STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675231	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACINTO NURSING & REHABILITATION CENTER, LLC	1405 HOLLAND HOUSTON, TX 77029

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 effectively maintain an infection prevention and control program designed to help prevent the spread of infections for 2 of 2 units and 41 of 62 residents reviewed for infection control and COVID-19. The facility failed to provide a clean and secure place for donning and doffing of personal protective equipment for the COVID-19 unit. The facility failed to ensure that PPE was readily available to all staff at all times for the COVID-19 unit. The facility failed to ensure staff were performing proper hand hygiene, using PPE, and donning/doffing PPE. The facility failed to ensure staff were wearing face masks and face shield while in the Covid-19 isolation unit per CDC guidelines and quarantine orders. The facility failed to ensure that biohazards waste from COVID-19 isolation rooms had biohazard containers with lid or cover. The facility failed to ensure 2 residents with indwelling urinary catheter attached to urine bags had their urine bags properly secured and not in contact with the floor. These failures could affect all residents and placed them at risk of infection and COVID-19. Findings include: Station 2-Back Observation and interview on 06/21/20 from 11:00am revealed the following: Prior to entering the facility, PPE was received from the front desk in a disposable bag and taken through the back door to station 2-back. Donning was done outside the unit by the trash container. There was a night stand outside and next to the night stand was a large yellow trash can. RN Z said oncoming staff had to ring the doorbell to receive their PPE from the staff inside and don PPE outside before going in. She said outgoing staff doff outside at the same spot before leaving. When asked about CDC (Center for Disease Control) guidelines and cross contamination, she said right now this all what we have. Observation on 06/21/20 at 11:10am revealed there were 16 residents on the unit, all positive for Covid-19. Observation and interview on 6/21/20 between 11:15am to 11:30am revealed the following - -room [ROOM NUMBER] occupied by 3 residents had a yellow bag and a red bag with contents on the floor. During an interview at this time LVN B said the yellow bag was for soiled sheets and the red bag was for soiled briefs and other disposable items. -room [ROOM NUMBER] had one red bag with used PPE on the floor. -Rooms # 302 occupied by 2 residents had red bags with used PPE on the floor. -room [ROOM NUMBER] occupied by one resident had red bags with used PPE on the floor. -room [ROOM NUMBER] occupied by one resident had red bags with used PPE on the floor. -room [ROOM NUMBER] occupied by 3 residents had yellow and red bag with used PPE on the floor. Observation on 06/21/20 at 11:30am, During an exit from station 2-back, surveyor and RN Z doffed PPE outside the unit at the back door placing all clean equipment on top of a night stand next to the dirty container identified by RN Z as contaminated container for biohazards. She said, This is all we have. Doffing was done by the back door outside the facility. Observation on 6/24/2020 at 3:00 PM in Station 2-back revealed resident isolation rooms [ROOM NUMBERS], each with biohazard containers without coverings or lids. Observation on 6/24/2020 at 3:10 PM revealed CNA J wearing N 95 mask, Face shield, and gown providing meal assistance in room [ROOM NUMBER] to one resident on bed C without performing hand hygiene nor donning gloves. CNA did not perform hand hygiene after exiting room [ROOM NUMBER]. Observation on 6/24/2020 at 3:15 PM in revealed CNA J and CNA I (both wearing N 95 mask, face shield, and gown) entered resident room [ROOM NUMBER] to assist resident in bed B. Both CNAs did not perform hand hygiene prior to donning gloves. Both CNAs doffed their gloves then used alcohol-based sanitizer for hand hygiene but did not doff gowns prior to exiting room [ROOM NUMBER] after providing care/assistance to 1 resident. Interview on 6/24/2020 at 3:18 PM with LVN C, he said hand hygiene with either alcohol-based hand rub or hand washing with soap and water when hands were soiled must be done before and after resident care or resident contact. Observation on 6/24/2020 at 3:25 PM revealed LVN B administered oral medication to 1 