STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE HEALTH AND REHABILITATION CENTER	**1106 GOLFVIEW 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.

(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 establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 3 of 27 residents (Resident#5, #6, and #7) residents reviewed for infection control. -The facility failed to maintain a system of wiping surfaces that minimized the risk of cross-contamination by wiping surfaces in COVID19 positive residents' rooms, then PUI rooms. -The facility failed to implement procedures to reduce the risk of infection for COVID-19 negative Residents #5, #6, and #7 who resided on the COVID-19 positive hall among positive residents. -The facility failed to ensure staff were knowledgeable regarding which residents were COVID-19 positive and which residents were PUI. These failures placed COVID-19 negative residents on the COVID positive unit at higher risk for exposure to, and possible contraction of COVID19. Findings include: Record review of the Admission Record for Resident #1 revealed she was [AGE] years of age, and was admitted to the facility on [DATE]. Review of the COVID19 lab result revealed the nasopharynx sample was collected on 07/18/20 and the result was dated 07/20/20. The Test Result reflected COVID19 Positive. A Progress Note dated 07/29/20 at 7:00 p.m. reflected the resident returned from the hospital with a [DIAGNOSES REDACTED]. Record review of the Admission Record for Resident #5 revealed he was [AGE] years of age, and was admitted to the facility on [DATE]. Record review of Resident #5's COVID19 lab result revealed the nasopharynx sample was collected on 07/18/20 and the result was dated 07/21/20. The Test Result reflected COVID19 Not Detected. Record review of the Admission Record for Resident #6 revealed he was [AGE] years of age, and was admitted to the facility on [DATE]. Record review of Resident #6's COVID19 lab result revealed the nasopharynx sample was collected on 07/18/20 and the result was dated 07/28/20. The Test Result reflected COVID19 Not Detected. Record review of the Admission Record for Resident #7 revealed she was [AGE] years of age, and was admitted to the facility on [DATE]. Record review of Resident #7's COVID19 lab result revealed the nasopharynx sample was collected on 07/18/20 and the result was dated 07/21/20. The Test Result reflected COVID19 Not Detected. Interview on 07/30/20 at 9:45 a.m. with the Administrator she said the 100 Hall was the facility's designated COVID-19 unit. Record review of the resident roster dated 07/29/20 revealed there were 27 residents residing on the 100 Hall. In an interview on 07/30/20 at 4:50 p.m. on the 100 Hall with LVN A, she said there were COVID-19 positive residents and some 'exposed' residents on the hall. She said she did not work on the hall very often, and would have to check the computer to check which residents were COVID-19 positive and which were exposed. Observation on 07/30/20 at 4:52 p.m. of the 100 Hall revealed all of the resident room doors were open. In an interview on 07/30/20 at 4:55 p.m. on the 100 Hall, CNA B said all of the residents on the hall were COVID19 positive. Observation on 07/31/20 at 11:50 a.m. of the 100 Hall revealed Hskp C was wiping surfaces on the end of the hallway. He had three cloths in his hands, and wiped the handrails and doorknobs in the hallway. He did not have a spray bottle with him. Continued observation revealed Hskp C entered room [ROOM NUMBER], occupied by Resident #1. Hskp C exited the room and went into room [ROOM NUMBER], occupied b Resident #2. Observation revealed Hskp C wiped the overbed table, the restroom door handle, and the room door handle with the same three cloths. He then wiped the handrail between rooms [ROOM NUMBERS]. Continued observation on 7/31/20 at 11:54 a.m. of Hskp C revealed he entered room [ROOM NUMBER], occupied by Resident #3 and Resident #4. Hskp C wiped the overbed table, the restroom door handle, and the room door handle with the same three cloths. Both residents were observed to be in the room. Continued observation on 7/31/20 at 11:56 a.m. of Hskp C revealed he entered room [ROOM NUMBER], occupied by Resident #5 and Resident #6, who were COVID-19 negative. Hskp C wiped the overbed tables, the restroom door handle, then the room door handle with the same three cloths used in the previous COVID-19 positive rooms. At no time during the above continuous observations did Hskp C rinse the three cloths or spray anything on the cloths or the surfaces. Continued observation of Hskp C on 7/31/20 at 12:00 p.m. revealed he walked to the other end of the hallway to a housekeeping cart. There was a small bucket on top of the cart with liquid in it. Hskp C dipped the three cloths into the solution and wrung them out. In an interview on 07/31/20 at 12:01 p.m., Hskp C said the solution in the bucket was bleach and water. He said that was what he was using to clean/sanitize. In an interview on 07/31/20 at 2:20 p.m., Hskp Supv D said Hskp C was assigned to the COVID19 unit (100 Hall). She said the protocol was to clean and sanitize the common areas with a spray sanitizer and let it sit. She said the same protocol was to be used in the resident rooms, including the overbed tables. When informed of the technique observed of Hskp C, Hskp Supv D acknowledged Hskp C did not sanitize correctly. Observation and interview on 07/31/20 at 12:10 p.m. of LVN E revealed she was standing in front of the medication cart near room [ROOM NUMBER], occupied by Resident #7. When asked if she knew which residents were COVID-19 positive, and which were COVID-19 negative, she said she did not know. Observation and interview on 07/31/20 at 12:12 p.m. revealed CNA F gathering clean linens on the 100 Hall. CNA F said she did not know if any of the residents on the hall were COVID-19 negative. In an interview on 07/31/20 at 2:00 p.m., the DON said the criteria for residing on the 100 Hall was a positive COVID-19 test result. She said Resident #5 and Resident #6 were residing on the 100 Hall prior to that hall being transformed into the COVID-19 unit. She said both residents refused to change rooms to a different hall. She said both residents were COVID-19 negative. Record review of Resident #6's progress note dated 07/21/20 at 11:22 a.m. revealed confirmation that Resident #6 had refused to move. In an interview on 07/31/20 at 2:10 p.m., the ADON said they could not locate documentation regarding Resident #5's refusal to change rooms. As of the time of exit, the facility did not present documentation to validate Resident #5 had refused to move. In an interview on 07/31/20 at 3:00 p.m., the Administrator said Physician G wanted Residents #5, #6, and #7 to remain on the 100 Hall because the negative test results weren't received until 07/28/20. She said Resident #5 and Resident #6 had refused to move. In a telephone interview on 07/31/20 at 3:45 p.m., Physician G said the results for some of the residents were received late. She said Residents #5 and #6 were her patients and knew they remained on the 100 Hall. She said Resident #7 was not her patient, and did not know about him. She said she did not talk with the Administrator about Resident #7.

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.