STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675764	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING BRANCH TRANSITIONAL CARE CENTER	1615 HILLENDAHL RD HOUSTON, TX 77055

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 environment and to help prevent the development and transmission of communicable diseases and infections 1 of 2 COVID units reviewed for infection control. -The facility failed to ensure the plastic barrier separating the COVID positive section from the COVID negative section of hall was properly secured to prevent potential spread of COVID-19 to residents in the negative rooms. -The facility failed to ensure staff who were providing care to COVID positive residents wore appropriate PPE to include face shield or goggles. -The facility failed to ensure biohazard linen was properly stored on the COVID positive unit. These failures could affect all residents and placed them at risk of exposure to infectious disease. Findings include: Plastic barrier Observation and interview on 7/25/20 at 4:01 pm of the 3-West COVID positive unit with Maintenance revealed, a clear protective plastic barrier separating the hot (positive) and cold (negative) zones. The top left and right corners of the barrier were not properly secured, exposing the cold zone to the hot zone. When asked if the plastic barrier was supposed to be secured, Maintenance stated yes, and he will get right on it. Observation on 7/27/20 at 10:22 am of the 3-West COVID positive unit revealed, the clear protective plastic barrier separating the hot zone from cold zone was not properly secured. The tape securing the top right and bottom left corners had come loose leaving two large holes and exposing the cold zone to the hot zone. Interview on 7/27/20 at 11:39 am with Administrator, when asked why the protective barrier on the COVID positive unit was not properly secured, he stated they are trying to keep up with the plastic so there are not any incidents. He stated early this morning they had a 911 call and EMS had to go through the barrier. He further stated Maintenance staff is supposed to check the plastic barriers every two hours daily to ensure it is secured. Interview on 7/27/20 at 1:12 pm with Maintenance, when asked what his job responsibilities were at the facility, he stated he covers all floors, primarily 3-East. He said he puts up the plastic barriers and checks them and if anything needs to be done, or if the barrier needs to be secured he does that. When asked how often the plastic barrier is checked to ensure it is secured properly, he stated usually 3-4 times daily, further stating it could be more. He said he checks the barriers when he gets into work at 6 am, stating his routine is checking the floors, the A/C chiller, then he works his way down the floors. He said if he sees anything that needs to be done, he does it. Further interview on 7/27/20 at 1:12 pm with Maintenance, he stated 3-West was not his floor, but he noticed the plastic barrier coming down around 9-9:30 am. He said it was now replaced, stating he put a whole new plastic barrier up. When asked when he noticed the barrier on 3-West was not properly secured, he stated after he took out the biohazard trash, stating he checked 3-East and 3-West and he saw it was coming down, so he checked it. When asked if any staff notified him the plastic barrier was not secured, he said at this time we did not receive a notification about the barrier. He stated that is the problem, lack of communication. When asked who can report to him if the barrier is not properly secured, he stated, anyone could tell him. He further stated, Again it's communication. PPE Interview on 7/25/20 at 1:33 pm with the ADON, when asked what PPE should staff wear while working on the COVID positive units, he stated staff were supposed to wear a gown, N95, face shield, and gloves. Observation and interview on 7/25/20 at 3:44 pm of RN A revealed she was standing at the medication cart on the COVID positive unit wearing a gown, N95 mask, gloves, and shoe covers. She was not wearing a face shield or goggles. When asked if she was supposed to have on goggles or a face shield, she stated yes. The ADON stopped her and asked her why she was not wearing a face shield and asked her to obtain one. Interview on 7/25/20 at 3:45 pm with the ADON, when asked if staff working on the COVID positive unit were supposed to wear a face shield or goggles, he stated yes. Observation and interview on 7/25/20 at 3:46 pm of CNA A and CNA B on the COVID positive unit revealed CNAs A and B entered a resident's room wearing a gown, gloves, and N95 mask. Neither were wearing a face shield or goggles. When asked if they had goggles or a face shield to wear and why they were not wearing them, CNA A stated, yes, they should wear a face shield or goggles, further stating, there was a short supply today. When asked if there was a problem at the facility with a PPE shortage, both CNAs stated, Today there was a shortage. The ADON had the two CNAs obtain face shields before completing patient care. Observation and interview on 7/27/20 at 10:34 am with CNA C on the COVID positive unit revealed, the CNA was wearing a gown, N95 mask, and shoe covers. She was not wearing a face shield or goggles. When asked if she was supposed to have a face shield on, she stated yes. When asked if there had been issues with a PPE shortage, or having the appropriate PPE available to work on the COVID positive unit, she stated sometimes there is a shortage, stating last week there was issues with not having face shields. When asked who was responsible for obtaining and/or stocking the PPE, she said they got PPE from central supply on the first floor, further stating central supply could bring the PPE up if there was none on the floor. Observation and interview on 7/27/20 at 10:35 am, revealed Housekeeping Aide inside room [ROOM NUMBER] (COVID Positive resident's room on the COVID positive unit) mopping. She was observed wearing gown, hair cover, and N95. She was not wearing goggles or a face shield. Interview with Housekeeping Aide at that time she said she was responsible for cleaning this unit. She