STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675052	A. BUILDING _____ B. WING _____	04/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAPORTE HEALTHCARE CENTER	208 SOUTH UTAH LA PORTE, TX 77571

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure and attain or maintain the highest practicable physical, mental and psychological well-being of each resident related to sufficient staffing and COVID-19. -The facility failed to have sufficient nursing staff working at the facility on the COVID positive and negative units. These failures placed residents at risk of infection and COVID-19, unnecessary discomfort, decreased quality of life and their needs not being met. Findings include: Telephone interview on 4/6/20 at 10:45am with the Administrator, when asked if he had sufficient staffing to maintain overall facility operations, he stated they have contacted five agencies to assist with staffing, stating right now they are maintaining. He further stated, Honestly, I feel once the tests come back there will be a lot of staff on a 14-day quarantine. He stated he has a meeting today at 11:00pm with the company to discuss pulling staff from other sister facilities. Record review of the facility Census and Conditions of Residents dated 4/09/20 revealed a census of 41. Record review of the facility's Daily census report dated 4/9/20 revealed 20 residents on the COVID negative (North) unit and 21 residents on the COVID positive (South) unit. Interview on 4/9/20 at 8:51am with the Regional Chief Clinical Coordinator, she stated of the staff were out of work due to testing positive for COVID. She said two nurses from sister facilities were currently working at the facility. She said they were having problems with getting agency nurses to work and/or stay, stating the facility was a great place to work, but the agencies were telling their staff not to work due to COVID. When asked who the DON was, she stated both the DON and ADON tested positive for COVID and were not working. She said they currently have an interim DON who started yesterday. Further interview on 4/9/20 at 8:51am with the Regional Clinical Coordinator, she said the plan was to reach out to the agencies and put an S.O.S. for help. She said they were having problems getting agency nurses to work at the facility because they did not want to work on the COVID positive unit. When asked about staffing on both units she said there was currently one CNA and one nurse on the COVID negative side and one nurse and MA on the COVID positive side. Interview on 4/9/20 at 9:24am with the Housekeeping Supervisor, he stated they normally have two housekeeping staff working on the floor and one housekeeper assigned to the laundry room. He stated they currently only have two housekeepers including himself to maintain laundry and housekeeping duties. He stated the manager and one housekeeper tested negative but were no longer working at the facility, stating they may come back but he was not sure. He further stated one housekeeper tested positive and was not working. When asked if one housekeeper was assigned to the COVID side, he stated they both clean the positive and negative side but change their PPE. He stated he was working on the COVID positive unit today. Observation and interview on 4/9/20 at 9:55am. CNA A was observed wearing a yellow gown with a surgical face mask and gloves performing patient care on the COVID negative unit. When asked if she was assigned to the COVID negative unit, she stated she was the only CNA for the entire building stating the positive unit did not have a CNA. When asked if she did any patient care on the COVID positive side, she stated she helped pass trays on both sides. When asked if she used the N95 mask when she goes to the positive unit, she said she had not asked for a N95, further stating she puts two surgical masks on when she goes to the positive unit. Observation and Interview on 4/9/20 at 10:28am with the Regional Nurse, she was observed passing medications on the COVID positive unit wearing a surgical mask, face shield, gown, and gloves. She stated she started working at the facility on Monday or Tuesday of this week. She stated she was working as the MA on the COVID positive side. When asked about staffing on the COVID positive side, she said there was one nurse and herself, with no CNA. Observation of the Regional Chief Clinical Coordinator on 4/9/20 at 10:35am, she was observed on the COVID positive unit checking on residents on the unit. She was observed wearing a yellow gown and surgical face mask. Observation on 4/9/20 at 11:12am of the Administrator revealed he assisted Resident #8 back into the facility after she returned from [MEDICAL TREATMENT]. The resident was sitting in a w/c wearing a facemask. The Administrator was observed checking her temperature and pushing the resident in her w/c to the COVID negative unit. Interview on 4/9/20 at 11:46am with the Administrator, when asked if they had dedicated staff working on the COVID positive unit, he stated they did not have enough staff to do so, and staff were going back and forth. He said they were changing their PPE between halls. He said it may take some time to get the documents requested