STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675863	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANK M TEJEDA TEXAS STATE VETERANS HOME	**200 VETERANS DR FLORESVILLE, TX 78114**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable interior for 4 of 4 resident rooms (Residents #5, #7,#8 #11), in that: Facility housekeeping did not clean Residents' #5, #7, #8, #11 rooms for four days. This deficient practice could place residents at risk of feelings of dissatisfaction. The findings were: Record review of staff In-service training conducted on 03/24/2020, with 33 staff signatures, revealed: Class Attendance Record for Subject: Residents being monitored for possible COVID-19 exposure, Team Members providing care, please document each entrance into the room of the resident(S) being monitored and RN Supervisor, please change out sheet at midnight. Each day should have its own sheet. 1. Record review of Resident #5's face sheet, dated 05/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 9, which indicated the resident was moderately cognitively impaired. Record review of Resident #5's care plan, dated 04/13/2020, revealed: At risk for falls related to poor safety awareness, Unsteady gait, Psychoactive drug use, Poor Balance. Resident has tested positive for COVID-19. Has mood/behavior problems, refuses to take showers at times, feels tired, trouble concentrating on things at times. [MEDICAL CONDITION] related to Diabetes. Observation on 04/20/2020 at 12:45 PM revealed the Resident Care Team Member Tracking on Resident #5's door did not have signatures of the housekeeping staff entering the room for 04/18/2020, 04/19/2020, 04/20/2020, and 04/21/2020. Observation on 04/20/2020 at 12:45 PM of Resident #5's room revealed small room trash can was full of trash beside the resident'ss bed. Further observation revealed there was an empty tissue box on Resident #5's bedside table and a pile of used tissues on the floor next to his bed. Unable to interview Resident #5 on 4/20/2020 at 12:45 PM due to BIMS score of 9, which indicated the resident was moderately cognitively impaired. 2. Record review of Resident #7's face sheet, dated 05/12/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's Quarterly MDS, dated [DATE], revealed a BIMS score of 99, which indicated the resident was unable to complete the assessment. Record review of Resident #7's care plan, dated 04/15/2020, revealed: Resident has tested positive for COVID-19. Resident will not experience medical complications [REDACTED]. Impaired cognitive function or impaired thought processes related to Dementia, maintain current level of cognitive function through the next review date. Observation on 04/20/2020 at 12:45 PM revealed the Resident Care Team Member Tracking on Resident #7's door did not have signatures of the housekeeping staff entering the rooms for 04/18/2020, 04/19/2020, 04/20/2020, and 04/21/2020. Unable to interview Resident #7 on 4/20/2020 at 12:45 PM due to a BIMS score of 99, which indicated the resident was unable to complete the assessment. 3. Record review of Resident #8's face sheet, dated 05/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicted the resident was cognitively intact. Record review of Resident #8's care plan, dated 04/27/2020, revealed, resident has tested positive for COVID-19. Resident refused to separate from his wife who is negative. They choose to remain in isolation in the same room. Diabetes Mellitus and utilize insulin therapy. hypertension. ADL Self Care Performance Deficit related to Hypertension, Diabetes, and age-related weakness. Observation on 04/20/2020 at 12:45 PM revealed the Resident Care Team Member Tracking on Resident #8's door did not have signatures of the housekeeping staff entering the room for 04/18/2020, 04/19/2020, 04/20/2020, and 04/21/2020. 4. Record review of Resident #11's face sheet, dated 05/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which indicted the resident was moderately cognitively impaired. Record review of Resident #11's care plan, dated 04/27/2020, revealed resident potential for alterations in well-being: Resident is at risk for infection & emotional distress related to measures in place to minimize exposure & associated risks. Communicable disease response COVID-19, INFLUENZA Resident chooses to stay in the room with her husband who is COVID-19 positive. Resident understands the risks involved. has short term memory problems with impaired cognitive function or impaired thought processes related Cerebellar Stroke Syndrome, Diabetes Mellitus and is on insulin therapy. Observation on 04/20/2020 at 12:45 PM revealed the Resident Care Team Member Tracking on Resident #11's door did not have signatures of the housekeeping staff entering the room for 04/18/2020, 04/19/2020, 04/20/2020, and 04/21/2020. Observation of Resident #8's and #11's (married residents) room on 04/22/2020 at 4:20 PM revealed the room was unkept with trash on the floor and there were nine dining trays stacked on a chair in the corner. During an interview with CNA OO on 04/20/2020 at 1:00 PM, CNA OO stated sometimes the dining trays came from the kitchen with disposable trays along with a regular tray and they took the disposable tray to the room. CNA OO confirmed they had taken regular trays into Resident #8's and #11's room but did not know how to bring the used dining trays out since this was a COVID- 19 positive room. During an interview with Housekeeper H on 04/20/2020 at 1:41 PM, Housekeeper H, on the 400 Hall, stated she cleaned all resident rooms in the facility with water and bleach. Housekeeper H confirmed she did not clean the rooms that were positive for COVID-19 and that she had been told this by her boss. Housekeeper H further stated she took the trash out of the regular rooms in regular trash bags, and stated she changed mop water after every four residents. Housekeeper H confirmed that she did not clean the COVID positive resident rooms at this time. During an interview with the Regional RN on 04/20/2020 at 1:55 PM, the Regional RN confirmed the Resident Care Team Member Tracking sheets on residents' doors were to be filled out daily by staff who went into and out of resident rooms. During an interview with the Regional RN on 04/22/2020 at 4:20 PM, the Regional RN confirmed the Resident Care Team Member Tracking on Resident #8's and #11's door indicated no housekeeping staff had entered the room on 04/18/2020, 04/19/2020, 04/20/2020, and 04/21/2020. The Regional RN confirmed staff were supposed to sign the sheet when they entered and exited a room. During an interview with the Administrator on 04/22/2020 at 5:00 PM, the Administrator confirmed the Resident Care Team Member Tracking forms were on the residents' doors in the COVID-19 unit and were to be signed whenever any care team member entered a resident's room. During an interview with Housekeeping Supervisor/Laundry Supervisor I on 04/24/2020 at 8:11 AM, Housekeeping Supervisor/Laundry Supervisor I stated the facility's policy for cleaning COVID-19 positive resident rooms would be the rooms were to be cleaned daily. Housekeeping Supervisor/Laundry Supervisor I confirmed staff were not cleaning the COVID-19 resident rooms. Housekeeping Supervisor/Laundry Supervisor I stated staff must properly use PPE with gown, facemasks, booties, and the housekeeping cart was to be left in the 400 Hall area. Housekeeping Supervisor/Laundry Supervisor I stated a housekeeper is designated to COVID-19 hall, housekeepers were supposed to dump water into toilet in each resident's room, disinfect mop handles after every room, and change mop water every room. Housekeeping Supervisor/Laundry Supervisor I confirmed this was a new policy, which had just started , but he could not confirm a date. Housekeeping Supervisor/Laundry Supervisor I stated three housekeepers had quit because of COVID-19, but further stated the facility was not short on housekeeping employees. Housekeeping Supervisor/Laundry Supervisor I confirmed the facility started on 04/23/2020 with cleaning COVID-19 rooms.

