit. The Dining Room had doors that connected it to Hall 300 and Hall 400. Halls 400, 500, and 600 were not identified as isolation units. Central supply was located in a room on Hall 600. Large amounts of resident equipment for use throughout the facility was in Hall 600. An observation and interview on 04/28/20 at 3:20 PM revealed Floor Tech O was leaving isolation Hall 300 with two barrels of linen. He did not remove his PPE or perform hand hygiene after exiting Hall 300. He walked past the nurse's station to Hall 600 (non-isolation hall) and placed the two barrels in a closet. Floor Tech O reported that he wore the same PPE all shift and never changed it or his gloves until the end of his shift. An interview on 04/28/20 at 3:25 PM with the Nurse Consultant, DON, and Administrator revealed staff were not expected to change their PPE when leaving an isolation hall and going to a non-isolation hall. The Nurse Consultant stated staff could wear the same PPE all shift and for any resident because everyone in the building was presumed positive. Review of an email, dated 04/06/20, from the County Health Department to the facility reflected: .Thank you for our discussion today. I understand that there is now at least one confirmed case in each of the 6 halls and you expressed it is no longer feasible to cohort residents into isolation units. As we discussed, since the confirmed cases are not all cohorted in the same halls, healthcare are advised to wear all recommended PPE for the care of all residents, regardless of presence of symptoms. Epidemiologist Q reviewed with you the CDC Strategies for Optimizing the Supply of PPE and Equipment for each PPE type . An interview on 4/29/20 at 12:35 PM with the County Health Department revealed staff were supposed to wear full PPE when entering the facility and where supposed to change their gown and gloves between each resident. He said he sent the facility an email with links regarding the use and conservation of their PPE. He said the facility was supposed to have designated staff working with positive residents only. Review of an email dated 04/16/20 at 4:20 PM from Epidemiologist R reflected: .Below are the recommendations made . 3. Recommend facility cohort COVID-19 positive residents and dedicate HCP (healthcare personnel) to only care for these residents. (They stated that they are unable to do this, but it was highly recommended to prevent in-facility transmission.) An interview with Epidemiologist Q on 04/29/20 at 10:30 AM revealed gowns and gloves had to be changed anytime a person exited an isolation hall and hand hygiene had to be performed. Observation and interview on 04/28/20 at 4:05 PM revealed CNA P was in Hall 300 (isolation hall). She was preparing linen to go into a resident's room. She took the linen and the dirty linen cart to the last resident's room on the hall. She exited Hall 300 wearing a gown, mask, face shield, and shoe covers and walked to the nurse's station. CNA P did not perform hand hygiene or change her gown when she left the isolation Hall 300. She stated she was Agency Staff and this was her first assignment with the agency since COVID-19 started. CNA P stated she did not change her gown between providing resident care, but she did change her gloves and perform hand hygiene. A male resident, name unknown, exited Hall 300 through the double doors and told CNA P he was ready for his shower. He was not wearing a mask. CNA P told the resident to give her 5 minutes and he entered back through the double doors to Hall 300. A different male resident then exited Hall 300 wearing a mask. He walked past the nurse's station and into a room on Hall 500 (non-isolation hall). An observation and interview on 04/28/20 at 6:45 PM with the Administrator revealed the smoking patio was entered by passing through the Dining Hall. One resident was observed smoking on the patio and the Administrator said the resident was COVID-19 positive and in Smoking Group One. We entered back into the dining room and another male resident was seated there. The Administrator said he was in Smoking Group 2, was COVID-19 negative, and was waiting for his turn to smoke. An observation on 04/28/20 at 7:00 PM revealed staff from the Texas Division of Emergency Management was speaking with facility administration and explaining the difference between hot, cold, and warm zones as it pertained to the COVID-19 virus. The Administrator reported to him that residents wandered between the isolation and non-isolation halls and that staff wore the same PPE going from positive halls to negative halls. An observation on 04/28/20 at 7:10 PM revealed Resident #12 (Refused COVID testing) exited Isolation Hall 300, passed by the nurse's station, and entered Isolation Hall 100. An observation on 04/29/20 at 9:00 AM revealed there were approximately eight residents smoking outside the back door of Hall 100. The residents were not social distancing (standing 6 feet apart). They were standing very close together. An interview on 04/29/20 at 9:20 AM with the

