STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675922	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKVIEW MANOR NURSING AND REHABILITATION	**206 N SMITH ST WEIMAR, TX 78962**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - 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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission for 5 of 7 (Residents #1, #2, #3, #4, and #5) reviewed for infection control; in that: - CNA A and CNA B pulled their face masks off their faces while assisting Resident #1 and Resident #2 during a meal. - Med Aide failed to perform hand hygiene when passing medications to Resident #3 and Resident #4. - CNA C was entered Resident #5's room who had isolation-precautions without gloves or a gown. These failure could place all residents at risk of spread of transmittable diseases, such as COVID-19. Findings Included: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old female, admitted on [DATE] and diagnosed with [REDACTED].#2 Record review of Resident #2's face sheet revealed a [AGE] year-old male, admitted on [DATE] and diagnosed with [REDACTED].#1 and CNA B was feeding Resident #2. Both CNAs had their surgical face masks pulled down, exposing the nose. In an interview at this time, CNAs A and B stated they pulled down their face masks because they have trouble breathing with the masks. When asked how masks are supposed to be worn while during resident care, they stated that is should cover both the mouth and the nose. In an interview on 4/30/20 at 11:50 AM, the DON stated that staff had been trained on how to properly wear a face mask. He said he was aware of staff complaining that masks were uncomfortable, but said that masks were to worn correctly at least during direct resident care. Resident #3 Record review of Resident #3's face sheet revealed a [AGE] year-old male, admitted on [DATE] and diagnosed with [REDACTED]. Resident #4 Record review of Resident #4's face sheet revealed a [AGE] year-old female, admitted on [DATE] and diagnosed with [REDACTED]. Observations of med pass on 4/30/20 at 12:56 AM revealed the Med Aide passing medications to Resident #3 and Resident #4, respectively. The Med Aide first gave Resident #3 her medication. Then, she prepared Resident #4's medication without performing hand hygiene and after touching her face mask. The Med Aide then gave the medications to Resident #4. In an interview with the Med Aide at this time, the Med Aide said she forgot to wash her hands in between passing meds to Resident #3 and Resident #4. Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female, admitted on [DATE] and diagnosed with [REDACTED]. In an interview on 4/30/20 at 10:52 AM, the Administrator stated five resident rooms were currently being used for isolation-precautions due to the concerns about the spread of COVID-19. Any new or re-admissions who did not have a negative COVID-19 test in the hospital were automatically placed on 14-day quarantine. These residents were monitored multiple times a day for signs or symptoms of the disease. [MEDICAL TREATMENT] patients also remained on isolation precautions due to risk of exposure when leaving and entering the facility regularly. Observations of hallway on 4/30/20 at 1:40 PM revealed CNA C entering and leaving Resident #5's room without using PPE, particularly gowns and gloves. In an interview at that time, CNA C stated she believed she may be have needed to don PPE. She said she felt it was unnecessary since the resident was just asking for her blinds to be closed. Observations of hallway on 4/30/20 at 1:50 PM revealed CNA C donning PPE, to assist with Resident #5 in room. CNA C left the room without washing her hands, but instead washed her hands at the nurses' station at the end of the hall. In an interview DON on 4/30/20 at this time, the DON stated he had trained his nursing staff on donning PPE as well as proper hand hygiene when providing care for resident in a room that was on isolation-based precautions. When asked about monitoring for staff compliance of infection control, he stated that he had been monitoring staff at different times throughout the day and on different shifts and he had not observed nursing staff missing opportunities for hand-hygiene or forgetting to don proper PPE prior to entering rooms. Record review of the COVID 19 Policy and Procedure updates (undated) revealed that, each staff member will enter the facility post screening and apply their face mask according to instructions before proceeding to patient care .full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 symptoms or diagnosed . Record review of the CDC guidelines, last revised 4/3/20 read in part, . 3) Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel . 4) Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available) . 5) Put on face shield or goggles. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common .

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