STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAITH MEMORIAL NURSING HOME	**811 GARNER RD PASADENA, TX 77502**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's representative when there was a significant change in the resident's physical health status and a decision to transfer the resident for 1 of 13 residents (CR #1) reviewed for notification of changes in that; The facility failed to notify CR #1's RP the resident tested positive for COVID-19. These failures placed residents at risk of delayed treatment and services. Findings include: Record review of CR #1's face sheet revealed a [AGE] year-old-male originally admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #1's SBAR dated 7/18/20 revealed, documentation showing the Primary Care Clinician/on call NP was notified of the resident's nausea and vomiting episode on 7/18 at 10:03pm and the resident's RP was contacted on 7/18 at 10:03pm. Record review of CR #1's follow up SBAR summary dated 7/19/20 at 10:08pm revealed, a Transfer to Hospital Note which read in part, Resident continues to have vomiting episodes, resident has dark brown emesis, resident denies having at any dark foods in color for lunch or dinner, resident is not c/o any pain at this time. BP: 144/78, HR: 77, O2: 96% on RA, T: 98.9 temporal artery. Resident is requesting to be sent out to hospital for further evaluation. There was no further documentation indicating the resident's RP was notified of the transfer or reason for transfer to the hospital. Further record review of CR # 1's nursing progress notes dated 7/20/20 at 08:49am read in part, resident hospitalized . Interview on 7/21/20 at 3:14pm with the ADON, when asked if CR #1's RP was notified of his positive COVID-19 test results as well as staff and other residents who tested positive, she stated the resident was tested on [DATE] and they received his results on 7/19/20. She said she did speak to the RP on 7/20/20 after she had previously called upset because no one let her know the resident was sent out. She stated during that conversation, she informed the RP that the residents nausea and vomiting may have been correlated with his positive COVID results. Further record review of CR #1's nursing progress notes dated 7/20/20 at 11:47am read in part, This nurse received a call from resident's RP, RP stated she was very upset she was unaware resident was sent out and has been attempting to reach the facility for a month with no answer. RP informed this nurse she would like to speak to the administrator. Message relayed. There was no further documentation indicating the resident's RP was notified of the transfer, reason for transfer to the hospital, or the positive COVID test results. Record review of Intake # 5 dated 7/20/20 revealed CR #1's RP was not notified of CR #1's positive COVID test result until 7/20/20. Further interview on 7/21/20 at 3:14 pm with the ADON, when asked if the RP should have been notified about CR #1's positive test for COVID once they received the positive results, she stated there should be a note documenting the RP was notified and if there was not one, then the RP was not notified until yesterday when she returned the RP's call. Further interview on 7/21/20 at 3:14 pm with the ADON, when asked where the notification of the COVID-19 results should be documented, she stated it would have been documented in the nursing progress notes, further stating corporate may have a separate list of notifications on another sheet of paper. Surveyor requested a copy of the notification list but was not provided this list to review. Record review of the facility's Caring for a Resident with Suspected/Confirmed COVID-19 Tool-Kit dated July 1, 2020 read in part, In the event that a resident is SUSPECTED or having COVID-19 .Notify the Medical Director and resident representative of suspected case . Record review of the facility's Resident Rights policy revised February 2017 read in part, The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .Resident's Legal Representative The legal representative supports the resident in decision making; accessing medical, social or other personal information of the resident; managing financial matters; or receiving notifications .
