STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSENBERG HEALTH & REHABILITATION CENTER	**1419 MAHLMAN ST ROSENBERG, TX 77471**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan meet professional standards of quality for 1 of 2 residents (Resident #3) reviewed for professional standards: -The facility failed to ensure Resident #3's treatment orders were followed as ordered by the physician. -LVN A documented administering a treatment to Resident #3 that she did not provide. These failures could affect all residents and place them at risk of decline in health and well-being. Findings include: Resident #3 Record review of the admission sheet for Resident #3 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's comprehensive MDS assessment dated [DATE] revealed a BIMS of 10 out of 15 indicating moderately impaired cognition. He required extensive assistance from staff for dressing, toilet use, personal hygiene, transfers and bed mobility. Resident #3 was frequently incontinent of bowel and bladder. Record review of Resident #3's Care plan dated 8/01/2019 revealed the following care plan: RAP/Problem/Need-Resident has a non-pressure wound 1) Bruise 2) Skin tear 3) Blister 4) Other Goal- Non-pressure wound will show improvement in size by next review date. Approach-Weekly skin assessment by nurses 2) Perform treatment per order, if no improvement within 2 weeks, report to M.D. 3) Keep family/responsible party and M.D. informed of resident's progress. Record review of P-1 complaint received on 06/18/20 revealed an allegation which read in part: . the resident had a va vascular clinic appointment at va medical center for a pacemaker evaluation. while in the treatment room, the resident had a bowel movement. when the complainant removed his brief, she noted that his penis was so infected it was huge and red. it had cakes of yeast on it. his scrotum was full of [MEDICAL CONDITION] where the yeast had infected his scrotum. it was huge and red as well. the folds in his leg and groin had cakes of cream or yeast, it was hard to tell. it was caked on so hard that the complainant could not take it off. the cream or yeast was not even white, it was brown. he has a rash on his legs. the complainant could not tell if it was from the briefs or if it was a yeast infection as well. the odor was so bad . Record review of Resident #3's physician's orders [REDACTED]. Record review of Resident #3's MAR for the month of June 2020 revealed an order to clean scratch areas to R groin and scrotum with NSS, pat dry and apply Z-guard BID until resolved was signed off at 9am on 6/19/20 by LVN A. Record review of Resident #3's nurses notes dated 6/12/20 written by RN A read in part: .Resident was observed with blood in his brief while care was being provided. Blood was cleaned off and scratch marks were noted on right groin and scrotum. Resident admits to scratching area with his nails. NP notified new order given to clean area with NSS, pat dry, apply Z-guard BID until resolved . In an interview on 6/19/20 at 10:50 am with the Treatment Nurse and LVN A, Treatment Nurse said she was aware Resident #3 had a rash and treatment orders were in place. She said nurses were responsible to perform treatments on his rash. In an interview and record review on 6/19/20 at 1:25 pm with LVN A, she said she applied itching cream for a rash on Resident #3's groin area twice this shift as he had complained about itching. This Surveyor reviewed Resident #3's MAR indicated [REDACTED]. Instead, she applied a [MEDICATION NAME] cream which had his name on it. When asked why she signed off on the order if she did not follow the order as prescribed for 9:00 am. LVN A said she did not know what Z-guard was. At this time, she asked RN A who was sitting at the nurse's station, what Z-guard was. RN A told her it was the orange tube in LVN A's med cart's bottom drawer. LVN A searched for the cream, confirmed with RN A and handed it to this Surveyor. She said she did not read the order correctly and signed off on it. She said she was doing what was best for the resident and applied the cream to stop the itch. She said it was important to follow the physician's orders [REDACTED]. In an interview on 6/19/20 at 1:37pm with the DON, he said the doctor's orders needed to be followed. Nurses need to ask for clarification if they did not know what exactly should be done. He said today was LVN A's first day off orientation on the floor. He said if the doctor's order was there it needed to be followed. LVN A should have asked RN A on the floor or himself for assistance. He said LVN A came to him as an experienced nurse. He said he would need