resident in room [ROOM NUMBER] without performing hand hygiene nor replacing gloves she wore after she prepared medication on her medication cart. Observation on 6/24/2020 at 4:00 PM revealed LVN E sitting at the nurse's station (open area) wearing gown, but no N 95 mask nor face shield. Interview with corporate nurse on 6/27/2020 at 12:20 PM said all staff who worked in the facility's covid-19 isolation units must wear full PPE which were N-95 mask, face shield, gowns and gloves. Station 1 Observation of the entrance by the back door of station 1 on 06/21/20 at 11:45am. Observation revealed multiple boxes of Biohazards boxes some with briefs, used PPE- shoe covers, gowns, face shield and mask around the dumpster. During an interview at this time RN Z said she did not know why these boxes were outside. She said they were supposed to be locked up until they were ready to pick up by the contractor. Prior to entering station one, the doorbell was pushed, Staff working inside provided PPE through the door. Donning was done outside by the dirty biohazard box outside the door. Observation on 06/21/20 of station 1 at 11:50am revealed there were 14 residents on the unit all were positive for Covid-19, Observation on 06/21/20 at 11:55am revealed room [ROOM NUMBER] had a red bag with used PPE on the floor. At this time, RN Z called to the nurse inside to find out what happened to all the boxes that were bought. Observation on 06/21/20 at 12:00pm revealed Resident # 7 walking around spitting on the floor attempting to go from room to room. She was re-directed back to the dining room/common area. Further observation revealed Resident # 2 walking around attempting to lie down by a resident sleeping on a bed in the hallway. Resident #7 and Resident #2 were not wearing masks. She was re-directed away from that area. During an interview at this time RN Z said the residents were from the secured unit and it was hard to maintain social distancing. Observation on 06/21/20 from 12:15pm to 1:30pm revealed in rooms 110, 112, 102, 103 &109 there were open biohazard boxes not covered in rooms. All boxes were in front of the resident's bed. Room # 105 had a red bag with used PPE on the floor. Observation on 6/22/20 at 1:20pm at the entrance to station 1 from the back door, behind the building: donning and doffing was done outside at the back door a few feet away from the trash dumpster. Biohazard box was next to the donning area. During an interview at this time RN Z said she had placed an order for [REDACTED]. Observation on 6/22/2020 at 1:45 PM revealed room [ROOM NUMBER] had a biohazard bin near the door. Upon entry noticed to be filled with used gloves and soiled under pads. Container had no cover or lid. Interview on 6/22/2020 at 1:50 PM with the isolation unit charge nurse LVN E, she said generally all biohazard containers should have a lid or covering. She added she would find one container with cover and will use it for the room. Observation and interview on 06/22/20 at 3:00pm, revealed CNA J walking from room to room answering call lights and assisting residents without PPE, gloves and not performing hand hygiene. Interview at this time he said he was just assisting residents. Interview on 6/22/2020 at 3:50 PM with RN Z about biohazard containers, she said all biohazard containers should have a cover. Residents #3 and #4 Record review of Resident #3's face sheet revealed a [AGE] year-old male admitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of Resident #3's care plan dated 10/23/19 revealed he was care planned for Urinary catheter: Indwelling catheter due to neuromuscular dysfunction of bladder. Record review of Resident #4's face sheet revealed a [AGE] year-old male admitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of Resident #4's care plan dated 5/28/20 revealed he was care planned for Urinary catheter: Indwelling catheter due to [MEDICAL CONDITION] bladder. Observation and interview on 6/22/2020 at 2:36 PM in the one of facility's Covid-19 isolation unit revealed room [ROOM NUMBER] with Resident #3 on bed B and Resident #4 on C bed. Both residents were awake and alert and were on air mattresses. Resident #4 verbalized no issues while resident #3 said his urine bag fell on the floor and nobody hung it back on his bed frame. Both residents had on indwelling catheter with tubing attached to a urine bag. Both urine bags were noted on the floor and not properly secured onto the bed frame.

