| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675799 | A. BUILDING _____ B. WING _____ | 05/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| BRENHAM NURSING AND REHABILITATION CENTER | 400 E SAYLES ST BRENHAM, TX 77833 |

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 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure that based on the comprehensive assessment of a resident, the facility ensured residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered plan of care for one (1) of ten (10) residents reviewed for quality of care during a coronavirus outbreak. (Resident #1) The facility failed to ensure Resident #1, who was medically unstable due to the coronavirus, was assessed and monitored after she returned from the hospital on [DATE] at 3:30 PM until 7 hours later when she was sent back to the hospital with [MEDICAL CONDITION] and respiratory distress and died in the ER. This failure resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to staff needing more time to monitor the plan of removal for effectiveness. This deficient practice could affect residents with the coronavirus and place them at risk for unidentified changes in condition, delay of necessary treatment and death. Findings included: Review of Resident #1's Face Sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #1's Significant Change Minimum Data Set ((MDS) dated [DATE] reflected Resident #1 had a Brief Interview for Mental Status Score of nine (9) indicating moderate cognitive impairment. Resident #1 was assessed to require supervision for all activities of daily living (ADLs). Review of Resident #1's Comprehensive Care Plan reflected a problem with the start date of [DATE] High risk for communicable respiratory infection- influenza/ pneumonia- due to age and resident lives in close proximity to others. Further review of Resident #1's Comprehensive Care plan reflected a problem with the start date [DATE] Resident is at risk for signs and symptoms of COVID-19. Interventions included observe for signs and symptoms of COVID-19, document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, respiratory issues. Review of Resident #1's Nursing progress notes dated [DATE] reflected an entry at 4:08 AM that the facility received notification that Resident #1 was COVID positive. An entry at 3:45 PM reflected resident returned from the emergency room (ER) at 3:30 PM. The note reflected Resident #1 returned on 2 liters of supplemental oxygen. An entry dated at 5:50 PM reflected a late entry for 10:45 AM on [DATE] that Resident #1 was assessed by the NP and her oxygen saturation was 85% on room air and oxygen was started at 2 liters Resident #1 was noted with temperature of 101.4 and a HR of 134. The nursing progress note indicated Resident #1 was sent to the ER and returned at 3:30 PM. The next entry in Resident #1's Nursing progress notes dated [DATE] was at 10:40 PM indicating Resident #1 was sent to the ER with [MEDICAL CONDITION] and respiratory distress. Review of Resident #1's Hospital Record dated [DATE] at 11:27 PM reflected DOS [DATE], Chief complaint SOB with [MEDICAL CONDITION], lethargy, resident is a DNR, EMS assessment oxygen saturation 50%, 6L NC ,[DATE]%; [MEDICATION NAME] 0.3 IM administered. She was found to have a saturation of 50% on room air she was recently diagnosed with [REDACTED].she does have history of [MEDICAL CONDITION], but in not on home oxygen at baseline. Vital signs BP: ,[DATE], Pulse 38, Temp 97.2 Resp 35, Sp02 90%. Critical Care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: [MEDICAL CONDITION]. Patient progress listed as Critical. Further review of Resident #1's hospital record reflected Resident #1 expired at on [DATE] at 12:50 AM in the ER with final [DIAGNOSES REDACTED]. Review of Resident #1's Electronic Medical Record (EMR) reflected Resident #1 did not have a nursing assessment completed upon her return to the facility at 3:30 PM on [DATE]. The EMR further reflected no vital signs documented for Resident #1 from the time she returned to the facility at 3:30 PM until the time she was sent back to the hospital at 10:40 PM (7 hours and 10 min later). In an interview on [DATE] at 6:30 PM the RNC stated the facility only had one nurse on the COVID unit on [DATE] and Resident #1's assessment after her return from the hospital was not completed. Record review of Resident #1's EMR reflected that no progress notes were charted for Resident #1 from [DATE] to [DATE]. No documented temperature on 3 days: ,[DATE], ,[DATE], ,[DATE]. No documented BP for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No pulse documented on 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No RR documented for 6 days: ,[DATE], ,[DATE],<br>,[DATE], ,[DATE], ,[DATE], ,[DATE]. No O2 sat documented for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No skilled assessments were documented for 8 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. Resident COVID positive on [DATE]. In an interview on [DATE] at 9:30 AM the facility NP stated the facility had gotten 20 more positive test for residents and were testing staff and had 12 positive staff. She stated both ADON RN's who were doing the q8hr assessments on the COVID residents tested positive and were sent home. She stated she was concerned about staffing on the unit. She was doing labs and the residents were dehydrated and she stated she wanted one staff just for hydrating the residents. The NP stated she was concerned that the nurse for 100 hall was also working on 200 hall (100 hall is the COVID) at night. Review of the facility census for [DATE] reflected 36 residents on the COVID unit. Review of the facility staffing for [DATE] reflected one (1) LVN on the COVID unit and no RN. In an interview on [DATE] at 5:15 PM the RNC (Reginal Nurse Consultant) stated that Resident's VS (vital sings) were on paper sheets. The RNC stated the VS for Resident #1 regarding the time period in question were not present. She stated her expectation of assessments were that they were to be done every time there was a change of condition. She stated that her expectation was that vital signs were done every shift. There are 3 eight-hour shifts. She stated that this has always been her expectation. In an interview on [DATE] at 5:27 PM the nurse on duty LVN A stated she was not the nurse on duty taking care of Resident #1 when she arrived back to the facility at 3:30 PM or was sent back out to the hospital at 10:40 PM. She stated she was in the facility at the time the patient needed to be sent to the hospital, but she was not the nurse on duty. LVN A stated she put the notes in the chart for the night nurse, which is why her name was in the chart. She stated she called the family, the nurse practitioner, charted, and did the paperwork for the resident to be sent out of the facility. LVN A stated she was the 6:00 AM-2:00 PM nurse for the resident. She stated during the 6:00 AM- 2:00 PM shift, the NP asked her if she had taken vitals yet on the resident on [DATE] and she stated that she did not have time to yet. The nurse practitioner took the O2 sat and it was at 84% at 11:05 AM. The nurse took the rest of the vital signs and the nurse practitioner after assessing Resident #1 sent her to the hospital. In an interview on [DATE] at 5:53 PM the 2:00 PM-10:00 PM shift nurse LVN B stated on [DATE] that she was the only nurse working that night. She stated that vital signs should be taken every shift and that assessments should be done before a resident gets sent out and when a resident comes back. Assessments should also be done when a resident is critical or is a priority. She stated that managed patients(Medicare/Medicaid) get assessments with vitals. She stated that in the case of Resident #1, she was not able to get a set of vitals because she had a lot going on. She stated that an aide came and told her around 10:00 PM that Resident #1 did not look good. LVN B stated she went in to look at Resident #1 and put her nasal cannula back on, but she was not able to obtain a O2 saturation level on the resident and that her pulse was 111 bpm and her BP was 115 over something she stated the resident was starting to appear cyanotic. A nonrebreather mask was placed on resident on 10Liters, and she called the nurse manager. She stated at that point Resident |

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

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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>#1's pulse was 156. Nurse practitioner was called, and resident was sent to ER, where she was told the resident died . In an interview on [DATE] at 1:40 PM the RNC stated the facility's COVID response plan did not have standing orders for assessments and care of COVID positive residents to guide the staff on their care and agreed that the COVID positive residents were clinically unstable and required close monitoring. Review of the facility's policy Change in a Residents Condition dated [DATE] reflected Our facility shall promptly notify the resident, his or her attending Physician .of changes in the resident's medical/ mental condition .prior to notifying the physician the nurse will make observations and gather pertinent information for the physician including information prompted by change of condition. On [DATE] at 6:40 PM the VPO, Administrator and RNC were notified the facility had an IJ situation for the above failures. The facility's first Plan of Removal (POR) was submitted by the VPO on [DATE] at 8:20 PM. The final POR was accepted by the survey team on [DATE] at 2:00 PM. Accepted Plan of Removal: Plan of Removal On [DATE], a complaint survey was initiated at Brenham Nursing and Rehabilitation Center at 400 E Sayles Street, Brenham TX . On [DATE], the facility was notified by the surveyor that a jeopardy had been called and needed to submit a letter of credible allegation. The Facility respectfully submits this Letter of Credible Allegation pursuant to Federal and State regulatory requirements. Submission of the Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiencies. The alleged immediate jeopardy allegations are as follows: Issue: Facility failed to provide needed care or services resulting in an actual decline in resident's physical wellbeing. Resident #1 was discharged from the facility on [DATE] and admitted to the hospital on [DATE]. *Effective [DATE], the Registered Nurse will reassess COVID 19 positive and COVID19 negative residents to identify residents with a potential change in condition related to COVID 19. Reassessment will include blood pressure, pulse, temperature, respirations, oxygen saturations. Deviations based on MD/ NP parameters will reported to the MD/NP. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee reeducated Licensed Nurses on the COVID-19 Assessment and Reporting Protocols related to the care, management and interventions for COVID 19 positive and COVID 19 negative residents. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee reeducated all facility staff on COVID 19 Symptom Reduction Protocols. COVID 19 Symptom Reduction Protocols include signs and symptoms reported to manifest with COVID 19 and measures to improve circumstance in resident conditions. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee will monitor compliance with vital signs, assessments and interventions through reconciliation of vital sign and assessment data/ documentation, as well as applicable interventions daily for seven days, then every other day for fourteen days, then three times weekly for three weeks and weekly for six weeks. *Effective [DATE], the Director of Nursing and/ or designee will monitor compliance with provision of needed care and services through rounding to observe for resident hydration, meal service and ADL care by observing facility and support staff provide care for five residents on each hall daily for seven days, then every other day for fourteen days, then three times weekly for three weeks and weekly for six weeks. On [DATE] an Quality Assurance Performance Improvement Meeting was held with the Administrator, Assistant Director of Nursing, Medical Director and two other persons present to discuss the above plan. The facility respectfully requests that the plan of removal be accepted, and immediate jeopardy be lifted. Monitoring for the Plan of Removal began on [DATE] at 2:00 PM. Staff were interviewed for understanding regarding the new procedure resident assessment, and assessment protocols for COVID positive residents. All staff interviewed had a good understanding of the training. The facility was monitored for adequate staffing. Resident charts were reviewed for assessments. On [DATE] at 2:45 PM the IJ was removed. However, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy with a scope of isolated due to the facility requiring time to train all staff and monitor their plan of removal. |