to do counseling with her. Record review of the facility's Transcribing Or Noting And Discontinuing Orders policy (Review date: 2/10/2020) read in part: .MEDICATION/TREATMENT ORDER TRANSCRIPTION) document the times of the administration ordered for prescribed medication or treatment according to center specified practice e.g. medication pass schedule. The Medication Administration Record [REDACTED]. Documentation- Medication Administration Record, [REDACTED].policy: the patient's clinical record provides a record of the health status, including observations, measurements, history and prognosis and serves as the primary document describing healthcare services provided to the patient. Fundamental Information: The clinical record is used by healthcare team to record, preserve and communicate the patient's progress and current treatment. Procedure: 4. Clinical document entries should be objective, factual information and communication that pertain to the care of the patient i.e. patient centered. 8. Counter signatures of clinical record entries are based on state laws and rules. 11. Initials are used to authenticate entries on flow sheets, medication record or treatment records. Documentation on flow sheets, medication and treatment records are completed daily and based on the physician orders. Documentation- Clinical record progress notes, physician orders, flow records .
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 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 for 4 of 5 residents (Resident #1, #2, #3 and #4) reviewed for infection control. -The facility failed to ensure staff, who were providing care to both the quarantined and non-quarantined residents wore appropriate PPE. - The facility failed to have signage on the door and PPE stations at the entrance of each of the 5 quarantine rooms. -The facility failed to place Resident #1 on quarantine upon admission. There was no sign posted on the door and no PPE outside the room for staff to don. -The facility failed to issue N95 respirators, face shields or goggles to staff caring for quarantined residents. - The facility failed to have hazardous trash and laundry bins for quarantined residents. These failures placed residents at risk of contracting an infectious disease which could result in serious illness. Findings Include: Record review of www.aappublications.org/news/2020/01/28/coronavirus revealed, The CDC continues to recommend health care personnel wear gowns, gloves and eye protection (goggles or face shields, not personal eyeglasses or contacts) when caring for patients with suspected or confirmed cases of COVID-19. Observation of the initial tour on 6/16/20 at 9:30 am revealed Hall 6 was considered the facility's quarantine hall. The 5 rooms in the hall did not have signs posted or PPE set up outside the rooms for staff to don prior to entering the room. Observation and interview during initial tour on 6/16/2020 at 9:31 am revealed CNA A was observed going in and out of quarantine resident's rooms with a surgical mask on. She went to room [ROOM NUMBER] then to room [ROOM NUMBER]. In the interview she said she was assigned to Hall 6. She said residents in that hall were new admits and re-admits that have come from the hospital. She said no PPE was required to care for these residents except for a mask. She said there were no residents in isolation. In an interview on 6/16/20 at 9:34 am with the DON, he said a gown, a mask, gloves and goggles/face shield were required while caring for the residents in quarantine. Surveyor observation revealed there was no PPE set up outside of quarantine rooms. He said guidance and directive are constantly changing with this virus. He said from 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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) regional office, the latest change was to provide PPE for quarantined residents therefore it is being implemented now. He said on Friday evening they had a conference call with corporate in which directives were given to have PPE available for quarantined residents while providing ADLs, such as incontinent care and feeding, as there was a risk of splashing body fluids. He said the facility received clarification on Monday and the Surveyor showed up on Tuesday. Therefore, they were setting up PPE now. He said the facility was reserving N95 masks for actual cases. He said, These people don't have 'active infection. Staff is only observing and assessing these residents, therefore, are only using surgical masks. He said there were 5 residents that went to [MEDICAL TREATMENT] routinely outside the facility who were not required to