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Housekeeping Supervisor/Laundry Supervisor I stated the facility was using bleach and water solution, changing curtains every day. Record review of the facility's policy titled (Corporate Name) Communities Titled Guidance for Suspected/Confirmed COVID-19 Residents, undated, revealed: Post Resident Care Team Tracking Log on doors of COVID-19 or suspected positive residents and other residents. Educate all team members to complete the information on the log before entering resident room and upon exit enter time and task performed. Record review of the facility's policy titled Cleaning and Disinfecting Resident's Rooms, undated, revealed: 3. Manufacturers' instructions will be followed for proper use of disinfecting products including: recommended use-dilution, material compatibility . Steps: Resident Rooms: daily. Record review of the facility's policy titled Guidance COVID Unit, undated, revealed: . Equipment should stay on the hall/unit ie housekeeping cart . Meal carts wiped down on the exterior and wheels before retrieving the cart to return to the dietary department. Biohazard trash and soiled linen transport to laundry outside the hall exit doors verses transporting across the inside of the community. Record review of the facility's policy titled Guidance for Suspected/Confirmed COVID-19 Residents: Upon Suspected/Confirmed COVID-19 [DIAGNOSES REDACTED]. Make every attempt to place a resident with know or suspected COVID-19 in a single-person room with the door closed. . Limit the number of team members permitted to enter the room. All team members who enter the room must adhere to standard, contact or droplet precautions. Use dedicated medical equipment for isolation residents if possible. . Assign consistent team members to the same unit/hall. Minimize entries into resident rooms by bundling care and treatment activities. Increase environmental sanitation of high touch areas and common areas. Deep clean and disinfect all potential exposed areas-resident rooms . Record review of the facility's policy titled Isolation Precaution, dated 03/2016, revealed: Transmission-based isolation precautions are used for residents who are documented or suspected to have infections or communicable diseases that can be transmitted by airborne or droplet transmission or by contact with dry contaminated surfaces. Transmission based isolation precautions are used in addition to Standard Precautions. In addition to Standard Precautions, Droplet Precautions may be implemented for a resident documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident coughing, sneezing, talking, or by the performance of procedures. Masks wear a mask when working within 3 feet of the resident. Standard Precautions, wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Resident-care equipment: reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 5 of 15 residents (Residents #8, #11, #13, #16, and #20) whose care plans were reviewed, in that: 1 Residents #11's and Resident #8's care plans had not been revised to reflect their desire to remain cohorted in the same room despite a positive COVID-19 [DIAGNOSES REDACTED].#8). 2. Resident #11's care plan had not been revised to reflect a need for isolation precautions. 3. Residents #13's, #16's, and #20's care plan were not revised to reflect a positive COVID-19 [DIAGNOSES REDACTED]. The findings were: 1. Record review of Resident #11's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's lab results, dated 4/15/20, revealed the resident was negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #8's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's lab results, dated 4/15/20, revealed the resident was positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #8's lab results, dated 4/15/20, revealed the resident was positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Observation on 4/21/20 at 10:35 AM revealed Residents #8 and #11 were cohorted in the same room. Further observation of the room revealed one handwritten positive sign and one handwritten negative sign on the residents' doors Interview on 4/22/2020 at 4:20 PM with Resident #8, confirmed Residents #8 and #11 had opted to remain cohorted together despite the risk of spread of COVID-19 to Resident #11. 2. Record review of Resident #11's care plan, initiated on 1/22/20, revealed the resident was at risk for infection related to COVID-19 and Influenza dated 3/13/20. Further review revealed the resident's care plan had not been updated to include the need for isolation precautions including contact and droplet precautions due to cohorting with a positive resident (Resident #8). 3. Record review of Resident #13's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #13's care plan, initiated on 12/20/19, revealed the resident was at risk for infection related to COVID-19 and Influenza dated 3/13/20. Further review revealed the resident's care plan had not been updated to include positive COVID-19 status or isolation droplet precautions. 4. Record review of Resident #16's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's lab results dated 4/25/20 revealed the resident was positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #16's care plan, initiated on 7/5/19, revealed a plan of care which included risk for infection related to COVID-19 and Influenza dated 3/13/20. Further review revealed Resident #16's care plan did not include an updated COVID-19 status or isolation droplet precautions. 5. Record review of Resident #20's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #20's lab results, dated 4/25/20, revealed the resident was positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #20's physician orders, dated 4/25/20, revealed an order to place the resident on droplet and contact precautions for COVID-19 positive diagnosis. Record review of Resident #20's care plan, initiated on 2/19/18, revealed on 3/13/20 a plan of care for alteration in wellbeing due to risk for infection related to Covid-19 and Influenza was started on 3/13/20. Further review revealed Resident #16's care plan did not reflect the residents positive COVID-19 status and isolation precautions which included contact and droplet precautions. Interview on 4/26/20 at 10:44 AM with the MDS Coordinator, confirmed Residents #8's and #11's care plan did not indicate their desire to remain cohorted together despite Resident #8's COVID-19 status. The MDS Coordinator further confirmed Residents #13, #16, and #20 did not have revised care plans that included a positive COVID-19 statuses and isolation precautions including contact and droplet precautions. During an interview with the Corporate LNFA on 5/21/20 at 2:45 PM, the Corporate LNFA confirmed the facility did not have a policy for care plans and instead used the RAI (Resident Assessment Tool).
