STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident had the right to have reasonable access to the use of a telephone for 1 of 3 Residents (Resident #51) whose records were reviewed, in that: Resident #51 was not provided with telephone use to contact family members. This deficient practice could place residents at risk of feelings of separation. The findings were: Record review of Resident #51's face sheet, dated 07/21/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #51's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 11, which indicated the resident had moderate cognitive impairment. Record review of Resident #51's Care Plan, with a review start date of 04/13/2020, revealed a focus area which read: Resident is at risk for alteration in psychosocial well being related to restriction on visitation due to COVID-19. The intervention for this focus area read: Encourage alternative communication with family and friends. During an interview with a family member of Resident #51 on 07/22/2020 at 2:42 PM, Resident #51's family member stated a phone call was placed to the facility and an unknown staff member told the family member that a cordless telephone could not be taken into Resident #51's room because it was an infection control issue. Observations on 07/22/2020 at 5:52 PM of the 100, 200, 300 Halls revealed there were no phones present for residents use. During an interview with Resident #51 on 07/23/2020 at 9:57 AM, Resident #51 confirmed she had no personal cell phone, and confirmed the facility has not supplied a phone for her to use. Resident #51 stated she had a land line in her previous room at the facility, but had to be moved due to COVID-19. Resident #51 further stated she was told by facility staff the phone company could not come into the facility to install a land line in her new room. Resident #59 further stated she would like to speak with her family and she was sad because she missed speaking with them. During an interview with Social Services Assistant PP on 07/23/2020 at 10:15 AM, Social Services Assistant PP confirmed the facility was not providing a phone for resident use due to concerns about spreading COVID-19. When asked if cold and hot zones could have dedicated phones for resident use, Social Services Assistant PP stated, corporate is working on getting more tablets so residents can (video call app) with families. During an interview with Activities Assistant KKK on 07/23/2020 at 1:36 PM, Activities Assistant KKK confirmed there were no community phones for residents to use. During an interview with a family member of Resident #51 on 07/23/2020 at 1:43 PM, Resident #51's family member stated that prior to the room changes that were done for all residents, Resident #51 had a phone line installed in her room. Resident #51's family member stated that due to the COVID-19 outbreak in the building the facility would not allow a telephone company to install a new wall mount for Resident #51's new room. Resident #51's family member confirmed staff on different days and different shifts had stated they were not allowed to take a phone into the resident's rooms due to infection control. Resident #51's family member stated it was hard to get in touch with staff and that she would leave a message for a staff member to call her back to provide an update on Resident #51 but, to get a return call, that is even worse. During an interview with LVN OO on 07/24/2020 at 2:41 PM, LVN OO confirmed there were no telephones for resident use on the C Hall of the building. When asked what explanations were given to residents to not use the phones, LVN OO stated she told residents, It is safer for them to not use the phone. LVN OO further stated the staff used tablets for video chats between family members and residents but the tablets were also being used for virtual physician visits. During an interview with the Administrator and DON on 07/25/2020 at 3:39 PM,. the Administrator and DON stated the facility did not use cordless phones for conversations between residents and family members because the facility allowed for video conference via a computer tablet. The Administrator stated there was no rule for not allowing for telephone calls for residents. During an email communication to the DON on 07/24/2020 at 12:18 PM the surveyor asked for a resident rights policy. Record review of an email communication from the DON to the surveyor on 07/24/2020 at 1:30 PM revealed a list of electronic documents. Further review revealed one of the documents was a policy titled, Resident Rights Policy, effective date 06/27/2019, revealed as its contents a 1 page document with 27 bullet points and one of the bullet points read: Telephone. Further review revealed there was no additional information assigned to the bullet point.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident has a right to secure and confidential personal and medical records for 1 of 1 resident (Resident #26) reviewed for confidentiality; in that: Resident #26's meal tray card with the resident's picture and other personal identifying information was observed on the ground near an open dumpster. This deficient practice could place residents who received meal tray cards at risk for having their medical information being unnecessarily exposed and their personal privacy violated. The findings were: Record review of Resident #26's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation of the facility's dumpster area on 07/20/2020 at 10:50 AM revealed there were three large commercial trash dumpsters with the side doors open, a trash bag of garbage that was not sealed and was partially hanging out of the dumpster, and garbage was on the ground around the dumpster. Further observation revealed a meal tray card was on the ground in front of the dumpster with Resident #26's name, picture, ID number, room number and hallway assignment, and dietary meal orders. During an interview with LVN SS on 07/20/2020 at 10:53 AM, LVN SS confirmed the dumpsters were left open with trash on the ground around the dumpster. LVN SS further confirmed Resident #26's meal card which contained the resident's personal HIPAA information was on the ground with the trash. During an interview with the DON on 07/20/2020 at 12:42 PM, the DON confirmed resident records should be shredded and not placed in the trash. During an interview with the Maintenance Supervisor on 07/21/2020 at 2:00 PM, the Maintenance Supervisor confirmed his duties included making rounds several times a day to ensure there was no trash on the ground and to keep the dumpsters closed. The Maintenance Supervisor further confirmed residents' medical records with identifying resident information should not be in the trash and should be shredded. During an email communication to the DON on 07/24/2020 at 12:18 PM the surveyor asked for a resident rights policy. Record review of an email communication from the DON to the surveyor on 07/24/2020 at 1:30 p.m. revealed a list of electronic documents. Further review revealed one of the documents was a policy titled, Resident Rights Policy, effective date 06/27/2019, revealed as its contents a 1 page document with 27 bullet points and one of the bullet points read: Privacy and Confidentiality. Further review revealed there was no additional information assigned to the bullet point.
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 provide services as outlined by the comprehensive care plan to meet professional standards of quality for 1 of 1 residents (Resident #37) observed for care, in that: LVN LL copied the morning blood pressure reading for Resident #37 onto an evening medication administration. This

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) deficient practice could place residents who receive medications at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings were: Record review of Resident #37's face sheet, dated 07/19/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's MAR for the 07/18/2020 medication pass for the resident revealed the 8:00 AM medication administration for [MEDICATION NAME] had a blood pressure reading of 216/116 as part of the administration. Further review revealed the evening medication pass for 07/18/2020 at 8:00 PM had the same blood pressure reading of 216/116 and the medication was administered by LVN LL. During an interview with LVN LL on 07/19/2020 at 7:06 PM, LVN LL confirmed she administered the 07/18/2020 evening [MEDICATION NAME] medication to Resident #37. LVN LL further confirmed the same blood pressure reading was documented on the resident's MAR. LVN LL stated she had obtained another blood pressure reading from Resident #37, but when asked by the surveyor if she had the correct blood pressure reading that could have been used instead of the morning reading, LVN LL could not provide the blood pressure reading she had taken. LVN LL further stated, It was a typo on my part. Record review of the facility's policy titled, Resident Records - Identifiable Information, effective date 11/28/2017, revealed under the section titled Medical Records: In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized.

