STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND HEALTH CARE CENTER	**705 JACKSON ST RICHMOND, TX 77469**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to include handwashing, appropriate personal protective equipment, and staff to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (CR #1) reviewed for infection control in that: -The facility failed to ensure staff wore appropriate PPE to care for CR #1 who was admitted to the facility with shortness of breath and wheezing and placed on quarantine. - The facility failed to ensure staff were provided with and utilized appropriate PPE to provide care to CR #1 while in quarantine. -LVN-C provided care for CR#1 without wearing the recommended PPE. -CNA-A was observed providing hydration to residents without washing or sanitizing her hands. -CNA-A was observed providing care on the MCU and the Skilled hall. She was observed providing the residents their lunch trays without washing or sanitizing her hands in between residents. These failures placed all residents in the facility at risk for exposure to an infectious disease. Findings include: CR#1 Record review of CR #1's clinical record revealed a [AGE] year old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. He was discharged to the hospital on [DATE]. Record review of CR # 1's MDS assessment dated [DATE] revealed CR #1 had a BIMS score of 3 out of 15 indicating severely impaired cognition. He was totally dependent for eating. He was occasionally incontinent of bowel and bladder. CR #1 did not exhibit the behavior of wandering. Review of section J of the MDS for health conditions revealed shortness of breath with exertion, sitting, and lying flat. Record review of CR#1's Physician orders [REDACTED].#1's Medication Administration Record [REDACTED]#1's nursing progress notes dated [DATE] documented by LVN D revealed the following: .Patient is [AGE] year old African American male admitted from hospital. Patient arrived via stretcher accompanied by 2 EMS. EMS reports that the patient was just given nebs and is wheezing and having shortness of breath while on oxygen. LVN-D assessed patient and immediately administer another neb, oxygen increased to 5 liters per nasal cannula. Patient oxygen is back 100% and he is reduced to 3 liters nasal cannula .Patient is noted to be wheezing after nebs and shortness of breath continued. MD is called and ordered to monitor patient for 24 hours and notify him if any new changes are assessed. Patient current vital signs are blood pressure ,[DATE], pulse 55, respirations 20, temperature 98.7, and oxygen saturation 100%. Resident head of bed is elevated 45 degrees and bed is lowered, he is made comfortable call light within in reach. Will continue to monitor resident closely . Record of CR#1's nursing progress notes dated [DATE] at 6:20 a.m. documented by LVN-E revealed the following: .Resident is refusing ADL care and has his blanket over his face. Attempted to spit at this nurse after throwing nebulizer mask to the floor. Contact/droplet precautions continue . Interview with LVN-C on [DATE] at 11:25 a.m. she said she took care of CR #1 that was in the Memory Care Unit on isolation and was the nurse that sent him out to the hospital. LVN-C said when she was taking care of CR #1, she was not wearing a face shield or an N-95 mask but a surgical mask. LVN-C said she was working the MCU as well as the Skilled unit today [DATE] and had been as well on [DATE]. LVN-C said CR #1 was sent out to the hospital on [DATE] for respiratory problems. Record review of CR#1's nursing progress notes dated [DATE] at 3:23 p.m. documented by LVN-C revealed the following: .At start of shift rounds made to resident noted using accessory muscles to breath. Oxygen intact .oxygen saturation ,[DATE]%. [MEDICATION NAME] suspension 0.25 mg/ml administered as scheduled oxygen saturation remained the same. Resident lethargic not alert per report/normal. The doctor contacted orders received to send to hospital for eval treatment . An attempt was made to contact LVN D via telephone on [DATE] at 12:37 p.m. A message was left for her to call the surveyor. During a telephone interview on [DATE] at 9:03 a.m. LVN D returned the surveyor's call and said she was the nurse that admitted CR #1 on [DATE] because the other nurse was busy admitting another resident that same day. LVN-D said CR #1 arrived at the NF in respiratory distress. LVN D said it was as though the hospital had rushed CR # 1 out of the hospital. LVN-D said CR #1 could not walk and was confined to the bed. LVN-D said CR #1 was initially admitted on the skilled hall then moved to the MCU and set up on isolation precautions. LVN D said while she was caring for CR #1 she wore a gown, N-95 mask, and gloves. Record