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Resident #3's urine bag was about 80 % filled while Resident #4 urine bag was half filled. Both residents were laying supine on their bed with head of their beds elevated about 45 degrees. Interview on 6/22/2020 on 2:45 PM with CNA H said she checked residents frequently and as often as every 5 minutes. CNA H said she and other CNA's were responsible in draining urine bags when full and, securing and maintaining urine bags below resident and onto the bed frame and make sure the bags did not touch the floor. Surveyor informed CNA H about the residents in room [ROOM NUMBER]. CNA H went to the resident's room and addressed the issue (secured the bags not to touch the floor) She drained the almost filled bag without mask nor providing hand hygiene. Interview on 6/22/2020 on 2:48 PM with LVN C said CNA's rounded residents every 2 hours and as needed. He added, CNA's drain the urine bags when they were full and secure them under the bed without touching the floor. He stated it was unacceptable that the urine bags were on the floor. Interview on 6/22/2020 on 2:55 PM with RN Z said CNA's were required to check on residents at least every 2 hours and nurses also checked residents. Added that CNA's were primarily tasked to drain urine bags and secure them under bed not to touch floor. Observation of room [ROOM NUMBER] occupied by 2 residents on 06/29/20 at 2:00pm revealed a red biohazard bag with contents on the floor and the bag half open. RN Z said this should not be on the floor. Observation on 06/30/20 at 10:30am revealed room [ROOM NUMBER] on station -back had a red bag with disposable waste on the floor. room [ROOM NUMBER] occupied by 3 residents. Record review of facility's undated policy on Urinary catheter care revealed the purpose of this procedure is to prevent catheter-associated urinary tract infections. Number 2 general guideline under infection control heading revealed Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag, be sure the catheter tubing and drainage bag are kept off the floor. Record review of facility's Novel Coronavirus Prevention and Response Plan updated 6/01/2020 read in part, Interventions to prevent the spread of respiratory germs within the facility: d. Support hand hygiene and respiratory/cough etiquette by residents, visitors, and employees by making sure tissues, soap, paper towels, and alcohol-based hand rubs are available. E. Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection . Procedure when Covid-19 is suspected: F. Implement standard, contact, and airborne precautions (droplet precautions if no airborne isolation room available). Wear gloves, gowns, goggles/ face shields, and masks (respirators) upon entering room and when caring for the resident.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 6 of 11 resident rooms (rooms # 104, 106, 107, 109, 110, & 112) reviewed for resident call system. The facility failed to ensure that room [ROOM NUMBER], #106, #107, #109, #110 and #112 had a functioning call system. This failure could affect residents on station 1 and placed them at risk of not being able to access staff for assistance or in the event of an emergency. Findings included: Observations on 6/21/20 between 1:30pm to 2:00pm, revealed that upon pushing the call light button, the light did not turn on and the communication system was not working in the following rooms: room [ROOM NUMBER] occupied by 2 residents room [ROOM NUMBER] occupied by 1 resident room [ROOM NUMBER] occupied by 2 residents room [ROOM NUMBER] occupied by 3 residents room [ROOM NUMBER] occupied by 3 residents room [ROOM NUMBER] occupied by 2 residents During an interview on 6/21/20 at 2:15pm, RN Z said station 1 was under construction prior to Covid-19 outbreak. She said she would call maintenance to work on the call system. In an interview on 7/11/20 at 1:00pm, the Administrator said he would take care of it as soon as possible. He said that there was an electrical somewhere.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in that: Rooms #109,110 and 112 did not have functioning toilets and access to water for resident and staff use in the bathroom. The bathroom sink in station 1 was not equipped with supplies for staff and visitors to perform hand hygiene. Resident's beds and chairs were not in good working condition. The dining room/activity area was not clean. Resident #8 and #9 did not have pillow covers for their stained pillows while they were in use. Resident's shower on station 1 was in not in good repair. These failures could affect all residents and placed them at risk of infection, injuries and health hazards. Findings include: Secure Unit Observation of the secured unit on 6/21/20 between 9:30am-10:15am revealed the following: -The dining room/activity room had food particles and dirty sticky floors. 