because some of the department heads who were also CNAs were working on the floor. He stated he was a CNA and was assisting on the floor as well. Further interview on 4/9/20 at 11:46am with the Administrator, when the surveyor requested the staff schedule for the week, the Administrator stated he could not provide a schedule for the week stating there really was not a schedule due to the staffing issue, stating the earliest schedule that could be provided would start on Saturday 4/11/20. Observation on 4/9/20 at 11:51am of the Administrator revealed, he entered the COVID positive unit with a face mask, yellow gown and gloves after interview was completed. He was previously observed pushing Resident #8 to the COVID negative unit at 11:12am. Observation of the Regional Chief Clinical Coordinator on 4/9/20 at 12:03pm, she was observed passing lunch trays to residents in their rooms on the COVID negative side. She was previously observed on the COVID positive side at 10:35am checking on residents. Interview on 4/10/20 at 12:19pm with CNA A, when asked about staffing on the COVID negative unit, she stated there was one nurse and CNA on the negative side and positive side, further stating the staffing was the same as yesterday. Record review of the facility's Notice To Person Who Owns or Controls Property: Quarantine of Property order from the local health department addressed to the facility dated 4/6/20 read in part, .Resident Monitoring and Restrictions .Implement protocols for cohorting ill residents with dedicated HCP .Cohorting: .All staff members need to wear PPE and be cohorted. Interview on 4/11/20 at 5:59am with LVN F. She said she worked the night shift with 1 CNA last night. She said she had been here since Wednesday from a sister facility in Abilene. She said she did care for residents on both the positive and negative side of the facility and the CNA also cared for residents on the positive and negative side but she said they worked one side and then switched to the other side and they have a system of using blue gowns for the positive side and yellow gowns for the negative side and both she and the CNA sanitized and changed gowns and masks when they moved from side to side. She said she and another LVN are from Abilene and are helping out by working 12 hour shifts for the next week. Interview on 4/11/20 at 6:05am with CNA E. She said she worked last night as the CNA and she was now waiting for the day shift to come in before she leaves. Observation on 4/11/20 at 6:15am revealed the only staff in the facility were LVN F and CNA E from night shift and 1 additional LVN who was scheduled to work the day shift. No additional day shift staff were present. Interview and observation on 4/11/20 at 6:33am with CNA E. She said last night she had to work both the COVID negative and COVID postive side. She said they usually had two aides at night, but last night it was just her. She said she and the LVN worked one side first and then changed gowns and went to the other side. She was observed to be wearing a surgical mask. When asked if she had an N95 mask she said the only mask she had was the one she was wearing. Interview on 4/13/20 at 2:25pm with the Interim DON and Administrator, the Interim DON stated they had the Social worker sitting at the entrance

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) from 9am-6pm to complete the COVID screening assessment further stating after 9pm, the nurse on the COVID negative unit will be responsible for the screening process. The DON stated they scheduled one nurse, two CNAs and 1 MA to work on the COVID positive side for the day and evening shift. She further stated the COVID negative side will have one nurse, 2 CNAs scheduled for the day and evening shift and the night shift both sides will have one nurse and one CNA scheduled. Interview and observation on 4/13/20 at 4:08pm with CNA D, she was observed wearing a face mask. She stated she was an agency nurse and she was assigned to the COVID positive side. She stated she was told she could only work on the positive side. When asked about staffing on COVID positive side, she said right now there was supposed to be two CNAs assigned for the 2-10pm shift, but two CNAs were supposed to be leaving since they worked the 6a-2p shift. She said she was theoretically the only CNA scheduled to work the 2p-10p shift. She said there was one nurse on the COVID positive side. When asked if she received training on PPE use and disposal, and screening. She said she received in-services on PPE use stating she was told she must wear a mask and shield, gowns, and gloves on the positive side. She said she was also trained on proper disposal of the PPE. Interview on 4/13/20 at 4:15pm with the Interim DON, she was informed by the surveyor that the COVID positive side had two CNAs from the 6a-2p shift that were still working on the unit because the evening CNA had not showed up to work. She stated she spoke to the CNAs and they said they were going to stay until they get someone in to work the evening shift. Interview on 4/13/20 at 4:29pm with the Administrator, he stated he was aware of the staffing issue and would stay and work on the COVID positive side if he needs to.