review of facility self-report 4 dated as reported on [DATE] read in part, .ON [DATE] AT 5:30 PM THE RESIDENT tested POSITIVE FOR COVID-19 AND EXPIRED IN THE HOSPITAL. RESIDENT WAS admitted TO RICHMOND HEALTH CARE CENTER ON [DATE] WITH NOTED WHEEZING AND RESPIRATORY DISTRESS ON TRANSPORT WITH EMS. THE NURSE IMMEDIATELY ASSESSED THE RESIDENT AND ADMINISTERED A NEBULIZER TREATMENT. OXYGEN WAS A MINISTERED, SATS WENT UP TO 100% AND MD WAS NOTIFIED. THE MD GAVE THE ORDER TO MONITOR THE RESIDENT FOR 24 HOURS AND NOTIFY IF ANY NEW CHANGES. THE VITAL SIGNS WERE STABLE AT THE MOMENT AT THAT TIME. THE D.O.N RE-NOTIFIED THE PHYSICIAN ON [DATE]. Medical Director STATED THAT HE DID NOT WANT TO SEND RESIDENT TO THE HOSPITAL AND TO CONTINUE TO MONITOR THE RESIDENT AND NOTIFY OF ANY CHANGES. THE MD STATED THAT A PROVIDER, HIMSELF OR THE MP (sic), WILL COME THE NEXT DAY. ON [DATE] THE FACILITY RECEIVED A HOSPITAL POST ACUTE CARE. FACILITY TRANSFERRED COVID-19 ASSESSMENT. THE SCREENER WAS RECEIVED FROM THE HOSPITAL ON ADMISSION AND THE RESIDENT DID NOT MEET THE CRITERIA FOR COVID-19 TESTING. THE RESIDENT WAS IMMEDIATELY PLACED ON DROPLET AND CONTACT PRECAUTIONS WHILE IN THE FACILITY. HE WAS IN A ROOM BY HIMSELF, STAFF ENTERED USING THE APPROPRIATE PPE INFECTION CONTROL PRACTICES. THE NURSES USE THE N-95 RESPIRATOR FOR ADMINISTRATION OF BREATHING TREATMENTS. [DATE] THE 3:39 PM, THE RESIDENT WAS discharged TO local MEDICAL CENTER DUE TO RESPIRATORY DISTRESS. THE RESIDENT HAD BEEN IN THE FACILITY APPROXIMATELY 18 HOURS. HE WAS admitted on [DATE] APPROXIMATELY 8:53 P.M. THE RESIDENT WAS tested AT THE HOSPITAL FOR COVID-19 ON [DATE] AND THE RESULTS WERE RECEIVED BY THE FACILITY ON [DATE] THAT RESIDENT IS POSITIVE FOR COVID-19 AND EXPIRED IN THE HOSPITAL. RESIDENT WAS TO BE discharged HOME ON HOSPICE. THE RESIDENT WAS ASSESSED BY (NAME & TITLE OF STAFF) ON [DATE] AT 8:20 PM UPON ADMISSION AND AGAIN AT THE TIME OF DISCHARGE ON [DATE] AT 1:00 PM, THE RESIDENT WAS SENT TO local hospital. NO INJURIES WERE NOTED. RESIDENT WAS TREATED AT THE HOSPITAL FOR RESPIRATORY SYMPTOMS. . Interview on [DATE] at 9:22 a.m. the Administrator said the facility had more than enough PPE and had contacted SETRAC for PPE. The Administrator said she had already received ,[DATE] shipments. The Administrator said she was also receiving PPE (N-95's, gloves, gowns, face shields, and shoe protectors) from the NF main supplier. The Administrator said the NF was also receiving PPE from their Corporate office, and utilized outside vendors. The Administrator said a daily inventory was taken on all of their PPE. The Administrator said she had approximately regarding PPE the following: 7 boxes of N-95 with 50 in a box, gowns 300, shoe protectors over 500 pairs, gloves ,[DATE] boxes, surgical masks over 300, and 100 face shields. The Administrator said the isolation rooms were deep cleaned every day. The Administrator said her staffing contingency would consist of regional corporate, sister facilities, and agency. She said the NF had an isolation hall which was the Skilled Hall and that she had designated staff for each hall and the staff did not float to other halls. The Administrator said when CR #1 came to the facility on [DATE] he was placed on the MCU on isolation with designated staff to take care of him. The Administrator said after CR #1 was sent back to the hospital on [DATE] due to respiratory distress, the hospital tested CR #1 for COVID-19 on [DATE] and the results on [DATE] revealed he was positive. Further interview with the Administrator at that time, said she then called the FORT BEND Health Department. The Administrator said she told the HD that she had placed CR #1 on isolation in the MCU with designated staff. The Administrator said she was instructed by the HD to monitor the residents and watch for s/s of COVID-19. The Administrator said the resident temperatures were being taken every 4

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) hours and oxygen saturation levels, along with vital signs, were done q shift. The Administrator said there had been no spikes in temperatures or other signs of COVID-19. The Administrator said the HD said an Epidemiologist would be coming to the NF the upcoming week and the Medical Director had weekly meetings with the NF. The Administrator said she spoke with the Medical Director on a daily basis. Interview on [DATE] at 12:20 p.m. with the Administrator and DON said the hospital screened CR #1 for COVID-19 testing criteria and deemed he did not meet criteria for testing. The Administrator said CR #1 had originally been at home prior to going into two different hospitals then admitted to the NF. The Administrator said CR #1 was in the hospital for 10 days. The DON said when