3 residents were observed in this area walking around. -room [ROOM NUMBER]'s bathroom had a foul odor, the commode had brown looking substance (like bowel movement) around it. The bathroom was dirty. -room [ROOM NUMBER] was dirty, floor sticky and toilet was stained. -In an interview at this time, the DON said she wondered where the housekeeper was. She said she would have it cleaned. She said the facility had two housekeepers, one on each side of the facility. one housekeeper on station 2-front and the secured unit and the second one was on station 1 and 2-back which were COVID infected units. Station 2 back Observation on 06/21/20 starting at 11:00am revealed- -Room # 331 occupied by 3 residents had no running water in the bathroom. -Room # 316 B had a broken bed that does not rise up. The bed was in a low position almost to the floor. Resident # 3 spoke in Spanish pointing to the bed. RN Z attempted to raise the bed but could not. During an interview at this time, RN Z said it was broken. Station 1 Observation on 6/21/20 between 12:00pm and 2:00 pm revealed the following: -A short hall way between activity room and room [ROOM NUMBER] had multiple broken equipment, a large table with assorted sheets, clothes, towels and unknown materials on the right-hand side. -Room # 109 occupied by 3 residents had resident's equipment directly against the wall. Observation revealed two scales, a mechanical lift and two wheelchairs in the room. In an interview at this time RN Z said those were for the residents and there was no where to store them. Observation revealed Resident #8 and #9 had no pillow covering on their pillow. Pillows had multiple stains. Observation revealed the toilet was not working and no cover for the water tank, the toilet had brown substance on it. The flooring was dirty and sticky. There was a foul odor in the bathroom. When the surveyor opened the bathroom door, Resident #4 said please do not open that door. The toilet does not work and it stinks. room [ROOM NUMBER] next to the exit door at the back was occupied by one resident. Resident was in bed in a low position. The foot of the bed was broken with pieces of plywood peeling off. This was brought to the attention of RN Z. She pulled off the footboard. -Room # 104 - One bed had a bed sheet that was stained with a brown substance that looked like bowel movement on her sheet. Her pillow had no pillow cover. Room was occupied by 2 residents. RN Z looked at the sheets and asked CNA G to take them out. -Observation of the bathroom in Station 1 revealed there was no soap nor paper towels. In an interview at this time, RN Z said housekeeping was responsible for replacing the soap and paper towels. Observation on 6/24/20 at 1:45 PM of the facility's Covid-19 isolation unit 1 revealed the shower area for residents was noted to have pervasive/foul odor upon opening the door, and revealed a puddle of stagnant water on the floor close to the drain. Cleaning materials stood on 1 corner, mop bucket beside toilet and 2 container bins with cover were also observed. Interview on 6/24/20 at 1:50 PM with RN Z stated staff was in the process of cleaning the shower area. She said the materials were not there this morning. She added she would make sure the shower room would be free of clutter when residents used it. Observation on 06/29/20 at 9:30am revealed Resident's bathroom on station 1 had standing water, the bathroom had dirty mop and mop bucket, yellow barrel full of unknown items . There was a strong odor from the bathroom. Door was open residents walking around. During an interview at this time, RN Z said the door would be locked. Record review of the undated policy Operational/Resident Care- Physical Environmental revealed in part: . The facility is designed, equipped, and maintained to protect the health and safety of the residents, personnel and the public . Policy: It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment. Policy Explanation and Compliance Guidelines: l . Identify manufacturers for bed frames, mattresses and bed rails used in this facility. 2. Review each manufacturer's recommendations and requirements for maintenance and bed inspections. 3. Ensure bed rails are securely and properly installed according to manufacturer's requirements. 4. When bed

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F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible. 5. Bed frame, mattress, and bed rail inspections will be conducted on each section of the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations. 6. If bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility will perform maintenance to the bed equipment or remove from use if not able to bring specs to the manufacturer's requirements.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of pest in that: Live crawling roach observed around the steam table in the dishwashing area in the kitchen. This failure could affect all residents and placed them at risk for infection, cross-contamination, food-borne illness. Findings included: Observation and interview on 06/28/20 at 3:30pm, revealed a cockroach crawling from the steaming table toward the 2 compartments sink in the kitchen. Interview at this time the Dietary Manager said the exterminator used to come in to spray but has not been back since the Covid outbreak. Interview on 06/25/20 at 3:40pm, Administrator 1 said he would look to see the last in-voice that was provided. Record review of the Pest prevention service reports revealed the last pest control service was dated 11/29/19. Record review of the Policy for Pest Control dated 2017 revealed: To provide an environment free of pest. 1. This facility will have a pest control contract that provides frequent treatment of [REDACTED]. It will allow for additional visits when a problem is detected Monitoring of the environment will be done by the facility's staff .