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 effectively maintain an infection prevention and control program designed to help prevent the spread of infections for 3 of 11 residents reviewed for infection control and COVID-19. -The facility failed to ensure CR #1 was isolated from other residents and wearing a face mask to prevent the spread of COVID-19 after he developed a cough on [DATE]. CR #1's COVID-19 assessments were not completed accurately for three days before he was hospitalized on [DATE] for treatment of [REDACTED]. -The facility failed to complete the daily COVID-19 assessments for CR #5 and Resident #6 per CDC guidelines. -The facility failed to ensure residents temperatures were taken every shift per CDC guidelines for 16 residents on [DATE]. -The facility failed to effectively screen and/or document COVID-19 visitor screening results in its entirety on all staff and/or visitors entering the building per CDC guidelines. -The facility failed to ensure staff were wearing face masks while in the building per CDC guidelines and quarantine orders. These failures resulted in an immediate jeopardy on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of widespread and severity of actual harm due to the facility requiring more time to monitor the plan of removal for effectiveness. These failures placed residents and staff at risk of infection and COVID-19. Findings include: CR #1 Record review of CR #1's face sheet revealed, a [AGE] year-old-male admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #1's nursing progress notes dated [DATE] read in part, Resident was seen by MD, noted resident coughing, was assessed and ordered chest X-ray stat. resident was out of bed in w/c denies any pain or discomfort, will continue to monitor and treat. Further record review of CR #1's nursing progress notes dated [DATE] read in part, CXR results faxed to physician, moderate opacity in the right lower lung concerning for PNA. New orders for [MEDICATION NAME] 500mg po BID x 7 days and Duo nebs QID x 7days. Management and guardian notified O2sats 96% on O2 at 3LPM per nasal cannula. No fever noted this shift. Further record review of CR #1's nursing progress notes dated [DATE] read in part, 6:20AM Resident Sitting on side of bed yelling I can't breathe!. Nurse entered room and noted resident has removed nasal cannula. Nurse replaced nasal cannula and assessed vitals. O2 74% on 2 LPM. Resident became more SOB even with O2. Nurse place a non-rebreather mask on at 10LPM. O2 sats increased to 88% but resident remains in respiratory distress. Physician notified and new order to send to ED. EMT transported resident and will let facility know where resident will be because of Covid-19. Resident had mask on at the time of transport. Family will be notified of location at that time. Further record review of CR #'1 nursing progress notes revealed, no documentation showing the resident was isolated from other residents or proper PPE was used when a new onset cough was identified on [DATE] to prevent spread of suspected COVID-19. Record review of CR #1's COVID-19 monitoring assessment dated [DATE] revealed, under Observation Details Symptoms: Cough (New Onset) No was checked. Further record review of CR #1's COVID-19 monitoring assessment dated [DATE] revealed, under Observation Details Symptoms: Cough (New Onset) No was checked. Further record review of CR #1's COVID-19 monitoring assessment dated [DATE] revealed, the resident was transferred to the hospital for SOB and decreased O2 sat on [DATE]. The COVID-19 assessment was not completed until [DATE]. Further record review of the assessment revealed, No was documented for Symptoms of Short of Breath (New Onset). Telephone interview on [DATE] at 10:45am with the Administrator, he stated one more resident, CR #2 tested positive for Covid-19 on Thursday, [DATE], and was sent out to the hospital at 4am. He stated CR #1 and CR #2 were still in the hospital. He said the roommate of CR #1, CR #3 was on Hospice and expired on Friday [DATE] and was not tested for Covid-19 further stating he was not sure if a postmortem test would be completed. He said the roommate of CR #2, CR #4 also passed away on Friday at 4am stating the roommate had a sudden change of condition then went into respiratory distress two minutes after the change of condition. He said EMS was called, and they worked on the resident, but he expired stating he never made it out of the EMS vehicle. He stated said he did not know if the two deceased residents would be tested for COVID-19. Further telephone interview on [DATE] at 10:45am with the Administrator, when asked if a resident had s/s of potential COVID exposure, did the staff or resident wear the appropriate PPE to prevent potential spread of [MEDICAL CONDITION], he said they follow the CDCs guidelines stating facemask guidelines did not come out until Friday, [DATE]. He further stated he thought the staff put themselves in harm's way stating they completed sign in sheets, vital signs every shift and when residents developed any s/s, PPE was utilized. He said they started wearing the facemasks on Monday, [DATE], after they had their first confirmed