| F 0725<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure and attain or maintain the highest practicable physical, mental and psychological well-being of each resident related to sufficient staffing during a coronavirus outbreak for one of four residents (Resident #1) reviewed for assessments and 85 residents reviewed for COVID-19. The facility failed to ensure there was enough licensed staff on duty to ensure resident assessments and resident monitoring were done to identify changes of condition in a medically unstable COVID-19 positive resident. Resident #1 was not assessed after she returned from the hospital on [DATE] at 3:30 PM until 7 hours later on the next shift when she was sent back to the hospital at 10:40 PM where the resident died in the ER. The facility further failed to have sufficient and dedicated staff working on the COVID positive unit and allowed staff to work on both the COVID positive and negative units, and failed to have sufficient direct care staff to meet the residents care needs. These failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm at a scope of pattern due to staff needing more time to monitor the plan of removal for effectiveness. These deficient practices could affect all residents and place the residents at risk for mental anguish, prolonged isolation time, coronavirus infections and death.<br>Findings included: In an interview on [DATE] at 9:30 AM the facility NP stated the facility had gotten 20 more positive test for residents and were testing staff and had 12 positive staff. She stated both ADON RN's who were doing the q8hr assessments on the COVID residents tested positive and were sent home. She stated the COVID unit would be full after all the positive residents were moved on the unit. She stated she was concerned about staffing on the unit. She was doing labs and the residents were dehydrated. She stated she wanted one staff just hydrating the residents. She stated they did IV's on two of the residents. She also stated the it was not recommended to hydrate too fast because the residents would develop [MEDICAL CONDITIONS]. The NP stated she was concerned that the nurse for 100 hall was also working on 200 hall (100 hall is the COVID) at night. Review of Resident #1's Face Sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #1's Significant Change Minimum Data Set ((MDS) dated [DATE] reflected Resident #1 had a Brief Interview for Mental Status Score of nine (9) indicating moderate cognitive impairment. Resident #1 was assessed to require supervision for all activities of daily living (ADLs). Review of Resident #1's Comprehensive Care Plan reflected a problem with the start date [DATE] High risk for communicable respiratory infection- influenza/ pneumonia- due to age and resident lives in close proximity to others. Further review of Resident #1's Comprehensive Care plan reflected a problem with the start date [DATE] Resident is at risk for signs and symptoms of COVID-19. Interventions included observe for signs and symptoms of COVID-19, document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, respiratory issues. Review of Resident #1's Nursing progress notes dated [DATE] reflected an entry at 4:08 AM that the facility received notification that Resident #1 was COVID positive. An entry at 3:45 PM reflected resident returned from the emergency room (ER) at 3:30 PM. The note reflected Resident #1 returned on 2 liters of supplemental oxygen. An entry dated at 5:50 PM reflected a late entry for 10:45 AM on [DATE] that Resident #1 was assessed by the NP and her oxygen saturation was 85% on room air and oxygen was started at 2 liters Resident #1 was noted with temperature of 101.4 and a HR of 134. Note indicated Resident #1 was sent to the ER. The next entry in Resident #1's Nursing progress notes dated [DATE] was at 10:40 PM indicating Resident #1 was sent to the ER with [MEDICAL CONDITION] and respiratory distress. Review of Resident #1's Hospital Record dated [DATE] at 11:27 PM reflected DOS [DATE], Chief complaint SOB with [MEDICAL CONDITION], lethargy, resident is a DNR, EMS assessment oxygen saturation 50%, 6L NC ,[DATE]%; [MEDICATION NAME] 0.3 IM administered. She was found to have a saturation of 50% on room air she was recently diagnosed with [REDACTED].she does have history of [MEDICAL CONDITION], but in not on home oxygen at baseline. Vital signs BP: ,[DATE], Pulse 38, Temp 97.2 Resp 35, Sp02 90%. Critical Care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: [MEDICAL CONDITION]. Patient progress listed as Critical. Further review of Resident #1's hospital record reflected Resident #1 expired at on [DATE] at 12:50 AM in the ER with finial [DIAGNOSES REDACTED]. Review of Resident #1's Electronic Medical Record (EMR) reflected Resident #1 did not have an assessment completed upon her return to the facility at 3:30 PM on [DATE]. The EMR further reflected no vital signs documented for Resident #1 from the time she returned to the facility at 3:30 PM until the time she was sent back to the hospital at 10:40 PM (7 hours and 10 min later). Record review of Resident #1's EMR reflected that no progress notes were charted for Resident #1 from [DATE] to [DATE]. No documented temperature on 3 days: ,[DATE], ,[DATE], ,[DATE]. No documented BP for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No pulse documented on 4 days: ,[DATE], ,[DATE], ,[DATE], |

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| F 0725<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>,[DATE]. No RR documented for 6 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No O2 sat documented for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No skilled assessments were documented for 8 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. Resident COVID positive on [DATE]. Review of the facility census for [DATE] reflected 36 residents on the COVID unit. Review of the facility staffing for [DATE] reflected one (1) LVN on the COVID unit and no RN. In an interview on [DATE] at 2:45 PM the RNC and VPO stated they were working on a plan for staffing once the unit was completed. Observation and interview on [DATE] at 9:51 AM with DSHS Epidemiologist revealed the facility halls dirty and in need of increased housekeeping. Call lights going off and isolation room doors open. The Epidemiologist stated the facility was in need of more staff for resident care. In an interview on [DATE] at 12:20 PM the facility NP stated the facility had been understaffed for two weeks and Corporate was asked for more staffing, but they refused. She stated she did not feel like the residents were getting the care they need such as hydration, feeding assist and just care in general. In an interview on [DATE] at 5:27 PM the nurse on duty LVN A stated she was not the nurse on duty taking care of Resident #1 when she arrived back to the facility at 3:30 pm or was sent back out to the hospital at 10:40 pm. She stated she was in the facility at the time the patient needed to be sent to the hospital, but she was not the nurse on duty. LVN A stated she put the notes in the chart for the night nurse, which is why her name was in the chart. She stated she called the family, the nurse practitioner, charted, and did the paperwork for the resident to be sent out of the facility. LVN A stated she was the 6 am-2 pm nurse for the resident. She stated during the 6 am- 2 pm shift, the NP asked her if she had taken vitals yet on the resident on [DATE] and she stated that she did not have time to yet. The nurse practitioner took the O2 sat and it was at 84% at 11:05 AM. The nurse took the rest of the vital signs and the nurse practitioner after assessing Resident #1 sent her to the hospital. In an interview on [DATE] at 5:53 PM the 2 pm-10 pm shift nurse LVN B stated on [DATE] that she was the only nurse working that night. She stated that vital signs should be taken every shift and that assessments should be done before a resident gets sent out and when a resident comes back. Assessments should also be done when a resident is critical or is a priority. She stated that managed patients (Medicare/Medicaid) get assessments with vitals. She stated that in the case of Resident #1, she was not able to get a set of vitals because she had a lot going on. She stated that an aide came and told her around 10:00 PM that Resident #1 did not look good. LVN B stated she went in to look at Resident #1 and put her nasal cannula back on, but she was not able to obtain a O2 saturation level on the resident and that her pulse was 111 bpm and her BP was 115 over something she stated the resident was starting to appear cyanotic. A nonrebreather mask was placed on resident on 10Liters, and she called the nurse manager. She stated at that point Resident #1's pulse was 156. Nurse practitioner was called, and resident was sent to ER, where she was told the resident died . In an interview on [DATE] at 6:30 PM the RNC stated the facility only had one nurse on the COVID unit on [DATE] and Resident #1's assessment after her return from the hospital was not completed. The RNC stated she was not aware there was only one nurse on the unit and that there was not an RN on the unit. Observation on [DATE] at 11:15 PM revealed the State Task Force staff arrive at facility. 13 staff were observed undergoing orientation to the facility. No staffing plan received from facility. In an interview on [DATE] at 10:40 AM with 2 CNA's on the 400 hall CNA E and CNA F both stated they often worked short staffed. They said they both worked the day shift 6:00 AM to 2:00 PM, and often stayed late sometimes until after supper meal, to help care for residents because many times the next shift didn't show up or showed up late. They said they had been very concerned about residents not getting the care they needed because there wasn't enough CNA's working (i.e bathing, incontinent care) Observation and interview on [DATE] at 10:43 AM revealed Resident #2 sitting in his doorway, he was wearing a mask. He was dressed for the day, slightly disheveled. He said he was concerned he had not been given his early AM medications. When asked if he received good care he said he had not received his morning medication. He said he had not received a shower in 6 days, he said he used an electric razor to shave himself. He said he slept in his recliner, as was his preference and had done so for several years. Surveyor asked the nurse on the hall about Resident #2 morning medications. She said he had not yet received medications which were scheduled for 07:00 AM, she said she was trying to figure things out which had placed her behind. She agreed she would give his morning medications. In an interview on [DATE] at 10:45 AM a Confidential Staff Member pulled surveyor to side and stated she wanted to talk. She stated she wanted the surveyor to know what Corporate staff were doing and stated she would like to provide a statement and would like to remain anonymous. Review of the Confidential Staff Members statement dated [DATE] reflected .[DATE] an ADON reached out to the RNC for help. Our DON is out on medical leave, an ADON is out on maternity leave, and another ADON out for 14 days. This would leave only 2 ADONs in the facility to complete all required tasks and staffing. After reaching out ADON got no response from the RNC . As I am not an ADON and do not have much involvement with staffing, I cannot give accurate information on staffing other than being aware that the facility has been understaffed for some time now. I can only speak on what I have witnessed. When asked if corporate would call in a staffing agency to fill in some of the open shifts the VPO reminded the facility that we must be down 12 aides on one shift before calling in agency. When request for staffing were given by multiple ADONs to administration ADONs were told that the facility did not have enough openings to request staffing agencies. In an interview on [DATE] at 12:20 PM Resident #3 stated she had breakfast and that staff have been much nicer today. She told me that before she has not had good care and that aides have been rude to her and acting like they knew more than her. She also stated they have been rough with her. She states that if they pay money for a place they should get good care. Observation on [DATE] at 12:45 PM revealed Resident #6 in room eating lunch. Resident #6's dinner tray from [DATE] was still in her room. Observation/ Interviews on [DATE] at 1:15 PM revealed 3 call lights going off on the COVID unit. The call lights continued to go off for 15 minutes. Surveyor observed Resident #2 in her doorway yelling hey to someone who passed her room and she finally got some help. A RN asked surveyor if she needed helped. Surveyor asked who was responsible for answering call lights and the RN stated anyone could answer them and asked Surveyor to tell the nurses at the nurse's station. Surveyor went to the nurse's station and asked multiple staff, who was responsible for answering call lights. The staff stated anyone could answer them. Surveyor informed then that the call lights had been going off for more than 15 minutes. Residents finally started to get assistance at this point. A written statement from a facility staff member was received by email on [DATE] at 2:09 AM. The staff member stated they wanted to remain anonymous to protect her job. Review of the written statement reflected .[DATE] multiple department heads worked on COVID unit in a CNA role due to low staffing. These staff also work with the residents off the COVID unit. On [DATE] the following was communicated to the RNC .we need some help. We just found out that another ADON is positive and since the DON can't be here, it's just one other staff besides myself. We are struggling with staff picking up extra. Is there a plan in motion to help with extra staff? No response was received from the RNC. In an interview on [DATE] at 11:00 AM Resident #3 stated she wanted to get up in her wheelchair and stated she had asked multiple people to get her up and no one would assist her. Review of the written statement dated [DATE] from the ADON reflected . I just have a lot of concerns regarding the VOP and his decisions he's making. In the very beginning we had little PPE to wear, he even said at one point we can wear the N95 masks for 5 days before discarding. Recently I asked if it was safe for me to do wound care on both sides of the building, I try to get south side (negative side) done first but it doesn't always happen this way. I spoke to the VOP and asked if this was safe for the residents and he reassured me it was as long as I wasn't continuously working on the COVID side, which I'm there every day. I'm still very leery of this and wanted clarification . On [DATE] at 6:40 PM the VPO, Administrator and RNC were notified the facility had an IJ situation for the above failures. The facility's first Plan of Removal (POR) was submitted by the VPO on [DATE] at 8:20 PM. The final POR was accepted by the survey team on [DATE] at 2:00 PM. Accepted Plan of Removal: Plan of Removal On [DATE], a complaint survey was initiated at Brenham Nursing and Rehabilitation Center at 400 E Sayles Street, Brenham TX . On [DATE], the facility was notified by the surveyor that a jeopardy had been called and needed to submit a letter of credible allegation. The Facility respectfully submits this Letter of Credible Allegation pursuant to Federal and State regulatory requirements. Submission of the Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiencies. The alleged immediate jeopardy allegations are as follows: Issue: The facility failed to ensure there was a sufficient number of skilled licensed nurses to provide care and respond to each resident's needs. *Effective [DATE], the Director of Nursing and/ or designee reviewed the licensed nurse staffing patterns for the facility. The review included the staff assignments for the Isolation Unit designated for COVID 19 residents, as well as the unit designated for the COVID 19 negative residents to determine facility staffing needs. This will be completed by [DATE]. *Effective [DATE], Brenham Nursing and Rehab identified alternate sources to secure licensed nursing staff for the facility. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee reviewed licensed nursing and ancillary nursing staffing patterns to take into consideration residents' assessment and care needs related COVID 19 up to and including revision in the current shifts from eight hour shifts to twelve-hour shift to |