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident, resident's representative, and ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for 1 of 13 residents (CR #1) reviewed for transfer/discharge in that; The facility failed to notify CR# 1's RP about his transfer to the hospital, or document notification of his transfer. This failure could affect discharged residents and place them at risk of having their discharge/transfer rights violated. Findings include: Record review of CR #1's face sheet revealed a [AGE] year-old-male originally admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #1's Quarterly MDS dated [DATE] revealed, a BIMS score of 14 indicating intact cognition. Interview on 7/20/20 at 1:57pm with the ADON, when asked if CR #1's RP was notified of his transfer to the hospital, she stated on 7/18/20 she attempted to call the RP, but she did not answer her phone stating she left a voice message. When asked, what date was the resident transferred to the hospital, she stated he was transferred on 7/19/20. When asked where the documentation was showing the RP was notified of the transfer on 7/19/20, she stated it was documented on the SBAR. She stated on 7/18/20 the resident was experiencing nausea and vomiting and by 7/19/20 the emesis had changed in color, so she received orders to get the resident evaluated for a GI bleed. She stated there was a follow up note on the SBAR indicating the RP was notified. She said she did not need to complete a new SBAR because the residents did not have new symptoms stating they only worsened. Record review of CR #1's SBAR dated 7/18/20 revealed, documentation showing the Primary Care Clinician/on call NP was notified of the resident's nausea and vomiting episode on 7/18/20 at 10:03pm and the resident's RP was contacted on 7/18/20 at 10:03pm. Record review of CR #1's follow up SBAR summary dated 7/19/20 at 10:08pm revealed, a Transfer to Hospital Note which read in part, Resident continues to have vomiting episodes, resident has dark brown emesis, resident denies having at any dark foods in color for lunch or dinner, resident is not c/o any pain at this time. BP: 144/78, HR: 77, O2: 96% on RA, T: 98.9 temporal artery. Resident is requesting to be sent out to hospital for further evaluation. There was no further documentation indicating the resident's RP was notified of the transfer or reason for transfer to the hospital. Record review of CR # 1's nursing progress notes dated 7/20/20 at 08:49am read in part, resident hospitalized . There was no further documentation indicating the resident's RP was notified of the transfer or reason for transfer to the hospital. Further record review of CR #1's nursing progress notes dated 7/20/20 at 11:47am read in part, This nurse received a call from resident's RP, RP stated she was very upset she was unaware resident was sent out, and has been attempting to reach the facility for a month with no answer. RP informed this nurse she would like to speak to the administrator. Message relayed. Record review of Intake # 5 dated 7/20/20 revealed CR #1's RP was not notified of CR #1's transfer to the hospital until 7/20/20. Interview on 7/21/20 at 2:15pm with the ADON, when informed the SBAR dated 7/18/20 showed documentation 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 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) RP was contacted about the residents nausea and vomiting, but the follow up SBAR dated 7/19/20 and progress notes dated 7/20/20 did not show any documentation she was notified of his transfer to the hospital, she stated she set up transportation for the resident's transfer to the hospital, but she had already left the facility because she worked the 2p-10p shift and the resident was transferred after she left. Further interview on 7/21/20 at 2:15pm with the ADON, when asked if she spoke to the RP after her initial failed attempt to contact her on 7/18, she stated she did not speak to the RP until 7/20/20 when the RP called upset because she was not aware the resident was sent out. When asked who should have notified the RP about the resident's transfer, she stated the nurse transferring the resident should notify the RP further stating LVN #1 should have notified her. She stated, LVN #1 is a new nurse so if he did not notify the RP, she would have to re-educate him on the policy. When asked what the policy was regarding notifying the RP of a resident transfer, she stated the nurse who does the transfer was responsible for notifying the RP and informing the RP where the resident was being transferred to and who the resident's care would be under. Further interview on 7/21/20 at 2:15pm with the ADON, when asked where the RP notification should be documented, she stated the transfer note can be completed on the SBAR, follow up SBAR or in the nursing progress note. She further stated LVN #1 should have completed a transfer progress note. Telephone interview on 7/21/20 at 3:51pm with LVN #1, when asked if he contacted CR #1's RP to notify her about the resident's transfer to the hospital, he stated he did not personally call the RP but was under the impression everything was already done and the resident was just waiting for transportation to pick him up. He stated he was told everything was taken care of, stating the residents paperwork was sitting on the counter. He stated he passed meds until transportation arrived. When asked who told him everything was done he stated the ADON told him this. Record review of the facility's Transfer & Discharge Procedure revised November 2017 read in part, Policy The facility will not transfer or discharge a resident except as provided by Federal and State regulations. Transfer and discharge procedures must provide sufficient preparation and orientation of the resident to ensure a safe, orderly transfer or discharge from the facility .