F 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 7 of 24 residents (Resident #3, #4, #9, #18, #37, #50, and #59) reviewed for quality of care related to COVID-19, in that: 1a. ADON RN RR did not follow physician orders [REDACTED].#4, and #9 when she did not obtain morning blood glucose levels, did not administer the morning doses of Insulin, and failed not notify the physician that the resident's orders had not been followed. b. ADON RN RR did not follow physician orders [REDACTED]. 2. ADON RN did not administer a one enteral bolus feeding and 110 ml water flush and did not give the feeding until the next bolus was due to Resident #4 as ordered by a physician and did not notify the physician the order had not been followed. 3. ADON RN RR did not administer medications per physician order [REDACTED]. 4. ADON RN RR did not administer medications per physician order [REDACTED]. 5. ADON RN RR did not administer medications per physician order [REDACTED]. [MEDICAL CONDITION] with heart failure. 6. ADON RN RR did not administer medications per physician order [REDACTED]. 7. Med Aide X did not report to licensed nurses about a change in Resident #37's condition. 8. The facility did not perform physician ordered monthly weights for Resident #50. 9. Resident #59 was not wearing her physician ordered ACE wrap. These deficient practices could place COVID-19 positive residents who rely on staff to manage their diabetes mellitus at risk of serious life threatening complications related to COVID-19 or complications of diabetes, their physician not being notified of missed medication, change of condition or not receiving physician ordered medications/therapies, and of not receiving the necessary care and a decline in health and/or death. The findings were: 1a. Record review of Resident #3's face sheet, dated 07/19/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's physician orders [REDACTED]. Further review revealed a physician order [REDACTED]. Record review of Resident #3's July 2020 MAR indicated [REDACTED]. Further review revealed blood glucose monitoring was scheduled for 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #3's blood glucose monitoring scheduled for 07/19/2020 at 7:00 AM was not completed until 12:23 PM when the next check was due resulting in a missed blood glucose monitoring check. Further review revealed Resident #3's [MEDICATION NAME] Flex pen Insulin scheduled for 07/19/2020 at 8:00 AM was not completed until 12:23 PM when the next dosage was due which resulted in a potential missed dosage. Record review of Resident #3's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #4's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's physician orders [REDACTED].#4's Insulin Humalog 100 u/ml per sliding scale was due to be administered on 07/19/2020 at 7:00 AM and was administered on 11:10 AM at the same time as the next dose which resulted in a missed dosage of medication. Record review of Resident #4's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #9's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's physician orders [REDACTED]. Further review revealed a physician order [REDACTED]. Record review of Resident #9's July 2020 MAR indicated [REDACTED]. Further review of Resident #9's MAR indicated [REDACTED]. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #9's blood glucose check scheduled for 7:00 AM was not completed until 11:59 AM when the next check was due which resulted in a missed blood glucose monitoring check. Further review revealed Resident #9's Insulin Humalog KwikPen 100 mg/ml per sliding scale was due to be administered at 7:00 AM and was administered on 11:59 AM at the same time as the next dose which resulted in a missed dosage of medication. Record review of Resident #9's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. b. Record review of Resident #18's face sheet, dated 07/27/2020 revealed an admission date of [DATE], with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #18's physician orders [REDACTED]. Further review revealed a physician order [REDACTED].#18's July 2020 MAR indicated [REDACTED]. Further review revealed [MEDICATION NAME]was scheduled two times a day at 7:00 AM and 7:00 PM. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #18's Humalog Insulin KwikPen 100 mg/ml per sliding scale was due to be administered at 7:00 AM and was administered on 11:08 PM at the same time as the next dose which resulted in a missed dosage of medication. Further review revealed Resident #18's [MEDICATION NAME] Insulin scheduled to be administered on 07/19/2020 at 7:00 AM was administered on 12:09 PM Record review of Resident #18's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. 2. Record review of Resident #4's physician orders [REDACTED].#9's physician orders [REDACTED]. Further review revealed the feed times were scheduled at 3:00 AM, 7:00 AM, 11:00 am, etc. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #4's enteral feed and water flush were due at 7:00 AM on 07/19/2020 but were was administered on 07/19/2020 at 11:10 AM, at the same time the next feeding was due resulting in a missed feed. 3. Record review of physician orders [REDACTED]. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #3 was scheduled to receive on 07/1920/20 [MEDICATION NAME] 75 mg at 8:00 AM [MEDICATION NAME] 75 mg but was not administered until 12:28 PM, Med-Pass 2.0 60 cc was scheduled for 8:00 AM but was not administered at 1:01 PM, Memantine 5 mg was scheduled for 8:00 AM but was not administered until 1:02 PM, and [MEDICATION NAME] 5 mg was scheduled to be administered at 8:00 AM but was not administered until 1:06 PM. 4. Record review of physician orders [REDACTED]. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #4 was scheduled to receive on 07/19/2020, [MEDICATION NAME] 100 mg at 7:00 AM but was not administered until 11:10 AM, [MEDICATION NAME] 10 mg was scheduled for 7:00 AM but was not administered until 11:11 AM, [MEDICATION NAME] Liquid was scheduled at 8:00 AM to be given with breakfast and but was not given until 11:11 AM, and Levetiracetam 5 ml was scheduled for 8:00 AM but was not administered until 11:10 AM. 5. Record review of physician orders [REDACTED]. disease with heart failure. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #9 was scheduled to receive: [MEDICATION NAME]-[MEDICATION NAME] aerosol 80-4.5 2 puffs was scheduled to be administered on 07/19/2020 at 7:00 AM but was administered on 11:59 AM, [MEDICATION NAME] 20 mg was scheduled for 8:00 AM but was administered at 12:57 PM, [MEDICATION NAME] 10 mg was scheduled for 8:00 AM but was administered at 1:00 PM, and [MEDICATION NAME] Extended Release 24 hour 25 mg was scheduled to be administered at 8:00 AM but was administered at 1:00 PM. 6. Record review of physician orders [REDACTED]. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #18 was scheduled to receive:[MEDICATION NAME] mg on 07/19/2020 at 8:00 AM but was not administered until 12:20 PM, [MEDICATION NAME] 300 mg was scheduled 8:00 AM but was administered at 12:46 PM, and Carvedilol was scheduled for 8:00 AM but was administered at 1:47 PM. Observation on 07/19/2020 at 10:30 AM revealed ADON RN RR was the only nurse visible on both the 100 and 200 Halls. Further observation

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) during medication pass revealed ADON RN RR's medication cart computer had all red resident medication boxes. During an interview with ADON RN RR on 07/19/2020 at 10:30 AM, ADON RN RR confirmed she was the only nurse scheduled on the 100 and 200 Halls. ADON RN RR further confirmed it was typical to have one nurse for each hallway. ADON RN RR confirmed the red resident medication boxes on the screen of the medication cart's computer indicated late medications which were due at 7:00 AM. During an interview with ADON RN RR on 07/19/2020 at 11:54 AM, ADON RN RR confirmed residents on the 200 Hall (all COVID-19 positive residents) did not receive their morning blood glucose checks and did not receive their morning dosages of Insulin as ordered by a physician, or their morning medications. ADON RN RR further confirmed she had not looked at any resident, completed vitals or assessments, or completed the medications of any resident on the 200 Hall. ADON RN RR stated she did not normally work on the floor and typically worked in management and did not know the residents. ADON RN RR confirmed the 100 Hall and 200 Hall typically staffed two licensed nurses, and further confirmed she had been scheduled to work both hallways. During an interview with ADON RN RR on 07/19/2020 at 6:00 PM, ADON RN RR confirmed she had not notified the Residents #3's, #4's, #9's, and #18's physicians of the residents' missing or late medications or notified the physicians until surveyor intervention. During an interview with the DON on 07/19/2020 at 5:18 PM, the DON confirmed the facility was having staffing issues. The DON stated if a staff member could not meet the needs of the residents the situation needed to be discussed with their supervisor. The DON further confirmed a resident's physician should be notified as soon as possible when a resident had a missed medication, confirmed late medications required a notification to the physician if it affected the next dosage, and further confirmed if the resident was declining the nurse should stop what they were doing and call the physician immediately. The DON stated the nurse should assess the resident first for missed medications and then call the physician and follow orders. 7. Record review of Resident #37's face sheet, dated 07/19/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's MAR for the 07/19/2020 medication pass for Resident #37 revealed the 8:00 AM medication administration for [MEDICATION NAME] had a blood pressure reading of 94/31 as part of the administration. Further review revealed Med Aide X had administered the [MEDICATION NAME] medication to the resident. During an interview with Med Aide X on 07/20/2020 at 1:04 PM, Med Aide X confirmed the blood pressure was low for Resident #37 on 07/19/2020, and further confirmed had she administered the [MEDICATION NAME] medication to the resident. Med Aide X further confirmed she did not report Resident #37's low blood pressure to the charge nurse. Med Aide X stated when residents had low blood pressures, or anything outside of their normal parameters, staff were supposed to hold the medication and report those findings to the charge nurses. During an interview with the DON on 07/21/2020 at 3:40 PM, the DON confirmed when Medication Aides obtained vital signs that abnormal or outside of a baseline parameter they were supposed to communicate with the nurses. 