STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675910	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOGAN PARK NURSING & REHABILITATION	**3203 SAGE ST MIDLAND, TX 79705**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inform residents or their RP in advance of the risks and benefits of proposed care. The facility did not give prior notice and receive verbal consent to cognitively-impaired resident's RP for Covid-19 testing. This deficient practice could place cognitively impaired residents at risk of receiving treatments or testing that was against personal believes or to make an informed decision about care. The findings were: During an interview on 9/10/2020 at 2:23 p.m. the social worker said when a resident tested positive for Covid -19 she was instructed to call that resident's roommates families/responsible parties and inform them those residents were going to be tested . She said when the facility tested all the residents in the facility she did not call for permission for the testing because nursing was supposed to call since they were the ones doing the testing. She confirmed she did not get the RP's consent for the Covid-19 test. During an interview on 9/10/2020 at 2:43 p.m. the DON said the social worker was responsible for calling the families and gaining verbal consent for the Covid-19 tests. When informed the social worker thought the nurses were getting the consent, the DON pulled up two random residents on the hall and scanned the records; she confirmed there were no records anywhere in the electronic chart indicating that the families were contacted about the pending tests. During a follow up interview on 9/10/2020 at 2:44 p.m. the social worker said the facility did not initially plan to test the residents so she did not know to get the family's consent. Review of the facility's testing book documented residents were tested on [DATE] and 9/3/2020 - 9/4/2020. Review of the facility's policy and procedure on Resident Rights revised December 2016 documented: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: participate in in decision-making regarding his or her care.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **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 ensure an infection prevention and control program designed to help prevent the development and transmission of communicable diseases was established and maintained for infection control related to COVID-19 ([MEDICAL CONDITION] that is spread from person to person causing mild to severe respiratory symptoms). The facility failed to ensure: Staff effectively wore their N-95 respirator masks while in the building. Masks were worn with the neck-strap under the chin, the neck staff completely missing, or were pulled down to the chin leaving the mouth and nose exposed (N-95 masks are a two-strap mask with one strap going behind the neck and the other strap going over the head); Staff and residents respected social distancing and did not congregate in groups of more than 10 people; The germicidal product used to decontaminate surfaces were left on the surface for the required amount of time; There were enough ABHR dispensers available to ensure that staff could use it between residents. This failure has the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections, particularly COVID-19. Findings include: Observation on 9/10/2020 at 9:47 a.m. showed the door-screener wore a N-95 mask with the neck strap under her chin. ADON A also wore N-95 mask with the neck strap under her chin. The DON's mask was a N-95 with an exhaust vent (since this mask does not filter exhales it is not approved for the prevention of the spread of respiratory virus). Observation on 9/10/2020 between 9:58 a.m. and 10:09 a.m. showed - The Floor Tech had an N-95 mask on, he pulled it away from his face to answer a resident; he pulled the mask away from his face when answering anyone, including the surveyor. The floor tech was observed on halls C and D - A CNA was in the D-hall shower room with his N-95 mask pulled down under his chin leaving his mouth and nose exposed. - An Agency CNA walked down Hall B with her entire N-95 mask on her chin leaving her mouth and nose exposed. - There was only one ABHR dispenser on Hall A and it was empty. - There was only one ABHR dispenser on Hall D. Observation on 9/10/2020 at 10:57 a.m. showed the AD in the dining room with 13 residents. The AD had her mask pulled down to her chin leaving her mouth and nose exposed. Eleven residents were not wearing a mask or were wearing their mask incorrectly leaving their nose and mouth exposed. The residents wandered through the dining room ignoring any type of social distancing. During an interview on 9/10/2020 at 11: ADON B said the facility had shut down communal activities. ADON B said the AD did a lot of hall activities and a lot of one on one activities. Observation on 9/10/2020 at 1:43 p.m. showed a nurse signing in. She had her N-95 mask on but the neck strap was under her chin. CNA C was at Nurse's Station B with a N-95 mask on but the neck strap was under her chin. Observation on 9/10/2020 at 1:47 p.m. showed CNA C still at Nurse's Station #2 sitting next to two additional staff with the chin strap under chin. Observation on 9/10/2020 at 1:50 p.m. showed a housekeeper spraying down the handrails with germicidal spray and immediately wiped it off the hand rail. Review of the instructions for the germicidal spray used to clean the handrails documented accessed on 9/14/2020: Disinfection / Cleaning / Deodorizing Directions: Remove heavy soil deposits from surface, then thoroughly wet surface with a use solution of 2 ounces of the germicidal spray per gallon of water. The use-solution can be applied with a cloth, mop, sponge, or coarse spray or by soaking. For sprayer applications, use a coarse spray device. Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Do not breathe spray. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry. Rinsing of floors is not necessary unless they are to be waxed. Prepare a fresh use-solution daily or more often if the solution becomes visibly dirty or diluted. During an interview on 9/10/2020 the Administrator said the germicidal spray was supposed to stay on the surface for 10 minutes. He said the Housekeeping Supervisor trained them on this process and he knew he talked to the specifically about that. The Administrator called the Housekeeping Supervisor who said there were in-services on that and that she reminded them of the wait time of every cleaner's wait time when she filled their spray bottles. The Administrator said his expectation on the mask use was that it be on if the staff is in the building unless they were eating or drinking. He said he expected his staff to try and social distance as much as possible in a smaller building. During an interview on 9/10/2020 ADON B said the bottom strap for the N-95 masks needed to be in place. She acknowledged the staff frequently had a strap under their chin and had a habit of sliding the mask under their chin leaving their mouth and nose exposed. She said it does no good for the staff to wear the mask like that, especially when talking to people. She reviewed her in-service binder and said she had no in-services from housekeeping about surfaces. ADON B said the facility in-serviced about mask use the previous week. ADON B said there were supposed to be 2 ABHR dispensers on each hall, one on each end of the hall. She said Hall D must have fallen off the wall and she would have Hall A refilled. During an interview on 9/10/2020 at 4:10 p.m. the Administrator said wearing the mask with the neck strap under the chin did not allow for a proper seal, he said is it did exactly nothing. He said activities was currently doing one on one activities and hallway activities. He was informed of the morning observation of the AD with 13 residents in the dining room. He replied the facility was waiting on further corporate guidance on group activities. While leaving the interview surveyor observed a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) staff member with her mask hanging around her ears at a nurse's station through the facility camera; the staff member would take a drink, type a little bit and then type a little more. The Administrator saw the action and acknowledged the staff member did not have a mask on. He said he staff member would claim she was drinking and acknowledged the improper mask use. Observation on 9/10/2020 at 5:04 p.m. showed 3 of 12 staff observed in resident hallways had the chin strap completely removed from their N-95 masks. Review of the 9/1/2020 in-service regarding mask use documented: you must keep the bottom and top strap on in the proper way on your N-95 mask (top strap on top of head and bottom at the base of your neck).
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	Based on interview and record review it was determined the facility failed to notify residents and or the residents' RP/family by 5:00 PM the following day, after a resident of the facility tested positive for Covid-19. On 7/9/2020 the facility received a laboratory-confirmed positive Covid-19 test result for a staff member. On 8/25/2020 another staff member received a laboratory-confirmed positive Covid-19 test. On 8/28/2020 a resident received a laboratory-confirmed positive Covid-19 test. The facility did not communicate this positive result to other residents or their RP/Family. The facility failed to ensure weekly communication with the family in either written or verbal communication regarding actions taken by the facility to prevent the spread of Covid-19. The facility's failure had the potential to affect all residents, residents' representatives, and residents' families of the facility. Findings include: During an interview on 9/10/2020 at 9:50 a.m. the Administrator said the Social Worker was responsible for calling the RP/POA about the first positive Covid-19 test in the building. He said they were trying to get an updated email list of RP/POA by the end of the week so he could send the emails out and he was aware it was a requirement since it came out (indicating he was aware it was not done). During an interview on 9/10/2020 at 2:23 p.m. the social worker said when a resident tested positive for Covid -19 she was instructed to call that resident's roommates families/RP and inform them those residents were going to be tested . She said she only called the roommates families/RP (3 other residents). The Social Worker said she had not maintained contact with the families about actions the facility was taking to ensure residents stayed negative. She said she did not document any of the family contact she had. She said she was currently working on getting family/RP emails to keep them informed of the facility's actions to prevent the spread of infection. During an interview on 9/10/2020 at 2:43 p.m. the DON said the social worker was responsible for calling the families. The DON reviewed two random residents on the electronic records, scanned the records and acknowledged there were no records indicating any kind of family/RP communication. During an interview on 9/10/2020 at 4:21 p.m. the Administrator was made aware the weekly emails communicating with RP's was not being sent. Review of the facility's Covid-19 policy and procedure, showed the facility used the CMS QSO Memo dated 4/19/2020 as their policy regarding weekly family/RP communication. The Memo documented: Facilities notify its residents and their representatives to keep them informed of the conditions inside the facility. At a minimum, nursing homes must inform residents and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours. Also, updates to residents and their representatives must be provided weekly, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours. Facilities will include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered. Review of the facility's Covid-19 policy and procedure showed the facility included the State of Texas' response plan to Covid-19 as part of their policy which documented: Keep all residents and their representatives up to date on the conditions inside the facility, such as when new cases of COVID-19 occur. Inform residents, their representatives, and families by 5 p.m. the next calendar day following the occurrence of a single confirmed infection of COVID-19 or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. Provide updates weekly, or sooner, when there are new COVID-19 cases, or three or more residents or staff with new-onset of respiratory symptoms.