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for facility residents reviewed for infection control as evidence by: The facility failed to have a designated entrance and exit in the COVID 19 unit. The facility failed to have a biohazard container to doff PPE upon exiting the COVID 19 unit. The facility staff failed to dispose of PPE when leaving the COVID 19 unit and entering negative units. The facility staff failed to sanitize the housekeeping cart after leaving the COVID 19 unit and entering negative units. The facility staff failed to don the appropriate PPE when entering COVID 19 positive unit. The facility failed to train housekeeping staff on the COVID 19 unit infection control measures. This failure could affect residents by placing them at risk for infections resulting in hospitalization , illness or death. Findings included: Observation on 07/16/20 at 2:10 PM revealed Housekeeper #1 and #2 donning PPE to go into the COVID 19 positive unit, with two housekeeping carts. Observation on 07/16/20 at 2:20 PM the Maintenance Director went onto the COVID 19 positive unit to get some boxes for the Dietary Manager. The Maintenance Director came back to the negative side through the entrance and he did not dispose of his PPE prior to reentering negative unit. Observation on 07/16/20 at 2:36 PM revealed LVN #2 entered the COVID 19 positive unit without putting on a gown and face shield, to deliver medication blister packs. Observation on 07/16/20 at 2:39 PM revealed two housekeepers exit the COVID 19 positive unit and entered the negative unit through the entrance. Housekeeping staff did not dispose of PPE prior to reentering negative unit and were wheeling housekeeping carts back to the negative unit. LVN #5 left the COVID 19 positive unit and came through the entrance back to negative unit. The housekeeping cart was not sanitized. In an interview on 07/16/20 at 2:42 PM Housekeeper #1 stated she just got back to the facility today. She said the other housekeeper was helping her because some other the other housekeepers quit. She said earlier, she went to the positive unit to clean the dining room. She was not aware of any flow of traffic or to take off PPE when leaving the positive unit. She said she was not trained. In an interview on 07/16/20 at 2:45 PM Housekeeper #2 stated she worked in laundry but was helping with housekeeping. She was not aware she needed to dispose of PPE. Staff did not have anywhere to exit the COVID 19 positive unit. She was not aware of the flow of traffic. She was not trained. Observation on 07/16/20 at 3:20 PM revealed RN#1 was on COVID 19 positive unit without gown or face shield. RN#1 comes back to the negative unit through COVID 19 positive unit and went to the nurses station. Observation on 07/17/20 at 3:24 PM revealed the Maintenance Director was on the COVID positive unit without a gown. Observation on 07/17/20 at 3:30 PM revealed the positive unit did not have biohazard bins set up for doffing at the rear of the building. In an interview on 07/16/20 at 2:57 PM LVN #2 stated she was just dropping off some medications at the end of her shift, she worked the secure unit today. She was not aware of flow of traffic, for the COVID 19 positive unit. They did not have any residents in the rear section of the unit. Staff enter and exit out of the same doors. She was not trained on COVID 19 unit. In an interview on 07/16/20 at 3:01 PM Maintenance Director stated when staff go to COVID 19 positive unit they are supposed to put on PPE. When staff leave the positive unit they take off PPE and sanitize. The facility completed an in-service with staff. In an interview on 07/16/20 at 3:07 PM RN#1 stated he was the District Director of Clinical. He said the facility was still in the process of getting everything together on the COVID 19 positive unit. He said he started working on it last night and had experience working create COVID 19 units. He said initially the facility did not have as many positive COVID 19 residents and they had to move things around. He said he was working on a dedicated staff breakroom, dedicated dietary cart, dedicated housekeeping cart, and a place to exit the unit. He also needed to create a supply room and a place to doffing PPE upon exit. He said he still needed to in-service housekeeping staff and dietary staff. In an interview on 07/16/20 at 3:23 PM RN #2 stated she was from another building and was helping the facility. She was supposed to follow the infection control system, but she just got here. She said today was her second day. She said when staff go in the positive unit they put on PPE and when you staff leave they take off the PPE. She said staff enter the COVID 19 positive unit and exit the same way. There was an exit on the other side of the positive