8. Record review of Resident #50's face sheet, dated 07/19/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #50's physician order [REDACTED]. Record review of Resident #50's vital signs revealed the resident's last entry for monthly weights was documented on 06/09/2020. Further review revealed Resident #50 was noted with a weight of 156.2 pounds in May and 150 pounds on 06/09/2020. During an interview with Restorative Aide LLL on 07/27/2020 at 8:56 PM, Restorative Aide LLL stated the Restorative Aides weighed the residents every month or as ordered. Restorative Aide LLL stated that because of the outbreak of COVID-19 in the facility the Restorative Aides had not been able to weigh all of the residents. During an interview with the DON on 07/27/2020 at 9:27 PM, the DON confirmed the residents' weights were supposed to be obtained every 30 days. 9. Record review of Resident #59's face sheet, dated 07/18/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #59's care plan, with an effective date of 05/21/2020, revealed a focus area which read: Potential for pain due to history [MEDICAL CONDITION] and resultant left sided weakness, arthropathy. Further review revealed the intervention for this focused area read: Ace Wraps to Left wrist/forearm. Record review of Resident #59's physician order [REDACTED]. Every day shift for pain. Observation on 07/26/2020 at 2:10 PM revealed Resident #59 did not have her wrap applied to her left hand or wrist. During an interview with Social Services Assistant PP on 07/26/2020 at 2:25 PM, Social Services Assistant PP confirmed Resident #59 was not wearing her wrap to her left hand. Record review of the facility's policy titled, Resident Rights Notification of Changes, effective date 11/28/2017 revealed as its objective: To promote and protect the rights of each resident admitted to the facility. Further review revealed: A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Record review of the facility's policy titled, Physician Services Frequency of Physician Visit, effective date 11/28/2017 revealed as its objective: To provide the appropriate medical care and services for each resident admitted to the facility. Further review revealed: The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Except as provided in paragraphs (c) (4) and (f) of this section, all required physician visits must be made by the physician personally. A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. Record review of the facility's policy titled, Quality of Care, effective date 11/28/2017, revealed as its objective: To provide the appropriate care and services needed for each resident admitted to the facility. Further review of the document provided revealed there was no additional information other than the objective. Record review of CDC's Symptoms of Coronavirus (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), last revised 05/13/2020, revealed: Watch for symptoms: People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea. Record review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, updated on 07/30/2020, revealed: People of any age with the following conditions are at increased risk of severe illness from COVID-19: type 2 diabetes mellitus. Actions you can take based on your medical conditions and other risk factors. Diabetes: Actions to take: continue taking your diabetes pills and insulin as usual, test your blood sugar and keep track of the results as directed by your healthcare provider.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Medication Aides have the specific competencies and skills sets necessary to care for 1 of 12 residents (Residents #37) who had changes in condition, in that: MA X did not report to licensed nurses about a change in Resident #37's condition. This deficient practice could place residents with change of condition at risk for declines in health status, hospitalization or death. The findings were: Record review of Resident #37's face sheet, dated 07/19/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's MAR for the 07/19/2020 medication pass for the resident revealed the 8:00 AM medication administration for [MEDICATION NAME] had a blood pressure reading of 94/31 as part of the administration. Further review revealed MA X administered the [MEDICATION NAME] medication. During an interview with MA X on 07/20/2020 at 1:04 PM, MA X confirmed the blood pressure was low for Resident #37, and further confirmed she had administered the [MEDICATION NAME] medication to the resident. MA X further confirmed she did not report the resident's low blood pressure to the charge nurse. MA X stated when residents had low blood pressures or anything outside of their normal parameters facility staff were supposed to hold the medication and report those findings to the charge nurses. During an interview with the DON on 07/21/2020 at 3:40 PM, the DON stated that when Medication Aides obtained vital signs that were abnormal or outside of a baseline parameter they were supposed to communicate those abnormal reading to the nurses. Record review of a facility's policy titled, Resident Rights Notification of Changes, effective date 11/28/2017, revealed as its objective: To promote and protect the rights of each resident admitted to the facility. Further review revealed: A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure in accordance with State and Federal laws, to store all drugs and biological's in locked compartments and to keep the medication cart locked when not in attendance by staff for 1 of 8 medication carts (C Hall Nurse Medication Cart) observed, in that: The Nurse Medication Cart on the C Hall was left unlocked and not in attendance by staff. This deficient practice could place residents who receive medications from the C Hall Nurse Medication Cart at risk for a drug diversion, mishandling of medication, and/or injury to residents. The findings were: Observation on 07/18/2020 at 6:50 PM revealed the Nurse Medication Cart, located on the C Hall between resident rooms [ROOM NUMBERS] was left unlocked and unattended by staff members. Further observation revealed there were no visible staff on the hallway and not immediately visible at the nurses station. Further observation revealed the C Hall Nurse Medication Cart contained a variety of accessible prescription medications, insulin, and sharps. During an interview with LVN OO on 07/18/2020 at 6:54 PM, LVN OO confirmed the C Hall Nurse Medication Cart had been left unlocked with no staff in attendance. LVN OO stated there had been a change of shift and she had already signed off the medication cart to another nurse. During an interview with the DON on 07/24/2020 at 4:28 PM, the DON confirmed medication carts were to be locked and further stated, the nurses know that the carts are supposed to be locked. Review of a facility policy, titled Pharmacy Services: Label/Storage of Drugs and Biologicals dated 11/28/17 revealed; To provide the appropriate pharmacy services and safe and effective medication use for each resident admitted to the facility. Reference: State Operations Manual, Appendix PP, 483.45(g)(h). Policy: Storage of Drugs and Biologicals: The facility must store all drugs and biologicals in locked compartments .and permit only authorized personnel to have access.
F 0814 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Dispose of garbage and refuse properly.** Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly for 3 of 3 of dumpsters reviewed for proper storage of garbage and refuse, in that; The there were three dumpsters with their side doors open, there was garbage hanging out of one side door, and there was garbage on the ground around the dumpsters. These deficient practices could place residents at risk for infection and a decreased quality of life due to an exterior environment which could attract flying pests, rodents, and other animals. The findings were: Observation of the facility's dumpster area on 07/20/2020 at 10:50 AM revealed there were three large commercial trash dumpsters with the side doors open, a trash bag of garbage that was not sealed and was partially hanging out of the dumpster, and garbage was on the ground around the dumpster. Further observation revealed there was garbage including used medical gloves on the ground around the dumpsters. During an interview with LVN SS on 07/20/2020 at 10:53 AM, LVN SS confirmed the dumpsters were left open with trash on the ground around the dumpster. During an interview with the Maintenance Supervisor on 07/21/2020 at 2:00 PM, the Maintenance Supervisor confirmed his duties included making rounds several times a day to ensure there was no trash on the ground and to keep the dumpsters closed. During an interview with the DON on 07/21/2020 at 6:00 PM, the DON confirmed the facility's policy titled Physical Environment: Safe/Functional/Sanitary/Comfortable Environment, dated 11/28/2017, applied to garbage and waste disposal. Record review of the facility's policy titled, Physician Environment: Safe/Functional/Sanitary/Comfortable Environment, dated 11/28/2017, revealed: To protect the health and safety of residents, personnel and the public Responsible Departments: Maintenance/Environmental Reference: State Operations Manual, Appendix PP 483.90 Policy: The facility shall provide a safe, functional, sanitary, and comfortable environment for residents.