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| F 0725<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 3)<br>maximize staff availability. This will be completed by [DATE]. *Effective [DATE], the Administrator and/ or designee established a four-month recruitment plan designed in four thirty-day increments to recruit and training staff needed to meet the changing needs of the facility based on the status of the COVID 19 positive and negative residents. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee reviewed the process for supervision of care provided to the residents by licensed nurses and ancillary nursing staff and established shift supervision structures to coordinate the provision of care and meeting of resident needs. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee reeducated Licensed Nurses on the COVID-19 Assessment and Reporting Protocols related to the care, management and intervention for COVID 19 positive and COVID 19 negative residents. This will be completed by [DATE]. *Effective [DATE], the Director of Nursing and/ or designee will monitor compliance with vital signs and assessments and interventions through reconciliation of vital sign and assessment data/ documentation, as well as applicable interventions daily for seven days, then every other day for fourteen days three times weekly for three weeks and weekly for six weeks. *Effective [DATE], the Director of Nursing and/ or designee will monitor compliance with licensed nurse staffing by reviewing the staffing schedules for all shift for licensed nurse to resident ratios based on resident acuity and unit needs daily for fourteen days, then every other day for two weeks, then weekly for two months. On [DATE] an Quality Assurance Performance Improvement Meeting was held with the Administrator, Assistant Director of Nursing, Medical Director and two other persons present to discuss the above plan. The facility respectfully requests that the plan of removal be accepted, and immediate jeopardy be lifted. Monitoring for the Plan of Removal began on [DATE] at 2:00 PM. Staff were interviewed for understanding regarding the new procedure resident assessment, and assessment protocols. All staff interviewed had a good understanding of the training. Staffing sheets, and staffing ratios were reviewed for sufficient staffing. Staffing was observed to ensure sufficient staff were assisting residents and residents needs were being met. The facility was monitored for adequate staffing. On [DATE] at 2:45 PM the facility Administrator was notified that the IJ was removed. However, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy with a scope of widespread due to the facility requiring time to train all staff and monitor their plan of removal. |
| F 0835<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Many | **Administer the facility in a manner that enables it to use its resources effectively and efficiently.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in the facility during a coronavirus outbreak for the 85 residents that contracted [MEDICAL CONDITION]. A) The Administrator failed to comply with recommendations provided by the facility's Medical Director, the Medical Director of the local health authority and the facility's Nurse Practitioner regarding coronavirus testing for staff and residents to contain and control the spread of Coronavirus to include infection control measures that included cohort and isolation of residents testing positive for the coronavirus, keeping doors of positive residents rooms closed, ensuring the staff had ample PPE (personal protective equipment), monitoring cleaning protocols for the facility. B) The facility Administrator further failed to implement a staffing plan that would ensure there was enough licensed staff on duty to ensure resident assessments and resident monitoring were done to identify changes of condition in medically unstable COVID-19 positive residents, to have sufficient and dedicated staff working on the COVID positive unit and allowed staff to work on both the COVID positive and negative units, and failed to have sufficient direct care staff to meet the residents care needs. The facility Administrator's failure to follow the recommendations provided by the medical professionals at the beginning of the coronavirus outbreak in the facility and the Administrator's failure to ensure there was enough licensed staff on duty to provide resident assessments and practice effective infection control measures led to 85 residents contracting [MEDICAL CONDITION] and the death of 22 of those residents. These failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm at a scope of widespread due to staff needing more time to monitor the plan of removal for effectiveness. These deficient practices could affect all residents and place the residents at risk for mental anguish, prolonged isolation time, coronavirus infections, unidentified changes in condition and death. Findings included: A) In an interview on [DATE] at 2:45 PM the Administrator stated the NP (Nurse Practitioner) had tested another 4 or 5 Residents today. He stated 4 or 5 staff had been tested for Covid-19 (coronavirus disease) and were positive. He stated the facility was unable to obtain tests kits for all the staff (100 plus staff). He stated 30 or 40 tests had been completed at the facility. He stated only 10 staff had been tested for Covid-19. The Administrator stated the first positive tests came back to the facility on [DATE]. He stated the facility contracted a laboratory and they stated they would provide testing for Covid-19. He stated the facility was sent test kits which were collected and then the lab failed to pick them up. Since the failure the corporation had been unsuccessful in finding another testing company. In an interview on [DATE] at 2:55 PM the facility's NP (Nurse Practitioner) stated she was monitoring the COVID residents on the unit and was doing the testing on her own. She stated the facility was not doing testing and stating they did not have the resources. She stated they were not testing staff and until they test everyone she would not be able to get ahead of the infections and stated it was going to get worse without testing. She stated with 100 residents and 100 staff she did not have the supplies to test that many people and the facility was not helping. In an interview on [DATE] at 9:30 AM the facility's NP stated the facility had gotten 20 more positive test for residents. The NP stated the COVID unit would be full after all the positive residents are moved onto the unit. She stated she was concerned about staffing on the unit because the nurse who was working on the 100 hall (the COVID unit) was also working on the 200 hall which had residents who had not tested positive for the coronavirus. She stated as of that day ([DATE]) the number of positive residents had gone up to 43 and the facility still needed to test 80 staff members. In an interview on [DATE] at 1:25 PM the facility MD provided the surveyor with his COVID response plan. He stated he provided this to facility on [DATE] and it was mostly ignored or not fully implemented. He stated if the facility had been more corporative at the beginning with testing and recommendations it might not have reached this point. Review of the Facility MD's Response Plan dated [DATE] reflected that he was recommending the following basic guidelines in an attempt to contain the COVID contagion in the building. The guidelines included but were not limited to quarantine/ isolation of residents with symptoms, implement transmission-based precautions (masks on all residents and anyone in the building), dedicate specific staff to care for only the affected and suspected residents, cohort existing COVID residents to dedicated area, if a resident becomes newly sick with symptoms isolate and test them ASAP, be quick to move to dedicated area, and attempt/encourage testing of all employees in an effort to catch asymptomatic carriers that may inadvertently be spreading [MEDICAL CONDITION]. Observation and interview on [DATE] at 10:15 AM of the facility with DSHS (Department of State Health Services) Epidemiologist revealed hallways and handrails dirty. Trash and gloves noted on floors and wedged into the hand rails. The epidemiologist recommended an increase of housekeeping staff needed. The facility needed to remove items from hallways and alcoves such as lifts, and equipment and the multiple resident use equipment need to be tagged to indicate if it was cleaned after use. Doors to isolation rooms were noted to be open and residents not wearing masks. The facility staff member training the staff on the proper use of PPE was noted not donning his own PPE appropriately. The Epidemiologist stated the donning/ doffing area at the entrance to the isolation unit needed better flow and access to hand sanitizer. All recommendations provided to the facility administration. In an interview on [DATE] at 12:20 PM the NP stated the facility had moved residents on the roster to make them appear to have been moved to a different room but did not actually move the residents. The NP stated the facility did not stop therapy when instructed to. She further stated she repeatedly told the facility and staff to keep isolation room doors closed. She stated she told the facility on [DATE] and instructed them to test all residents and that did not occur. She stated the facility would run out of PPE in the containers outside of isolation rooms and found that isolation rooms did not have biohazard boxes in the rooms. The NP further stated she provided swabs for testing and the facility's Corporate staff took the swabs away from the facility staff because they did not want all residents tested . The NP further stated Corporate did not want employees tested . In an interview on [DATE] at 12:30 PM the Medical Director of the local health authority stated he had made a time line of events that occurred at the facility that concerned him, and he would provide a written statement. Review of the Medical Director of the local health authority statement dated [DATE] reflected I am writing this letter to record my directives to the Medical Director (MD), administration and staff of the facility. As Local Health Authority, I have been monitoring the COVID 19 pandemic in |

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| F 0835<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 4)<br>cooperation with DSHS Region 7 and our local emergency management coordinator, since even before the outbreak of [MEDICAL CONDITION] in our county. I was first notified of cases at the facility by the NP on the morning of [DATE]. I had been made aware in passing on or about [DATE] of a PUI (patient under investigation) at the facility that had been sent to the hospital on [DATE]. His test came back positive on 5 April, at which point I was nearly immediately notified. My first call was to the medical director of the facility. At that time, there was a potential staff member that had been tested positive, and by this time there were more suspected cases in the building. My recommendations, which the facility MD and NP relayed to the facility directly, were to immediately isolate all PUI's, and to continue monitoring staff closely for symptoms. At this point, the facility already had stopped all visitors, and there was no communal dining, etc. Within two days, more cases were reported. I was in direct contact with the MD and NP on [DATE] and 7. By [DATE], there were at least 3 (and more PUI's suspected), and I was notified of this by early afternoon. A three-way conference call was arranged, the administrator of the facility, and the NP to discuss recommendations going forward for isolation of residents. My recommendation at that time was to move all positive patients and PUI's to the 300 hall, or if unable to for logistical reasons, to move them all to an isolated area in the 100 hall. I directed them to sequester all positives away from the general population, and to set up an isolation ward to assist with donning/doffing of PPE. Over the next few days cases continued to climb. I spoke with an infectious disease specialist and Local Health Authority to get further suggestions. He and I both agreed that testing all staff was paramount, although due to limited testing ability in the state it would be difficult. I spoke with the facility's MD that afternoon regarding these recommendations, which were to basically stop all unnecessary movement within the facility, stop physical therapy, close all doors that could be closed, and test all staff, and if possible, all patients. He stated he would take the lead on this as he was the medical director for the facility. I continued to follow up with the facility MD and NP daily. The cases unfortunately continued to climb. I was told by the facility MD, and the facility administrator, that corporate doctors did not agree with our recommendations. I did not personally speak with these corporate representatives as the facility MD said he would do so. He related to me that they were very much against testing anyone that did not have symptoms in the facility, for unclear reasons. A plan was made, and orders were written on or about Tuesday, [DATE] or Wednesday [DATE] to test all residents through a lab testing company through the nursing facility. I was told by the facility NP Wednesday [DATE], late in the day, that at the direction of the Corporation, no testing was to be performed on patients that we ordered, and the orders were canceled. The materials necessary to test were reportedly locked in the administrator's office to keep out of the hands of nursing. At this time, the facility MD and I decided that a meeting between corporate and ourselves must be set up as soon as possible due to the risk of continued spread. By this point, there were approximately 10 patients, with multiple PUIs. I drafted control orders for the facility, that clearly laid out a mitigation strategy of testing, complete isolation, closing doors, and assuming all patients had COVID until proven otherwise. These orders were given to the facility MD. On the morning of 16 April, the facility MD gave me his revised version of the control orders, with his signature. These were almost identical to mine in contact, and only different in language. I was told that as LHA (local health authority), I did not have direct authority to impose control orders, as I work through DSHS, and that the medical director and HHS had authority over the facility. The meeting between the facility VPO (Vice present of operations), and several other corporate officers, as well as the facility Administrator, NP, MD and myself occurred at 5:30 PM on Thursday 16 April. There was significant push back during this meeting, during which the facility MD read aloud his orders, regarding the testing of patients. The facility's VPO exact words were what does it matter if we test? What if they all already have it. My impression was that he did not grasp the severity of the situation, and I directly recommended they test everyone and that doors be closed. I also recommended that therapy cease except where absolutely indicated. I was told that was impossible, and that therapy was as important as [MEDICAL TREATMENT]. Again, I recommended it stop immediately. We were promised at this meeting that the isolation wall for the 100 hallway would be up within 24 to 48 hours. During this meeting, the facility NP clearly made administration aware that staff were not [MEDICATION NAME] appropriate distancing, PPE use, or hand hygiene. The facility MD and I both recommended that interventions be made to quickly remedy this. On Monday, 20 April, I was informed