quarantine. He said [MEDICAL TREATMENT] residents had their vitals taken and a head to toe assessment performed after they returned from [MEDICAL TREATMENT]. He said these residents were not placed in a private room due to high census. Instead, they were sharing a room with another resident who had not been recently admitted or readmitted . Observation and interview on 6/16/20 at 10:16 am revealed the Central Supply Aide was setting up PPE carts and isolation linen bins and biohazards in the 5 quarantined rooms. In the interview she said she was told today by the DON to set up PPE stations and barrels because residents in Hall 6 were quarantined residents that were either new or re-admits. She said PPE stations consisted of gowns, masks and red or yellow bags for the barrels. She said no face shields/goggles were given to her. In an interview on 6/16/20 at 10:28 am with RN A, she said she was in charge of Hall 6 which was the quarantine hall. She said residents in that hall have come from the hospital. She said they were either new admits or re-admits placed in quarantine for 14 days as a COVID precaution. She said she was in serviced yesterday by the ADON that gloves, gowns, surgical masks and a face shield were required to care for the residents in quarantine. When asked where the PPE was set up, she said she had the surgical mask on at all times, gloves were in the resident's rooms and gowns she could grab from the PPE station (pointing to the PPE station that the central supply aide was placing in Hall 6). She said the facility has not provided face shield/goggles yet. In an interview on 6/16/20 at 10:35 am with MA A, she said she was in serviced yesterday that residents in Hall 6, quarantine hall, required gloves, a gown and a face shield while passing meds. She said the facility was setting up PPE now for staff to use on residents in quarantine. Resident #1 Record review of the admission sheet for Resident #1 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan initiated 3/16/20 and revised on 3/29/20 revealed the following care plan: Focus: At risk for alteration in psychosocial well-being related to public health emergency related to visitor restriction, concern(s) r/t COVID-19. Goal: Resident will have free expression about experience during public health emergency. Resident will have minimal effects and realize the importance of public health emergency activity. Approach: Encourage alternative forms of communication with visitors. Assist with alternative forms of communication with visitor. Monitor for psychosocial changes (not sleeping, decline in eating, change in behavior, not attending activities). Record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed a BIMS of 02 out of 15 indicating severely impaired cognition. He required total dependence from staff for dressing, toilet use, personal hygiene, transfers and bed mobility. Resident #1 was always incontinent of bowel and bladder. Record review of Resident #1's Hospital's laboratory result dated 5/28/20 at 16:57 (4:57 p.m.). Test: [DIAGNOSES REDACTED]-CoV-2, Result: Not detected. This test was performed 8 days prior to admission. Observation on 6/16/2020 at 9:56 am reveled Resident #1's door was opened to the hallway with no isolation cart sitting near the door for staff and visitors to have access to personal protection equipment at the entrance to the room. There was no sign posted on the Resident's room door to indicate the resident was on quarantine and contact and droplet precautions. Further observation revealed there were no covered isolation bins in the room for trash or dirty linens to allow for disposal of contaminated items in a controlled manner. Resident #1 was lying in his bed. Further observation revealed Housekeeper A was sweeping the floor and Housekeeping Manager was changing curtains in Resident #1's room. Both staff had on a surgical mask and gloves. Staff were within 6 feet of the resident and were not wearing a face shield or eye goggles. Resident #1 did not have a mask on while the staff were in the room. In an interview on 6/16/20 at 10:10 am with the Housekeeping Manager and Housekeeper A, Housekeeping Manager said they were deep cleaning Room # 71. Resident on Bed A had moved out. He said during the deep cleaning they changed curtains, disinfect high touch areas, bathroom, and surface area, wipe down mattress, window seals and blinds. Housekeeper A and the Housekeeping Manager said this room was not an isolation room. There was no sign on the door or PPE set up for them to don PPE. Resident #2 Record review of the admission sheet for Resident #2 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #2's