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 50 of 138 residents (Residents #1-50) reviewed for neglect from Administration, in that: The Administrator did not act upon the facility's emergency plan for contingent staffing and did not escalate the staffing contingency plan past Stage 1 when 40 staff members (Staff A thru NN) tested positive for COVID-19 and additional staff did not show up for work. This staffing shortage led to four COVID-19 positive residents, Residents #3, #4, #9, and #18, not receiving treatment. This deficient practice could place residents at the facility at risk of infection from transmission of communicable diseases and result in a decline in health and/or death. The findings were: Record review of a facility provider report sent to HHSC on 07/15/2020 at 8:43 PM by the Administrator revealed: on 7/11/20 and on 7/14/20 the facility received the results of the facility wide COVID-19 testing which resulted in 50 positive residents and 40 positive staff members. Record review of CDC's Symptoms of Coronavirus (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), last revised 05/13/2020, revealed: Watch for symptoms: People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea. Record review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, updated on 07/30/2020, revealed: People of any age with the following conditions are at increased risk of severe illness from COVID-19: type 2 diabetes mellitus. Actions you can take based on your medical conditions and other risk factors. Diabetes: Actions to take: continue taking your diabetes pills and insulin as usual, test your blood sugar and keep track of the results as directed by your healthcare provider.Record review of Resident #3's face sheet, dated 07/19/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's physician orders [REDACTED]. Further review revealed a physician order [REDACTED]. Record review of Resident #3's July 2020 MAR indicated [REDACTED]. Further review revealed blood glucose monitoring was scheduled for 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #3's blood glucose monitoring scheduled for 07/19/2020 at 7:00 AM was not completed until 12:23 PM when the next check was due resulting in a missed blood glucose monitoring check. Further review revealed Resident #3's [MEDICATION NAME] Flex pen Insulin scheduled for 07/19/2020 at 8:00 AM was not completed until 12:23 PM when the next dosage was due which resulted in a potential missed dosage. Record review of Resident #3's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #4's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's physician orders [REDACTED].#4's Insulin Humalog 100 u/ml per sliding scale was due to be administered on 07/19/2020 at 7:00 AM and was administered on 11:10 AM at the same time as the next dose which resulted in a missed dosage of medication. Record review of Resident #4's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #9's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's physician orders [REDACTED]. Further review revealed a physician order [REDACTED]. Record review of Resident #9's July 2020 MAR indicated [REDACTED]. Further review of Resident #9's MAR indicated [REDACTED]. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #9's blood glucose check scheduled for 7:00 AM was not completed until 11:59 AM when the next check was due which resulted in a missed blood glucose monitoring check. Further review revealed Resident #9's Insulin Humalog KwikPen 100 mg/ml per sliding scale was due to be administered at 7:00 AM and was administered on 11:59 AM at the same time as the next dose which resulted in a missed

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	675638	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) dosage of medication. Record review of Resident #9's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #18's face sheet, dated 07/27/2020 revealed an admission date of [DATE], with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #18's physician orders [REDACTED]. Further review revealed a physician order [REDACTED].#18's July 2020 MAR indicated [REDACTED]. Further review revealed [MEDICATION NAME]was scheduled two times a day at 7:00 AM and 7:00 PM. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #18's Humalog Insulin KwikPen 100 mg/ml per sliding scale was due to be administered at 7:00 AM and was administered on 11:08 PM at the same time as the next dose which resulted in a missed dosage of medication. Further review revealed Resident #18's [MEDICATION NAME] Insulin scheduled to be administered on 07/19/2020 at 7:00 AM was administered on 12:09 PM Record review of Resident #18's progress notes revealed there was no documentation that the resident blood sugar was not checked, morning insulin was not administered or the physician had been notified of the missing and late blood glucose monitoring and insulin. Record review of Resident #4's physician orders [REDACTED].#9's physician orders [REDACTED]. Further review revealed the feed times were scheduled at 3:00 AM, 7:00 AM, 11:00 am, etc. Record review of Medication Administration Audit Report, dated 07/19/2020 at 7:22 PM, revealed Resident #4's enteral feed and water flush were due at 7:00 AM on 07/19/2020 but were was administered on 07/19/2020 at 11:10 AM, at the same time the next feeding was due resulting in a missed feed. During an interview with Staffing Coordinator LVN WW on 07/19/2020 at 8:40 AM, Staffing Coordinator LVN WW confirmed there were several staff members who were refusing to come to work because they were fearful. Staffing Coordinator LVN WW stated she was utilizing COVID-19 positive staff to work with COVID-19 positive residents. Staffing Coordinator LVN WW stated the facility did not pull staff from sister facilities and did not have any agency staff working at the facility. Staffing Coordinator LVN WW stated some management was working on the floor with residents and added she had communicated the scheduling and staffing needs to the DON. Staffing Coordinator LVN WW further stated, She (the DON) is aware. During an interview with the DON on 07/19/2020 at 8:43 AM, the DON confirmed the facility was on Stage 1 of 3 stages of emergency staffing. The DON stated Stage 1 was management working on the floor which was already occurring, Stage 2 was staffing from sister facilities which had not been done, and Stage 3 was utilizing a staffing agency for additional staff. The DON stated the facility did not have any contracts with a staffing agency that she was aware of but would confirm with the Administrator. Observation on 07/19/2020 at 10:30 AM revealed ADON RN RR was the only nurse visible on both the 100 and 200 Halls. Further observation during medication pass revealed ADON RN RR's medication cart computer had all red resident medication boxes. During an interview with ADON RN RR on 07/19/2020 at 10:30 AM, ADON RN RR confirmed she was the only nurse scheduled on the 100 and 200 Halls. ADON RN RR further confirmed it was typical to have one nurse for each hallway. ADON RN RR confirmed the red resident medication boxes on the screen of the medication cart's computer indicated late medications which were due at 7:00 AM. During an interview with ADON RN RR on 07/19/2020 at 11:54 AM, ADON RN RR confirmed residents on the 200 Hall (all COVID-19 positive residents) did not receive their morning blood glucose checks and did not receive their morning dosages of Insulin as ordered by a physician, or their morning medications. ADON RN RR further confirmed she had not looked at any resident, completed vitals or assessments, or completed the medications of any resident on the 200 Hall. ADON RN RR stated she did not normally work on the floor and typically worked in management and did not know the residents. ADON RN RR confirmed the 100 Hall and 200 Hall typically staffed two licensed nurses, and further confirmed she had been scheduled to work both hallways. During an interview with ADON RN RR on 07/19/2020 at 6:00 PM, ADON RN RR confirmed she had not notified the Residents #3's, #4's, #9's, and #18's physicians of the residents' missing or late medications or notified the physicians until surveyor intervention. During an interview with the DON on 07/19/2020 at 5:18 PM, the DON confirmed the facility was having staffing issues. The DON stated if a staff member could not meet the needs of the residents the situation needed to be discussed with their supervisor. The DON further confirmed a resident's physician should be notified as soon as possible when a resident had a missed medication, confirmed late medications required a notification to the physician if it affected the next dosage, and further confirmed if the resident was declining the nurse should stop what they were doing and call the physician immediately. The DON stated the nurse should assess the resident first for missed medications and then call the physician and follow orders. During an interview with the DON on 07/21/2020 at 5:18 PM, the DON revealed the Corporation got information from the CDC and then the Administrative staff/DON had a phone conference with Corporate to get the information. The DON stated shared staff might be unavoidable because of staffing issues and the number of staff call-ins a day. The DON stated, it's an unavoidable situation. When asked how staff were monitored for compliance with infection control policies and procedures the DON stated she observed staff but delegated to her management team. The DON further stated the facility used a chain of command: the DON monitored the ADONs, the ADONs monitored the floor nurses, and the floor nurses monitored the CNAs. The DON stated although she delegated monitoring if she was passing a nurse in the hallway and they were not wearing their mask appropriate she would stop what she was doing and addressed the issue. The DON stated the Administrator was responsible for oversight on ancillary services such as dining, housekeeping, etc. During an interview with the Administrator on 07/20/2020 at 11:20 AM, the Administrator confirmed the first COVID-19 positive at the facility occurred on 06/28/2020 when Resident #62 tested positive in the hospital after being sent to the ER for COVID-19 symptoms. The Administrator stated the facility was not equipped or prepared to take back and care for a COVID-19 positive resident. The Administrator stated Resident #62 was accepted back into the facility on [DATE] and placed in a hot zone. When asked what the facility did after receiving the first positive COVID-19 test the Administrator stated she did not know because she was was not there due to her own quarantine and would have to pull that information. The Administrator confirmed she physically returned to the facility on [DATE] but during her absence from the facility she had multiple daily calls to the facility while she was gone. The Administrator stated on 07/8/2020 the facility received a SICA (Special Infection Control Assessment) visit and many of the recommendations from the SICA visit were put in place including mitigation zones. The Administrator confirmed she had spoken to the local health department about