CR #1 arrived at the NF on [DATE], he was in respiratory distress. The DON said she called the Medical Director asking if she could send CR #1 back to the hospital and the MD told her no, and just to continue to monitor CR #1. The DON said CR #1 was placed on isolation in the MCU with designated staff. The Administrator said when the surveyor had initially asked her the question about designated staff caring for CR #1, she misunderstood because the staff that took care of the residents on the Skill Hall also covered the MCU as well. The Administrator said she would have to call back the Health Department for further directions concerning the 9 staff members and residents on MCU along with housekeeping that had been exposed to CR #1. Record review of CDC website cdc.gov revealed, .PRIORITIES FOR COVID-19 TESTING (Nucleic Acid or [MEDICATION NAME]) High Priority hospitalized patients with symptoms Healthcare facility workers, workers in congregate living settings, and first responders with symptoms Residents in long-term care facilities or other congregate living settings, including prisons and shelters, with symptoms Priority Persons with symptoms of potential COVID-19 infection, including: fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and/or sore throat. Persons without symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening of other asymptomatic individuals according to state and local plans. . During a telephone interview on [DATE] at 1:00 p.m. with the Medical Director, CR #1's physician, said he never tested CR#1 for COVID-19 before admitting the resident to the NF. He was CR #1's physician in the hospital and was the Medical Director for the nursing facility. The MD said the nurse did call him asking if CR #1 could be returned to the hospital on [DATE] but he denied the request and told the staff to monitor the resident's oxygen saturation and vitals. The MD said he did not give orders to place CR #1 on isolation. Further interview with the MD said he should have tested CR #1 for COVID-19 before admitting the resident to the SNF. When asked again why he kept CR #1 in the facility and did not order testing for COVID-19 he said CR #1 did not meet testing criteria. Interview on [DATE] at 8:32 a.m. LVN-C said she worked the weekend shift and the NF did not have a designated isolation/quarantine wing. Observation on [DATE] at 8:35 a.m. revealed CNA-A on the skilled hall entering and exiting resident rooms providing fluids to the residents without performing hand hygiene with either soap and water or hand sanitizer. Interview on [DATE] at 11:15 a.m. with the DON said she started working at the NF in February of 2020. The DON said the Skilled Hall was the designated hall as their isolation hall for COVID-19. The DON said residents that were placed on the Skilled Hall were new admissions, readmits, residents that spiked a temperature or had any respiratory issues. The DON said the NF had 8 rooms on the Skilled Hall that were private rooms. The DON said if the Skilled Hall did not have space to receive another resident that became sick or had spiked a temp or had respiratory issues, that resident would have to isolate in their room on the hall they reside on. Further interview with the DON at that time she said the NF had three residents now on the Skilled hall on isolation, rooms [ROOM NUMBER]. The DON said every resident in the building temperature was being taken every 4 hours and assessed for respiratory issues and oxygen saturation every shift. The DON said if a resident had a temp over 99, the NF would call the doctor and isolate the resident. The DON said the way the NF building was designed it did not make sense to be moving the residents around. The DON said some of the signs and symptoms of COVID-19 were shortness of breath, increase in temperature over a 100 degrees, headache, and dry cough. Observation on [DATE] at 11:25 a.m. in the Memory Care Unit revealed room [ROOM NUMBER] had an isolation hanger on the door with PPE inside of it. There was no sign on the door indicating isolation/quarantine status. LVN-C was removing her PPE at the doorway entrance that consisted of a gown and gloves. LVN-C was wearing a surgical mask instead of an N95 and she did not have on a face shield. Interview on [DATE] at 11:25 a.m. LVN-C said the resident in room [ROOM NUMBER] was on isolation precautions because he had been in the hospital and was a readmit. LVN-C said she worked the Skilled Hall as well as the MCU. LVN-C said whatever nurse that worked the skilled hall also worked the MCU as well and that was how the staffing was done for the MCU and Skilled Hall. LVN-C said the resident in room [ROOM NUMBER] had tested negative for COVID-19 at the hospital. This surveyor asked