comprehensive MDS assessment dated [DATE] revealed a BIMS of 15 out of 15 indicating intact cognition. He required supervision from staff for dressing, toilet use, personal hygiene, transfers and bed mobility. Resident #2 was always continent of bowel and bladder. Record review of Resident #2's Care Plan initiated 9/10/2019 revealed the following Care plan: Focus: [MEDICAL TREATMENT]-Resident receives [MEDICAL TREATMENT] related to [MEDICAL CONDITION] and is at risk for the potential complications of [MEDICAL TREATMENT]. Resident has an AV fistula. Goal: Resident will have no complications from routine [MEDICAL TREATMENT] through the next review date. Interventions: Encourage resident to attend scheduled [MEDICAL TREATMENT] appointments. Resident goes on Tuesday, Thursday and Saturday. Record review of Resident #2's Hospital to Post-Acute Care Facility Transfer-COVID -19 assessment dated [DATE] read in part: .has patient been laboratory tested for COVID-19? NO, test not performed because patient did not meet the CDC testing criteria. May transfer . Record review of Resident #2's physician's orders [REDACTED]. Further observation revealed there were no covered isolation bins in the room for trash or dirty linens to allow for disposal of contaminated items in a controlled manner. Resident #2 was lying in his bed. Observation on 6/16/2020 at 10:22 am revealed CNA A entered Resident #2's room. She was within 6 feet of the resident and had a surgical mask on. Resident was sleeping on his bed, he did not have a mask on. In an interview on 6/16/20 at 10:25 am with CNA A she said Resident #2 was a re-admit and goes to [MEDICAL TREATMENT] three times a week. She said she went in the room to wake the resident up, so he could eat his breakfast. She said resident was not on isolation/precautions. She said she was assigned to work on Hall 6. She said mask and gloves were required to care for these residents. Observation on 6/16/20 at 10:30 am revealed PPE were set up outside Resident #2's room. RN B was in the room within 6 feet of the resident. Resident did not have a mask on. In an interview on 6/16/20 at 10:32 am RN B said Resident #2 was a re-admit placed on quarantine for 14 days. He said he was in charge of Hall 3 and only had Resident#2 on quarantine hall due to continuity of care. RN B said Resident #2 was on Hall 3 prior to going to the hospital. RN B said Resident #2 was not on any kind of precaution. When asked about the PPE station outside of Resident#2's room, RN B said he did not know why a PPE station was there. He said only surgical mask and gloves were required to care for quarantine residents. Resident #3 Record review of the admission sheet for Resident #3 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's comprehensive MDS assessment dated [DATE] revealed a BIMS of 10 out of 15 indicating moderately impaired cognition. He required extensive assistance from staff for dressing, toilet use, personal hygiene, transfers and bed mobility. Resident #3 was frequently incontinent of bowel and bladder. Record review of Resident #1's Care Plan initiated 3/26/20 revised on 5/1/20 revealed the following care plan: Focus: At risk for alteration in psychosocial well-being related to public health emergency related to visitor restriction, concern(s) r/t COVID-19. Resident is at risk for infection/signs and symptoms of COVID-19. Goal: Resident will have free expression about experience during public health emergency. Resident will have minimal effects and realize the importance of public health emergency activity. Approach: Encourage alternative forms of communication with visitors. Assist with alternative forms of communication with visitor. Monitor for psychosocial changes (not sleeping, decline in eating, change in behavior, not attending activities). Follow facility protocol for COVID-19 screening/precautions. Observe for and promptly report signs and symptoms: fever, coughing, shortness of breath, or other respiratory issues. Educate staff, Resident, family, visitors of COVID-19 signs and symptoms and precaution. Resident will wear a mask for precaution. Record review of Resident#3's nurses notes dated 6/18/20 at 18:11 (6:11 p.m.) revealed read in part: . Resident returned back to facility from VA appointment in stable condition, accompanied by two paramedics on a stretcher. Family Member waited outside the door while resident was dropped in his room [ROOM NUMBER]A. Resp. even and non labored, denies of any pain. Vital signs as follows: 97.7 - 78 - 19 - 147/76 - 96%. Note from VA Hospital indicates sharp debridement of left upper arm distal excision was performed. Would care