symptom strategies for return to work for staffing. Further interview with the Administrator on 07/20/2020 at 11:20 AM, the Administrator confirmed the facility was in Stage 1 of staffing during a crisis. The Administrator stated the facility had already gone to 12 hour shifts and was using management on the floor to assist with staffing holes. The Administrator stated even prior to the pandemic the facility utilized management on the floor when necessary and had cross trained nurses as med-aides and confirmed the facility was utilizing the waiver to use NAs as CNAs. The Administrator confirmed Stage 2 consisted of seeking staffing from sister facilities and confirmed that she spoke daily on a conference call with other facilities. The Administrator stated every facility was the same and receiving staff from sister facilities was not a possibility. The Administrator stated Stage 3 of the emergency plan involved seeking assistance from agency staffing. The Administrator stated she had called the agency the facility had a contract with yesterday. The Administrator stated the agency was price gouging and was requesting time and half as payment. The Administrator further stated she had requested two CNAs who were willing to work with COVID-19 positive residents and had been denied. When asked about the shortage of CNAs during the night shift on 07/19/2020 the Administrator replied she did not communicate with the Staffing Coordinator. The Administrator stated the Staffing Coordinator communicates with other nurses and the DON. The Administrator then stated the facility was in, crisis staffing. Further interview with the Administrator on 07/20/2020 at 11:20 AM, the Administrator stated she monitored the facility through observations, rounds, and skill checks. The Administrator stated she monitored directly and also delegated the task of monitoring the facility, and had hired an Education Coordinator to train staff. The Administrator stated she felt like the facility did a phenomenal job of keeping COVID-19 out of the facility for four months since the pandemic began. The Administrator stated in June the county declared a widespread rate of infection. The Administrator stated staff did a great job of trying to protect the residents. The Administrator stated she followed everything, she read hundreds of emails, and followed all of the changes. When asked if there was anything else she could have done to prevent the spread of the infection the Administrator stated, employees were asymptomatic, staff was forthcoming with symptoms, and she could not have done anything differently. During an interview with the Administrator on 07/20/2020 at 1:52 PM, the Administrator approached surveyors and stated, the facility COVID-19 policy was based on CDC guidance. The Administrator declined to show where in the binder (a binder containing facility records and policies surveyors commonly requested during investigations) provided to surveyors the most current policy for COVID-19/pandemic was located. The Administrator stated she had already given the binder to surveyors to review and the policy was located in the binder. Request for an interview on 07/21/2020 at 12:15 PM with the Administrator and the DON present was denied. The Administrator held up her hand and motioned to indicate she was not available. During an interview with the DON on 07/21/2020 at 1:20 PM, the DON stated the building was in crisis mode and COVID-19 positive staff could care for negative

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TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) residents. The DON stated that as a last resort this was acceptable. The DON further stated she did not believe any positive staff were working with negative residents at this time but she was not sure, she needed to check with the Staffing Coordinator. The DON stated they were currently on Stage 1 of staffing per their emergency response manual, which indicated management stepped in to assist. The DON stated Stage 2 was requesting assistance from their sister facilities. The DON stated Corporate took care of Stage 2. The DON further stated Stage 3 was assistance from agency staffing. The DON stated she only knew the COVID-19 status and working status of the nursing staffing and not ancillary staff and indicated each department manager takes care of their own staffing. During an interview with the DON on 07/21/2020 at 5:18 PM, the DON confirmed she had previously informed surveyors the facility was on Stage 1 of their emergency staffing plan. The DON stated the facility was currently in crisis staffing which meant COVID-19 positive staff could take care of COVID-19 positive residents if the staff member was asymptomatic. The DON further stated that if an asymptomatic staff stated they had a cough and the staff thought the cough could be just allergies [REDACTED]. The DON stated the facility could put COVID-19 positive staff with negative residents as a last resort. The DON confirmed that on Sunday, 07/19/2020, for night shift she had opened up the staffing to any staff, COVID-19 positive or negative, who was willing to come to work and staff could work with any resident. The DON stated the Staffing Coordinator was not intentionally putting positive staff with negative residents but at this point staff could work on any unit. The DON confirmed she felt like sister facilities were already aware of what was going on with this facility and if their sister facilities had the staff to offer they would have already done so. During an interview with the President of Operations (POO) (Corporate) on 07/26/2020 at 4:54 PM, the POO confirmed outside communication going to the facility went through him first and then he distributed the information to the facility by verbally calling the Administrator or the DON to relay the information. The POO confirmed he had spoken directly with the Health Department and that Health Department had also spoken to the Administrator and DON. Record review of an email sent to the DON on 07/27/2020 at 11:16 AM from surveyors revealed a request for a copy of the staff and resident COVID-19 test results. On 07/27/2020 at 12:01 PM the DON replied, I have forwarded this to the Administrator. She has this information and will reply. No response was received from the Administrator. Interview on 7/27/20 at 2:15 PM, the Administrator stated each facility department communicated with her via daily meetings and as needed. She further revealed she is made aware of their needs during that time. She monitors department compliance with facility policies and procedures via staff-in-services and rounds. Record review of the facility's policy titled, Administration, dated 11/29/2017, revealed: Objective: To attain or maintain the optimal physical, mental, and psychosocial well-being of each resident. Responsible Departments: Administration Reference: State operation Manual, Appendix PP 483.70 Policy: A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Further review revealed this was the entire policy in its entirety.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were accurate and complete in accordance with accepted professional standards and practices for 1 of 1 residents (Resident #37) reviewed for medical records, in that: LVN LL copied the morning blood pressure reading for Resident #37 onto an evening medication administration. This deficient practice could place residents who receive medications at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings were: Record review of Resident #37's face sheet, dated 07/19/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's MAR for the 07/18/2020 medication pass for the resident revealed the 8:00 AM medication administration for [MEDICATION NAME] had a blood pressure reading of 216/116 as part of the administration. Further review revealed the evening medication pass for 07/18/2020 at 8:00 PM had the same blood pressure reading of 216/116 and the medication was administered by LVN LL. During an interview with LVN LL on 07/19/2020 at 7:06 PM, LVN LL confirmed she administered the 07/18/2020 evening [MEDICATION NAME] medication to Resident #37. LVN LL further confirmed the same blood pressure reading was documented on the resident's MAR. LVN LL stated she had obtained another blood pressure reading from Resident #37, but when asked by the surveyor if she had the correct blood pressure reading that could have been used instead of the morning reading, LVN LL could not provide the blood pressure reading she had taken. LVN LL further stated, It was a typo on my part. Record review of the facility's policy titled, Resident Records - Identifiable Information, effective date 11/28/2017, revealed under the section titled Medical Records: In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 56 of 138 Residents (Residents #1-#50, #56, #57, #58, #62, #70, and #71) observed for infection control, in that: 1. The facility did not prevent staff who tested positive for COVID-19 from returning to work and exposing residents and staff who had tested negative while providing care to residents. The facility did not follow return to work criteria provided by the epidemiologist and based on current CDC guidelines. 2. Staff did not wear appropriate PPE while providing care to residents and did not wear PPE appropriately while in the facility which was under droplet precautions for COVID-19 positive residents and staff. 3. The facility did not clearly mark mitigation zones and did not ensure isolation signs were used to identify which residents were under droplet isolation precautions. 4. The facility did not establish infection control precautions and procedures for housekeeping services to prevent the spread of COVID-19 5. The facility did not implement CDC guidelines for prevention of spread of COVID-19 by failing to ensure Residents #70 and #71 social distanced during a meal service. These failures resulted in identification of Immediate Jeopardy (IJ) on 07/19/2020. While the IJ was removed 07/26/ 0, the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place to ensure residents were being monitored and assessed for signs and symptoms of COVID-19. These deficient practices affected all residents and placed residents who were positive for COVID-19 at risk for a decline in health and/or death. The findings were: Record review of a facility provider report sent to HHSC on 07/15/2020 at 8:43 PM by the Administrator revealed: on 7/11/20 and on 7/14/20 the facility received the results of the facility wide COVID-19 testing which resulted in 50 positive residents and 40 positive staff members. 