that the wall was still not up . By Friday, the number of cases in the facility had risen to over 60, with a total of 11 deaths at the time of this writing. My thoughts on this situation is that, based on the data and discussions with both the facility MD and NP, that numerous times the administration of the facility were given information and the opportunity to lessen the spread of COVID 19. At times, we were directly challenged on how we wanted to proceed, and orders of a physician/FNP that were legally written were disobeyed at the direction of corporate officers. I am saddened by the way this was handled and feel that steps need to be taken to assure that this does not happen in this, or any facility, ever again. In an interview on [DATE] at 6:40 PM the VPO stated he felt the facility followed all the CDC guidelines in regard to the COVID outbreak. The VPO stated the facility tried to test everyone, but the labs would not provide the test kits or would not pick up the test collected and stated the kits taken away from staff were because they were the wrong test kits. The VPO stated residents room doors were not closed and infection control measures might not be followed right now because they are moving residents to get the positive residents away from the negative residents. Observation on [DATE] at 10:50 AM making rounds with the DSHS Epidemiologist and Associate Commissioner for HHSC revealed multiuse equipment still noted in hallways and alcoves without labels to identify if they were clean, residents still not wearing masks, floors remain dirty and residents that were positive needed to be moved to the isolation unit doors were open. Observation/ Interview on [DATE] at 11:20 PM revealed none of the 13 residents on the 300 or 400 hall had been transferred to the isolation unit yet. The VPO stated the staff were making sure equipment and belongings could be secured prior to moving the residents. Observation on [DATE] at 11:40 PM the isolation unit revealed empty rooms to be cleaned and ready to receive residents. In an interview on [DATE] at 10:45 AM a Confidential Staff Member pulled surveyor to side and stated she wanted to talk. She stated she wanted the surveyor to know that Corporate staff took testing swabs away from staff to prevent them from testing and stated she would like to provide a statement and would like to remain anonymous. Review of the Confidential Staff Members statement dated [DATE] reflected Between the dates of [DATE]th and [DATE]th it was never mentioned to the employees that they had a plan in action to begin testing employees, even after employees expressed wanting to be tested . At one-point employees were told if they were tested , they would have to be out of work for 14 days and would have to use their own PTO. [DATE] the VPO and RNC came to the facility to provide lunch for facility staff members. Neither one walked inside facility to ensure that all protocols where being followed. On [DATE] ADON received orders from the FNP to test all remaining residents in the facility. Orders were later given by the facility MD to cover all remaining orders in facility due to his Medical Director status. The Facility spoke with our outside lab company to ask if they would be able to run COVID test for us. They called back to inform facility that they could run the test for us, and a lab tech would deliver the testing kits later that afternoon. On [DATE] Via text message the RNC asked the ADON if there were written orders to test all remaining residents in the facility. When ADON informed her that there were verbal telephone orders that had been entered into PCC the RNC instructed her to hold off on testing. ADON informed her that all orders had been approved by the facility MD and entered into PCC as well as the lab for all specimens to be collected. At that time ADON was instructed to be on a conference call in administrators office. ADON came back into conference room and voiced to me that the VPO stated that the facility will not test all residents. It goes against CDC and CMS guidelines to blanket test all residents. The only way the facility would get over this was to practice proper hand hygiene and social distancing. While talking with the ADON about the phone call, the Administrator came into the conference room and removed all testing kits off the table. At this time, it was the ADONS, and me present in the conference room. A phone conference with CEO, COO, CNO, LHA MD, the facility FNP and MD, the Administrator, RNC and VPO was scheduled for later that evening. One of the ADONs requested to be on the call for added input, the facility MD stated that this would be great thing for any additional input. Later that afternoon ADON was informed that corporate wants no one else in the meeting. [DATE] one of the ADONs reached out to the RNC for help . After reaching out the ADON got no response from the RNC . During this time, I witnessed the VPO instruct other team members to move residents that had a negative test result into a room that a patient with a positive test results without it being properly deep cleaned. [DATE]th while assisting another staff member to identify which test results that were received on [DATE]th were staff members and residents so that she could notify family members of test results. I noticed that there was a COVID positive resident on the south unit and a COVID negative patient on the isolation unit. The VPO instructed staff who needed to be moved and to where. I brought this to his attention. After sitting back down at my computer I overheard him ask the RNC how to move the residents without the state surveyors noticing. At this time the NP asked me for a resident room roster, I walked into the admissions office for a roster at that time and the Admissions Director told me that the VPO had instructed her to NOT give anyone from the state a room roster . In an interview on [DATE] at 12:20 PM the facility NP |

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| F 0835<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 5)<br>stated she had made a timeline of events that occurred at the facility and would provide a written statement. The NP stated she had been at the facility everyday since the outbreak started and witnessed facility failures first hand. Review of the facility's NP written statement dated [DATE] reflected This is the statement of events personally witnessed to the best of my recollection at the facility from [DATE]th through 27th 2020. On [DATE] the facility was instructed to close all doors, stop all therapy room to room, and have all staff tested by myself and the LHA (local health authority) MD. This was disregarded by the facility. Again, staff were recommended to be tested , therapy stopped, and doors closed on [DATE] after additional positives were found. Again, this was disregarded by the facility. On [DATE] we attempted to test all the facility residents. These swabs were ordered through a lab. The nursing staff started collecting these specimens and then were told to stop by the Administrator on the direction of the VOP. The swabs were taken away from staff and placed in the Administrators office to prevent them being collected. A meeting was held with LHA MD, the facility MD, me and several corporate members via teleconference on the night of [DATE]. It was stated they did not want to test staff because they were worried they would have too many staff positives and then no staff to manage the facility. This was again requested by LHA MD, facility MD and me despite this concern. It was also requested in writing by the facility MD to keep same staff to isolation hallway- not mix with non-isolation hallway, stop therapy, and to test everyone including staff. This again was disregarded. One corporate official also stated that if this was all over the building then what was the point of testing everyone. On [DATE] at the direction of LHA MD a true isolation unit was recommended. It was said this would be done ASAP at that time. On Monday [DATE] the facility decided to test staff but did not help facilitate this or give staff direction on how to get this done. Staff were told they would have to be out until test results were back even if it was done for screening. We asked for a sign-up list for staff to voluntarily be tested . Then staff were told they would have to be out until test results were back even if it was done for screening, so all the staff removed their names. Therapy continued until [DATE]. Doors remained open until [DATE]. 100 and 200 hall shared one ,[DATE] nurse until [DATE]. Staff took care of positive and negative patients till [DATE]. The residents were all tested at my direction with swabs from state on [DATE], [DATE], [DATE]. I personally witnessed staff asking for additional outside staffing help as early as [DATE]. They were disregarded. I personally witnessed staff entering isolation rooms with masks only on. I also was notified by one family that they did not know their family member was positive for > 48 hrs. post diagnosis. PPE was not adequately stocked outside of isolation rooms and bins were not in rooms to dispose of PPE. Patients with positive results were kept in rooms with negative patients for > 18 hrs. post diagnosis. In an interview on [DATE] at 3:45 PM the VPO came to the surveyor and stated he made a mistake and moved the wrong resident last night and placed a negative resident on the COVID unit and a positive resident remained on the negative side. Observation on [DATE] at 8:25 PM on the isolation unit revealed a trash bag with various contents on the floor outside room [ROOM NUMBER]. Review of the census reflected room [ROOM NUMBER] had<br>housed Resident #6 prior to her going out to hospital this evening (Resident progress notes reflected she left at 6:37 pm. Further observation revealed the double glass doors at the end of 100 hall had a large trash bag outside. This was the second night in a row trash was observed outside this door. The implication was staff are breaking containment to remove trash. A written statement from a facility staff member was received by email on [DATE] at 2:09 AM. The staff member stated they wanted to remain anonymous to protect her job. Review of the written statement reflected .Between the dates of [DATE] and [DATE], there was no effort from our corporate offices to begin testing staff members in spite of multiple requests to do so. The answer that was given from corporate was that if an employee needed to be tested , they were to contact their healthcare provider. There was never mention to the employees that our company was trying to put into a plan of action to begin providing testing for employees even though it was expressed to them (the company) that they wanted to get tested .Sunday [DATE] the first resident from our facility, that was in the hospital was tested for novel coronavirus and had a positive result. There was still no effort from corporate offices to begin testing employees . Up until this date, no effort from Corporate offices were made to fit test N95's for the employees. The only available PPE we had were surgical masks, the yellow disposable gowns, Medium N95 masks, gloves, Hair covers and clear glasses that didn't wrap around our eyes to protect them from the side. No foot covers available at this time. A concern made to the Administrator regarding inappropriate clear glasses, no new clear goggles or face shields made available to staff in facility . [DATE] the VPO and RNC came to facility to provide lunch for facility staff members. Neither one of them entered the facility to assess how protocols were being followed. [DATE] It was relayed to ADON's and Administrator that the Lab could provide 80 testing kits, but the tests could be only be run by the Lab and the results could take at least 5 days for the results. The testing kits were ordered but the lab technician could not bring them to our facility until [DATE] . the Lab technician dropped off testing supplies and instructions on how tests were to be performed and how to store them prior to pick up. Orders for labs were entered into PCC and into the Lab website . I was asked by the Administrator to come to his office to talk to the VPO and RNC. I was told by the VPO that it was against CDC recommendations to blanket test the entire facility. I expressed that I had a verbal order to test all residents from the facility MD and the testing would be started. VPO expressed to me again that it was against CDC recommendations and was told to not test residents but continue social distancing and washing our hands. I left the Administrators office and returned to the conference room where other staff were present and was visibly upset. The Administrator entered the room after me and removed all testing kits from our possession and locked them in his office .[DATE] the facility continues to have orders for testing every resident that has not been tested . No testing kits available except for the Lab testing kits. ADON's continue to have no access to testing kits .[DATE] .the VPO and RNC have finally arrived at the facility and entered our building after 18 days of having multiple residents and staff members positive for the novel coronavirus and 4 days since notifying the RNC of the need for extra staff.<br>Observation/Interview on [DATE] at 9:05 AM during rounds with the Epidemiologist he stated he still had concerns regarding items in the hallways and alcoves, and resident belongings in the halls (which were potentially contaminated). He further stated the house keeping staff need to pick up the pace on getting rooms cleaned out that are empty that had COVID positive residents in them. In an interview on [DATE] at 8:00 AM the ADON stated she would like to provide a statement. Review of the statement dated [DATE] from the ADON reflected . I just have a lot of concerns regarding the VOP and his decisions he's making. In the very beginning we had little PPE to wear, he even said at one point we can wear the N95 masks for 5 days before discarding. Recently I asked if it was safe for me to do wound care on both sides of the building, I try to get south side (negative side) done first but it doesn't always happen this way. I spoke to the VOP and asked if this was safe for the residents and he reassured me it was as long as I wasn't continuously working on the COVID side, which I'm there every day. I'm still very leery of this and wanted clarification I have been treated so poorly by this man, completely booted out of my position because I question him on issues and I speak for the residents which I care about deeply. From the very beginning the facility MD wanted all residents tested and the VOP had the Administrator literally take the swabs out of our hands after we had already collected some and stated it was not necessary. I truly believe that if corporate would have followed orders from doctors we would not have seen as many deaths and other issues from this .I do blame corporate for the deaths we have had. And not only do I, it's just a lot of staff will not speak up .I will probably get fired for even writing this to you, but I had to clear my conscience knowing these decisions, I believe in my heart were very wrong for everyone involved. We asked about testing staff weeks ago before they FINALLY did it. I just can't wrap my head around the thought process . Review of the facility's COVID-19 numbers reflected as of [DATE] 85 residents had contracted [MEDICAL CONDITION] and 22 residents had died . The facility's COVID-19 numbers also reflected 29 staff members had contracted [MEDICAL CONDITION]. Review of the facility's policy Outbreak of Novel Coronavirus (2019-nCoV) dated [DATE]<br>reflected Suspected outbreaks of Novel Coronavirus within the facility will be promptly identified and appropriately handled per the CDC recommendations. The Administrator or Director of Nursing (DON) will notify the local health department in case of an outbreak. Personal Protective equipment (e.g., gowns, gloves, NOISH-certified disposable N95 respirators) will be provided to our employees . Review of the facility's policy Reportable Diseases dated [DATE] reflected .Should any residents or staff suspected or diagnosed as having a reportable communicable/infectious disease according to State-Specific criteria, such information shall be promptly reported to appropriate local and/ or state health department officials . B) In an interview on [DATE] at 9:30 AM the facility NP stated the facility has gotten 20 more positive test for residents and are testing staff and have 12 positive staff. She stated both ADON RN's who were doing the q8hr assessments on the COVID residents tested positive and were sent home. She stated the COVID unit will be full after all the positive residents are moved on the unit. She stated she is concerned about staffing on the unit. She is doing labs and the residents are dehydrated she stated she wanted one staff just hydrating the residents. She stated they did IV's on two of the residents. She also stated the it is not recommended to hydrate to fast because the residents will develop [MEDICAL CONDITIONS]. The NP stated she was concerned that the nurse for 100 hall was also working on 200 hall (100 hall is the |

