STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE HEIGHTS REHABILITATION SUITES	6650 SOUTH SONCY ROAD AMARILLO, TX 79119

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 0563 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide immediate access to a resident by immediate family and other relatives of the resident, subject to a resident's right to deny or withdraw consent at any time; and failed to provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; for 1 of 8 residents reviewed for resident rights (Resident #1). The facility denied the family of Resident #1 immediate access to the resident during end of life and while the resident was on hospice. The facility denied the hospice nurse responsible for the hospice care of Resident #1 reasonable access to the resident on multiple occasions when she requested such access to complete essential hospice services including a hospice admission assessment. The facility's failure places residents at risk of emotional and psychological harm by not receiving visits from family and loved ones during end of life or other critical situations, and at risk of physical harm from not receiving essential health services such as hospice care. Findings include: Record review of the clinical record for Resident #1 revealed a [AGE] year-old male resident admitted to the facility initially on 09/21/2018 and most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The clinical records indicated that Resident #1 was positive for COVID-19 and in the COVID-19 positive area of the facility. Record review of Resident #1's face sheet indicated that he was on hospice services through Hospice A. Record review of Resident #1's comprehensive care plan revealed the following, dated 09/08/2020, in part: Problem (Resident #1) is on Hospice A and is at risk for physical decline and deterioration, pain, malnourishment Goal My needs will be met and pain and comfort will be maintained at my level of tolerance x 90 days. Approach Involve social worker with any end of life, emotional needs, coping skills, etc During an interview on 09/17/2020 at 8:02 AM, Individual #2 reported that she is an RN and that the nurses that represent Hospice A have not been allowed into the facility to complete assessments and hospice care for Resident #1 even though the resident is supposed to be receiving services from the hospice company and its nurses. Individual #2 reported that the facility has only allowed visits by Hospice A nurses to occur by telephone, which is how they had to complete the resident's hospice admission assessment, placing them at the mercy of what they were told by facility staff. Individual #2 continued to report that she did not feel that the telephonic visits were sufficient enough to deliver essential hospice services that are effective, particularly a hospice admission assessment. Individual #2 claimed that she has been told by multiple members of facility staff that Resident #1 is actively dying and that she was told by facility staff that Hospice A nursing staff will not be permitted into the facility to pronounce Resident #1's death when such an incident occurs. Individual #2 reported that she is aware of occasions on 09/09/2020, 09/211/2020, and 09/14/2020 during which an Hospice A nurse attempted to gain physical access to Resident #1 and was denied such access by facility staff. During an interview on 09/17/2020 at 9:05 AM, Individual #4 reported that she was a family member of Resident #1 and has been told by hospice nurses that the resident was at the end of life. Individual #4 reported that the facility has not allowed for family to have visitation or access to the resident despite requests for such access over the last week except for a single brief closed window visit that occurred in the last day or two that was granted only to Resident #1's wife. During an interview on 09/17/2020 at 9:57 AM, LVN B reported that only one hospice agency comes into the facility to see residents, which she believed to be Hospice B. During an interview on 09/17/2020 at 10:07 AM, CNA C reported that hospice personnel are not allowed in the facility to her knowledge. During an interview on 09/17/2020 at 10:09 AM, CNA D reported that the facility does not allow hospice nurses into the building. During an interview on 09/17/2020 at 10:12 AM, LVN E reported that hospice personnel are not coming into the facility, but that they are given report by the facility nurses over the phone. During an interview on 09/17/2020 at 10:14 AM, CNA F was asked if hospice personnel can come into the facility, and she stated, from what I know, no. During an interview on 09/17/2020 at 10:16 AM, CNA G reported that, to her knowledge, hospice personnel are not coming into the facility. During an interview on 09/17/2020 at 10:36 AM, RN A reported that the facility is not accepting any visitors in the building, not even during end of life situations. RN A reported that hospice nurses and personnel are not allowed into the COVID-19 positive area of the building. RN A reported that Resident #1 is positive for COVID-19 and resides in the COVID-19 positive area of the facility. RN A claimed that Resident #1 has been actively dying for a few days but the facility is not allowing for family or hospice to come in and see the resident. RN A reported that the resident is at the end of life and, in her opinion, will not likely live through this weekend. RN A reported that she has been asked by hospice nurses at least three separate times if they could come in and assess Resident #1, but she has had to tell them no because the facility DON told her that hospice nurses may not come into the building to assess him. RN A reported that the family and wife of Resident #1 have requested to have end of life visits with the resident on multiple occasions, but she has also had to tell them no because the facility DON told her that family could not come into the facility for visits. During an interview on 09/17/2020 at 11:18 AM, Individual #3 reported that she is an RN employed by Hospice A who is assigned to the care of Resident #1. Individual #3 reported that she requested access to Resident #1 on 09/09/2020 to perform a hospice admission assessment but was denied access to the resident and the building by facility staff. She claimed that facility staff told her that she was not allowed access to the building per the facility DON. Individual #3 reported that she attempted to gain access to Resident #1 a second time on 09/11/2020 but was denied access to the resident and the building by facility staff who told her that there were no members of administration or management present at the facility to approve her access. Individual #3 reported that she requested access to Resident #1 a third time on 09/14/2020 and was again