1. Record review of a facility In-Service given to Housekeeping Staff, with no other departments listed and dated 06/25/2020, revealed: COVID absences-If employee has: a positive COVID test, signs and symptoms of COVID, confirmed primary exposure (direct contact with someone who tested positive for COVID), doctor note telling them to quarantine for 14 days. The employee will be sent home and paid their regularly scheduled hours for 14 days . Employee must report daily any symptoms and temperature. If employee fails to report symptoms or temperature it is considered a NCNS (no call no show). This is for the facility to track anyone sick or potentially sick. We are obligated to track and report this information to the state as requested. It is the employee's responsibility to report this information to the facility daily. Record review of an email dated 07/19/2020 sent to the DON from the Health Department Epidemiologist revealed: Thank you for reaching out to me today with your request for details on previous guidance and communication between your facility and the Health Department. Upon notification of your first positive resident, not affiliated to an outside the facility exposure, your facility was encouraged to place the entire facility on droplet precautions until exposure extent could be established. Guidance was provided on: critical staffing measures, cohorting positive cases (hot zone), isolation and monitoring of all exposed populations and return to work criteria for healthcare workers following acute infection. Record review of a facility document (undated) of COVID-19 positive staff members provided by the DON after surveyors requested a list of positive staff who had continued to work after testing positive for COVID revealed: - On 07/15/2020, LVN K, LVN H, and CNA JJ worked in a cold zone with COVID-19 negative residents, and CNA HH worked on a warm zone with COVID-19 negative residents. - On 07/16/2020, CNA JJ worked in a cold zone with COVID-19 negative residents - On 07/17/2020, Dietary Aide N worked on the cold zone kitchen preparing food for COVID-19 negative residents. - On 07/18/2020, Dietary Aide N worked on the cold zone kitchen preparing food for COVID-19 negative residents. - On 07/19/2020, Dietary Aide N worked on the cold

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) zone kitchen preparing food for COVID-19 negative residents. - On 07/20/2020, Dietary Aide N worked on the cold zone kitchen preparing food for COVID-19 negative residents, and CNA L worked on a warm zone with COVID-19 negative residents. - On 07/21/2020, CNA L worked on a warm zone with COVID-19 negative residents. Observation in the warm zone on hallway E at 07/18/2020 at 11:49 AM revealed room Resident #56's room door revealed a sign typed on an 8 x 11 piece of copy paper that stated, change PPE after each use. Further observation revealed Resident #56's room door did not have any other signs to indicate the resident was on droplet or isolation precautions. Further observation revealed the door did not have PPE hanging on or near the resident's door to indicate isolation precautions. During an interview with the DON on 07/17/2020 at 5:30 PM, the DON stated COVID-19 positive staff was working in the facility but only with COVID-19 positive residents. During an interview with the Staffing Coordinator LVN WW on 07/18/2020 at 8:00 AM, the Staffing Coordinator LVN WW stated staff was divided into either hot or cold zones. Staffing Coordinator LVN WW stated some COVID-19 positive staff were working in the facility but only with COVID-19 positive residents. Staffing Coordinator LVN WW stated there were no gaps in staffing at this time and they had been able to fill the available shifts. During an interview with LVN JJJ on 07/19/2020 at 5:39 AM, LVN JJJ confirmed there were three nurses during the night shift to work four hallways, and only two CNAs for all four hallways. LVN JJJ further confirmed shared staffing worked on all hallways without regard for residents' COVID-19 status. During an interview with CNA III on 07/19/2020 at 5:59 AM, CNA III confirmed she had been only 1 of 2 CNAs assigned for four hallways during the night shift. CNA III further confirmed she still did not have the results of her COVID-19 test, so she did not know if she was positive or negative for COVID-19. CNA III confirmed she was assigned to residents on the cold and warm zones worked with both residents who were negative for COVID-19 and those on isolation/quarantine with COVID-19 symptoms. During an interview with MA FFF on 07/19/2020 at 6:45 AM, MA FFF confirmed she was assigned to work on both C and E hallway warm zones with both COVID-19 symptomatic and asymptotic residents. MA FFF confirmed she wore the same gown for all residents except residents with signs to change PPE. During an interview with NA TT on 07/19/2020 at 7:33 AM, NA TT stated the residents on the E wing warm zone were not COVID-19 symptomatic and had been quarantined because they went out of the facility to doctor visits. During an interview with CNA ZZ on 07/19/2020 at 8:23 AM, CNA ZZ confirmed she was assigned to work with all residents on the C hallway warm zone including residents who were COVID-19 symptomatic and those who were COVID-19 asymptomatic and under observation. During an interview with LVN OO on 07/19/2020 at 8:25 AM, LVN OO confirmed she was assigned to work with both COVID-19 asymptomatic and symptomatic residents on the C and E hallways (both warm zones). LVN OO confirmed staff wore the same gown between resident contacts except when a resident was COVID-19 symptomatic. LVN OO stated there were no dedicated staff for COVID-19 symptomatic residents. LVN OO stated both COVID-19 symptomatic and asymptomatic residents could have their doors open. During an interview with Staffing Coordinator LVN WW on 07/19/2020 at 8:40 AM, Staffing Coordinator LVN WW confirmed there were several staff members who were refusing to come to work because they were fearful. Staffing Coordinator LVN WW stated she was utilizing COVID-19 positive staff to work with COVID-19 positive residents. Staffing Coordinator LVN WW stated the facility did not pull staff from sister facilities and did not have any agency staff working at the facility. Staffing Coordinator LVN WW stated some management was working on the floor with residents and added she had communicated the scheduling and staffing needs to the DON. Staffing Coordinator LVN WW further stated, She (the DON) is aware. During an interview with the DON on 07/19/2020 at 8:43 AM, the DON confirmed the facility was on Stage 1 of 3 stages of emergency staffing. The DON stated Stage 1 was management working on the floor which was already occurring, Stage 2 was staffing from sister facilities which had not been done, and Stage 3 was utilizing a staffing agency for additional staff. The DON stated the facility did not have any contracts with a staffing agency that she was aware of but would confirm with the Administrator. During an interview with the DON on 07/21/2020 at 1:20 PM, the DON stated the building was in crisis mode and COVID-19 positive staff could care for negative residents. The DON stated as a last resort this was acceptable. The DON further stated she did not believe any positive staff was working with negative residents but she was not sure, she needed to check with the Staffing Coordinator. The DON stated they were currently on Stage 1 of staffing per their emergency response manual. The DON state Stage 1 indicated management stepped in to assist, and Stage 2 was requesting assistance from sister facilities. The DON stated Corporate took care of Stage 2. The DON stated Stage 3 was assistance from agency staffing. The DON stated she only knew the COVID-19 status and working status of nursing staffing and not ancillary staff and indicated each department manager took care of their own staffing. During an interview with the DON on 07/21/2020 at 4:55 PM, the DON confirmed she received the facility's list of COVID-19 positive staff and residents on 07/15/2020. The DON further confirmed one dietary staff member worked in the cold zone kitchen preparing food for COVID-19 negative residents from 07/15/2020 to 07/20/2020. The DON confirmed she was aware of the only one staff member who had tested positive for COVID-19 continuing to work, and stated the staff was wearing gloves and a mask. During an interview with the DON on 07/21/2020 at 5:18 PM, the DON confirmed she had previously informed surveyors the facility was on Stage 1 of their emergency staffing plan. The DON stated the facility was currently in crisis staffing which meant COVID-19 positive staff could take care of COVID-19 positive residents if the staff member was asymptomatic. The DON further stated that if an asymptomatic staff stated they had a cough and the staff thought the cough could be just allergies [REDACTED]. The DON stated the facility could put COVID-19 positive staff with negative residents as a last resort. The DON confirmed that on Sunday, 07/19/2020, for night shift she had opened up the staffing to any staff, COVID-19 positive or negative, who was willing to come to work and staff could work with any resident. The DON stated the Staffing Coordinator was not intentionally putting positive staff with negative residents but at this point staff could work on any unit. The DON confirmed she felt like sister facilities were already aware of what was going on with this facility due to daily corporate conference calls which included other facility staff and if their sister facilities had the staff to offer they would have already done so. During an interview with Dietary Aide O on 07/27/2020 at 1:50 PM, Dietary Aide O confirmed he was positive for COVID-19 and continued to work at the facility despite the diagnosis. Dietary Aide O stated he was asymptomatic except for headaches and had not missed work since the [DIAGNOSES REDACTED]. Dietary Aide O confirmed he was assigned to work in the cold zone kitchen where his main duty was washing dishes. Dietary Aide O confirmed his duties include handling clean dishes that were used for residents who did not have COVID-19. During an interview with Dietary