unit. In an interview on 07/16/20 at 3:35 PM the Restorative Aide stated staff were supposed to sanitize hands, put on gown, mask, face shield, and shoe covers to enter COVID 19 positive unit. When staff come out of the positive unit they doff PPE, and discard in biohazard bin. She said there should be a biohazard bin in the rear of the facility to exit. In an interview on 07/16/20 at 3:41 PM LVN #3 stated staff were supposed to don mask, face shield, and gown when going to COVID 19 positive unit. She said staff were supposed to doff PPE when they leave the unit. She said there was a way to exit out the back of the COVID 19 unit. In an interview on 07/17/20 at 12:51 PM RN#1 stated the COVID 19 unit had a dedicated housekeeping cart, dietary cart, She said the entrance was in the front and the exit was in the back. She said they started in-services on COVID 19 unit protocols. In an interview on 07/17/20 at 3:16 PM Administrator stated the facility had 25 positive residents in the facility and 13 positive residents in the hospital. In an interview on 07/17/20 at 3:35 PM the Maintenance Director stated he would find a biohazard bag for the surveyor to dispose of PPE. The nurses should have set this up he was not sure about all the nursing stuff. Observation on 7/21/20 at 9:20 AM revealed front lobby opened into a COVID 19 positive hall without any covering or closed doorway. Screening was completed, but no hand sanitizer was located at the desk or in lobby. Sign in sheet requested visitor to clean hands with gel. Interview on 7/21/20 at 9:20 AM, ADON said there was usually hand sanitizer there on the desk. She did not know where it was. She said the hallway next to the lobby was COVID positive. This hallway had been set up recently. Observation on 7/21/20 at 10:11AM revealed Dietary Aide coming into the hallway with only a N95 on going from kitchen to lobby/office and back again. Interview on 7/21/20 at 10:15 AM, Dietary Aide said he was unaware that this was a COVID positive hall. He said he had been told to wear full PPE if he went into a COVID positive hall. He said they took the kitchen carts to the doorway and the nurses take it from there. He said they take the cart to the secured unit door and down to the negative hallway. Observation on 7/21/20 at 10:15 AM revealed the hallway for the carts is a positive COVID hallway and the carts go through it to go to the negative hallway. Observation on 7/21/20 at 10:20 AM revealed staff at front lobby being screened and have N95 on. The staff entered the hallway and goes down the positive COVID 19 hall without any PPE on. They clock in and retrieve PPE's 2 doors down and next to resident doors. Interview on 7/21/20 at 10:30 AM, LVN #2 said she puts on her PPE at the door to the secured unit (this is after entering the other positive COVID hall). She said she takes off her PPE before leaving the secured unit. Interview on 7/21/20 at 10:35 AM, MA #1 said she puts on her PPE in the first hallway and takes it off when she leaves the secured unit. Observation on 7/21/20 at 10:40 AM revealed LVN #4 entered the building through the front lobby. He was wearing no PPE. The person waited until 10:46 AM before someone

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) came to screen him. Interview on 7/21/20 at 10:46 AM, LVN #4 said he was waiting to go to work. He said he was aware the hallway near the lobby was positive COVID and he would get his PPE after he was screened. Observation on 7/21/20 at 10:47 AM revealed LVN #4 walked down the COVID hall to put on his PPE. He walked to the cart with PPE's next to resident's room. Interview on 7/21/20 at 1:05 PM, ADON said she was not aware the PPE needed to be where staff entered the COVID unit. She also said they were supposed to take off the PPE's in the back hallway and exit by laundry not at the secured unit. Record review of facility policy titled Coronavirus COVID 19 - CMS update - July 15, 2020 stated in part, As of May 14, full PPE is recommended in the following areas .dedicated area where residents with suspected or confirmed COVID-19 are located . and .develop a schedule for regular cleaning and disinfection of shared equipment, and frequently touched surfaces in resident rooms and common areas. Ensure that high-touch surfaces are frequently cleaned and disinfected Record review of the facility policy/protocol Managing COVID-19 in your Center dated 03/30/20 revealed . Summary: The immediate response to the COVID-19 outbreak is one of infection containment and prevention. This will continue to be our primary focus moving forward. However, as we move forward in this outbreak we must also prepare for anticipated scenarios Planning for a positive COVID-19 case or cases in your center We must be prepared to care for these residents .Personal Protective Equipment: The PPE recommended when caring for a resident with known or suspected COVID-19 includes: N-95 Respirator or Surgical Facemask .Eye Protection Put on eye protection (i.e., goggles or disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area . .Remove eye protection before leaving the resident room or care area .Gowns Put on a clean isolation gown upon entry into the resident room or area Remove and discard the gown in a dedicated container for waste or linen before leaving the resident room or area