STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455625	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTA VISTA REHABILITATION AND HEALTHCARE	510 PAREDES LINE RD BROWNSVILLE, TX 78521

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were treated in a respectful manner that maintained or enhanced each resident's dignity, for five Residents (R#4, R#7, R#8, R#9, and R#10) of 10 residents observed for assistance with eating. RA A, MA F, CNA G, Medical Records Staff H, and LVN/MDS I stood over residents while assisting the residents with eating instead of sitting next to the residents at eye level, in Hall 100 and Hall 400, during the lunch meal. These failures could place residents who required assistance from staff for eating at risk for feeling uncomfortable and disrespected and could decrease their self-esteem and/or quality of life. Findings included: 1) Record review of R#4's Admission Record, dated 08/14/20, revealed R#4 was 73-years-old and was admitted to the facility on [DATE]. R#4's [DIAGNOSES REDACTED]. Record review of R#4's Minimum Data Set (MDS) assessment, dated 07/28/20, revealed R#4: -was able to make herself understood and was able to understand others, -had severely impaired cognition, -was dependent on staff for eating, Helper does all of the effort., and -requires limited assistance of one person for eating. Record review of R#4's Care Plan, dated 04/21/19, revealed R#4 required one staff participation to eat and required total assistance to eat. Observation on 08/12/20 at 11:29 a.m. revealed RA A assisting R#4 by feeding R#4 with a spoon. RA A was standing in front of R#4 in Hall 3, in front of R#4's room. R#4 was sitting in her wheelchair with a bedside table in front of her. In an interview on 08/12/20 at 11:40 a.m., RA A said usually the staff would assist the residents with feeding while sitting down in a chair next to them or in front of them. RA A said she did not do this because, since the residents were now eating in the hallway, she did not want to block the hallway with the chair. 2) Record review of R#7's Admission Record, dated 08/14/20, revealed R#7 was 85-years-old and was admitted to the facility on [DATE]. R#7's [DIAGNOSES REDACTED]. Record review of R#7's Minimum Data Set (MDS) assessment, dated 07/24/20, revealed R#7: -had unclear speech, -was usually able to make self-understood and was usually able to understand others, -had severely impaired cognition, and -was totally dependent on staff for eating, Helper does all of the effort. Observation on 08/12/20 at 11:46 a.m. revealed MA F assisting R#7 by feeding R#7 with a spoon. MA F was standing in front of R#7 in Hall 1, outside of R#7's room. R#7 was sitting in a wheelchair with a bedside table in front of her. In an interview on 08/12/20, at the time of the observation, MA F said she was not sitting next to the resident to assist with feeding because she forgot to grab a chair. MA F said staff were supposed to be seated next to the residents, at their eye level, during feeding assistance. 3) Record review of R#8's Admission Record, dated 08/14/20, revealed R#8 was 44-years-old and was admitted to the facility on [DATE]. R#8's [DIAGNOSES REDACTED]. Record review of R#8's Minimum Data Set (MDS) assessment, dated 07/29/20, revealed R#8: -has unclear speech, -was able to make herself understood and was able to understand others, -had moderately impaired cognition, and -requires total assistance from one staff for eating. Record review of R#8's Care Plan, dated 08/04/20, revealed: (R#8) has nutritional problems or potential nutritional problem related to mechanically altered diet. She is on a regular diet with mechanical soft textures and thin liquids. -She has a hard time swallowing, give her liquado (shake) with breakfast per family. Observation on 08/12/20 at 11:49 a.m. revealed CNA G assisting R#8 by feeding R#8 with a spoon. CNA G was standing in front of R#8 in Hall 1, in front of R#8's room. R#8 was sitting in her wheelchair with a bedside table in front of her. In an interview on 08/12/20, at the time of the observation, CNA G said usually the staff would assist the residents with feeding while sitting down on a chair next to them or in front of them. CNA G said she was not sitting down to assist R#8 with feeding because she forgot to get a chair. 