Aide N on 07/27/2020 at 6:35 PM, Dietary Aide N confirmed she was positive for COVID-19, was asymptomatic, and the facility was aware of her COVID-19 status. Dietary Aide N confirmed she had continued working in the facility and had not missed any work despite her positive COVID-19 status. Dietary Aide N stated her schedule was four days on and two days off. Dietary Aide N stated she had only been assigned to work in the cold zone where food preparation was performed for negative residents. Dietary Aide N stated the kitchen was, very understaffed. Dietary Aide N confirmed she prepared food for all residents in the facility including those residents who do not have COVID-19. Dietary Aide N stated she received no special or specific instructions about returning to work with COVID-19 other than to wash her hands frequently and wear proper PPE. Record review of an email sent to the DON on 07/27/2020 at 11:16 AM from surveyors revealed a request for a copy of the staff and resident COVID-19 test results. On 07/27/2020 at 12:01 PM the DON replied, I have forwarded this to the Administrator. She has this information and will reply. No response was received from the Administrator prior to exit. During an interview with the Local Health Department Epidemiologist on 07/21/2020 at 10:55 AM, the Local Health Department Epidemiologist stated she had discussed with the facility return to work for positive staff members which included: isolation/quarantine for 14 days from test date, complete resolution of symptoms and then when staff returns to work they should not be placed with severely immunocompromised residents. Staff should follow strict PPE usage including no less than N95 mask. Ideally, they should not return to work until 2 negative tests. The Epidemiologist stated she did discuss return to work for staff to include a minimum 10 days from testing who were afebrile for minimum of 3 days and had a complete resolution of symptoms. The Epidemiologist recommended positive staff should not return to work unless the facility was inoperable without this staff. And then this staff should only work with positive resident to provide patient care only. Not housekeeping or dietary services. The Epidemiologist confirmed she sent several emails to the facility with information to included: return to work criteria and resolution of COVID-19 symptoms. Record review of an email dated 07/21/2020 at 6:21 PM from the Epidemiologist to the DON confirmed that it was her directive to put the facility on droplet precautions. The Epidemiologist confirmed she had given recommendation of how to allow staff to return to work after a positive COVID-19 test. The Epidemiologist confirmed that she had discussed with the facility, hot zone, isolation and return to work. Record review of a document titled Return to Work Criteria, undated, from the Local Health Department revealed: 1. Symptomatic HCP for COVID-19 with or without positive test a. symptoms-based strategy: exclude from work until: i. At least 3 days (72 hours) since symptoms have resolved and ii. At least 10 days have passed since symptoms first appeared b. Test based strategy: exclude from work unit: i: resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms and negative test results from an FDA approved COVID-19 PCR test from a minimum of two consecutive

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	675638	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) respiratory specimens. These specimens should be collected at least 24 hours apart so that there are a total of two negative tests. 2. Asymptomatic HCP with positive COVID-19 PCR test: a. time-based strategy-exclude from work until the follow are met: i. 10 days have passed since the date of their first positive COVID-19 diagnostic test (with no further symptoms) Note: if HCP develops symptoms you must follow one of the two strategies in 1. a. b. test-based strategy i. negative results of an FDA approved COVID-19 PCR test from a minimum of two consecutive respiratory specimens. These specimens should be collected at least 24 hours apart so that there are a total of two negative test. 3. Strategies to Mitigate HCP shortages: Maintaining appropriate staffing is essential to providing a safe work environment for Resident and HCP. It is important to prepare for shortages. As part of this, asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work in a crisis capacity strategy to address staffing shortages if they wear a facemask for source control for 14 days after the exposure. 2. Observation on 07/17/2020 at 10:02 AM revealed HK T was cleaning resident rooms on the 200 hallway which was designated as a hot zone with COVID-19 positive residents with her eye protection resting on top of her head and not covering her eyes. Further observation revealed HK T was not wearing gloves while cleaning resident rooms. During an interview with HK Ton 07/17/2020 at 10:50 AM, HK T confirmed she was not wearing eye protection or gloves while cleaning resident rooms. HK T stated she had not received training on how to wear PPE. HK T stated there was no schedule for cleaning high touch surfaces. Observation on 07/17/2020 at 10:26 AM revealed ADON RN RR was observed without eye protection on both the 100 and 200 Halls which were designated as hot zones with COVID-19 positive staff and residents. During an interview with ADON RN RR on 07/17/2020 at 10:26 AM, ADON RN RR confirmed she was not wearing eye protection while on the 100 and 200 Halls. Observation on 07/17/2020 at 10:56 AM revealed Activity Director/CNA D and two other staff entered an unidentified resident's room on the 200 hallway hot zone while the resident was in the room seated in a wheelchair. Further observation revealed Activity Director/CNA D's eye protection were on the top of his head and not covering his eyes while he was in the resident's room. During an interview with Activity Director/CNA D on 07/17/2020 at 10:56 AM, Activity Director/CNA D confirmed he was not wearing eye protection while in a resident room. Activity Director/CNA D stated his goggles fogged up and that why he did not have them on. Observation on 07/17/2020 at 11:43 AM revealed CNA X entered and then exited a resident room with her goggles on top of her head and with the sleeves of her isolation gown pulled up to her elbows exposing skin below the elbow to the wrist. During an interview with CNA X on 07/17/2020 at 11:43 AM, CNA X confirmed she had rolled up the sleeves to the isolation gown and was not wearing eye protection while performing resident care. Observation on 07/17/2020 at 3:25 PM revealed HK VV was cleaning resident rooms while residents were present in the rooms without eye protection. During an interview with HK VV on 07/17/2020 at 3:25 PM, HK VV confirmed she was not wearing eye protection while cleaning resident rooms. During an interview with MDS Coordinator LVN GGG on 07/19/2020 at 7:05 AM, MDS Coordinator LVN GGG stated she was a member of the management team and was assigned to do whatever needed to be done. MDS Coordinator LVN GGG stated staff expectations included wearing a face shield/eye protection when in direct contact with a resident who was symptomatic for COVID-19 such as a cough in which [MEDICAL CONDITION] particles could be spread. MDS Coordinator LVN GGG stated staff did not need to wear face shield or eye protection at the nurses station or on the cold zone hallways. Observation on 07/19/2020 at 7:15 AM revealed the Admissions Coordinator (COVID-19 positive staff) walking thru the building in the cold zone with her mask not on all the way. Further observation revealed the bottom straps were not on her head and were observed hanging down in front of her face and her face shield was in her hands. Further observation revealed the Admissions Coordinator walked over to the doffing station located near the exit door even though she was not exiting the building and secured her face mask and put on her face shield. During an interview with the Admissions Coordinator on 07/19/2020 at 7:15 AM, the Admissions Coordinator confirmed she did not have her face mask all the way on and had left the bottom strap hanging down in front of her face and also did not have her face shield on. Observation on 07/19/2020 at 9:18 AM in the laundry room revealed Laundry Staff NNN and Laundry Staff OOO were together inside of the laundry building. Further observation revealed Laundry Staff OOO's face mask was completely removed and sitting on a shelf in the laundry area. During an interview with Laundry Staff OOO on 07/19/2020 at 9:18 AM, Laundry Staff OOO confirmed she was not wearing a face mask. Laundry Staff OOO stated she had just come out of the bathroom and had taken her face mask off when she went into the bathroom and would put it back on after she exited the bathroom area. Further interview with Laundry Staff OOO indicated she had been instructed to wear the face mask in the building. Observation on 07/19/2020 at 9:35 AM revealed the Administrator and DON were in the DON's office with their face masks off and less than 6 feet away from one another, as observed through a window. Observation on 07/19/2020 at 10:31 AM of kitchen area in hot zone revealed Dietary Aide R (COVID positive staff) was preparing food in the kitchenette. Further observation revealed Dietary Aide R had her N95 mask pulled down with her nose exposed while preparing sandwiches. Further observation revealed the 2 kitchen doors had been propped open. One door entered into the hot zone resident hallway, the other door opened onto a hot zone common area. During an interview with Dietary Aide R on 07/19/2020 at 10:35 AM, Dietary Aide R confirmed her N95 mask was pulled down underneath her nose. Dietary Aide R stated the mask had slipped down and she wasn't allowed to touch her face. Dietary Aide R stated she had not received any training on proper mask usage and had not been fit tested . Dietary Aide R confirmed she had tested positive for COVID. Observation on 07/19/2020 at 12:15 PM revealed the Administrator and DON were in the DON's office together with their face masks off. Further observation revealed the Administrator and DON were sitting across from one another at the nurses' desk approximately 3-4 feet apart. Observation on 07/19/2020 at 6:30 PM revealed the Administrator and DON were in the DON's office together with their face masks off. Further observation revealed the Administrator and DON were sitting across from one another at the nurses' desk approximately 3-4 feet apart. Observation on 07/21/2020 at 6:38 PM revealed ADON RN RR was performing medication pass on the 100 Hall, which was a designated a hot zone with COVID-19 positive residents and staff. Further observation revealed ADON RN RR was not wearing eye protection. During an interview with ADON RN RR on 07/21/2020 at 6:38 PM, ADON RN RR confirmed she was not wearing her face shield (eye protection), and stated she was not wearing it because it made her feel sweaty. ADON RN RR confirmed she was supposed to be wearing her face shield. During an interview with the DON on 07/26/2020 at 11:14 AM, the DON confirmed the facility policy was for all staff to wear a mask in the facility at all times. The DON confirmed the Administrative offices, including the DON's office, was located in the hot zone. The DON stated she felt like if they were in her office and socially distancing that droplet precautions were appropriate and wearing a mask was not necessary. During an interview with the Local Health Department Epidemiologist on 07/21/2020 at 10:55 AM, the Local Health Department Epidemiologist stated her recommendations included: All residents should be placed on droplet precautions which included all staff wearing all PPE all the time in the facility. Proper donning and doffing of a gown between every resident use. The Epidemiologist stated she did not recommend conservation of PPE and had helped the facility secure addition PPE including gowns. 