

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>675214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/08/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>THE RESORT AT TEXAS CITY</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1720 N LOGAN ST TEXAS CITY, TX 77590</b>	
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 0610  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Respond appropriately to all alleged violations.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to report results of their investigation within 5 days of the incident to the State Survey Agency for COVID-19. The facility failed to report the results of their investigation after reporting an allegation of infection control to HHSC. This failure could affect all residents and placed them at risk of not being informed of incidents that could affect their health and well being. Findings include: Record review of the Intake Investigation Worksheet for Intake # 1 dated 6/18/20, revealed the facility self-reported an allegation of infection control when Nurse A tested positive for COVID-19 on 6/17/20. The review further revealed the employee went to the emergency roiaognom on [DATE] for non-related symptoms and was found to be positive for Covid-19. Interview with the Current Administrator and DON on 7/8/20 at 9:30 AM revealed Nurse A did not work at the facility from 6/17/20 through 7/2/20. They said the employee self-quarantined at home and tested negative for Covid-19 prior to returning to her employment. The Administrator and DON further stated all 90 employees were re-tested on [DATE] and no other employees tested positive for COVID-19. Interview with the DON on 7/8/20 at 12:25 PM revealed she was told by the former Administrator to call in the incident but not instructed to submit the Provider Investigation Report. Interview with the Current Administrator on 7/8/20 at 12:45 PM revealed he could not locate the report on the computer system and would complete the report immediately. Record review of the Provider Investigation Report, submitted to the State Agency and surveyors on 7/8/20 by the current Administrator revealed the previous Administrator was notified on 6/18/20 that Nurse A had tested positive for COVID-19 and the employee had quarantined at home. The review further revealed Nurse A tested negative for Covid-19 and was cleared by the local health department to return to work on 7/2/20.		

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.