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 5 residents (#30) reviewed for oxygen in that: CNA TT administered oxygen to Resident #30 at 5 LPM via nasal cannula instead of the physician ordered amount of 2-3 LPM based on oxygen saturation. This deficient practice could place residents who receive oxygen at risk of receiving incorrect or inadequate oxygen support and could result in a decline in health. The findings were: Record review of Resident #30's face sheet, dated 5/19/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #30's physician orders [REDACTED]. Record review of Resident #30's vitals sign record revealed on 4/26/20 at 1:07 PM the resident had an oxygen saturation of 98% on room air. Record review of Resident #30's Significant Change MDS, dated [DATE], revealed a BIMS score of 3, which indicated the resident was severely cognitively impaired. Record review of Resident #30's care plan, dated 12/6/2018, revealed the resident had [MEDICAL CONDITION] and had interventions which included, Give oxygen therapy as ordered by the physician. Observation on 4/26/20 at 12:49 PM revealed CNA TT applied a nasal cannula to Resident #30 in the dining room and turned the oxygen to the highest setting of 5 LPM. During an interview on 4/26/20 at 1:00 PM with CNA TT, confirmed she had placed oxygen on Resident #30 at 5 LPM. CNA TT confirmed the nurses should administer oxygen. During an interview on 4/26/20 at 1:07 PM with LVN V, confirmed only nurses could apply oxygen to the residents. During an interview on 4/26/20 at 1:28 PM with the DON, confirmed CNA TT placed oxygen on Resident #30 at 5 LPM. The DON further confirmed the rate of LPM was wrong and only nursing staff should place oxygen on residents. Record review of the facility's policy titled Oxygen Administration, undated, revealed: Responsible Discipline: Licensed Nurses Procedure: 3. Obtain physician orders [REDACTED]. oxygen source to be used. b. method of delivery. c. flow rate of delivery d. oxygen saturation monitoring parameters.
F 0744 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.**

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F 0744 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who displayed or was diagnosed with [REDACTED].#28) reviewed for treatment and services, in that: The facility did not develop and implement interventions to address Resident #28's behaviors and emotional distress prior to being discharged to the hospital and discharged from the facility. This deficient practice could place residents with dementia at risk for their medical, physical, and psychological needs not being met and result in a decline in health. The findings were: Record review of Resident #28's face sheet, dated 5/14/20 revealed, an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #28 was discharged to the hospital on [DATE] and discharged from the facility on 5/14/20. Record review of Resident #28's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 4, which indicated the resident was severely cognitively impaired. Further review revealed Resident #28 had no symptoms of [MEDICAL CONDITION], no symptoms of [MEDICAL CONDITION], and no behavioral symptoms including no rejection of care behaviors. Record review of a Resident #28's Quarterly IDT meeting, dated 3/5/20, revealed there were, no significant changes in the past 3 months. (Resident #28) has a good appetite. He eats all meals in the dining room. He occasionally participates in activities and his son visits often. There are no concerns/preferences at this time. The team will monitor for changes. Record review of Resident #28's physician orders, dated 4/29/20, revealed orders for [MEDICATION NAME] tablet 0.5 mg, give 1 tablet every 12 hours as needed for anxiety for 14 days, and [MEDICATION NAME] tablet 2 mg/ml, inject 1 mg intramuscularly every 12 hours as needed for anxiety and agitation. Record review of Resident #28's MARs for April and May of 2020 revealed [MEDICATION NAME] tablets and [MEDICATION NAME] IM injection were not documented as administered and there were no documented attempts to administer the medications. Record review of Resident #28's Rehab screening tool, dated 5/5/20, revealed the resident had a witnessed fall where, he had gotten up to close the door to his room, became upset at a staff member walking by in the hallway and attempted to throw his milk carton at her. Patient fell backward onto his bottom. Record review of Resident #28's ABC Tool related to behavior, dated 5/8/20, revealed the resident was, yelling, name calling, calling team members prostitutes, throwing water and throwing urine at team members. Further review revealed the rest of the form was incomplete. The areas of the form titled, context of behavior including relevant history, diagnoses, psychotic symptoms, vitals signs, etc., and activators including, what happened just before the problem behavior, interpersonal, environmental, psychological, and medical factors, contributing were all left blank. Interventions included, try to redirect. Record review of Resident #28's Transfer Form, dated 5/8/20, revealed the resident was sent to the hospital for chest pain. Further review revealed the form did not indicate the resident's behaviors. Record review of Resident #28's Care Plan revealed on 9/9/19 a plan of care was created and last revised on 11/4/19 for, memory problems with impaired cognitive function/impaired thought process, with interventions that included, cue, reorient and supervise as needed, notify MD for any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status and present just one thought, idea, question or command at a time. Further review revealed a plan of care created on 11/4/19 and last revised on 12/2/19 for potential to demonstrate verbally: yelling out loud, cursing and physically abuse behaviors. Related to: dementia, poor impulse control. Interventions included: Assess and anticipate my needs for food, thirst, toileting, comfort level, body, position, pain, etc., assess my understanding of the situation, psychiatric/psychogeriatric consult as indicated, redirect. Further review of the Care Plan revealed on a plan of care titled, Potential for alterations in well-being: resident is at risk for infection and emotional distress related to measures in place to minimize exposure and risk associated with COVID-19 and Influenza. Interventions included: notify MD and RP of any change in condition as clinically indicated, monitor for psycho-social changes, observe and report any changes in mental status caused by situational stressors. Record review of Resident #28's progress notes revealed: -3/2/20: Resident #28 is up and dressed daily and is not in bed most of the day. The resident spends most of the time out of his room. The Resident had no problems socializing with others . -4/27/20: The resident's RP was notified that as a precaution the residents room would be moved due to COVID-19 precautions. -4/29/20: . received consent to give PRN [MEDICATION NAME] agitated/anxiety. -5/1/20: continue with confusion, UA