case. Further telephone interview on [DATE] at 10:45am with the Administrator, when asked what the facility's screening process included, he said they screened everyone initially stating he has a COVID Binder with the information. He said temperatures were checked, questionnaires from the CDC guidelines were completed and all persons entering the facility must use ABHR prior to entering and must wear a face mask. He further stated anyone entering the facility must wear a facemask as of [DATE]. When asked if staff were working at other health care facilities or if they were only working at this facility, he stated he had been asked this before and he really did not know if staff worked a 2nd job, they may not say if they were. Interview on [DATE] at 11:18am with the Administrator, he stated the CDC instructions were not clear and two days prior to CR #1 testing positive for COVID, he was in contact with staff and other residents stating he was not wearing a face masks. He said once the resident started to cough on [DATE] a CXR was done and he was started on antibiotics. He stated prior to this he was not wearing a mask and was in contact with other residents. He said the resident could have been infected at the previous facility he transferred from. He stated no one was wearing a mask and residents were not being isolated, again stating the instructions were bad. Staffing/PPE Observation and interview on [DATE] at 9:55am with CNA A, the CNA was observed wearing a yellow gown with a surgical face mask and gloves performing patient care on the COVID negative unit. When asked if she was assigned to the COVID negative unit, she stated she was the only CNA for the entire building stating the positive unit did not have a CNA. When asked if she did any patient care on the COVID positive side, she stated she helped pass trays on both sides. When asked if she used the N95 mask when she goes to the positive unit, she said she had not asked for a N95, further stating she puts two surgical masks on when she goes to the positive unit. Observation of the Regional Chief Clinical Coordinator on [DATE] at 10:35am, she was observed on the COVID positive unit entering resident rooms and checking on residents. She was observed wearing a yellow gown and surgical face mask. Observation and interview on [DATE] at 11:09am of the laundry room, the surveyor was unable to enter the dirty side of the laundry room due to large grey barrels full of laundry blocking the door. To enter the room, the surveyor had to enter the side with the dryers. There were four large grey barrels full and overflowing with laundry, and three clear plastic bags with dirty mop heads and cloths inside of the bags sitting on the floor by the door. Interview on [DATE] at 11:11am with the Housekeeping Supervisor, when asked who was responsible for laundry if they only have two housekeepers including himself, he stated that was something they had to work on further stating Housekeeper A will be working on the laundry today. Observation on [DATE] at 11:12am of the Administrator revealed he assisted Resident #8 back into the facility after she returned from [MEDICAL TREATMENT]. The resident was sitting in a w/c wearing a facemask. The Administrator was observed checking her temperature and pushing the resident in her w/c to the COVID negative unit. Interview on [DATE] at 11:46am with the Administrator, when asked if they had dedicated staff working on the COVID positive unit, he stated they did not have enough staff to do so, further stating staff were going back and forth and were changing their PPE. He said it may take some time to get the documents requested because some of the department heads whowere also CNAs were working on the floor. He stated he was also a CNA and was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) assisting on the floor as well. Observation on [DATE] at 11:51am of the Administrator revealed he entered the COVID positive unit with a face mask, yellow gown and gloves after interview was completed. He was previously observed pushing Resident #8 to the COVID negative unit at 11:12am. Observation of the Regional Chief Clinical Coordinator on [DATE] at 12:03pm, she was observed passing lunch trays to residents in their rooms on the COVID negative side. Record review of the facility's Notice To Person Who Owns or Controls Property: Quarantine of Property order from the local health department addressed to the facility dated [DATE] read in part, .Resident Monitoring and Restrictions .Implement protocols for cohorting ill residents with dedicated HCP .Cohorting: .All staff members need to wear PPE and be cohorted. Observation on [DATE] at 12:10pm revealed, Chef A answered the front door and was not wearing a face mask. She checked the surveyor's temperature after asking if she was supposed to check it and requested surveyor to use the ABHR and complete the COVID screening questions. She walked back into the kitchen without wearing a face mask and did not review the screening assessment completed by the surveyor. Observation of CNA A on [DATE] at 1:24pm. She was observed walking from the COVID negative unit to the dining room without a face