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) Administrator, Nurse Consultant, and DON revealed that Resident #13 was sent to the hospital for lethargy overnight and was COVID-19 positive. The facility identified six new residents who tested positive for COVID-19 on Hall 600 on 04/28/20. They stated Hall 600 was changed to an isolation hall. They reported they did not know what resulted in the new positive results, but that the facility residents were not cohorted based on [DIAGNOSES REDACTED]. They said up until that point, there were COVID-19 positive residents on every hall. An interview on 04/29/20 at 12:45 PM with the Medical Director revealed the facility did not have any specific protocols regarding caring for residents positive for COVID-19. He said the residents were treated symptomatically and assessed once per shift. Staff were supposed to call him with any changes in condition. He said if residents had the same diagnosis, staff could wear the same PPE all shift, and not change it. He said glove changes and hand hygiene could be completed between residents. He said the PPE did not need to be necessarily changed in the facility because everyone in the facility had been exposed and there was nothing they could do to prevent the negative residents from developing it. He said this was his first visit to the facility since residents were COVID-19 positive, but he was in constant contact with the facility by phone and video. He said there was nothing that could have been done differently to prevent the spread of [MEDICAL CONDITION] in the building. An observation and interview on 04/30/20 at 10:45 AM with Resident #14 revealed he was seated in his wheelchair in the front room of the facility and was wearing a mask. He was alert and awake and reported he was feeling well. The Administrator reported Resident #14 resided on an isolation hall. The Nurse Consultant said the resident had tested positive for the COVID-19 virus and had one negative test result at that time and needed one more negative test to come out of isolation. An interview with RN J on 5/1/20 at 10:20 AM revealed she did not receive training to change her gown between each resident. She said changing her gown depended on the type of contact she provided for residents. RN J stated the residents on the isolation halls kept leaving the hall and had to be re-directed back to their room. She said the facility could have prevented the spread of [MEDICAL CONDITION] if they had stopped the positive residents from leaving their hall. She said she provided care to Resident #1 and Resident #9. Resident #1 spiked a temperature and he was transferred to an isolation room on Hall 600. Resident #9 passed away after she was found on the floor. She said she was doing hourly checks with Resident #9 because her oxygen saturation was low. She said the resident was constantly removing her oxygen tubing and she kept having to re-direct the resident to put it back on. RN J said on 04/13/20 she felt ill and went to the emergency room after work. She tested positive for the COVID-19 virus and had to stay home for 2 weeks. An interview with CNA S on 05/01/20 at 10:35 AM revealed he/she was trained that his/her gown only had to be changed if it was dirty and staff did not need to change PPE between residents. An interview with LVN T on 05/02/20 at 1:45 PM revealed she had been trained that PPE only needed to be changed if she went outside the facility. She said they had several residents who refused to stay on their hall and they were supposed to try and re-direct them. An interview with CNA U on 05/02/20 at 2:00 PM revealed he/she received training that staff were able to wear the same PPE for all residents and staff did not need to change PPE between residents. An interview with CNA V on 05/02/20 at 2:10 PM revealed she/he was trained that the same PPE could be worn for all residents and staff did not need to change PPE between residents. An interview with LVN W on 05/02/20 at 2:20 PM revealed she only changed her PPE when she left her assigned hall for the day and the facility had multiple residents who wandered onto other halls. She said she thought the spread of [MEDICAL CONDITION] could have been slowed if the facility would have tested everyone at the same time and isolated those who tested positive. An interview with the Nurse Consultant on 05/03/20 at 3:20 PM revealed Epidemiologist R asked if the facility had cohorted residents. The Nurse Consultant said the health department did not give instructions to do that. She said residents were not cohorted until 04/24/20. Review of the Facility Policy, Infection Control, dated May 2017 reflected: Policy .The program will: Perform surveillance and investigation to prevent .the spread of infection; Prevent and control outbreaks and control cross-contamination using transmission-based precautions in addition to standard precautions; . Implement hand hygiene (hand washing) . Review of the COVID-19 Focused Survey for Nursing Homes, dated 03/20/20, and filled out by the facility reflected the facility did not identify any concerns in the areas of: Do staff perform hand hygiene (even if gloves are used) in the following situations? Before and after contact with the resident . Is PPE appropriately removed and discarded after resident care, prior to leaving the room ., followed by hand hygiene? 