collected-pending pick up, will continue to monitor. antibiotics started. -5/3/20: activities notified nurse she witnessed Resident #28 fall in his room, I closed his door because it was open. He then started yelling . threw a milk carton with milk in the hallway aiming at staff . fell backwards landing on his buttocks . no injuries noted. -resident refused vitals. Resident name calling, saying get out of my room, refused meds . will continue to monitor. RN/DON made aware of behaviors. -5/4/20: Resident name calling, yelling, grabbing. RN/DON made aware. -5/4/20: Resident had been calling out for his family member and yelling obscenities to the staff when trying to attend to resident. -5/4/20: refusing medication this am will continue to monitor, MD notified. -5/5/20: resident upset tonight at staff, stated, we are the ones who came in and held him down and poked his nose, dumb b*****, p**********, I will call you when I need you. Resident hollered out a lot, call light on a lot, able to medicate after several attempts. -5/6/20: Resident #28 was, continued foul in mood, yelling at staff, will continue to monitor. -5/6/20: Resident #28 came out of room to back exit door setting alarm off. CNA attempted to redirect patient back to room. Resident noted very agitated and yelling at CNA. Resident ripped isolation signs off his door and tore them to pieces and started to push isolation barrel and trash box out of his room. This nurse went to assess who started yelling, oh you get the hell out of here you damn prostitute. RN notified of residents increased behaviors. -5/8/20: Spoke to med/management this morning to discuss Resident #28's refusal of meds and agitated behavior. Order received for [MEDICATION NAME] Q12 hours IM PRN. RP does not consent to [MEDICATION NAME] IM injection. -5/8/20: ADON RN made aware of behaviors, will continue to monitor -5/8/20: staff report Resident #28 throwing urine at them, throwing water in cup at staff, name calling, Resident is yelling for his family member, attempted to redirect the resident . becomes verbally upset. Resident complains of painful urination, will continue to monitor. -5/8/20: social worker noted: spoke with the resident's RP about the medication ([MEDICATION NAME] IM injection) proposed . RP consented to allow Resident #28 to receive the medication. LMSW communicated this to the ADON. -5/8/20: Resident #28 complains of left sided chest pain in the epigastric area, stated for the week or two he had chest pains reflux. Resident yelling out, resident stated it hurts all over. ADON (name) notified and assessed the resident, ADON (name) suggested [MEDICATION NAME] and Tylenol, ADON advises notify MD. MD called, waiting for call back. PRN Tylenol and [MEDICATION NAME] given per suggestion. -5/8/20: No further complaints of chest pain. Report given to MD, MD stated send to ER with chest pain ADON notified of orders who stated, if he goes he will not be able to take him back, suggested calling MD back and letting him know that. MD made aware the resident reported no further pain and made the resident that the resident could not come back to the facility if sent out. Will continue to monitor. -5/8/20 at 6:30 PM: Resident had chest pain during day shift which resolved with [MEDICATION NAME] and Tylenol. Resident #28 asked staff to call his son because he would know what to do for him since he felt as if nothing was being done to help him. MD informed of continued chest pain. Order to send to ER. During an interview on 5/21/20 with MDS Coordinator OOO, stated Resident #28 would constantly turn on his call light and call out verbally. MDS Coordinator OOO stated Resident #28 would go into the room and the resident would become verbally aggressive and tell staff to get out of his room. MDS Coordinator OOO stated the resident had a recent room change and that was what started with the increased aggression. MDS Coordinator OOO stated the situation was, non-stop, and, sad, and, very bad because other residents were becoming upset. MDS Coordinator OOO stated there was no pleasing Resident #28. The resident had racial prejudice and stated, I think he knows what he is saying and it's derogatory. MDS Coordinator OOO stated she had spoken with the RP a couple of times but did not document the discussions. MDS Coordinator OOO confirmed she not notified the resident's physician. MDS Coordinator OOO stated the staff had discussed interventions in morning meeting but there was no pleasing the resident. MDS Coordinator OOO confirmed she had not updated Resident #28's care plan to reflect the change of condition or increased behaviors. During an interview on 5/21/20 at 1:59 PM with LVN PPP stated Resident #28 was belligerent when staff tried to administer the resident his medications. LVN PPP confirmed the resident refused medications and care. LVN PPP stated she was supposed to notify the ADON, the DON, and the resident's physician for a change of behaviors. The LVN stated because she worked on night shift she did not notify the ADON, the DON, or the resident's physician. During an interview on 5/21/20 at 2:12 PM with LVN VV, stated Resident #28 called staff, racially negative words, and used profanity towards staff members. LVN VV stated the resident was throwing water and urine out of his door and in her opinion seemed to be aware of what he was doing. LVN VV stated she did not attempt to give Resident #28 [MEDICATION NAME] that she remembered and stated, if she had given it she would have documented it. LVN VV stated she had notified the ADON and social services of the resident's behaviors and indicated the ADON indicated that psychological services was going to be called. LVN VV confirmed she did not notify the residents physician or psychological services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0744 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) about the residents increase in behaviors. During an interview on 5/21/20 at 3:27 PM with LVN NNN, confirmed Resident #28 had a change of condition with an increase in behaviors. LVN NNN stated the resident was calling staff, p********** and w*******, and further stated the resident was very confused. LVN NNN confirmed the resident was refused care, did not understand what was going on with COVID-19 Infection Control, and did not understand why the room doors had to stay closed or why his family member was not visiting. LVN NNN stated the resident was yelling, get the hell out of my room, and refused medications. When LVN NNN was asked why there were no documented attempts to administer Resident #28 [MEDICATION NAME] for anxiety, LVN NNN stated, I do not remember an event or any aggressive behavior in which he would have needed [MEDICATION NAME]. LVN NNN further stated the staff interventions for the behavior were attempts at redirection. During an interview on 5/21/20 at 3:48 PM with ADON K, confirmed Resident #28 had behaviors which consisted of yelling, resisting care and, throwing stuff. ADON K stated Resident #28 had been transferred from another hallway because