4) Record review of R#9's Admission Record, dated 08/14/20, revealed R#9 was 83-years-old and was admitted to the facility on [DATE]. R#9's [DIAGNOSES REDACTED]. Record review of R#9's Minimum Data Set (MDS) assessment, dated 07/01/20, revealed R#9: -was able to make herself understood and was able to understand others, -had severely impaired cognition, and -required extensive assistance from one staff for eating. Record review of R#9's Care Plan, dated 05/12/20, revealed: (R#9) continues on NAS (No Added Salt) diet with Puree texture and thin liquids. She eats 100 % of her meals, she eats with total assistance . Observation on 08/12/20 at 11:52 a.m. revealed Medical Records Staff H assisting R#9 by feeding R#9 with a spoon. Medical Records Staff H was standing in front of R#9, in Hall 1, in front of R#9's room. R#9 was sitting in her wheelchair with a bedside table in front of her. In an interview on 08/12/20, at the time of the observation, Medical Records Staff H said she would usually come from her office to assist with feeding the residents who required feeding assistance because there were several residents who required assistance. Medical Records Staff H said usually the staff would assist the residents with feeding while sitting down in a chair next to them or in front of them. Medical Records Staff H said she did not sit down to assist R#9 with feeding because the hall was crowded and there was not enough room in the hallway to feed all the residents while staff were sitting on chairs next to them. 5) Record review of R#10's Admission Record, dated 08/14/20, revealed R#10 was 63-years-old and was admitted to the facility on [DATE]. R#10's [DIAGNOSES REDACTED]. Record review of R#10's Minimum Data Set (MDS) assessment, dated 05/20/20, revealed R#10: -was able to make herself understood and was able to understand others, -had severely impaired cognition, and -required extensive assistance from one staff for eating. Record review of R#10's Care Plan, dated 07/21/20, revealed: (R#10) continues on an NAS diet with mech (mechanical) soft thin liquids. He is also on Medpass (supplement) 2x (two times) a day. He eats up to 100% of his meals and he eats with limited to total assist. Observation on 08/12/20 at 11:54 a.m. revealed LVN/MDS I was assisting R#10 by feeding R#10 with a spoon. LVN/MDS I was standing in front of R#10, in Hall 1, in front of R#10's room. R#10 was sitting in the wheelchair with a bedside table in front of him. In an interview on 08/12/20, at the time of the observation, LVN/MDS I said he worked as the MDS nurse. LVN/MDS I said he would come to assist the residents who required assistance with feeding during meals because there were several residents who required assistance. LVN/MDS I said he was standing up to feed R#10 because there was not a lot of room in the hallway to sit down on a chair next to the resident. In an interview on 08/12/20 at 12:00 p.m., DON E said the staff who were feeding residents were required to sit next to, or across from, the resident who was being assisted. DON E said, due to the circumstances with COVID-19 (Coronavirus), the facility was not using the dining room for feeding assistance as they were before. DON E said this was the reason the feeding assistance was happening in the hallways. DON E said the staff was not required to sit down in chairs while feeding the residents because they had tried doing that and there was just too much clutter in the way with the bedside tables, resident wheelchairs and the staff chairs. DON E said he feared that if a code was called down the hallway, staff would have a hard time getting down the hallway with all the obstacles in the way. DON E said the residents were not being assisted with eating in their rooms because they were used to eating with other people around them. DON E said he had seen a decline in the amount of food the residents were eating in their rooms versus outside in the hallways. DON E acknowledged it could be a dignity issue for staff to stand next to the residents while assisting with feeding, but said the facility was trying different interventions to control the spread of COVID-19 and keeping the residents eating their meals. DON E said he and Administrator D had discussed opening the dining room again for assisted feeding only.

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

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F 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Record review of the facility policy titled, Resident Rights, revealed the policy did not address dignity issues.