mask on. She stood at a computer located in the dining room and began typing on the computer. The Social Worker walked up to CNA A in the dining room, the social worker was wearing a face mask and gown and began to have a conversation with the CNA. The CNA continued with the conversation and did not put a face mask on. Observation of Chef A on [DATE] at 1:21pm, she was observed leaving the kitchen to answer the front door. The chef was not wearing a face mask when she walked out of the kitchen to answer the door. She opened the door and let Chef B into the building. Chef A walked back into the kitchen without putting a face mask on. Observation of Chef B on [DATE] at 1:22pm, she was observed standing at the front entrance waiting for staff to assist her with completing the COVID screening assessment. She was not wearing a face mask upon entrance and while waiting for staff to assess her. The Chef was observed taking her own temperature until the Administrator came to assist. Observation on [DATE] at 1:28pm of the Administrator and Chef B, the Administrator was observed walking to the front entrance wearing a face mask and gown to screen Chef B. After he completed the screening, Chef B entered the kitchen without wearing a face mask. Observation on [DATE] at 1:30pm, Chef A and Chef B were observed talking in the kitchen without face masks on. Observation and interview on [DATE] at 1:31pm of CNA A, the CNA walked from the dining room to the double door of the COVID negative unit without a face mask on. The surveyor asked the CNA if she was aware she should have a face mask on while in the facility. She stated she was eating lunch and that was why she removed it. The surveyor informed the CNA that she was observed without a face mask from 1:24pm until 1:31pm when the surveyor intervened. She then stated she ate Frito chips and that the mask gets hot. The surveyor again informed the CNA that she was supposed to have the mask on while in the facility. The CNA put the mask on after surveyor intervention. Observation and interview on [DATE] at 1:33pm with the Culinary Service Manager, she was observed leaving the kitchen with a face mask on. When asked if kitchen staff should wear face masks while in the facility and kitchen area, she stated yes. She was informed of the observations earlier of Chef A and Chef B in the kitchen. After surveyor intervention, the Culinary Service Manager waked into the kitchen and asked Chef A and Chef B to put their masks on. Record review of COVID-19 Long-Term Care Facility Guidance dated [DATE] read in part, .For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility . Record review of the Second Notice to Person Who Owns or Controls Property: Quarantine of Property dated [DATE] read in part, .Incorporate COVID-19 into emergency management operations planning for the facility .Healthcare Personnel Monitoring and Restrictions: Implement use of facemask for HCP while in the facility . CR #5 Record review of CR #5's face sheet revealed a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #5's COVID-19 Assessments revealed, COVID-19 assessments were not completed for six days, [DATE] through [DATE]. Record review of CR #5's vital signs report revealed the following Heart Rate results: on [DATE], HR was 115 bpm; on [DATE] there was no documentation of a HR; on [DATE], HR was 107 bpm; on [DATE], HR was 119 bmp; on [DATE], HR was 113 bpm; and on [DATE], HR waas 111 bpm. Record review of CR #5's temperature log revealed the following: on [DATE] at 12:00am, temperature was 99.5; on [DATE] at 10:35am, temperature was 99.0; on [DATE], temperature was 99.0; and on [DATE] at 9:45am and 4:42pm, temperature was 99.7. Record review of CR #5's nursing progress notes revealed, no documentation showing the MD and/or NP were notified the resident had a COC with consistently elevated HR for five days and an elevated temperature from baseline for three days. Further record review of nursing progress notes revealed on [DATE] the NP was notified of the residents COC and gave orders to transfer the resident to the hospital. Further record review of CR #5's nursing progress notes dated [DATE] read in part, Contacted RP in regard to resident behavior; he is guarding, expressing pain, especially in right arm. BP at this time Temp 99.7, ,[DATE], P 111, SPO@ 95%. Awaiting further instruction from physician at this time. Resident took all am medication as ordered. Resting quietly in bed at this time. CNA reported that his behavior has not been his usual and that he slumps over excessively while up in w/c. Further record review of CR #5's nursing notes dated [DATE] read in part, 4:17PM Resident bp ,[DATE], P 64, R 16, Spo2 77%. Temp orally 99.7. Resident put on 02 with non-rebreather; 85% with 02 open. Called EMS. Contacted RP; Resident to be transferred to (local hospital). (Family member) verbalized understanding. Resident #6 Record review of Resident #6's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's COVID-19 Assessments revealed, COVID-19 assessments were not completed for 12 days, [DATE] through [DATE]. Interview on [DATE] at 8:36am with LVN A, when asked if a resident had changes in any vital signs