of positive COVID-19 cases, and confirmed Resident #28 had a difficult time adjusting to the move. ADON K confirmed [MEDICATION NAME] for anxiety was not documented as administered although she remembered a nurse administered the resident a dose of the medication right before his discharge to the hospital. ADON K confirmed she did not notify the resident's physician or psychological services of an increase in behaviors or of the resident's refusals to take his medication. ADON K further confirmed she was aware that the resident's RP had consented to an IM [MEDICATION NAME] injection after the RP initial refusal. ADON K stated, I was not about to give that man an IM injection of [MEDICATION NAME] after he (RP) screamed at me. ADON K stated the facility was not equipped to handle Resident #28's behaviors, and confirmed the Administrator was aware of the resident's behaviors prior to discharge. During an interview on 5/21/20 at 3:56 PM with the DON, stated she first became aware of Resident #28's significant change in behavior approximately 1-2 days prior to his discharge to the hospital. The DON confirmed Resident #28 had behaviors when he first came to the facility due to dementia but the resident had adjusted and the move to a new room due to COVID-19 had triggered the change in behaviors. The DON stated the resident did not object to the recent move. The DON confirmed she had not notified the residents physician or psychosocial services. The DON stated she had reached out to med-management group to adjust the resident's medications and they performed a tele-visit on the day of Resident #28's discharge from the facility. The DON confirmed staff was expected to monitor resident behaviors and for a change of condition was expected to fill out a SBAR report, notify the resident's physician and psychological services physician to get a psych consulted, notify the social worker and the DON. The DON further confirmed staff was expected to follow physician orders. Record review of facility's policy titled Changes in Resident Condition, dated 5/2017 revealed: 2. Changes in condition shall be communicated from shift to shift through the 24 hour report management system. 3. Changes in the resident status that affect the problem(s)/goal(s) or approach(s) on his/her care plan shalll be documented as revisions and communicated to the interdisciplinary caregivers.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide or obtain timely laboratory services to meet the needs of 1 of 14 residents (Resident #28) reviewed for ordered laboratory work, in that: The facility did not obtain a urinalysis (UA) for Resident #28 as ordered by a physician. This deficient practice could place residents at risk for a delay in identifying or diagnosing a problem, adjusting medications, and ensuring treatment needs were identified and addressed. The findings were: Record review of Resident #28's face sheet, dated 5/14/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #28's physician orders [REDACTED]. Record review of Resident #28's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 4, which indicated the resident was severely cognitively impaired. Record review of Resident #28's progress notes revealed: -5/1/20: continue with confusion, UA collected-pending pick up, will continue to monitor. antibiotics started. -5/4/20: Resident name calling, yelling, grabbing. RN/DON made aware. -5/4/20: refusing medication this am will continue to monitor, MD notified. -5/8/20: staff report Resident #28 throwing urine at them, throwing water in cup at staff, name calling, Resident is yelling for his family member, attempted to redirect the resident . becomes verbally upset. Resident complains of painful urination, will continue to monitor. Interview on 5/21/20 at 3:27 PM with LVN NNN, confirmed Resident #28 had a change of condition with an increase in behaviors, and further confirmed Resident #28's physician ordered UA had not been completed. During an interview on 5/21/20 at 3:48 PM with ADON K, confirmed Resident #28 had behaviors which consisted of yelling, resisting care, and, throwing stuff. ADON K confirmed there was no evidence via a lab slip, communication from the lab, or documentation that the UA for Resident #28 had been completed. During an interview on 5/30/20 at 3:56 PM with the DON, confirmed staff were expected to follow physician orders.
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 observation, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 2 residents (Resident #11) reviewed for informed consent, in that: The facility did not document informed consent for Resident #11 and her RP (Resident #8) who continued to cohort in the same room with the knowledge that Resident #8 was positive for COVID-19 and Resident #11 was not. This deficient practice could place residents at risk for infection and a decline in health if informed consent is not obtained and documented in the residents' permanent medical record. The findings were: Record review of Resident #11's face sheet, dated 4/26/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #8 was listed as Resident #11's RP. Record review of Resident #8's face sheet, dated 4/26/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 9, which indicated the resident was moderately cognitively impaired. Record review of Resident #11's lab results, dated 4/15/20, revealed the resident was negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #8's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #8's lab results, dated 4/15/20, revealed the resident was positive for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). Record review of Resident #8's physician orders, dated 4/25/20, revealed an order to place the resident on droplet and contact precautions for COVID-19 positive diagnosis. Observation on 4/21/20 at 10:35 AM revealed Residents #8 and #11 were cohorted together in the same room. Further observation of the room revealed one handwritten positive sign and one handwritten negative sign on the residents' doors. During an interview on 4/22/2020 at 4:20 PM with Resident #8, confirmed the residents had opted to remain cohorted together despite the risk of spread of COVID-19 to Resident #11. Resident #8 confirmed both residents were informed of the risks and had agreed to stay together. During an interview on 4/22/2020 at 4:25 PM with LVN O, confirmed Residents #11 and #8 had spoken with their physician and had been informed of the risk to Resident #8 if the residents chose to remain living in the same room. LVN O further confirmed both Residents #11 and #8 were in agreement to stay in the same room. During an interview on 4/26/20 at 10:44 AM with the MDS Coordinator, confirmed Residents #8's and #11's medical records did not include an informed consent and their care plans did not indicate the desire to remain cohorted despite the COVID-19 status of Resident #8. At the time of exit on 5/21/20 the facility had not provided a policy for documentation in the permanent medical record as requested to the Corporate LNFA.