said she was in-serviced on wearing proper PPE in this unit. She said she was aware that you were supposed to wear gown, foot thing, cap, shield, gloves, and N95. When asked why she was not wearing goggles or a face shield, she said there were not any there. Observation and interview on 7/27/20 at 10:40 am, revealed Hospitality Aide going into resident room [ROOM NUMBER] (COVID Positive resident's room). She was observed wearing gown, N95 mask and shoe covers. She did not have on goggles or a face shield. She went inside the resident's room, took a styrofoam container out of the room, came out and disposed it in the biohazard box. She was within 6 ft of the resident. Interview with her at this time, she said she was the Hospitality Aide. She said she assisted with feeding, passing trays, refilling water, throwing trash out, and stuff like that. She said she was in-serviced on wearing full PPE. She said she knew she was supposed to wear a gown, N95 mask, goggles or face shield, and gloves. She said she was not wearing a face shield right now because she was wearing glasses and thought it was ok to not wear a face shield. When asked if anyone told her if that was ok, she said no one told her but she thought it was ok. Interview on 7/27/20 at 11:39 am with the Administrator, when asked what PPE should staff wear when working on the COVID positive unit, he stated face protection, which could be goggles or a face shield, a gown, foot and head protection. When asked who was responsible for filling the PPE on the units, he stated central supply. He stated if they are running low, staff can call for refills daily to ensure PPE is stocked, further stating the unit manager also has backup PPE supplies. When asked who is responsible for ensuring staff are wearing the appropriate PPE while working on the COVID positive unit, he stated the ADON and charge nurse further stating they also make corrections if staff are not wearing the appropriate PPE. Interview with Central Supply staff on 7/27/20 at 11:55 am, she said she worked at the facility full time. She said she was responsible for purchasing and ordering items and also refilling PPE on the units. She said she refilled the units daily or as needed and also the nurses all have her phone number, so they can call her at any time if they need anything else. She said they give the PPE to the unit manager. She said the facility has enough PPE and they were not short on anything. She said they get supplies from corporate, CMS, and FEMA. Record review of the PPE count list provided to surveyors on 7/27/20 revealed the facility had 330 face shields and 70 goggles. Record review of the facility's 2019 Novel Coronavirus Competency Validation

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Checklist read in part, .1.) Identifies the proper PPE to gather and verbalize that all appropriate PPE is available at point of use Isolation gown, Gloves, Face shield or goggles, N95 Respirator-that has been fit tested from annual fit testing . Record review of the facility's COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel dated 03/21/20 read in part, Preferred PPE - Use N95 or Higher Respirator: Face shield or goggles When respirators are not available, use the best available alternatives, like a facemask, One pair of clean non-sterile gloves, Isolation gown. Further record review of the facility's COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel dated 03/21/20 read in part, Acceptable Alternative PPE - Use Facemask: Face shield or goggles, Facemask N95 or higher respirators are preferred but facemasks are an acceptable alternative. One pain of clean, non-sterile gloves, Isolation gown. Linen storage Observation of the shower room on the COVID positive unit on 7/25/20 at 3:50 pm revealed, one soiled white towel and one white sheet hanging over the top of the shower room door preventing the door from closing. Sitting on the floor of the shower room were three clear linen bags full of residents clean clothing and one linen bag torn open exposing clean wash clothes and towels. Sitting on the floor next to the clear linen bags were two full yellow linen biohazard bags. Interview on 7/25/20 at 3:50 pm with the Director of Clinical Services, when asked if soiled linen should be hanging over the door of the shower room, he stated no. When asked if clean linen bags should be sitting on the floor of the shower room, he stated no, they should not be on the floor, they should be stored on a cart. When asked if the yellow biohazard linen bags should be stored on the floor of the shower room next to clean linen, he stated, no the biohazard bags should be stored in the soiled linen room. Further interview on 7/25/20 at 3:50 pm with the Director of Clinical Services, when asked what the facility's policy was on storage of biohazard linen bags, he stated staff are supposed to take the soiled linen from the resident's room and put it in the soiled storage room, further stating the biohazard linen is then taken down the stairs of the COVID positive unit, outside and to the laundry room. Interview on 7/25/20 at 3:55 pm with Maintenance, he stated the yellow biohazard linen bags are supposed to go from the residents' room, to the soiled linen room, downstairs and outside to laundry which he stated is in the back of the building. Interview on 7/27/20 at 11:39 am with the Administrator, when asked if the yellow biohazard linen bags should be stored in the shower room on the floor, he stated it should not be on the floor or stored with the clean linen. Record review of the facility' Handling, Transport and Storage of Laundry updated July 22, 2020 read in part, Laundry includes resident's personal clothing, linens (i.e., sheets, blankets, pillows), towels washcloths .Regardless of the location where the laundry is processed, all laundry is handled, stored, processed and transported in a safe and sanitary method .Linen Storage .Clean linen must always be kept separate from contaminated linen through the use of separate rooms, closets, or other designated spaces with closing door as the most secure methods for reducing the risk of accidental contamination .