to be continued/change dressing every other day. Remove old [MEDICATION NAME] packing, cleanse with saline, pat dry, pack with [MEDICATION NAME], then xeroform, cut to size, then top with 4 x 4 gauze. Instruction states that no permanent HD access till arm incisions are fully healed. RTC in 4 weeks. Furthermore, resident's Family Member has concerns. Called this writer outside the door, requested that the (resident) be given bath or shower with water at least three times a week. She wants the facility to do better, provide proper pericare and apply cream given by VA hospital. Resident also returned with some [MEDICATION NAME] packing. [MEDICATION NAME] and cream placed in nurses' cart . Observation on 6/19/2020 at 11:32 am revealed Resident #3 in his room.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) There were two CNAs, CNA B and an another, in the room within 6 feet with only surgical masks on. In an interview on 6/19/20 at 11:35 am with CNA B, she said the aides had just provided incontinent care to Resident #3. She said the resident moved from Hall 6 to Hall 1 after he returned from his appointment yesterday evening. In an interview on 6/19/20 at 11:40 am with LVN A and RN A, RN A said Resident #3 was readmitted to the facility on [DATE] and was placed in the quarantine Hall 6 for 14 days. The resident then went out of the facility yesterday for a vascular (wound debridement to upper arm) and cardiology (pacemaker) appointment to the VA hospital and was moved to room [ROOM NUMBER] in Hall 1. In an interview on 6/19/20 at 1:09 pm with the DON, he said they needed to have a discussion with the interdisciplinary team and regional consultant on how they were going to address separating residents that go out to [MEDICAL TREATMENT] and other appointments. Resident #4 Record review of the admission sheet for Resident #4 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #4's comprehensive MDS assessment dated [DATE] revealed a BIMS of 03 out of 15 indicating severely impaired cognition. She required extensive assistance from staff for dressing, toilet use, personal hygiene, transfers and bed mobility. Resident #4 was always incontinent of bowel and bladder. Record review of Resident #4's Care Plan initiated 3/29/20 and revised on 4/3/20 revealed the following care plan: Focus: At risk for alteration in psychosocial well-being related to public health emergency related to visitor restriction, concern(s) r/t COVID-19. Goal: Resident will have free expression about experience during public health emergency. Resident will have minimal effects and realize the importance of public health emergency activity. Approach: Encourage alternative forms of communication with visitors. Assist with alternative forms of communication with visitor. Monitor for psychosocial changes (not sleeping, decline in eating, change in behavior, not attending activities). Record review of Resident #4's Hospital to Post-Acute Care Facility Transfer-COVID -19 assessment dated [DATE] test results were negative. Which was 6 days prior to admission. Record review of Resident #4's physician's orders [REDACTED]. Record review of Resident #4's physician's orders [REDACTED]. Observation on 6/19/2020 at 11:56 am revealed Resident #4's door was opened to the hallway with no isolation cart sitting near the door for staff and visitors to have access to personal protection equipment at the entrance to the room. There was no sign posted on the Resident's room door which indicated the resident was on isolation precautions. Resident #4 was sitting on her wheelchair working on the bicycle. Observation on 6/19/20 at 12:05 pm revealed a gown was hanging on the hook in the donning and doffing room. The gown's right-hand sleeve was torn. Further observation revealed CNA C was donning a gown in the donning and doffing room in quarantine Hall 6. She went to Resident #4's room with a surgical mask, gown and gloves on. She had a clear bag with linens in her hands. Resident #4 had a cloth mask on. CNA C was observed making Resident #4's bed. She came out of the room with a gown on and a clear bag with linens. She placed the linens in the clean linens cart sitting out in the hallway and went to the donning and doffing room, removed her gown and hung it on the hook before washing her hands. In an interview on 6/19/20 at 12:21 pm with CNA C, she said she was assigned to work in Hall 6 with the quarantine residents. She said staff were reusing their gowns to care for all the residents in quarantine and discarding in the donning and doffing room if soiled. She said she went to Resident #4's room to make the bed but ended up not using all