STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455705	A. BUILDING _____ B. WING _____	**05/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MONTEVISTA AT CORONADO	**1575 BELVIDERE EL PASO, TX 79912**

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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on interview and record review the facility did not inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of more than a single confirmed infection of COVID-19 when 3 of 3 employees (Dietary worker A, Dietary worker B, and Nurse aide C) were diagnosed positive for COVID-19. Dietary worker A, Dietary worker B, and Nurse aide C were diagnosed positive for COVID-19 (5/16/20) and the facility did not inform residents or their representatives of the confirmed infection by 5 p.m. the next calendar day. This failure could place residents and their representatives at risk for not being aware of the presence of COVID-19 in the community and at risk for infections. The findings were: In an interview on 5/26/2020 at 10:03 AM, the DON stated that the facility had conducted testing on 5/15/2020 for all residents and staff in the facility. He further stated that three employees for the nursing facility were found to be positive for COVID-19. Record review of the testing results for Dietary worker A, Dietary worker B, and Nurse aide C revealed that these tests had been collected on 5/15/2020 and 5/16/2020. The testing results were documented as being reported positive on 5/16/2020. In an interview on 5/26/2020 at 10:37 AM, the DON stated that the facility had mailed out letters to notify residents and their representatives that the facility would be testing all of the staff and residents in the facility. He further stated that after testing results were received the facility notified residents and representatives that the residents had tested negative. He further stated that he did not instruct any staff making these calls to notify representatives regarding the positive test results in the staff. In an interview on 5/26/2020 at 11:43 AM, Nurse D stated that she had helped make calls to resident representatives in order to notify them of the test results for their residents. She denied notifying the representatives about positive test results found in the staff tested . In an interview on 5/26/2020 at 11:45 AM, Nurse E stated that she had helped make calls to resident representatives in order to notify them of the test results for their residents. She denied notifying the representatives about positive test results found in the staff tested . In an interview on 5/26/2020 at 11:41 AM the DON stated that the facility had sent out letters in order to notify residents and their representatives on 5/18/2020 of the status of COVID-19 test results for residents and staff. The letter also detailed steps the facility was taking in order to mitigate the further spread of COVID-19 in the facility. Record review of the facility letter, COVID-19 Testing Update dated 5/18/2020 revealed that the letter documented presence of COVID-19 positive staff as well as steps the facility was taking in order to mitigate the further spread of infection in the facility. In an interview on 5/26/2020 at 12:02 PM, the DON stated that the testing company provided results for to the facility by uploading the results to a web portal. He further stated that only the DON could access the portal and had to do so from the facility. He explained that he did receive text alerts when test results were uploaded but could not access them until he was in the facility on Monday 5/18/2020 (his regularly scheduled shift). He also stated by saying that on 5/18/2020 he viewed the results on the portal for the first time and became aware of the positive results. The DON concluded by stating that the facility did not have a written policy for notifying residents and their representatives regarding COVID-19 cases, but that the facility was following regulations as issued by CMS. Record review of the CMS Memo dated 5/6/2020 referencing QSO-20-29-NH revealed on page 2, under COVID-19 Reporting. The facility must (3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19 .

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