from baseline which were not listed on the COVID assessment, should the nurse monitor and notify the MD and/or NP of these changes, she stated she would assume the changes would be monitored because of all of the different symptoms that could occur, further stating the MD would be notified of any changes. When asked if changes in vital signs should be documented, she stated yes, they would be documented in the vital signs tab in the EHR and would always be documented in the progress notes and in the focused assessment. Interview on [DATE] at 9:14am with the Interim DON, when asked how often the COVID-19 assessments were completed on residents, she stated every shift. When asked if there would be a reason the assessment would not be completed, she said no further stating if they were in the facility, the assessment would be completed. When asked if a resident had any changes in vital signs from baseline should the MD and/or NP be notified of the changes, she stated if it was a change of condition then the MD should be notified so it can be addressed, and orders followed. She said the changes in vital signs should be documented under the vital signs tab further stating, you should also see something in the progress notes. Further interview on [DATE] at 9:14am with the Interim DON, when she was informed CR #5 and Resident #6 were missing several days of the COVID-19 assessments, she stated she would have to follow up with this stating it may be documented elsewhere in the EHR. When the DON was informed CR #5's roommate tested positive for COVID-19 and was moved to the COVID positive hall on [DATE] and CR #5 began to have changes in his HR and temperature from baseline starting on [DATE]. She was further informed there was no documentation showing what monitoring was completed and if the MD or NP were notified, she stated she would have to ask about the MD notification, she was not sure if it was completed. Interview on [DATE] at 10:15am with the Administrator, when informed CR #5 and Resident #6 had multiple days of missing COVID-19 assessments, he stated they started moving residents on [DATE] through [DATE] stating, possibly those COVID assessments weren't not done due to moving residents to the positive side and the staffing issue. He further stated there were a lot of moving parts for that time frame. Further interview on [DATE] at 10:15am with the Administrator, when asked why the MD and/or NP were not notified CR #5 had six consistent days of an elevated HR and three consistent days of elevated temperatures from baseline when his roommate who tested positive for COVID and had to be moved to the positive side on [DATE], he stated at no time was the residents' temperature not taken or reach the CDCs recommendations regarding COVID which he stated was 100.4. Further interview on [DATE] at 10:15am with the Administrator, when asked if the resident had changes in his vital signs from baseline and shared a room with a positive COVID residents should the NP and/or MD have been notified of the changes, he stated the temperature and HR were reflecting changes from baseline, and the NP was notified on [DATE] and a FaceTime visit was completed and IV and other measures were ordered further stating the resident began to experience other symptoms and was sent out on ,[DATE]. Record review of CR #5's physician orders [REDACTED]. There was no further documentation showing orders prior to [DATE], or IV orders. Record review of a CMS letter ,[DATE] for Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Nursing Homes dated [DATE] read in part, .Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day .Implement active screening of residents and staff for fever and respiratory symptoms Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) risk for COVID-19 Record review of COVID-19 Long-Term Care Facility Guidance dated [DATE] read in part, .In accordance with previous CDC guidance, every resident should be assessed for symptoms and have their temperature checked every day . Record review of the facility's March COVID-19 Visitor Screening log revealed, the screening questionnaire was not completed in its entirety on [DATE] for 14 visits. Record review of the facility's April COVID-19 Visitor Screening log revealed, the screening questionnaire was not completed in its entirety on [DATE] for 33 visits, on [DATE] for 29 visits, on [DATE] for 33 visits, on [DATE] for 29 visits, and on [DATE] for 14 visits. Record review of COVID-19 Long-Term Care Facility Guidance dated [DATE] read in part, .In accordance with previous CMS guidance, every individual regardless of reason entering a long-term facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked . Record review of the facility's temperature log dated [DATE] revealed, 16 residents on the COVID negative side had their temperatures taken once daily and not twice daily per the Quarantine order. Record review of the facility's Notice to Person Who Owns or Controls Property: Quarantine of Property order from the local health department dated [DATE] read in part, .COVID-19 residents who tested negative are now considered Persons Under Monitoring (PUMs), PUMs need to be monitored