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 15 of 143 Residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10 11, 13, 16, 19, 20 and 31) observed for infection control, in that: 1. The facility failed to have structures in place which included an infection control and prevention program to prevent the transmission of COVID-19 for 15 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #16, #20) and nine staff members (CNA A, CNA B, CNA C, CNA D, LVN E, Dietary Aide F, LVN G, CNA OO and LVN XX). 2. The facility failed to separate residents who were identified as being positive for COVID-19 from the rest of the resident population and were using the same staff to provide direct patient care. 3. The facility failed to follow CDC guidelines on screening for COVID-19 and restrict visitors into the facility. 4. Staff did not wear appropriate PPE when entering a positive COVID-19 resident room or a presumptive positive room under isolation precautions.

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	675863	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) 5. The facility failed to establish infection control precautions for laundry services. 6. The facility stored new PPE including masks and gowns in the same closet as COVID-19 positive residents personal belongings. 7. The facility failed to implement CDC guidelines for social distancing residents in the memory care unit. 8. LVN VV assessed Resident #31 (quarantined resident) vital sign and failed to clean the stethoscope, blood pressure cuff or thermometer afterwards. LVN cleaned the pulse oximeter with an alcohol wipe instead of a disinfectant wipe. 9. ST FFF did not sanitize her hands or change her gloves after having contact with her own facemask and contact between two residents. 10. CNA TT touched residents food with bare hands and did not sanitize hands between resident contact. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed [DATE], 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 could affect residents at the facility and place them 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 facility's policy (undated) titled Plan for Residents admitted or readmitted and Existing Resident during COVID 19 Pandemic read Planning: The COVID -19 infection control guidance developed by the Centers for Disease Control and Prevention (CDC) recommends the use of standard, contract and airborne precautions, including eye protection. The intent of the community plan should be able to maintain infection control practices to prevent the spread of infection .3. Isolate and evaluate admitted , readmitted or Existing residents who present with signs symptoms: e. restrict the number of team members permitted to enter the room, ALL team members who enter the room must adhere to the following: i. Standard precautions (gloves) ii. Contact precautions (gowns) iii. (goggles or face shield) iv. Airborne precautions (e.g. N95 mask or face mask) Evaluate and assess the resident: i. every shift temperature checks. ii. every shift pulse ox and record. iii every shift heart rate and record. iv. every shift evaluation of respiratory signs and symptoms. v. daily physical and respiratory assessment by a licensed nurse. Record review of facility's policy on Infection Control, Standard Precautions dated 2011 read Standard Precautions will be used in the care of all residents regardless of their [DIAGNOSES REDACTED]. Record review of a CMS letter titled, COVID-19 Long-Term Care Facility Guidance, dated [DATE], revealed: To provide critical, needed leadership for the Nation's long-term care facilities to prevent further spread of COVID-19, CMS and CDC are now recommending the following immediate actions to keep patients and residents safe: 1. Nursing Homes should immediately ensure they are complying with all CMS and CDC guidance related to Infection Control. 3. Long-term care facilities should immediately implement symptom screening for all. In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc) should be asked about COVID-19 symptoms and they must also have their temperature checked. 4. Long-term care facilities should ensure all staff are using appropriate PPE when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE. For the duration of the state of emergency in their state, all long-term care facility personnel should wear a facemask while they are in the facility. Full PPE should be worn per per CDC guidelines for the care of any resident with known or suspected COVID-19 .If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED]. 5. To avoid transmission within long-term care facilities, facilities should use separate staffing teams for COVID-19 positive residents to the best of their ability and work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19 negative residents from COVID-19 positive residents and individuals with unknown COVID-19 status. 1. Record review of Resident #1- #11, #13, #16 and #20 clinical records revealed: Record review of a Provider Investigative Report, dated [DATE], revealed eight residents (Residents #1, 2, 3, 4, 5, 6, 7, and 8) had tested positive for COVID-19. Resident #1 had expired at the hospital on [DATE] and Resident's #2, 3, 4, and 6 were hospitalized . Residents #5, 7, and 8 were asymptomatic and remained at the facility. The facility reported 2 staff members had tested positive and the facility was working with the health department to identify an exposure point. Further review revealed 100% of the residents were tested for COVID-19 with testing pending and the facility was working with the health department for testing for staff members. Record review of Resident #1's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review of the face sheet revealed Resident #1 was discharged from the facility on [DATE] and expired at the hospital on [DATE]. Record review of Resident #1's COVID-19 laboratory test,0 dated [DATE] and reported to the facility on [DATE] revealed the test was positive for [DIAGNOSES REDACTED]-CoV-2. Record review of Resident #1's Annual MDS dated [DATE] revealed a BIMS of 15 which indicated the resident was cognitively intact. Record review of Resident #1's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. On [DATE] HHSC received a facility self-report from the facility Administrator which revealed the facility had been notified by a local hospital that Resident #1 had tested positive for COVID-19. Further review of the self-report revealed the facility had increased monitoring of resident vital signs and increased team surveillance checks. Staff was re-educated on infection control and use of masks. The facility reported an increase in sanitization of areas to every 2 hours. Record review of Resident #2's face sheet, dated [DATE] revealed an admission date of [DATE] with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Further review revealed Resident #2 was discharged to the hospital on [DATE]. Record review of Resident #2's Annual MDS dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. Record review of Resident #2's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #2's progress note dated [DATE] revealed family notified facility Resident #2 was diagnosed with [REDACTED]. Record review of Resident #3's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review of Resident #3's face sheet revealed the resident was discharged to the hospital on [DATE]. Record review of Resident #3's COVID-19 laboratory test dated [DATE] and reported to the facility on [DATE] was positive for COVID-19. Record review of Resident #3's Quarterly MDS dated [DATE] revealed a BIMS of 7, which indicated a severe cognitive impairment. Record review of Resident #3's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #4's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #4 was discharged to the hospital on [DATE] and later expired at the hospital. Record review of Resident #4's