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 prevent the development and transmission of communicable disease and infections, for four Residents (R#1, R#2, R#5, R#6), of five residents observed for infection control practices. 1) CNA A wore a surgical mask underneath her KN95 mask (mask that provides 95% protection against all particles that are greater than 0.3 m in diameter). 2) RA B did not perform hand hygiene between R#1 and R#2 during meal set up. 3) CNA C did not perform hand hygiene between R#5 and R#6 during meal set up. These failures could affect residents who were dependent upon care and place them at risk for healthcare associated cross-contamination, infections, and COVID-19 (Coronavirus). Findings included: 1) Observation on 08/12/20 at 2:45 p.m. revealed CNA A was standing in the hallway of Hall 4 (Warm Zone), documenting on the computer. CNA A was wearing a surgical mask underneath her KN95 mask. In an interview at the time of the observation, CNA A said she wore the surgical mask underneath the KN95 mask because she felt she was able to get a better seal this way. In an interview on 08/12/20 at 2:47 p.m., the DON said the Warm Zone meant an area housing newly admitted residents and residents with symptoms of COVID-19 who were pending test results. The DON said the staff may wear the surgical mask under the KN95 mask or however they felt more comfortable. The DON said some staff wore the surgical mask and KN95 mask this way because they felt they got a better seal. In an interview on 08/12/20 at 2:55 p.m., the Administrator said she was not aware the surgical mask could not be worn under the KN95 mask. Record review of the facility policy titled, Infection Control Policy/Procedure, revised November 2007, revealed: Respirators: 1. Wear respirator to protect from inhalation of infectious aerosols (e.g., [DIAGNOSES REDACTED]) 2. How to don respirator: Select a fit tested respirator Place over nose mouth and chin Fit flexible nose piece over nose bridge Secure on head with elastic Adjust to fit. Record review of the HHSC COVID-19 Response for Nursing Facilities (Version 3.4), dated 08/12/20, revealed: 1) The respirator must be put on correctly and worn during the exposure. 2) The respirator must fit snugly against the user's face to ensure that there are not gaps between the user's skin and respirator seal. 2) Observation on 08/12/20 at 11:19 a.m. revealed RA B was observed putting clothing protectors on five residents sitting in the hallway of Hall 3. The residents were in their wheelchairs with bed side tables in front of them. RA B grabbed a folded-up clothing protector from a bedside table set up in the hall way with multiple clean clothing protectors. RA B got the first clothing protector and put it on R#1. Immediately after putting the clothing protector on R#1, RA B went back to the table with the clean clothing protectors, obtained another one, and placed it on R#2. There was no hand hygiene performed between placing the clothing protectors on R#1 and R#2. In an interview on 08/12/20 at 11:44 a.m., RA B said staff were supposed to perform hand hygiene with the hand sanitizing foam between every resident. 3) Observation on 08/12/20 at 11:35 a.m., revealed R#5 and R#6 were sitting in their wheelchairs, with bedside tables in front of them, in the hallway in front of their rooms. CNA C placed R#5's meal tray on the bedside table and set up her meal by opening the meal and beverage containers for R#5. CNA C then grabbed a cloth napkin from a table that had multiple clean napkins on it located in the hallway and placed it on R#6's bedside table. CNA C did not perform hand hygiene after setting up R#5's meal tray and before grabbing the clean cloth napkin and setting it on R#6's bedside table. In an interview on 08/12/20 at 11:38 a.m., CNA C said she should have sanitized her hands after setting up R#5's meal tray and before getting a clean cloth napkin for R#6. In an interview on 08/12/20 at 2:32 p.m., Administrator D said staff should sanitize their hands between each resident. Administrator D said the residents who required assistance with feeding were sitting outside of their rooms in the hallways during meals due to the dining room being closed because of a rise in COVID-19 cases. Record review of the facility policy titled, Hand Washing, revised May 2007, revealed: Policy: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Purpose: Hand washing is generally considered the most important single procedure for preventing nosocomial infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Although antiseptics and other hand washing agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the hand washing technique followed. Record review of HHSC COVID-19 RESPONSE FOR NURSING FACILITIES, Version 3.4, dated 08/12/20, revealed: Impact of environment on COVID-19 response: .Meals can be served in the dining room for residents who require assistance with feeding if social distancing is practiced.