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| F 0835<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Many | (continued... from page 6)<br>COVID) at night. Review of Resident #1's Face Sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change Minimum Data Set ((MDS) dated [DATE]<br>reflected Resident #1 had a Brief Interview for Mental Status Score of nine (9) indicating moderate cognitive impairment. Resident #1 was assessed to require supervision for all activities of daily living (ADLs). Review of Resident #1's Comprehensive Care Plan reflected a problem with the start date [DATE] High risk for communicable respiratory infection-influenza/ pneumonia- due to age and resident lives in close proximity to others. Further review of Resident #1's Comprehensive Care plan reflected a problem with the start date [DATE] Resident is at risk for signs and symptoms of COVID-19. Interventions included observe for signs and symptoms of COVID-19, document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, respiratory issues. Review of Resident #1's Nursing progress notes dated [DATE] reflected an entry at 4:08 AM that the facility received notification that Resident #1 was COVID positive. An entry at 3:45 PM reflected resident returned form the emergency room (ER) at 3:30 PM. The note reflected Resident #1 returned on 2 liters of supplemental oxygen. An entry dated at 5:50 PM reflected a late entry for 10:45 AM on [DATE] that Resident #1was assessed by the NP and her oxygen saturation was 85% on room air and oxygen was started at 2 liters Resident #1 was noted with temperature of 101.4 and a HR of 134. Note indicated Resident #1 was sent to the ER. The next entry in Resident #1's Nursing progress notes dated [DATE] was at 10:40 PM indicating Resident #1 was sent to the ER with [MEDICAL CONDITION] and respiratory distress. Review of Resident #1's Hospital Record dated [DATE] at 11:27 PM reflected DOS |
| F 0837<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Many | **Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the governing body failed to implement policies regarding the management and operation of the facility for the 85 residents in the facility that contracted the COVID-19 virus and for one (1) of ten (10) residents reviewed for assessment. -The Vice President of Operations (VPO) and Regional Nurse Consultant (RNC) failed to provide instruction and oversight for the facility when the facility failed to follow recommendations provided by the facility's Medical Director, the Medical Director of the local health authority and the facility's Nurse Practitioner regarding coronavirus testing for staff and residents and followed the recommended infection control measures to prevent the spread of the coronavirus in the facility. -The VPO and RNC failed to assist the facility in modifying their staffing ratios to ensure the facility had enough licensed staff on duty to provide resident assessments, monitoring and care for the clinically unstable COVID-19 positive residents. -The RNC failed to develop and implemented assessment protocols for the facility to monitor and identify changes in clinically unstable COVID-19 positive residents. These failures led to 85 residents contracting the COVID-19 virus and the death of 22 of those residents. These failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm at isolated and a severity level of no actual harm with potential for more than minimal harm at a scope of widespread due to staff needing more time to monitor the plan of removal for effectiveness. These deficient practices could affect all residents and place the residents at risk for mental anguish, prolonged isolation time, coronavirus infections, unidentified changes in condition and death. Finding included: In an interview on [DATE] at 2:45 PM the Administrator stated the NP (Nurse Practitioner) had tested another 4 or 5 Residents today. He stated 4 or 5 staff had been tested for Covid-19 (coronavirus disease) and were positive. He stated the facility was unable to obtain tests kits for all the staff (100 plus staff). He stated 30 or 40 tests had been completed at the facility. He stated only 10 staff had been tested for Covid-19. The Administrator stated the first positive tests came back to the facility on [DATE]. He stated the facility's contracted a laboratory and they stated they would provide testing for Covid-19. He stated the facility was sent test kits which were collected and then the lab failed to pick them up. Since the failure the corporation had been unsuccessful in finding another testing company. In an interview on [DATE] at 2:55 PM the facility's NP (Nurse Practitioner) stated she is monitoring the COVID residents on the unit and is doing the testing on her own. She stated the facility is not doing testing and stating they do not have the resources. She stated they are not testing staff and until they test everyone she will not be able to get ahead of the infections and stated it is going to get worse without testing. She stated with 100 residents and 100 staff she does not have the supplies to test that many people and the facility is not helping. In an interview on [DATE] at 9:30 AM the facility NP stated the facility has gotten 20 more positive test for residents and are testing staff and have 12 positive staff. She stated both ADON RN's who were doing the q8hr assessments on the COVID residents tested positive and were sent home. She stated the COVID unit will be full after all the positive residents are moved on the unit. She stated she is concerned about staffing on the unit. She is doing labs and the residents are dehydrated she stated she wanted one staff just hydrating the residents. She stated they did IV's on two of the residents. She also stated the it is not recommended to hydrate to fast because the residents will develop [MEDICAL CONDITIONS]. The NP stated she was concerned that the nurse for 100 hall was also working on 200 hall (100 hall is the COVID) at night. She stated as of today the number of positive residents had go up to 43 and the facility still needs to test 80 staff members. Review of Resident #1's Face Sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change Minimum Data Set ((MDS) dated<br>[DATE] reflected Resident #1 had a Brief Interview for Mental Status Score of nine (9) indicating moderate cognitive impairment. Resident #1 was assessed to require supervision for all activities of daily living (ADLs). Review of Resident #1's Comprehensive Care Plan reflected a problem with the start date [DATE] High risk for communicable respiratory infection- influenza/ pneumonia- due to age and resident lives in close proximity to others. Further review of Resident #1's Comprehensive Care plan reflected a problem with the start date [DATE] Resident is at risk for signs and symptoms of COVID-19. Interventions included observe for signs and symptoms of COVID-19, document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, respiratory issues. Review of Resident #1's Nursing progress notes dated [DATE] reflected an entry at 4:08 AM that the facility received notification that Resident #1 was COVID positive. An entry at 3:45 PM reflected resident returned form the emergency room (ER) at 3:30 PM. The note reflected Resident #1 returned on 2 liters of supplemental oxygen. 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Critical Care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: [MEDICAL CONDITION]. Patient progress listed as Critical. Further review of Resident #1's hospital record reflected Resident #1 expired at on [DATE] at 12:50 AM in the ER with finial [DIAGNOSES REDACTED]. Review of Resident #1's Electronic Medical Record (EMR) reflected Resident #1 did not have an<br>assessment completed upon her return to the facility at 3:30 PM on [DATE]. The EMR further reflected no vital signs documented for Resident #1 from the time she returned to the facility at 3:30 PM until the time she was sent back to the hospital at 10:40 PM (7 hours and 10 min later). Record review of Resident #1's EMR reflected that no progress notes were charted for Resident #1 from [DATE] to [DATE]. No documented temperature on 3 days: ,[DATE], ,[DATE], ,[DATE]. No documented BP for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No pulse documented on 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No RR documented for 6 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No O2 sat documented for 4 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE]. No skilled assessments were documented for 8 days: ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE]. Resident COVID positive on [DATE]. Review of the facility census for [DATE] reflected 36 residents on the COVID unit. Review of the facility staffing for [DATE] reflected one (1) LVN on the COVID unit and no RN. In an interview on [DATE] at 1:25 PM the facility MD provided the surveyor with his COVID response plan. He stated he provided this to facility on [DATE] and it was mostly ignored or not fully implemented. He stated if the facility had been more corporative at the beginning with testing and recommendations it might not have reached this point. Review of |

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| | 675799 | A. BUILDING _____ B. WING _____ | 05/15/2020 |

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| F 0837<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 7)<br>the Facility MD's Response Plan dated [DATE] reflected that he was recommending the following basic guidelines in an attempt to contain the COVID contagion in the building. The guidelines included but were not limited to quarantine/ isolation of residents with symptoms, implement transmission-based precautions (masks on all residents and anyone in the building), dedicate specific staff to care for only the affected and suspected residents, cohort existing COVID residents to dedicated area, if a resident becomes newly sick with symptoms isolate and test them ASAP, be quick to move to dedicated area, and attempt/encourage testing of all employees in an effort to catch asymptomatic carriers that may inadvertently be spreading [MEDICAL CONDITION]. In an interview on [DATE] at 2:45 PM the RNC and VPO stated they were working on a plan for staffing once the unit was completed. Observation and interview on [DATE] at 10:15 AM of the facility with DSHS (Department of State Health Services) Epidemiologist revealed hallways and handrails dirty. Trash and gloves noted on floors and wedged into the hand rails. The epidemiologist recommended an increase of housekeeping staff needed. The facility needed to remove items from hallways and alcoves such as lifts, and equipment and the multiple resident use equipment need to be tagged to indicate if it was cleaned after use. Doors to isolation rooms were noted to be open and residents not wearing masks. The facility staff member training the staff on the proper use of PPE was noted not donning his own PPE appropriately. The Epidemiologist stated the donning/ doffing area at the entrance to the isolation unit needed better flow and access to hand sanitizer. All recommendations provided to the facility administration. In an interview on [DATE] at 12:20 PM the NP stated the facility had moved residents on the roster to make them appear to have been moved to a different room but did not actually move the residents. The NP stated the facility did not stop therapy when instructed to. She further stated she repeatedly told the facility and staff to keep isolation room doors closed. She stated she told the facility on [DATE] and instructed them to test all residents and that did not occur. She stated the facility would run out of PPE in the containers outside of isolation rooms and found that isolation rooms did not have biohazard boxes in the rooms. The NP further stated she provided swabs for testing and the facility's Corporate staff took the swabs away from the facility staff because they did not want all residents tested . The NP further stated Corporate did not want employees tested . The facility NP stated the facility had been understaffed for two weeks and Corporate was asked for more staffing, but they refused. She stated she did not feel like the residents were getting the care they need such as hydration, feeding assist and just care in general. In an interview on [DATE] at 12:30 PM the Medical Director of the local health authority stated he had made of time line of events that occurred at the facility that concerned him, and he would provide a written statement. Review of the Medical Director of the local health authority statement dated [DATE] reflected I am writing this letter to record my directives to the Medical Director (MD), administration and staff of the facility. As Local Health Authority, I have been