of the linens. So, she took the clean linens and placed them back in the clean linens cart. She said she was last in serviced on infection control two weeks ago. She said she was not aware she could not take things out of the quarantine resident rooms. She said residents in Hall 6 were not in isolation. CNA C said the gown that was hanging on the hook in the donning and doffing room, which appeared to be used, belonged to the CNA that worked night shift. She said the CNA might have forgotten to dispose the used gown in the biohazard barrel in the donning and doffing room. In an interview on 6/19/20 at 12:25 pm with the DON, he said residents in quarantine were treated as isolation residents. He said the linens should be put in the laundry if taken to a quarantined room and not used as it is a risk for spreading infection. Observation on 6/19/20 at 12:28 pm revealed the Physical Therapist Assistant was in Resident#4's room with a gown, gloves and a surgical mask on. Resident #4 had a cloth mask on. The PTA was observed within 6 feet of the resident. In an observation and interview on 6/19/20 at 12:32 pm with the PTA she was observed coming out of the resident's room holding two weights in her hands. She said Resident #4 was in quarantine as she was a new admit. She said she went in the resident's room as she needed to get the resident off the bicycle and take the 2 pounds weights off her legs. She said the weights did not belong to the resident and were used on multiple residents. She said she would sanitize the weights before she placed them on another resident as it was a risk for infection. She said the resident did not have an infection and was just on quarantine to monitor signs and symptoms of COVID. In an interview on 6/19/20 at 12:41 pm with the DON and the ADON, the ADON said staff were reusing the gowns to care for all the residents in quarantine. The ADON said staff were given one gown to be used throughout their shift. If the gown gets soiled, the facility can provide them with a new one. The ADON said the same gown would be used to provide incontinent care as well. The DON said the gowns were to be hung in the donning and doffing room after each use. Staff should discard the gown at the end of their shift, wash their hands and then exit the building. The DON and the ADON both said they did not see any infection control concerns and that they would reuse the gowns as they were conserving PPE. In an interview on 6/19/20 at 12:54 pm with the DON, he said after the Surveyor shared her observations, he investigated and found out that the gown belonged to the nurse, RN A, in the quarantine hall. He said they were conserving the gowns but if the integrity of the fabric was damaged/torn, they needed to be discarded as it was a risk for infections. He said he discarded the gown in the donning and doffing biohazard barrel and educated the nurse. In an interview on 6/19/20 at 1:16 pm with the DON and the ADON, the ADON said guidance from corporate office was based on CDC recommended directives which stated only a surgical mask was required to care for residents in quarantine. She said in the event anything changes, like the resident starts showing presumptive signs such as cough or body aches, staff immediately need to change to a N95 mask at that time. The DON said the Vice President of Clinical Services, set and looked at it and made sure all the facilities are in compliance. In an interview on 6/19/20 at 1:20 pm with the Administrator and the DON, the Administrator said the facility needed clarification from corporate on [MEDICAL TREATMENT] residents and residents that went out for other appointments. In an interview 6/16/20 at 10:45 am with the Administrator, she said they had a conference call on Friday with corporate where they were updated on the use of PPE for the residents in quarantine. The Administrator said they had sufficient PPE but were conserving N95 masks in the event of positive COVID cases. She said the facility was keeping up with the CDC, DADS long term care guidelines and conference calls with regional for any changes. She said a Regional Consultant Nurse updates them when changes are in place. She said the facility has N95 masks ready to go but is conserving them for active cases. She said on the Friday evening conference call, the Regional Nurse Consultant advised them to have full PPE (mask, gown, gloves and face shield) available for quarantined residents. She said since they had full census, they will try to see if they could cohort the [MEDICAL TREATMENT] residents together. She said 5 [MEDICAL TREATMENT] (received [MEDICAL TREATMENT] outside the