3. Record review of a facility map provided by the Administrator after surveyors entrance into the facility showed cold (negative COVID-19 status), warm (residents under observation and residents with symptoms for COVID-19 without a positive test) and hot zones (COVID-19 positive). Record review of Resident #56's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #56's Quarterly MDS, dated [DATE], revealed a BIMS score of 4, which indicated the resident was severely cognitively impaired. Record review of Resident #56's progress notes, dated 07/17/2020, revealed, NP informed Resident #56 had a non-productive harsh cough today. Resident is afebrile and had no other symptoms. NP informed resident tested negative for COVID on 7/11/20. Record review of Resident #56's progress noted, dated 07/24/2020, revealed: COVID result is positive. Will need to move over to COVID area. Record review of Resident #57's face sheet, dated 07/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #57's Quarterly MDS, dated [DATE], revealed a BIMS score of 7, which indicated the resident was severely cognitively impaired. Review of Resident #57's progress notes, dated 07/18/2020, revealed, Resident was moved to (warm zone) due to cough/congestion and a temp of 99.3. Observation on 07/17/2020 at 9:30 AM revealed the facility entrance into the hot zone did not have any signage to notify visitors the facility was a hot zone that contained residents and staff with active COVID-19 infection. Further observation revealed the signs posted on the outside of the locked entry door included cough etiquette and a notice that visitors were restricted. Further observation revealed the facility map given to surveyors upon entrance was not posted on the door or entrance of the facility. Observation on 07/17/2020 at 9:40 AM revealed upon entrance to the facility visitors were screened and then instructed to proceed to a donning station. Further observation revealed there was no signage located at the donning station to indicate which isolation precautions were necessary, which zone visitors had entered and no signage indicating which protective equipment to don or which zone was entered. During an interview with Receptionist UU on 07/17/2020 at 9:40 AM, Receptionist UU confirmed she did not know which protective equipment was required to wear on the hot zone, and stated visitors should wear whatever equipment was in the box. Observation on 07/17/2020 at 10:12 AM revealed resident Rooms 200, 202, 204, 205, 206, and 207 located in the hot

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) mitigation zone with active COVID-19 cases did not have signage indicating the residents were under any isolation precautions. Further observation revealed there were no over the door hangers or containers with PPE to indicate the residents in these rooms were under isolation precautions or which PPE should be worn while entering the resident rooms. There was no signage to indicate the area was a hot zone. Observation on 07/17/2020 at 11:18 AM revealed the D hallway (separated hot zone on the designated cold side of the building) did not have any signs indicating what PPE was required on this hallway or what mitigation zone was being entered. Observations on 07/17/2020 at 11:20 AM revealed residents in Rooms 1, 3, 4, 5, 6, 7, 8, 9, 10, 13, and 15 on the D hallway did not have a sign that indicated the residents in these rooms were on droplet isolation precautions. Further observation revealed there were no over the door hangers with PPE or any other indication of what PPE were required to be worn in the resident rooms. Observation on 07/17/2020 at 3:00 PM revealed Resident #56 (confirmed positive 07/24/2020) was outside of the resident room on the E hallway (warm zone) with a mask on. Further observation revealed staff did not redirect the resident at this time. Further observation revealed all resident room doors were open. There were no signs indicating which mitigation zone the hallway had been designated. Resident #56's and #59's room door had a sign that read, change PPE after each use. There were no signs on any of resident doors to indicate if any of the residents were under isolation precautions or that droplet precautions were in place. Observation on 07/17/2020 at 3:05 PM revealed LVN OO was entering and exiting several residents' rooms on the warm zone without changing her gown. During an interview with LVN OO on 07/17/2020 at 3:18 PM, LVN OO confirmed Residents in warm zone include resident with symptoms who do not have a positive COVID-19 test and residents who are asymptomatic. The LVN confirmed residents could come out of their rooms in warm zone but with masks on. Observation on 07/17/2020 at 3:20 PM on the C Hallway (warm zone) revealed there were no isolation signs on the doors to indicate the residents were under isolation precautions. Observation in the warm zone on hallway C at 07/18/2020 at 10:48 AM revealed there was no signs to indicate which mitigation zone the C hallway was designated. Further observation revealed residents on this hallway did not have signs to indicate the residents were under observation/quarantine and there were no signs to indicate any isolation precautions. Observation in the warm zone on hallway E at 07/18/2020 at 11:15 AM revealed occupied resident Rooms 1, 2, 3, 9, 11, and 12 had their door open and there were no signs to indicate these residents were under observation or quarantine and no signs to indicate if any isolations precautions were in place. Further observation revealed none of these resident rooms had PPE hanging on the door. Observation on 07/18/2020 at 11:19 AM revealed one small paper sized 8 x 11 sign to side of the entrance to hallway E stated, warm zone. Designated staff only beyond this point. Further observation revealed there were no other signs or directions on what PPE should be worn in the area. Observation in the warm zone on hallway E at 07/18/2020 at 11:49 AM revealed room Resident #56's room door revealed a sign typed on an 8 x 11 piece of copy paper that stated, change PPE after each use. Further observation revealed Resident #56's room door did not have any other signs to indicate the resident was on droplet or isolation precautions. Further observation revealed the door did not have PPE hanging on or near the resident's door to indicate isolation precautions. Observation in the warm zone on hallway E at 07/18/2020 at 11:51 AM of Resident #60's room revealed the door was open with the resident inside of the room. Further observation revealed there were no isolation signs, no quarantine signs, and no signs to change to, change PPE after each use. Observation on 07/18/2020 at 5:39 PM revealed resident Rooms 101, 102, 103, and 109 in the COVID-19 positive area hot zone had a sign to indicated contact precaution should be followed instead of a droplet precaution sign. Further observation revealed rooms [ROOM NUMBERS] did not have any sign indicating any type of precautions were in place. Observation on 07/19/2020 at 7:40 AM-8:25 AM revealed LVN OO performed med pass and CNA ZZ entered multiple resident rooms on the C hallway which was designated as a warm zone without changing her gown between each room. Observation on 07/19/2020 at 7:40 AM revealed Resident #57 was sitting in the warm zone hallway with his mask covering his mouth only with the nose exposed. Several staff members passed the resident and did not redirect the resident. Observation on 07/19/2020 at 7:45 AM revealed Resident #58 was in bed with his door open and his mask off in the warm zone. Further observation revealed there were no
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview, and record review, the facility failed to provide a functional and comfortable environment for residents, staff, and the public for 1 of 8 halls (200 Hall), in that: Soiled linens had been left on the floor in residents' rooms in the hot zone (200 Hall) where residents were positive for COVID-19. This deficient practice could place residents on all halls at risk of feelings of frustration and feeling uncomfortable and lead to cross contamination of infection. The findings were: Observation on 07/17/2020 at 10:08 AM revealed there was dirty linen on the floor in several residents' rooms on the 200 Hall which was designated as a hot zone with COVID-positive residents. During an interview with HK T on 07/17/2020 at 10:50 AM, HK T confirmed there was dirty linen on the floor in residents' rooms on the 200 Hall. During an interview with ADON LVN LL on 07/17/2020 at 10:10 AM, ADON LVN LL confirmed there was dirty linen on the floor in residents' rooms on the 200 Hall. Record review of a facility's policy titled, Physical Environment Safe/Functional/Sanitary/Comfortable Environment dated 11/28/2017, revealed: The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.