monitoring the COVID 19 pandemic in cooperation with DSHS Region 7 and our local emergency management coordinator, since even before the outbreak of [MEDICAL CONDITION] in our county. I was first notified of cases at the facility by the NP on the morning of [DATE]. I had been made aware in passing on or about [DATE] of a PUI (patient under investigation) at the facility that had been sent to the hospital on [DATE]. His test came back positive on 5 April, at which point I was nearly immediately notified. My first call was to the medical director of the facility. At that time, there was a potential staff member that had been tested positive, and by this time there were more suspected cases in the building. My recommendations, which the facility MD and NP relayed to the facility directly, were to immediately isolate all PUI's, and to continue monitoring staff closely for symptoms. At this point, the facility already had stopped all visitors, and there was no communal dining, etc. Within two days, more cases were reported. I was in direct contact with the MD and NP on [DATE] and 7. By [DATE], there were at least 3 (and more PUI's suspected), and I was notified of this by early afternoon. A three-way conference call was arranged, the administrator of the facility, and the NP to discuss recommendations going forward for isolation of residents. My recommendation at that time was to move all positive patients and PUI's to the 300 hall, or if unable to for logistical reasons, to move them all to an isolated area in the 100 hall. I directed them to sequester all positives away from the general population, and to set up an isolation ward to assist with donning/doffing of PPE. Over the next few days cases continued to climb. I spoke with an infectious disease specialist and Local Health Authority to get further suggestions. He and I both agreed that testing all staff was paramount, although due to limited testing ability in the state it would be difficult. I spoke with the facility's MD that afternoon regarding these recommendations, which were to basically stop all unnecessary movement within the facility, stop physical therapy, close all doors that could be closed, and test all staff, and if possible, all patients. He stated he would take the lead on this as he was the medical director for the facility. I continued to follow up with the facility MD and NP daily. The cases unfortunately continued to climb. I was told by the facility MD, and the facility administrator, that corporate doctors did not agree with our recommendations. I did not personally speak with these corporate representatives as the facility MD said he would do so. He related to me that they were very much against testing anyone that did not have symptoms in the facility, for unclear reasons. A plan was made, and orders were written on or about Tuesday, [DATE] or Wednesday [DATE] to test all residents through a lab testing company through the nursing facility. I was told by the facility NP Wednesday [DATE], late in the day, that at the direction of the Corporation, no testing was to be performed on patients that we ordered, and the orders were canceled. The materials necessary to test were reportedly locked in the administrator's office to keep out of the hands of nursing. At this time, the facility MD and I decided that a meeting between corporate and ourselves must be set up as soon as possible due to the risk of continued spread. By this point, there were approximately 10 patients, with multiple PUIs. I drafted control orders for the facility, that clearly laid out a mitigation strategy of testing, complete isolation, closing doors, and assuming all patients had COVID until proven otherwise. These orders were given to the facility MD. On the morning of 16 April, the facility MD gave me his revised version of the control orders, with his signature. These were almost identical to mine in contact, and only different in language. I was told that as LHA (local health authority), I did not have direct authority to impose control orders, as I work through DSHS, and that the medical director and HHS had authority over the facility. The meeting between the facility VPO (Vice present of operations), and several other corporate officers, as well as the facility Administrator, NP, MD and myself occurred at 5:30 PM on Thursday 16 April. There was significant push back during this meeting, during which the facility MD read aloud his orders, regarding the testing of patients. The facility's VPO exact words were what does it matter if we test? What if they all already have it. My impression was that he did not grasp the severity of the situation, and I directly recommended they test everyone and that doors be closed. I also recommended that therapy cease except where absolutely indicated. I was told that was impossible, and that therapy was as important as [MEDICAL TREATMENT]. Again, I recommended it stop immediately. We were promised at this meeting that the isolation wall for the 100 hallway would be up within 24 to 48 hours. During this meeting, the facility NP clearly made administration aware that staff were not [MEDICATION NAME] appropriate distancing, PPE use, or hand hygiene. The facility MD and I both recommended that interventions be made to quickly remedy this. On Monday, 20 April, I was informed that the wall was still not up . By Friday, the number of cases in the facility had risen to over 60, with a total of 11 deaths at the time of this writing. My thoughts on this situation is that, based on the data and discussions with both the facility MD and NP, that numerous times the administration of the facility were given information and the opportunity to lessen the spread of COVID 19. At times, we were directly challenged on how we wanted to proceed, and orders of a physician/FNP that were legally written were disobeyed at the direction of corporate officers. I am saddened by the way this was handled and feel that steps need to be taken to assure that this does not happen in this, or any facility, ever again. In an interview on [DATE] at 5:15 PM the RNC (Reginal Nurse Consultant) stated that Resident's VS (vital sings) were on paper sheets. The RNC stated the VS for Resident #1 regarding the time period in question were not present. She stated her expectation of assessments were that they were to be done every time there was a change of condition. She stated that her expectation was that vital signs were done every shift. There are 3 eight-hour shifts. She stated that this has always been her expectation. In an interview on [DATE] at 5:27 PM the nurse on duty LVN A stated she was not the nurse on duty taking care of Resident #1 when she arrived back to the facility at 3:30 pm or was sent back out to the hospital at 10:40 pm. She stated she was in the facility at the time the patient needed to be sent to the hospital, but she was not the nurse on duty. LVN A stated she put the notes in the chart for the night nurse, which is why her name was in the chart. She stated she called the family, the nurse practitioner, charted, and did the paperwork for the resident to be sent out of the facility. LVN A stated she was the 6 am-2 pm nurse for the resident. She stated during the 6 am- 2 pm shift, the NP asked her if she had taken vitals yet on the resident on [DATE] and she stated that she did not have time to yet. The nurse practitioner took the O2 sat and it was at 84% at 11:05 AM. The nurse took the rest of the vital signs and the nurse practitioner after assessing Resident #1 sent her to the hospital. In an interview on [DATE] at 5:53 PM the 2 pm-10 pm shift nurse LVN B stated on [DATE] that she was the only nurse working that night. She stated that vital signs should be taken every shift and that assessments should be done |

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| F 0837<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 8)<br>before a resident gets sent out and when a resident comes back. Assessments should also be done when a resident is critical or is a priority. She stated that managed patients(Medicare/Medicaid) get assessments with vitals. She stated that in the case of Resident #1, she was not able to get a set of vitals because she had a lot going on. She stated that an aide came and told her around 10:00 PM that Resident #1 did not look good. LVN B stated she went in to look at Resident #1 and put her nasal cannula back on, but she was not able to obtain a O2 saturation level on the resident and that her pulse was 111 bpm and her BP was 115 over something she stated the resident was starting to appear cyanotic. A nonrebreather mask was placed on resident on 10Liters, and she called the nurse manager. She stated at that point Resident #1's pulse was 156. Nurse practitioner was called, and resident was sent to ER, where she was told the resident died . In an interview on [DATE] at 6:30 PM the RNC stated the facility only had one nurse on the COVID unit on [DATE] and Resident #1's assessment after her return from the hospital was not completed. The RNC stated she was not aware there was only one nurse on the unit and that there was not an RN on the unit. In an interview on [DATE] at 6:40 PM the VPO stated he felt the facility followed all the CDC guidelines in regard to the COVID outbreak. The VPO stated the facility tried to test everyone, but the labs would not provide the test kits or would not pick up the test collected and stated the kits taken away from staff were because they were the wrong test kits. The VPO stated residents room doors were not closed and infection control measures might not be followed right now because they are moving residents to get the positive residents away from the negative residents. Observation on [DATE] at 11:15 PM revealed the State Task force staff arrive at facility. 13 staff were observed undergoing orientation to the facility. No staffing plan received from facility. Observation on [DATE] at 10:50 AM making rounds with the DSHS Epidemiologist and Associate Commissioner revealed multiuse equipment still noted in hallways and alcoves without labels to identify if they were clean, residents still not wearing masks, floors remain dirty and residents that were positive needed to be moved to the isolation unit doors were open. In an interview on [DATE] at 1:40 PM the RNC stated the facility's COVID response plan did not have standing orders for assessments and care of COVID positive residents to guide the staff on their care and agreed that the COVID positive residents were clinically unstable and required close monitoring. Observation/ Interview on [DATE] at 11:20 PM revealed none of the 13 residents on the 300 or 400 hall had been transferred to the isolation unit yet. The VPO stated the staff were making sure equipment and belongings could be secured prior to moving the residents. Observation on [DATE] at 11:40 PM the isolation unit revealed empty rooms to be cleaned and ready to receive residents. In an interview on [DATE] at 10:40 AM with 2 CNA's on the 400 hall CNA E and CNA F both stated they often worked short staffed. They said they both worked the day shift 6:00 AM to 2:00 PM, and often stayed late sometimes until after supper meal, to help care for residents because many times the next shift didn't show up or showed up late. They said they had been very concerned about residents not getting the care they needed because there wasn't enough CNA's working. Observation and interview on [DATE] at 10:43 AM revealed Resident #2 sitting in his doorway, he was wearing a mask. He was dressed for the day, slightly disheveled. He said he was concerned he had not been given his early AM medications. When asked if he received good care he said he had not received his morning medication. He said he had not received a shower in 6 days, he said he used an electric razor to shave himself. He said he slept in his recliner, as was his preference and had done so for several years. Surveyor asked the nurse on the hall about Resident #2 morning medications. She said he had not yet received medications which were scheduled for 07:00 AM, she said she was trying to figure things out which had placed her behind. She agreed she would give his morning medications now. In an interview on [DATE] at 10:45 AM a Confidential Staff Member pulled surveyor to side and stated she wanted to talk. She stated she wanted the surveyor to know that Corporate staff took testing swabs away from staff to prevent them from testing and stated she would like to provide a statement and would like to remain anonymous. Review of the Confidential Staff Members statement dated [DATE] reflected . On [DATE] the facility was instructed by our corporate office that the facility would no longer be receiving visitors into the facility at this time, except for private sitters. On [DATE] we informed families that there could no longer be any private sitters at this point. Between the dates of [DATE]th and [DATE]th there was never mentioned to the employees that they had a plan in action to begin testing employees, even after employees expressed wanting to be tested . At one-point employees were told if they were tested , they would have to be out of work for 14 days and would have to use their own PTO. [DATE] VPO and the RNC came to the facility to provide lunch for facility staff members. Neither one walked inside facility to ensure that all protocols where being followed. On [DATE] ADON received orders from the NP to test all remaining residents in the facility. Orders were later given by the facilely MD to cover all remaining orders in facility due to Medical Director status. Facility spoke with our outside lab company to ask if they would be able to run COVID test for us. They called back to inform facility that they could run the test for us, and a lab tech would deliver the testing kits later that afternoon. On [DATE] Via text message the RNC asked the ADON if there were written orders to test all remaining residents in the facility. When ADON informed her that there were verbal telephone orders that had been entered into PCC (point click care) instructed her to hold off on testing. ADON informed her that all orders had been approved by the MD and entered into PCC as well as the lab for all specimens to be collected. At that time ADON was instructed to be on a conference call in administrators office. ADON came back into conference and voiced to me that the VPO stated that the facility will not test all residents. It goes against CDC and CMS guidelines to blanket test all residents. The only way the facility would get over this was to practice proper hand hygiene and social distancing. While talking with the ADON about the phone call, the Administrator came into the conference room and removed all testing kits off the table. At this time, it the ADONs, and myself were present in the conference room. A phone conference with CEO, COO, CNO, MD (LHA), the facility NP, the facility MD, the Administrator, the RNC and the VPO was scheduled for later that evening. ADON requested to be