2. Resident Care .is the facility restricting residents (to the extent possible) to their rooms except for medically necessary purposes? If there is a case in the facility, and residents have to leave their room, are they wearing a face mask, performing hand hygiene, limiting the movement in the facility, and performing social distancing? Has the facility isolated residents with known or suspected COVID-19 .? Review of the Centers for Disease Control and Prevention (CDC) guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic revealed: . 2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection in a single-person room with the door closed. The patient should have a dedicated bathroom . As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift. Determine how staffing needs will be met as the number of patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection increases and if HCP become ill and are excluded from work . To the extent possible, patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers). Limit transport and movement of the patient outside of the room to medically essential purposes . Patients should wear a facemask or cloth face covering to contain secretions during transport. If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room . Personal Protective Equipment HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection . HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. Personal Protective Equipment Training Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I) external icon. HCP must receive training on and demonstrate an understanding of: when to use PPE (,) what PPE is necessary how to properly don, use, and doff PPE in a manner to prevent self-contamination (,) how to properly dispose of or disinfect and maintain PPE (,) the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator or Facemask (Cloth face coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended.) Put on an N95 respirator (or equivalent or higher-level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask . Eye Protection Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Personal eyeglasses and contact lenses are NOT considered adequate eye protection. Ensure that eye protection is compatible with the respirator so there is not interference with proper positioning of the eye protection or with the fit or seal of the respirator. Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. Gloves Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated. Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene. Gowns Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. Accessed on 07/15/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html An Immediate Jeopardy/Immediate Threat was identified on 04/28/20. The Administrator, Nurse Consultant, and DON were notified of the Immediate Jeopardy on 04/28/20 at 5:10 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 05/01/20 at 4:30 PM and reflected the following: All staff are being in-serviced on the correct donning of PPE. The following procedure will be followed: staff will don a set of the required PPE (goggles/face shield, gown and N95 mask). All staff will change their gowns out with each resident encounter. When a staff member leaves a positive hallway, they will doff their gown when coming out of the hallway, perform hand hygiene and don a clean gown. This in-service was started on 04/28/20 by the DON/designee. Facility will continue to have designated staff for the COVID-19 positive hallways. Current staffing patterns are the following: 100 Hall (positive) 1 dedicated nurse and 2 dedicated CNA, 200 Hall (positive) 1 dedicated nurse and 1 dedicated CNA, 300 Hall (residents predominately have 1 negative test) 1 dedicated nurse and 1 dedicated CNA, 400 and 500 hall (residents have either refused, or had 2 negative test or have had 1 negative test) will have a dedicated nurse and 2 CNA. The designated staff for each hallway will be responsible to enforce that COVID-19 positive residents to stay on their residing hallway. They will also make sure no residents from other hallways enter the positive hallway. Facility will continue to have separate smoke breaks for COVID-19 positive residents from the residents who are negative. During smoke breaks residents will maintain social distancing practices. An updated line listing of resident's status will be placed in the nurse's narcotic binders for the staff to have a quick reference to identify the testing stages of each resident. The DON/designee will be responsible to update the line listing in the narcotics books as changes occur. As residents have had two negative COVID-19 test they will be removed from isolation. The