facility) residents were spread out throughout the building sharing a room with another resident who had not been recently admitted or readmitted . The Administrator said she was not aware that those residents needed to be in quarantine. The facility reported having the following PPE supplies on hand: N95 masks- 900 Goggles- 30 Gowns- 800 Masks with shield -75 In an interview 6/16/20 at 11:10 am with the ADON, she said she had started in service yesterday for Hall 6. Staff needed to be in full PPE when giving care. PPE required a gown, a mask, gloves and a face shield/goggles. She said staff was setting up PPE now. She said the in service was still on going. In an interview on 6/23/20 at 11:18 am with RN A, she said she was in serviced by the ADON and the Administrator couple of days ago that new admits, readmits and resident that go out for appointments upon their return will be quarantine for 14 days on Hall 6 for observation. She said the resident that was exposed while sharing the room with Resident #3 on Hall 1 was also moved to hall 6 for monitoring. She said surgical mask, goggles, gown and gloves were required to care for quarantine residents. She said staff was no longer reusing their gowns. Staff were to don prior to entering the room and take off their gowns in the resident's room. She said [MEDICAL TREATMENT] resident and frequent blood transfusion residents were moved to Hall 3. In an interview on 6/23/20 at 11:25 am with RN B, he said residents that received [MEDICAL TREATMENT] out of the facility had been moved to Hall 3. He said gown, gloves, surgical mask were required to care for those residents. He said sign were posted on their doors and PPE was available with Friday evening or Saturday of last week. Observation on 6/23/20 at 11:28 am revealed Hall 3 room [ROOM NUMBER], #132 and #137 now had signs posted on the doors and PPE stations sitting near the door for staff access prior to entering the room. Observation on 6/23/20 at 11:41 am revealed CNA D going into room [ROOM NUMBER], which now had a sign on the door. He donned full PPE (gown, gloves, surgical mask). In an interview on 6/23/20 at 12:06 pm with the DON, he said based on the surveyor's recommendations and concerns stated on 6/16/20, the facility has rearranged [MEDICAL TREATMENT] residents to cohort with other [MEDICAL TREATMENT] residents in Hall 3. Signs are posted on their doors and PPE is set up outside the rooms. He said residents will not be going out for appointments. Resident #3 went to an appointment and was placed in quarantined Hall 6 along with his roommate for monitoring. He said staff were no longer reusing the gowns to care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSENBERG HEALTH & REHABILITATION CENTER	1419 MAHLMAN ST ROSENBERG, TX 77471

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	(continued... from page 3) for all the quarantined residents. He said they were to discard the gown in the resident's room as it was a risk for spreading infections. The Administrator was in charge of handing out N95 masks to the staff. He said he needed to check with the Administrator where they stand with that. In an interview on 6/23/20 at 12:17 pm with the Administrator, she said she spoke with the Health Department, Epidemiologist, Corporate Nurse and looked at CDC guidelines. They all said only a surgical mask was required to care for quarantined residents. She said the CDC states the use of an N95 mask is not a requirement. She said HHSC was the only one telling the facility they needed to provide N95 masks to the staff. She said she will provide N95 masks to satisfy HHSC. She said she will distribute N95 masks to staff now. Observation on 6/23/20 at 1:23 pm revealed all staff were wearing N95 mask. Signs were posted and PPE was set up outside of residents rooms on quarantine (hall 6) and [MEDICAL TREATMENT] (hall 3) Record review of facility's in-service-program attendance record dated 6/15/20 presented by ADON to all the departments. Topic included on Hall 6 need to be in full PPE when giving care-gown/mask/gloves/ face shield/goggles. Record review of facility's in-service-program attendance record dated 6/18/20 presented by ADON to the nursing staff. Topic included Nurses/CMA shield, mask, gloves, gown per room. No moving linens between rooms. CMA -shield, gloves, mask. Record review of facility's in-service-program attendance record dated 6/19/20 at 3pm presented by ADON and the Administrator to all the departments. Topic included Infection control PPE gown/gloves, goggles, donning/doffing, linen handling, [MEDICAL TREATMENT]-pt in and out hospital Record review of facility's in-service-program