on the call for added input, the facility MD stated that this would be great thing for any additional input. Later that afternoon the ADON was informed that corporate wants no one else in the meeting. [DATE] ADON reached out to the RNC for help. Our DON is out on medical leave, ADON out on maternity leave, and another ADON out for 14 days. This would leave only 2 ADONs in the facility to complete all required tasks and staffing. After reaching out ADON got no response from the RNC. [DATE]rd while assisting VPO with moving residents with positive test results to the isolation unit I was asked by a resident to fix his tv. While fixing it VPO asked me to continue with the room move and that hooking up a tv at this point was not important. [DATE]th while moving residents with positive results over to the isolation unit I was unhooking a tv, and the VPO again stopped me and stated don't worry about the tv they will not need it. Just bring the resident, they do not need a tv in their room while on the unit. During this time, I witnessed the VPO instruct other team members to move residents that had a negative test result into a room that a patient with a positive test results without it being properly deep cleaned. [DATE]th while assisting another staff member identify which test results that were received on [DATE]th were staff members and residents so that she could notify family members of test results. I noticed that there was a COVID positive resident on the south unit (negative side) and a COVID negative patient on the isolation unit. The VPO instructed staff who needed to be moved and to where. I brought this to his attention. After sitting back down at my computer I overheard him ask the RNC how to move the residents without the state surveyors noticing. At this time the NP asked me for a resident room roster, I walked into the admissions office for a roster at that time Admissions Director told me that the VPO had instructed her to NOT give anyone from the state a room roster. As I am not an ADON and do not have much involvement with staffing, I cannot give accurate information on staffing other than being aware that the facility has been understaffed for some time now. I can only speak on what I have witnessed. When asked if corporate would call in a staffing agency to fill in some of the open shifts the VPO reminds facility that we must be down 12 aides on one shift before calling in agency. When request for staffing were given by multiple ADONs to administration ADONs were told that the facility did not have enough openings to request staffing agencies. In an interview on [DATE] at 12:20 PM the facility NP stated she had made a timeline of events that occurred at the facility and would provide a written statement. The NP stated she had been at the facility every day since the outbreak started and witnessed facility failures first hand. Review of the facility's NP written statement dated [DATE] reflected This is the statement of events personally witnessed to the best of my recollection at the facility from [DATE]th through 27th 2020. On [DATE] the facility was instructed to close all doors, stop all therapy room to room, and have all staff tested by myself and the LHA (local health authority) MD. This was disregarded by the facility. Again, staff were recommended to be tested , therapy stopped, and doors closed on [DATE] after additional positives were found. Again, this was disregarded by the facility. On [DATE] we attempted to test all the facility residents. These swabs were ordered through a lab. The nursing staff started collecting these specimens and then were told to stop by the Administrator on the direction of the VOP. The swabs were taken away from staff and placed in the Administrators office to prevent them being collected. A meeting was held with LHA MD, the facility MD, me and several corporate members via teleconference on the night of [DATE]. It was stated they did not want to test staff because they were worried they would have too many staff positives and then no staff to manage the facility. This was |

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| F 0837<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 9)<br>again requested by LHA MD, facility MD and me despite this concern. It was also requested in writing by the facility MD to keep same staff to isolation hallway- not mix with non-isolation hallway, stop therapy, and to test everyone including staff. This again was disregarded. One corporate official also stated that if this was all over the building then what was the point of testing everyone. On [DATE] at the direction of LHA MD a true isolation unit was recommended. It was said this would be done ASAP at that time. On Monday [DATE] the facility decided to test staff but did not help facilitate this or give staff direction on how to get this done. Staff were told they would have to be out until test results were back even if it was done for screening. We asked for a sign-up list for staff to voluntarily be tested . Then staff were told they would have to be out until test results were back even if it was done for screening, so all the staff removed their names. Therapy continued until [DATE]. Doors remained open until [DATE]. 100 and 200 hall shared one ,[DATE] nurse until [DATE]. Staff took care of positive and negative patients till [DATE]. The residents were all tested at my direction with swabs from state on [DATE], [DATE], [DATE]. I personally witnessed staff asking for additional outside staffing help as early as ,[DATE]/ |
| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for the 85 residents in the facility that contracted the COVID-19 virus. A.) The facility failed to follow recommendations provided by the facility's Medical Director, the Medical Director of the local health authority and the facility's Nurse Practitioner regarding coronavirus testing for staff and residents. B.) The facility failed to follow recommendations provided by the facility's Medical Director, the Medical Director of the local health authority and the facility's Nurse Practitioner regarding infection control measures to prevent the spread of the coronavirus in the facility that included: -cohorting of residents testing positive for the coronavirus (COVID), -keeping doors of positive residents closed to contain the spread of infection. -supply staff with ample PPE (personal protective equipment) to protect residents for cross transmission. -monitoring cleaning and sanitation protocols for the facility and, -cohorting of staff to ensure the staff that provided care for the positive residents did not also provide care to the residents without the coronavirus. The facility's failure to follow these recommendations at the beginning of the coronavirus outbreak in the facility lead to 85 residents contracting [MEDICAL CONDITION] and the death of 22 of those residents. These failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm at a scope of widespread due to staff needing more time to monitor the plan of removal for effectiveness. These deficient practices could affect all residents and place the residents at risk for mental anguish, prolonged isolation time, coronavirus infections and possible death. Findings included: A.) Review of the facility's COVID-19 numbers reflected as of [DATE] 85 residents had contracted [MEDICAL CONDITION] and 22 residents had died . The facility's COVID-19 numbers also reflected 29 staff members had contracted [MEDICAL CONDITION]. In an interview on [DATE] at 2:45 PM the Administrator stated the NP (Nurse Practitioner) had tested another 4 or 5 Residents today. He stated 4 or 5 staff had been tested for Covid-19 (coronavirus disease) and were positive. He stated the facility was unable to obtain tests kits for all the staff (100 plus staff). He stated 30 or 40 tests had been completed at the facility. He stated only 10 staff had been tested for Covid-19. The Administrator stated the first positive tests came back to the facility on [DATE]. He stated the facility's contracted a laboratory and they stated they would provide testing for Covid-19. He stated the facility was sent test kits which were collected and then the lab failed to pick them up and since that failure the corporation had been unsuccessful in finding another testing company. In an interview on [DATE] at 2:55 PM the facility's NP stated she was monitoring the COVID residents on the isolation unit and was doing the testing on her own. She stated the facility was not doing testing and stated they did not have the resources. She stated they were not testing staff and until they test everyone she will not be able to get ahead of the infections and stated it is going to get worse without testing. She stated with 100 residents and 100 staff she does not have the supplies to test that many people and the facility is not helping. In an interview on [DATE] at 9:30 AM the facility's NP stated the facility had gotten 20 more positive test for residents. The NP stated the COVID unit would be full after all the positive residents are moved onto the unit. She stated she is concerned about staffing on the unit because the nurse who is working on the 100 hall (the COVID unit) is also working on the 200 hall which has residents who have not tested positive for the coronavirus. She stated, as of [DATE], the number of positive residents had gone up to 43 and the facility still needed to test 80 staff members. In an interview on [DATE] at 1:25 PM the facility MD provided the surveyor with his COVID response plan. He stated he provided this to the facility on [DATE] and it was mostly ignored or not fully implemented. He stated if the facility had been more cooperative at the beginning with testing and recommendations the spread of [MEDICAL CONDITION] might not have reached this point. Review of the Facility MD's Response Plan dated [DATE] reflected that he was recommending basic guidelines in an attempt to contain the COVID contagion in the building. The guidelines included but were not limited to . if a resident becomes newly sick with symptoms isolate and test them ASAP . attempt/encourage testing of all employees in an effort to catch asymptomatic carriers that may inadvertently be spreading [MEDICAL CONDITION]. In an interview on [DATE] at 12:20 PM the NP stated she told the facility on [DATE] and instructed them to test all residents and that did not occur. The NP further stated she provided swabs for testing and the facility's Corporate staff took the swabs away from the facility staff because they did not want all residents tested . The NP further stated Corporate staff did not want employees tested for fear of sidelining staff. In an interview on [DATE] at 12:30 PM the Medical Director of the local health authority stated he had made a time line of events that occurred at the facility that concerned him, and he would provide a written statement. Review of the Medical Director of the local health authority statement dated [DATE] reflected . I spoke with an infectious disease specialist and Local Health Authority to get further suggestions. He and I both agreed that testing all staff was paramount, although due to limited testing ability in the state it would be difficult .I was told by the facility MD, and the facility administrator, that corporate doctors did not agree with our recommendations. I did not personally speak with these corporate representatives as the facility MD said he would do so. He related to me that they were very much against testing anyone that did not have symptoms in the facility, for unclear reasons. A plan was made, and orders were written on or about Tuesday, [DATE] or Wednesday [DATE] to test all residents through a lab testing company through the nursing facility. I was told by the facility NP Wednesday [DATE], late in the day, that at the direction of the Corporation, no testing was to be performed on patients that we ordered, and the orders were canceled. The materials necessary to test were reportedly locked in the administrator's office to keep out of the hands of nursing. At this time, the facility MD and I decided that a meeting between corporate and ourselves must be set up as soon as possible due to the risk of continued spread. By this point, there were approximately 10 patients, with multiple PUIs. I drafted control orders for the facility, that clearly laid out a mitigation strategy of testing . These orders were given to the facility MD. On the morning of 16 April, the facility MD gave me his revised version of the control orders, with his signature. These were almost identical to mine in context, and only different in language. I was told that as LHA (local health authority), I did not have direct authority to impose control orders, as I work through DSHS, and that the medical director and HHS had authority over the facility. The meeting between the facility VPO (Vice President of Operations), and several other corporate officers, as well as the facility Administrator, NP, MD and myself occurred at 5:30 PM on Thursday 16 April. There was significant push back during this meeting, during which the facility MD read aloud his orders, regarding the testing of patients. The facility's VPO exact words were what does it matter if we test? What if they all already have it. My impression was that he did not grasp the severity of the situation, and I directly recommended they test everyone .The facility MD and I both recommended that interventions be made to quickly remedy this. On Monday, 20 April, I was informed that the wall was still not up . By Friday, the number of cases in the facility had risen to over 60, with a total of 11 deaths at the time of this writing. My thoughts on this situation is that, based on the data and discussions with both the facility MD and NP, that numerous times the administration of the facility were given information and the opportunity to lessen the spread of COVID 19. At times, we were directly challenged on how we wanted to proceed, and orders of a physician/FNP that were legally written were disobeyed at the direction of corporate officers. I am saddened by the way this was handled and feel that steps need to be taken to assure that this does not happen in this, or any facility, ever again. In an interview on [DATE] at 6:40 PM the VPO stated he felt the facility followed all the CDC guidelines in regard to the COVID outbreak. The VPO stated the facility tried to test everyone, but the labs would not provide the test kits or would not pick up the test collected and stated the kits taken away from staff were because they were the wrong test kits. |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 10)<br>In an interview on [DATE] at 10:45 AM a Confidential Staff Member pulled surveyor to side and stated she wanted to talk. She stated she wanted the surveyor to know that Corporate staff took testing swabs away from staff to prevent them from testing and stated she would like to provide a statement and would like to remain anonymous. Review of the Confidential Staff