STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676398	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX HOLLOW POST ACUTE	310 AMERICA DRIVE BROWNSVILLE, TX 78526

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 prevent the potential spread of COVID-19, for three Halls (Hall 100, Hall 200 and Hall 300) of five halls reviewed for infection control practices. 1) The facility did not consistently assure staff were donning and doffing PPE in separate areas. 2) The facility did not consistently assure housekeeping staff were not returning to the areas with COVID-19 negative residents after cleaning areas with COVID-19 positive residents. 3) Staff did not ensure that Resident (R) #1 wore a facial mask when she was taken out of her room for rehabilitation services. These failures could place residents at risk of contracting COVID-19, resulting in possible serious illness or death. Findings included: Record review of an Email sent by the facility to HHSC on 06/25/20 at 12:02 p.m. revealed the facility had 35 COVID -19 positive residents in the facility and had 28 staff who had tested positive for COVID -19. Observation on 06/25/20 at 2:00 p.m., surveyor observed the facility was divided into zones. Hall 100 was the yellow zone (area with presumptive COVID-19 residents and newly admitted residents), Halls 200 and 300 were the red zone (areas with COVID-19 positive residents), Halls 400 and 500 were the green zone (areas with COVID-19 negative residents), and Hall 600 was empty. During an interview on 06/25/20 at 2:16 p.m., HK A said she had a different housekeeping cart for each hallway. HK A said she started on the green zone, then worked the yellow zone, then moved to the red zone. HK A said after cleaning the red zone, she disinfected herself with a disinfecting spray, then went back to the green zone to pick up any trash from residents' rooms and the nurses station. HK A said no one had ever told her not to go back to the green zone hallways after cleaning the red zone. HK A said at least four of her housekeeping co-workers were sick and she and another housekeeper were the only ones left. HK A said it was hard to keep up. During an interview on 06/25/20 at 3:25 p.m., the Administrator said the housekeepers were told that they were to work in the order of the facility's zones, from green, to yellow, to red, then leave home for the day. The Administrator said if housekeepers were doing anything else, they were doing it of their own accord. During an interview on 06/25/20 at 3:50 p.m., HK A reiterated that no one had ever told her not to go back to the green zone hallways after cleaning the red zone. During an observation and interview on 06/25/20 at 4:50 p.m., surveyor accompanied by the ADON, went to the entrance to the red zone. Surveyor observed that the donning and doffing of PPE took place between two plastic walls, with a zipper in the middle. Surveyor observed that, on one side of the area there was the unused PPE and on the other side there was a carton box with a red bag. The ADON said all staff used the main entrance to check in for work. The ADON said staff who worked in the red zone had to put on full PPE to go inside the red zone. The ADON said before entering the red zone, staff disinfected their shoes with a disinfecting spray. She said, at the end of the shift, staff from the red zone doffed PPE in the same area as donning, but, there was never two staff members there at the same time. The ADON said staff in the red zone used the main entrance for exiting the facility. During an interview on 06/25/20 at 5:45 p.m., the Administrator said the staff working the red zone entered the facility through the front entrance, that all staff used, so they were not immediately entering a hot zone (red zone) without the proper PPE. The Administrator said the staff would then go to the designated hall, don PPE, then proceed into the warm (yellow zone) and hot zones (where COVID -19 positive residents were housed). The Administrator said, when staff left, they doffed the PPE, sprayed their shoes with disinfectant, then exited through the front entrance. In an interview on 06/26/20 at 7:50 a.m., HK C said her shift started at 6:00 a.m., and due to being short staffed, there was no time to punch out (clock out). HK C said she worked from green, to yellow, disinfected herself, then went to the red zone. HK C said, if needed, she sanitized, then went back to the green zone and communal areas for a last round. HK C said she had no Supervisor and they were doing their best to keep the facility clean. Observation on 06/26/20 at 11:10 a.m. revealed, upon entrance to the yellow zone (back entrance), there was a biohazardous waste box with a red biohazard bag to the right corner and another box of individually wrapped Tyvek suits (protective suits) in front of the biohazard box. There was no barrier or separation between the donning and doffing areas. During an interview on 06/26/20 at 11:14 a.m., LVN B said the PPE donning and doffing were both done at the back entrance to the facility. LVN B said they donned the Tyvek suits there. She said they used a different disposable gown when going into each room, then at the end of their shift, doffed at the same back entrance. Record review of R#1's electronic medical record revealed R#1 was an [AGE] year-old female who was readmitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Quarterly Minimum Data Set (MDS) assessment, dated 07/13/20, revealed R#1 had severely impaired cognition and required extensive assistance for activities of daily living. Record review of R#1's comprehensive care plan, initiated 03/28/20, revealed: Resident has a psychosocial well-being problem potential due to CMS (Centers for Medicare and Medicaid Services) Guidance for limiting the transmission of COVID-19 for nursing homes. Observation on 07/20/20 at 9:55 a.m. revealed R#1 was wheeled out of her room by PT E. R#1 was not wearing a facial mask. PT E wheeled R#1 down the 400 hall. In an interview on 07/20/20 at 9:57 a.m., PT E said she had forgotten to put a facial mask on R#1 and needed to return back to R#1's room to find a mask for R#1. PT E opened R#1's drawers and got a facial mask, then placed it on R#1. R#1 did not attempt to remove the mask. PT E said she was aware that residents needed to wear a face mask when outside their room but she had forgotten to put a face mask on R#1. In an interview on 07/20/20 at 10:31 a.m., LVN F said R#1 might occasionally respond to her name but was not alert to orientation or place. LVN F said R#1 would not know that the face mask was used to prevent the spread of infection and would not tell staff to put a face mask on her before leaving her room. In an interview on 07/20/20 at 10:45 a.m., the Administrator said staff tried very hard to make sure residents were wearing face masks when outside their rooms. The Administrator said some residents took their face masks off. In an interview on 07/20/20 at 3:23 p.m., CNA G said R#1 was not aware of the need to use a face mask outside her room to prevent the spread of infection. CNA G said R#1 would not tell staff to put a face mask on her. CNA G said sometimes R#1 would attempt to take her face mask off, but she was easily re-directed. In an interview on 07/21/20 at 9:10 a.m., the DON said some residents could remove their face masks. The DON said the incident happened in the green area where there were no positive COVID-19 residents, and PT A had been wearing a mask. The DON said she had in-serviced staff again on the importance of residents wearing a face mask when outside their rooms. Review of the facility's Policies and Practices-Infection Control, dated 10/2019, revealed: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control policies and practices are to: a. prevent, detect, investigate and control infections in the facility. Review of the Texas Health and Human Services: COVID-19 Response for Nursing Facilities, dated 06/02/20, revealed: -outbreak definition; a confirmed outbreak COVID-19 is defined as one or more laboratory confirmed cases of COVID-19 identified in either a resident or paid/unpaid staff. -Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, residents should wear a face mask.

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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