LVN-C why did she not have on an N-95 mask and LVN-C said she thought she needed the face shield and N-95 if a resident was coughing. Observation on [DATE] at 11:35 a.m. revealed Resident #5 in the MCU in his room eating, no distress observed. Observation on [DATE] at 11:35 a.m. revealed Resident #6 in the MCU room [ROOM NUMBER]-A bed with the door closed. Observation on [DATE] at 11:40 a.m. revealed CNA-A in the MCU delivering lunch to the residents on regular plates instead of disposables. CNA A was going in and out of the resident rooms not performing hand hygiene before entering or exiting the rooms. Further observation was made of hand sanitizers along the hallway in the MCU mounted on the wall. Further observation was made when CNA-A was done passing out trays on the MCU, CNA-A went to the dining room to assist with feedings in the dining room without performing hand hygiene. Observation was made of hand sanitizing solution on top of a food cart in the dining area. Interview on [DATE] at 11:50 a.m. with CNA-A said she was supposed to sanitize her hands before entering a resident room and as exiting a resident room in order to kill any germs. Interview on [DATE] at 10:20 a.m. with the Administrator who said the facility was not accepting any admissions and no one had been discharged from the NF since [DATE]. The Administrator said the census for the Memory Care Unit was still at 16 and 7 for the Skilled Hall. She said there will be a total of 23 residents and 15 staff members being tested for COVID-19 which would start on [DATE]. The Administrator said she was told by the HD that an Epidemiologist would be coming out to the NF this week. Record review of CDC.gov website revealed in part, .The PPE recommended when caring for a patient with known or suspected COVID-19 includes: Respirator or Facemask (Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19 or other situations where a respirator or facemask is warranted) Put on an N95 respirator (or higher level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use or reuse strategies to optimize PPE supply. Higher level respirators include other disposable filtering facepiece respirators, PAPRs, or [MEDICATION NAME] respirators. N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient ' s room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask. ?If reusable respirators (e.g., powered air-purifying respirators (PAPRs)) are used, they must be cleaned and disinfected according to manufacturer ' s reprocessing instructions prior to re-use. *When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program. Eye Protection ?Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Personal eyeglasses and contact lenses are NOT considered adequate eye protection. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer ' s reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. Gloves Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated. Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene. Gowns Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. If there are shortages of gowns, they should be prioritized for: *aerosol generating procedures *care activities where splashes and sprays are anticipated *high-contact patient care activities that provide opportunities for transfer of pathogens to the *hands and clothing of HCP. Examples include: *dressing *bathing/showering *transferring *providing hygiene *changing linens *changing briefs or assisting with toileting *device care or use *wound care Additional strategies for optimizing supply of gowns are available. Facilities should work with their health department and healthcare coalitionexternal icon? to address shortages of PPE. 3. Patient Placement For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization . If hospitalization is not medically necessary, home care is

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) preferable if the individual ' s situation allows. If admitted , place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom. Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients who will be undergoing aerosol generating procedures (See Aerosol Generating Procedures Section) As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with known or suspected COVID-19. Dedicated means that HCP are assigned to care only for these patients during their shift. . Record review of the NF policy on Infection Control revised [DATE] read in part: .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections . Record review of the NF policy on Handwashing/Hand Hygiene revised [DATE] read in part: .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .Before and after assisting a resident with meals .before and after entering isolation precaution settings .