Admission MDS dated [DATE] revealed a BIMS score of 12, which indicated a moderate cognitive impairment. Record review of Resident #4's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #5's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's COVID-19 laboratory test dated [DATE] and reported to the facility on [DATE] revealed the Resident was positive for COVID-19. Record review of Resident #5's Quarterly MDS dated [DATE] revealed a BIMS score of 9, which indicated a moderate cognitive impairment. Record review of Resident #5's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #6's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #6 was discharged to the hospital on [DATE]. Record review of Resident #6's COVID-19 laboratory test dated [DATE] and reported to the facility on [DATE] revealed the resident was positive for COVID-19. Record review of Resident #6's Annual MDS dated [DATE] revealed a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #6's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #7's face sheet, dated [DATE], revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's COVID-19 laboratory results dated [DATE] and reported to the facility on [DATE] revealed the resident was positive for COVID-19. Record review of Resident #7's Quarterly MDS dated [DATE] revealed the residents BIMS score was 99, which indicated a severe cognitive impairment. Record review of Resident #7's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #8's face sheet, dated [DATE], revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's lab results dated [DATE] revealed the resident was positive for COVID-19. Record review of Resident #8's Quarterly MDS, dated [DATE], revealed a BIMS' of 15, which indicated the resident was cognitively intact. Record review of Resident #8's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #9's face sheet, dated [DATE], revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed the resident was discharged to the hospital on [DATE]. Record review of Resident #9's COVID-19 laboratory test dated [DATE] and reported to the facility on [DATE] revealed the resident was negative for COVID-19 at this time. Record review of Resident #9's Quarterly MDS dated [DATE] revealed a BIMS score of 12, which indicated a moderate cognitive impairment. Record review of Resident #9's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. During an interview with the Administrator on [DATE] at 11:20 AM, the Administrator confirmed Resident #9 had tested positive for COVID-19 in a second round of testing which wasn't reported to the facility until the resident was in the hospital. Record review of Resident #10's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #10 was discharged to the hospital on [DATE] and expired on [DATE]. Record review of Resident #10's Quarterly MDS dated [DATE] revealed a BIMS score of 4, which indicated a severe cognitive impairment. Record review of Resident #10's Care Plan for revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #10's hospital medical records dated [DATE] revealed the resident was admitted to the hospital with [REDACTED]. Record review of Resident #11's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's lab results, dated [DATE], revealed the resident was negative for COVID-19. Record review of Resident #11's lab results dated [DATE] revealed the resident was positive for COVID-19. Record review of Resident #11's Quarterly MDS dated [DATE] revealed a BIMS score of 10, which indicated the resident had a moderate cognitive impairment. Record review of Resident #11's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #13 face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #13 was discharged to the hospital on [DATE] and expired at the hospital on [DATE]. Record review of Resident #13's 2nd COVID-19 laboratory test dated [DATE] revealed the resident was positive for COVID-19. Record review of Resident #13's Quarterly MDS dated [DATE] revealed a BIMS score of 5, which indicated a severe cognitive impairment. Record review of Resident #13's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #16's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #16 was discharged to the hospital on [DATE] and expired on [DATE]. Record review of Resident #16's 2nd laboratory test results for COVID-19 dated [DATE] revealed the resident was positive for COVID-19. Record review of Resident #16's Quarterly MDS dated [DATE] revealed a BIMS score of 13, which indicated the resident was cognitively intact. Record review of Resident #16's Care Plan revealed Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #16's Care Plan initiated on [DATE] revealed the resident was at risk for COVID-19 with interventions which included observe isolation precautions as clinically indicated. Further review of the Care Plan revealed the Resident was positive for COVID-19 with a start date of [DATE] with interventions which included observe droplet isolation precautions. Record review of Resident #20's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #20's 2nd laboratory test results for COVID 19 dated [DATE] revealed the resident was positive for COVID-19. Record review of Resident #20's Significant Change MDS dated [DATE] revealed a BIMS score of 99, which indicated a severe cognitive impairment. Record review of Resident #20's Care Plan for Potential for alterations in well-being: Resident is at risk for infection and emotional distress related to measures in place to minimize exposure and associated risks COVID-19 and Influenza started on [DATE] with interventions which included: monitor vital signs and health condition, notify PCP and RP of any change of condition as clinically indicated and observe isolation precautions as clinically indicated. Record review of Resident #20's progress notes dated [DATE] revealed resident was positive for COVID-19. Record review of a Staff Spreadsheet for COVID-19 testing provided by the Administrator revealed: -CNA A risk for exposure was not documented and tested positive for COVID-19 on an unknown date -CNA B was listed at high risk for exposure and tested positive for COVID-19 on [DATE] -CNA C was listed at high risk for exposure and tested positive for COVID-19 on [DATE]. -CNA D was listed as high risk for exposure and tested positive for COVID-19 on [DATE]. -LVN E was listed at high risk for exposure and tested positive on an unknown date -Dietary Aide F was listed as low risk for exposure and tested positive on [DATE]. -LVN G was listed as a medium risk for exposure and tested positive on [DATE]. -CNA OO was listed as high risk for exposure and tested positive for COVID-19 on [DATE] -LVN XX risk for exposure was not documented, tested negative for COVID-19, later developed symptoms and tested positive on an unknown date. 2. Observation on [DATE] at 1:30 PM of the 400-Hall revealed the positive COVID-19 residents were intermingled in the same hall with negative residents and were using the same staff to provide care. During an interview on [DATE] at 4:55 AM LVN RR confirmed COVID-19 positive residents resided on the same hallway as negative residents. During an interview on [DATE] at 5:35 AM LVN RR stated, I can't believe they have both positive and negative resident on the same hall way and they are using the same staff for both halls. We are trying to be careful not to cross contaminate, but it's going to happened. Especially with staff coming in and out of the resident rooms. During an interview on [DATE] at 12:51 PM ADON AAA confirmed positive and negative residents were intermingled on the same hall. ADON AAA stated it was hard to separate the residents because the night shift had less staff to take care of all the residents on both sides, so they had to share staff. ADON AAA further stated she did not give staff instructions or direction on keeping the negative residents separate from the positive residents. During an interview on [DATE] at 11:22 AM ADON K (Infection Control Preventionist) confirmed residents who had tested negative for COVID-19 were still on the same unit as residents who had tested positive. ADON K further confirmed they did not have dedicated staff to care for the COVID positive residents. During an interview on [DATE] at 8:58 AM the DON confirmed negative residents had not been separated from positive residents on the COVID-19 designated hall. Record review of the facility's policy titled Pandemics, undated, revealed, 1. The Administrator and DON has been designated as the staff persons responsible for assessing and coordinating staffing needs during a pandemic outbreak in the community. Tier 1-Containment isolated to a hall/unit: If the community has the ability to place