attendance record dated 6/20/20 presented by the DON to nursing staff. Topic included nurses/CMA shield, mask, gloves, gown per room. CMA-shield, gloves and mask. No moving linens between rooms. Record review of facility's in-service-program attendance record dated 6/21/20 presented by the ADON to all the departments. Topic included PPE: gown/mask/gloves for quarantine Record review of facility's in-service-program attendance record dated 6/22/20 presented by the ADON at 10pm to nursing staff. Topic included nurses/CMA shield, mask, gloves, gown, goggles per room. CMA-shield, gloves and mask. No moving linens between rooms. Record review of facility's Conservation of Personal Protective Equipment policy dated 3/18/2020 revealed read in part: .Process: These recommendations continue to protect from droplet exposure (which is how COVID-19 and most other respiratory viruses are spread). Position a trash can or labeled (staff name/date) plastic bag inside the resident room and near the exit for discarding soiled PPE after removal, or prior to exit of the room. MASK SUMMARY: suspected or confirmed case COVID 19 staff should use N95 mask if available. GOWN SUMMARY: Extended use of isolation gown (disposable or cloth), such that the same gown is worn by the same employee when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). EYE PROTECTION SUMMARY: Designated recovering employees for provision of care to known or suspected COVID-19 patients . Record review of facility's Infection Control Guidelines policy dated (Review date: 5/2/2019) revealed read in part: .Anticipated Outcome: The purpose for this policy is to reduce and prevent the spread of infections by the use of evidenced based techniques established infection control policies and procedures. Process: The Licensed Nurses supervise direct care staff in daily activities to assure appropriate precautions/techniques are observed, assesses the patient's isolation needs, initiates appropriate precautions in accordance with our established policies and current CDC Infection Control Isolation Guidelines, consults with the Medical Director (and/or the resident's attending physician) as soon as possible to obtain written order for same; and consults the Infection Control Practitioner/Nurse for questions regarding isolation, infection control issues, and questions relative to infectious diseases. 3. Staff shall use personal protective care equipment (PPE) according to established facility policy governing the use of PPE. F. Clean linens is kept separate from contaminated linen . Record review of facility's Infection Prevention Manual For Long Term Care Section 4 Isolation dated (2012) revealed read in part: .Purpose: It is the intent of this facility that: 1) all resident blood, body fluids, excretions and secretions other than sweat will be considered potentially infectious; I. Gloves- gloves should be worn whenever exposure to the following is planned or anticipated: saliva, mucous membranes. II. Masks and eyewear (or face shields)- should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids. III. Gowns/Aprons (fluid resistant)- should be worn when there is potential for soiling clothing with blood/body fluids. IV. Private room-consider when resident hygiene is poor or in cases where body/body fluids cannot be contained. V. Handwashing/hand hygiene- refer to policy on handwashing/hand hygiene. Waterless products are encouraged and should be placed in strategic locations. PERSONAL PROTECTIVE EQUIPMENT (PPE) I. PPE is provided to all employees. Each employee is responsible for knowing where the equipment is kept in the department. II. The type of PPE should be appropriate for the procedure being performed and the types of exposure anticipated. III. PPE available includes gloves, fluid resistant gowns and aprons, masks, and eye protection (or face shields). RESPIRATORY HYGIENE/COUGH ETIQUETTE IN HEALTHCARE SETTING- IV. DROPLET PRECAUTIONS: Advise healthcare personnel to observe Droplet precautions (i.e., wearing a surgical or procedure mask with eye protection for close contact) . Record review of facility's Surveillance Plan: Infection Control Surveillance COVID 19 policy (Revision: 4/21/20) revealed read in part: .policy-to minimize exposures and spread of respiratory pathogens including 2019-nCoV. Fundamental Information- Isolation Precautions are implemented for residents with known or suspected COVID-19 in a private room (if available), or other actions taken based on national (e.g. CDC), state, or local public health authority recommendations. Procedure patient placement-the resident should be placed in a private room with th