denied access to him and the building by facility staff. Individual #3 reported that she was informed by a facility charge nurse on 09/15/2020 around 8:34 AM that Resident #1 had started actively dying. Individual #3 reported she requested access to the resident a fourth time after receiving that information and was denied access by staff again. Individual #3 reported that it was at that time she was informed by facility staff that she would not be allowed access to the resident to pronounce his death when it occurred, and that facility staff would be carrying out that task. Individual #3 reported that her only assessments of Resident #1 have been based on what facility staff have told her over the phone. She reported that she requested video chat to see the resident but was told that video was not available. Individual #3 reported that the current methods of telephonic communications are not adequate for her to provide essential hospice services. Individual #3 claimed that the family has been requesting end of life visits with the residents and have not been allowed to have them. She reported that her hospice company has provided the family with full sets of PPE, and that Resident #1's wife recently tested negative for COVID-19, but the facility has continued to disallow visits from them. During an interview on 09/17/2020 at 1:05 PM, Individual #5 reported she is a family member of Resident #1 and has requested end of life visits with the resident multiple times over the last few days but has been denied access to the resident by facility staff. Individual #5 reported that she has spoken to the facility ADM who told her that in person

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 0563 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) visits could not occur but that he may be able to arrange window visits. Individual #5 reported that Resident #1's wife was allowed a brief closed window visit yesterday after multiple requests for visits. During an interview with DON and ADM on 09/17/2020 at 1:18 PM, they were asked if hospice personnel are allowed into the facility. DON reported that hospice personnel can enter the building every 14 days or if a resident declines, she reported that one hospice nurse was denied entry to the facility recently because she had been in a facility with positive COVID-19 cases recently. DON was asked if the facility allows hospice nurses and personnel into their COVID-19 positive unit, and she replied, No, we do telemed. DON was asked what type of telemed is provided for hospice services and replied, A teleconferencing system where nurses can tell the hospice nurses whatever they need to know. She continued to claim that there is a cell phone in the COVID-19 positive area capable of video chat. DON was asked if the facility allows visitors into the COVID-19 positive area of the building for end of life situations and she replied, No, that would be putting them at risk. When asked about Resident #1 and his condition, both ADM and DON reported that the resident was on hospice services with Hospice A, and both claimed that they have never been made aware by anyone that the resident is in the end of life. When asked what guidance or regulatory information she was using or referencing to make the determination that hospice personnel and family visits should be restricted for Resident #1 or residents of the COVID-19 positive area, DON replied that she was using guidance that was conveyed to her by her corporate compliance nurse. When asked if she was aware of what guidance or information her corporate compliance nurse was using, DON reported that she was not aware of it but would inquire. During an interview on 06/17/2020 at 1:56 PM, Individual #3 reported that she has never failed a COVID-19 screening and that she only visits one other facility, and that facility does not have any positive cases of COVID-19 in house. Individual #3 reported that she has never cared for or been exposed to a patient that was positive for COIVD-19. During an interview on 09/17/200 at 2:44 PM, RN A was asked to clarify whether she personally notified the DON and/or ADM that Resident #1 was actively dying and in the end of life. RN A replied, oh gosh yes, multiple, multiple times. RN A continued to report that she was told multiple times by both the ADM and DON that hospice personnel and visitors would not be allowed in the facility for Resident #1. RN A reported that she first notified the DON on 09/15/2020 that Resident #1 had gone active and is actively dying, and told the DON that the resident's wife and family were requesting to visit him before he passes. RN A reported that the DON told her on that day that they could not visit. Record review of the facility provided screening log, dated 08/19/2020, and presented as evidence that a hospice nurse had been denied entry to the facility for failing the screening revealed that the hospice nurse who failed the screening did so on 08/19/2020, was not a hospice nurse assigned to the care of Resident #1, and did not work for Hospice A, but for Hospice B. Record review of facility provided document titled Admission Handbook, date 09/01/2020, revealed in part: Resident Rights 33. Access by Advocates Each resident has the right to have the facility provide reasonable access to the resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withhold consent at any time. 34. Access and Visitation Rights Each resident has the right to receive visitors of his/her choosing at the time of his/her choosing (including but not limited to a spouse of the same or opposite sex, domestic partner, another family member or friend), subject to the resident's right to dent visitation when applicable, in a manner that does not impose on the rights of another resident. The Facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to a resident's right to deny or withdraw consent at any time. Record review of document by CMS, titled Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, dated 03/13/2020, reference QSO-20-14-NH, and accessed from https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf, revealed in part: Guidance for Limiting the Transmission of COVID-19 for Nursing Homes For ALL facilities nationwide: Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain [MEDICATION NAME] care situations, such as an end-of-life situation. Exceptions to restrictions: Health care workers: Facilities should follow CDC guidelines for restricting access to health care workers found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidancerisk-assesment-hcp.html. This also applies to other health care workers, such as hospice workers, EMS personnel, or [MEDICAL TREATMENT] technicians, that provide care to residents. They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).