twice a day . The facility Administrator, CEO, Regional VPO, Regional nurse, and Regional clinical coordinator were notified on [DATE] at 12:51 PM that an IJ situation had been identified due to the above failures. The IJ template was provided. A Plan of Removal was submitted by the Administrator on [DATE]. After several revisions, the final Plan of Removal was accepted on [DATE] at 11:34 AM. The plan of removal included the following: On [DATE], the facility implemented a schedule for a dedicated staff member to be at the sole entrance of the facility from 9am-6pm, after that the staff on the negative hall will be responsible to be attentive to the doorbell to continue the screening of staff/visitor upon entry of the facility that began [DATE]. On [DATE], the designated screening staff were educated by the Nurse Manager on the screening schedule and the staff/visitor screening log, screening questions and the log being completed in entirety prior to allowing staff/visitors entrance to the facility. On [DATE] 100% of staff educated or will be educated before the next scheduled shift by the Nurse Manager/Designee on the screening questions such as temperature, cough, sore throat and shortness of breath to include that a negative response or a temperature of 100.0 may not be allowed entry into the facility. On [DATE], the Regional Nurse Manager educated the Administrator on randomly auditing the screening log five days a week for completion and retaining all screening logs for record keeping. On [DATE], the facility implemented blue gowns to be utilized on the positive COVID unit and yellow gowns to be utilized on the negative unit. 100% of staff educated or will be educated before the next scheduled shift by the Nurse Managers/Designee on the distinction of gowns and not to cross units. On [DATE], 100% of staff educated, or will be re-educated before the next scheduled shift by the Nurse Managers/Designee on infection control protocol, hand washing and utilization of PPE. On [DATE], Nursing Managers/Designee will conduct hand washing and PPE competencies on 100% of staff, or staff will be educated before the next scheduled shift. On [DATE], the Administrator requested additional Housekeeping staffing from contracted provider in addition to the two staff members they currently have. On [DATE], the Administrator submitted a request through SETRAC for medical volunteers. On [DATE], the facility implemented a new schedule to identify which staff are designated to the Positive and Negative Units. On [DATE], the Nurses and CNAs were re-educated by Nursing Management/Designee to continue COVID-19 monitoring on all residents including monitoring for shortness of breath, cough, temperature and sore throat. On [DATE], the facility purchased two additional oral thermometers which are currently in house. The facility also ordered 2 temporal thermometers that will arrive to the center by [DATE]. On [DATE], the facility initiated the HHSC Infection Control Self-Assessment. On [DATE], the Administrator and Interim DON were re-educated to continue to follow the CDC, HHSC and Harris County Public Health Department guidelines related to COVID-19. On [DATE], the facility identified that the COVID-19 Unit requires 1 Nurse, 1 Medication Aide, 2 Certified Nursing Assistants on day and evening shifts and 1 Nurse and Certified Nursing Assistant on night shift. The Negative unit requires the same staffing, less the Certified Medication Aide. On [DATE], the facility contacted eight agency providers across the state of Texas to request assistance in filling the identified open shifts. On [DATE], the facility implemented COVID-19 pay stipend to employees working in the center. On [DATE], the facility extended the COVID-19 pay bonus and a weekly bonus to direct care staff across the company that were interested in communing to LaPorte to pick up shifts. In addition to the COVID-19 pay stipend and weekly bonus the facility is covering lodging, mileage, and meals for any company staff/agency staff commuting to LaPorte to assist in filling open shifts. Any open shifts not covered with LaPorte staff, SLP support staff from sister facilities, or agency provided staff will be filled by Regional and/or Corporate appropriately certified/licensed staff. The surveyor monitored the POR and included the following: Interview on [DATE] at 5:59am with LVN F. She said she worked the night shift with 1 CNA last night. She said she had been here since Wednesday from a sister facility in Abilene. She said she did care for residents on both the positive and negative side of the facility and the CNA also cared for residents on the positive and negative side but she said they worked one side and then switched to the other side and they have a system of using blue gowns for the positive side and yellow gowns for the negative side and both she and the CNA sanitized and changed gowns and masks when they moved from side to side. She said she and another LVN are from Abilene and are helping out by working 12 hour shifts for the next week. Interview on [DATE] at 6:05am with CNA E. She said she worked last night as the CNA and she was now waiting for the day