Administrator/Director of Nursing/Assistant Director of Nursing will assess all residents who have been potentially exposed to cross contamination. Administrator/Director of Nursing will consultant with the Vice President of Clinical, Vice President of Operations, Vice President of compliance and the Regional Nurse Consultant on any potential exposure related to any staff member/resident and CDC and state guidelines will be reviewed daily on the daily end of day call for 21 days after the last confirmed case. Residents will be monitored every shift for any changes of condition. Any changes of condition will be reported to the Director of Nursing and Assistant Director of Nursing immediately. DON/designee will monitor that the appropriate process for PPE is being followed for all hallways. This monitoring will be completed daily by the DON. The Regional Nurse Consultant will monitor the process completed by the DON. A social distancing monitoring tool has been created and will be utilized by nursing department supervisors to randomly make rounds per day on each positive COVID-19 hall to ensure compliance with [MEDICATION NAME] social distancing and remaining on their residing hallway. The Regional Nurse Consultant will monitor the process is completed by the DON. The DON/designee will be responsible to update the line listing in the narcotics books as changes occur. This will allow the staff to have a quick reference regarding resident COVID-19 status. The DON will do randomly ask staff to verbalize how they can obtain the information regarding the status of the resident regarding COVID-19 daily. The follow protocol from the Medical Director will be put in place for COVID-19 positive residents. Vital signs including temp, respirations, blood pressure, pulse and oxygen saturations will be completed every shift. A Respiratory Assessment will be completed every shift including auscultating lung sounds. The MD will be notified of any adverse lung sounds, diminished breathing, or respiratory distress. All COVID-19 positive residents will have standing Oxygen orders of 02 Saturation less than 92% will be placed on 2-5L oxygen via either nasal cannula or face mask. MD will be notified as well. A clinician will round on the positive residents 3 times a week and prn via telehealth. Any changes condition assessed the MD will be notified immediately. Monitoring of the facility's Plan of Removal included the following: Interviews and observations were conducted on 05/02/20 starting at 12:30 PM and continued through 05/03/20 at 3:45 PM with 15 staff members from various shifts regarding in-services which included the CDC guidelines for the use of PPE, staff assignments with COVID-19 positive residents, monitoring of residents, and facility monitoring of residents wandering. The staff members were able to: Describe the correct process for wearing PPE and performing hand hygiene. Describe the process for assigning staff and monitoring residents. Describe the monitoring process of COVID-19 positive residents. Identify residents who were COVID-19 positive and those who were not. Observations revealed residents were not wandering onto other halls, staff were changing their PPE per CDC guidelines, and residents were assigned to halls based on their [DIAGNOSES REDACTED]. Interviewed staff members and shifts were: LVN E- worked 6:00 AM to 2:00 PM CNA U- worked 6:00 AM to 2:00 PM CNA V- worked 6:00 AM to 2:00 PM LVN W- worked all shifts CNA X- worked 2:00 PM to 10:00 PM CMA Y- worked double shifts Restorative aide Z- worked 10:00 pm to 6:00 AM and 6:00 AM to 2:00 PM Kitchen Staff AA - worked day shift Kitchen Staff BB - worked day shift LVN K - worked 2:00 PM to 10:00 PM CNA CC - worked 2:00 PM to 10:00 PM LVN DD - worked double shifts LVN EE - worked double shifts CNA FF- worked 2:00 PM to 10:00 PM Dietary Aide GG- worked split shifts An interview with the Administrator on 05/03/20 at 12:55 PM revealed going forward the facility would be following the CDC guidelines and she would ensure the facility completed infection control surveillance, cohorting of residents and staff, and increased monitoring and auditing of staff infection control measures. An interview with the DON on 05/01/20 at 10:55 AM revealed going forward the facility would be following the CDC guidelines and the staff would be wearing their PPE appropriately, and as the Infection Control Preventionist he would be tracking and trending infection information. An interview with the Nurse Consultant on 01/19/18 at 1:50 PM revealed going forward the facility would be following the CDC guidelines for infection control and monitoring the spread of [MEDICAL CONDITION] in the facility. She said she would continue to update the facility line listing and send HHSC a summary of her findings daily. The Administrator was notified on 05/03/20 at 3:40 PM, the Immediate Jeopardy was removed. While the immediacy was removed on 05/03/20, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing in-servicing and monitoring the plan of removal.