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(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 6) [MEDICAL CONDITION] residents in separate rooms on the identified hall/unit the plan will be implemented. The isolating/containment of al hall/unit with consistent assignment by specific team members further educated for the [MEDICAL CONDITION]/pandemic situation. 3. Record review of visitor screening questionnaires, dated [DATE]-[DATE], revealed some of the questionnaires were incomplete and screening questions were left blank. Further review revealed some of the questionnaires did not have the name of the person completing the questionnaire and the date was not always filled in. Observation on [DATE] at 12:15 PM upon entrance to the facility revealed visitors' temperature and oxygen saturation were obtained by Receptionist UU instructed the visitors to fill out a questionnaire on a bedside table (that was placed away from the immediate screening area and across from the desk where the actual screening occurred). The questionnaire was completed by the visitor and was not monitored or reviewed by a staff member before entrance into the facility. Further observation revealed no instructions were given to visitors for social distancing, hand hygiene or cough etiquette before entrance into the facility occurred. Observation on [DATE] at 12:17 PM revealed a delivery driver entered the lobby area to deliver packages after being allowed in by facility staff through locked entrance doors. The Delivery driver was not asked to leave the packages outside of the facility for disinfection prior to entrance into the facility and was not asked by staff to answer any screening questions or have his temperature and oxygen saturation measured prior to entrance into the facility. Observation on [DATE] at 5:45 PM in the main entrance with the Corporate Nurse revealed an (unidentified) agency nurse member entered the facility without wearing a mask. The agency nurse rang the doorbell and a staff member from inside the facility opened the front entrance door and allowed the agency nurse to enter into the facility without wearing a mask. Following the observation, the Corporate Nurse acknowledged the agency nurse had entered the facility without wearing a mask. Observation on [DATE] at 10:49 AM revealed a contracted phlebotomist was not asked any health questions regarding symptoms of COVID-19 and was allowed to enter the facility. Observation on [DATE] at 8:30 AM revealed a food service delivery driver was allowed into the facility to deliver packages. The delivery driver was observed walking from the maintenance entrance thru the facility corridors to the front Receptionist desk for screening. Following a temperature and pulse oximeter check the food service delivery driver was allowed back thru the facility for delivery services. Interview on [DATE] at 9:15 AM, Receptionist UU confirmed she had not been providing instructions on social distancing, hand hygiene and cough etiquette and had allowed visitors to self-fill out the form questionnaire regarding COVID-19 exposure and symptoms without reviewing the forms. Interview on [DATE] at 9:51 AM, the Corporate Nurse revealed the staff member who entered the facility was an agency nurse. The Corporate Nurse confirmed that a facility staff member who was already at the facility had to unlock both set of double locked doors to let the agency nurse into the facility without a mask. Interview on [DATE] at 11:22 AM, ADON K (Infection Control Preventionist) stated: For visitor screening: Employees are screened by a nurse, visitors are screened by the receptionist. The facility received Corporate guidance that no one over 99.7 or oxygen saturation in low 90's or whom had answered yes to travel screening questions could be allowed in to the facility. The ADON RN K further stated, a person with symptoms and low-grade fever should not have been allowed in to the facility but a visitor with a temp of 99.6 would be allowed into facility. Interview on [DATE] at 4:30 AM with Night Shift Supervisor RN JJ stated she had received guidance from the Corporate RN this week, (after State entrance) to use the questionnaire to ask the screening questions. Screening also including a temperature check and oxygen saturation reading for anyone coming into the facility. RN JJ stated a temperature of 99.7 or greater required a recheck for temperature accuracy and may require further questioning. RN JJ stated that prior to surveyor entrance, the questionnaire was filled out by the visitor or staff member entering facility and placed in a file that was given to the Administrator. Interview on [DATE] at 8:58 AM with the DON revealed the House Supervisor screens staff and visitors at night and the Receptionist screens staff and visitors during the day. The DON stated she did not know who reviewed the answers to the questionnaire, but indicated the forms go directly to the Administrator. The DON confirmed delivery drivers should not be allowed into the facility and should drop their packages outside. The DON stated service providers such as lab, x-ray, etc. should be allowed into the facility after a proper screening. Interview with Administrator on [DATE] at 11:26 AM, the Administrator stated staff who were considered high risk for exposure were still allowed to work pending testing because they were not symptomatic, and they were screened with the screening process. The Administrator stated she reviewed the questionnaires and the log sheets and followed up with any employee who had symptoms in illness to make sure they had been sent home and had not clocked in to work. The Administer further stated, visitors with symptoms should not be allowed into the facility. Record review of the facility's policy titled Prevent COVID-19 Screening Checklist-Recommendations for Visitors/Service Providers, dated [DATE], revealed: All individuals entering the building should be asked the following questions: 1. Has the individual washed their hands or used alcohol-based hand rub on entry? 2. Ask the individual if they have any of the following symptoms? Fever in last 4 hours, sore throat, runny nose, nausea or vomiting, cough, abdominal pain, diarrhea, shortness of breath. 3. Ask the individual if they have: been recently tested for COVID-19, have you or a family member traveled outside of your city or town in the last 14 days? Worked in another health care setting with confirmed COVID-19 cases? Ask the purpose of visit or entry. 5. Remind the individual to: wash hands or use ABHR hand sanitizer frequently and throughout their time in the building. Do not shake hands with, touch or hug individuals during their visit. Limit distance to 6 feet between yourself and resident as much as possible. 4. Observation on [DATE] at 12:50 PM revealed LVN V had a full beard and was wearing a surgical mask instead of a N95 mask. Interview on [DATE] at 2:40 PM with LVN V, confirmed he had a full beard and was wearing a surgical mask instead of a N95 mask. LVN V confirmed he had not been test fitted for a N95 mask and had not received any