shift to come in before she leaves. Observation on [DATE] at 6:15am revealed the only staff in the facility were LVN F and CNA E from night shift and 1 additional LVN who was scheduled to work the day shift. No additional day shift staff were present. Interview and observation on [DATE] at 6:33am with CNA E. She said last night she had to work both the COVID negative and COVID postive side. She said they usually had two aides at night, but last night it was just her. She said she and the LVN worked one side first and then changed gowns and went to the other side. She was observed to be wearing a surgical mask. When asked if she had an N95 mask she said the only mask she had was the one she was wearing. Record review of the visitor/staff COVID screening log dated ,[DATE]-[DATE] revealed all questions completed, temperatures documented and signatures of the staff reviewing the questions. Record review of staff in-services dated ,[DATE], [DATE], and ,[DATE] revealed, in-service completed by the Regional nurse on topics; PPE positive and negative side, reusable (blue) gowns and disposable (yellow) gowns, proper screening of visitors/staff, IC policy, COVID-19 outbreak (south hall) isolation stations, hand hygiene, handling of linen/storage, after hours (6p) negative hall screen, s/s COVID-19 night shift nurse screen staff. Record review of In-service training report dated [DATE] revealed, in-service topic on Audit of screening logs for completion, retaining logs for record keeping, continued to follow CDC + HHSC Guidelines pertaining to COVID-19, COVID-19 Designated staff at entrance completed by the Regional nurse for Administrative staff. Record review of the Facility COVID-19 Self-assessment was completed and signed by the interim DON on [DATE]. Observation on [DATE] of the facility's PPE revealed, the facility had adequate surgical and N95 face mask, face shields, gowns, gloves, and ABHR on both the COVID negative and positive units. Observation on [DATE] at 11:34am revealed the Social Worker sitting at the entrance screening staff/visitors upon entrance. She was observed checking temperatures, asking the COVID screening questions, and ensured visitors/staff used ABHW upon entrance. Further observation revealed, the Social worker ensuring the COVID screening log was completed in its entirety. Interview on [DATE] at 11:34 am with the Social Worker, she stated she was responsible to ensure all persons entering the facility are properly screened upon entrance and the COVID screening assessment was completed. She stated she will sit at the entrance from 9am-6pm and after 6pm, the nurse on the negative COVID unit will be responsible for completing the COVID screening process. Interview on [DATE] at 2:25pm with the Interim DON and Administrator, the Interim DON stated they have the Social Worker sitting at the entrance from 9am-6pm to complete the COVID screening assessment further stating after 9pm, the nurse on the COVID negative unit will be responsible for the screening process. The DON stated they have scheduled one nurse, two CNAs and 1 MA scheduled to work on the COVID positive side for the day and evening shift. She further stated the COVID negative side will have one nurse, 2 CNAs scheduled for the day and evening shift and the night shift both sides will have one nurse and one CNA scheduled. Interview and observation on [DATE] at 2:38pm with LVN A revealed, the LVN wearing a yellow gown, with face mask, and gloves. She stated she was screened upon entrance into the facility stating her temperature was taken, she was asked the COVID questions, and used ABHR. She stated she was in-serviced on proper PPE use and disposal. When asked if she is assigned to the COVID negative unit or working on both positive and negative unit, she stated, she can only work on the negative side. When asked how often residents were screened and what type of screening was completed, she stated they were screened every shift for a cough, SOB, fever, and if they have any change of condition. Further interview on [DATE] at 2:38pm with LVN A, when asked about staffing on the COVID negative side, she stated there was one nurse and two CNAs. Interview and observation on [DATE] at 2:44pm of CNA A, she was observed wearing a yellow gown, gloves, and face mask. When asked if she was assigned to the negative side to work, she stated yes, and she can only work on the negative side. When asked what type of in-service she received, she stated she had an in-service on proper use of PPE and PPE disposal, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675052	A. BUILDING _____ B. WING _____	**04/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAPORTE HEALTHCARE CENTER	**208 SOUTH UTAH LA PORTE, TX 77571**

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) different types of gowns used on the positive and negative side, stating the blue gowns are to be used on the positive side and yellow are for the negative side. When asked if she is screened upon entrance into the facility, she stated yes, her temperature is taken, she uses ABHR upon entrance and is asked the COVID screening questions. Interview and observation on 4//,[DATE] at 2:57