Members statement dated [DATE] reflected Between the dates of [DATE] and [DATE]th it was never mentioned to the employees that they had a plan in action to begin testing employees, even after employees expressed wanting to be tested . At one-point employees were told if they were tested , they would have to be out of work for 14 days and would have to use their own PTO . On [DATE] ADON received orders from the FNP to test all remaining residents in the facility. Orders were later given by the facility MD to cover all remaining orders in facility due to his Medical Director status. The Facility spoke with our outside lab company to ask if they would be able to run COVID test for us. They called back to inform facility that they could run the test for us, and a lab tech would deliver the testing kits later that afternoon. On [DATE] Via text message the RNC asked the ADON if there were written orders to test all remaining residents in the facility. When ADON informed her that there were verbal telephone orders that had been entered into PCC the RNC instructed her to hold off on testing. ADON informed her that all orders had been approved by the facility MD and entered into PCC as well as the lab for all specimens to be collected. At that time ADON was instructed to be on a conference call in administrators office. ADON came back into conference room and voiced to me that the VPO stated that the facility will not test all residents. It goes against CDC and CMS guidelines to blanket test all residents. The only way the facility would get over this was to practice proper hand hygiene and social distancing. While talking with the ADON about the phone call, the Administrator came into the conference room and removed all testing kits off the table. At this time, it was the ADONS, and me present in the conference room. A phone conference with CEO, COO, CNO, LHA MD, the facility FNP and MD, the Administrator, RNC and VPO was scheduled for later that evening. One of the ADONs requested to be on the call for added input, the facility MD stated that this would be great thing for any additional input. Later that afternoon ADON was informed that corporate wants no one else in the meeting . In an interview on [DATE] at 12:20 PM the facility NP stated she had made a timeline of events that occurred at the facility and would provide a written statement. The NP stated she had been at the facility every day since the outbreak started and witnessed facility failures first hand. Review of the facility's NP written statement dated [DATE] reflected This is the statement of events personally witnessed to the best of my recollection at the facility from [DATE]th through 27th 2020 . Again, staff were recommended to be tested . On [DATE] we attempted to test all the facility residents. These swabs were ordered through a lab. The nursing staff started collecting these specimens and then were told to stop by the Administrator on the direction of the VOP. The swabs were taken away from staff and placed in the Administrators office to prevent them being collected. A meeting was held with LHA MD, the facility MD, me and several corporate members via teleconference on the night of [DATE]. It was stated they did not want to test staff because they were worried they would have too many staff positives and then no staff to manage the facility. This was again requested by LHA MD, facility MD and me despite this concern . It was also requested in writing by the facility MD . to test everyone including staff. This again was disregarded. One corporate official also stated that if this was all over the building then what was the point of testing everyone. On Monday [DATE] the facility decided to test staff but did not help facilitate this or give staff direction on how to get this done. Staff were told they would have to be out until test results were back even if it was done for screening. We asked for a sign-up list for staff to voluntarily be tested . Then staff were told they would have to be out until test results were back even if it was done for screening, so all the staff removed their names . A written statement from a facility staff member was received by email on [DATE] at 2:09 AM. The staff member stated they wanted to remain anonymous to protect her job. Between the dates of [DATE] and [DATE], there was no effort from our corporate offices to begin testing staff members in spite of multiple requests to do so. The answer that was given from corporate was that if an employee needed to be tested , they were to contact their healthcare provider. There was never mention to the employees that our company was trying to put into a plan of action to begin providing testing for employees even though it was expressed to them (the company) that they wanted to get tested .Sunday [DATE] the first resident from our facility, that was in the hospital was tested for novel coronavirus and had a positive result. There was still no effort from corporate offices to begin testing employees . [DATE] It was relayed to ADON's and Administrator that the Lab could provide 80 testing kits, but the tests could be only be run by the Lab and the results could take at least 5 days for the results. The testing kits were ordered but the lab technician could not bring them to our facility until [DATE] . the Lab technician dropped off testing supplies and instructions on how tests were to be performed and how to store them prior to pick up. Orders for labs were entered into PCC and into the Lab website . I was asked by the Administrator to come to his office to talk to the VPO and RNC. I was told by the VPO that it was against CDC recommendations to blanket test the entire facility. I expressed that I had a verbal order to test all residents from the facility MD and the testing would be started. VPO expressed to me again that it was against CDC recommendations and was told to not test residents but continue social distancing and washing our hands. I left the Administrators office and returned to the conference room where other staff were present and was visibly upset. The Administrator entered the room after me and removed all testing kits from our possession and locked them in his office .[DATE] the facility continues to have orders for testing every resident that has not been tested . No testing kits available except for the Lab testing kits. ADON's continue to have no access to testing kits . In an interview on [DATE] at 8:00 AM the ADON stated she would like to provide a statement. Review of the statement dated [DATE] from the ADON reflected . From the very beginning the facility MD wanted all residents tested and the VOP had the Administrator literally take the swabs out of our hands after we had already collected some and stated it was not necessary. I truly believe that if corporate would have followed orders from doctors we would not have seen as many deaths and other issues from this .I do blame corporate for the deaths we have had. And not only do I, it's just a lot of staff will not speak up .I will probably get fired for even writing this to you, but I had to clear my conscience knowing these decisions, I believe in my heart were very wrong for everyone involved. We asked about testing staff weeks ago before they FINALLY did it. I just can't wrap my head around the thought process . B.) In an interview on [DATE] at 1:25 PM the facility MD provided the surveyor with his COVID response plan. He stated he provided this to the facility on [DATE] and it was mostly ignored or not fully implemented. Review of the Facility MD's Response Plan dated [DATE] reflected that he was recommending basic guidelines in an attempt to contain the COVID contagion in the building. The guidelines included but were not limited to quarantine/ isolation of residents with symptoms, implement transmission-based precautions (masks on all residents and anyone in the building), dedicate specific staff to care for only the affected and suspected residents, cohort existing COVID residents to dedicated area, if a resident becomes newly sick with symptoms isolate and test them ASAP, be quick to move to dedicated area, and attempt/encourage testing of all employees in an effort to catch asymptomatic carriers that may inadvertently be spreading [MEDICAL CONDITION]. Observation and interview on [DATE] at 10:15 AM of the facility with DSHS (Department of State Health Services) Epidemiologist revealed hallways and handrails dirty. Trash and gloves noted on floors and wedged into the hand rails. The epidemiologist recommended an increase of housekeeping staff. The facility needed to remove items from hallways and alcoves such as lifts, and equipment and the multiple resident use equipment needed to be tagged to indicate if it was cleaned after use. Doors to isolation rooms were noted to be open and residents were not wearing masks. The facility staff member training the staff on the proper use of PPE was noted not donning his own PPE appropriately. The Epidemiologist stated the donning/ doffing area at the entrance to the isolation unit needed better flow and access to hand sanitizer. All recommendations had been provided to the facility administration. In an interview on [DATE] at 12:20 PM the NP stated the facility had moved residents on the roster to make them appear to have been moved to a different room but did not actually move the residents. The NP stated the facility did not stop therapy when instructed to. She further stated she repeatedly told the facility and staff to keep isolation room doors closed. She stated the facility would run out of PPE in the containers outside of isolation rooms and found that isolation rooms did not have biohazard boxes in the rooms. In an interview on [DATE] at 12:30 PM the Medical Director of the local health authority stated he had made a time line of events that occurred at the facility that concerned him, and he would provide a written statement. Review of the Medical Director of the local health authority statement dated [DATE] reflected I am writing this letter to record my directives to the Medical Director (MD), administration and staff of the facility. As Local Health Authority, I have been monitoring the COVID 19 pandemic in cooperation with DSHS Region 7 and our local emergency management coordinator, since even before the outbreak of [MEDICAL CONDITION] in our county. I was first notified of cases at the facility by the NP on the morning of [DATE]. I had been made aware in passing on or about [DATE] of a PUI (patient under investigation) at the facility that had been sent to the hospital on [DATE]. His test came back positive on 5 April, at which point I was nearly immediately notified. My first call was to the medical director of the facility. At that time, there was a potential staff member that had been tested positive, and by this time there were more suspected |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 11)<br>cases in the building. My recommendations, which the facility MD and NP relayed to the facility directly, were to immediately isolate all PUI's, and to continue monitoring staff closely for symptoms. At this point, the facility already had stopped all visitors, and there was no communal dining, etc. Within two days, more cases were reported. I was in direct contact with the MD and NP on [DATE] and 7. By [DATE], there were at least 3 (and more PUI's suspected), and I was notified of this by early afternoon. A three-way conference call was arranged, the administrator of the facility, and the NP to discuss recommendations going forward for isolation of residents. My recommendation at that time was to move all positive patients and PUI's to the 300 hall, or if unable to for logistical reasons, to move them all to an isolated area in the 100 hall. I directed them to sequester all positives away from the general population, and to set up an isolation ward to assist with donning/doffing of PPE. Over the next few days cases continued to climb . I spoke with the facility's MD that afternoon regarding these recommendations, which were to basically stop all unnecessary movement within the facility, stop physical therapy, close all doors that could be closed, and test all staff, and if possible, all patients. He stated he would take the lead on this as he was the medical director for the facility. I continued to follow up with the facility MD and NP daily. The cases unfortunately continued to climb . I drafted control orders for the facility, that clearly laid out a mitigation strategy of complete isolation, closing doors, and assuming all patients had COVID until proven otherwise . My impression was that he did not grasp the severity of the situation, and I directly recommended . that doors be closed. I also recommended that therapy cease except where absolutely indicated. I was told that was impossible, and that therapy was as important as [MEDICAL TREATMENT]. Again, I recommended it stop immediately. We were promised at this meeting that the isolation wall for the 100 hallway would be up within 24 to 48 hours. During this meeting, the facility NP clearly made administration aware that staff were not [MEDICATION NAME] appropriate distancing, PPE use, or hand hygiene . In an interview on [DATE] at 6:40 PM the VPO stated residents room doors were not closed and infection control measures might not be followed right now because they are moving residents to get the positive residents away from the negative residents. Observation on [DATE] at 10:50 AM making rounds with the DSHS Epidemiologist and Associate Commissioner for HHSC revealed multiuse equipment still noted in hallways and alcoves without labels to identify if they were clean, residents still not wearing masks, floors remain dirty and residents that were positive and needed to be moved to the isolation unit doors were open. Observation/ Interview on [DATE] at 11:20 PM revealed none of the 13 COVID positive residents on the 300 or 400 hall had been transferred to the isolation unit yet. The positive and negative residents were still intermingled. The VPO stated the staff were making sure equipment and belongings could be secured prior to moving the residents. Observation on [DATE] at 11:40 PM revealed the isolation units empty rooms were clean and ready to receive residents. In an interview on [DATE] at 10:45 AM a Confidential Staff Member pulled surveyor to side and stated she wanted to talk and stated she would like to provide a statement and would like to remain anonymous. Review of the Confidential Staff Members statement dated [DATE] reflected .[DATE] the VPO and RNC came to the facility to provide lunch for facility staff members. Neither one walked inside facility to ensure that all protocols where being followed . [DATE] one of the ADONs reached out to the RNC for help . After reaching out the ADON got no response from the RNC . During this time, I witnessed the VPO instruct other team members to move residents that had a negative test result into a room that a patient with a positive test results without it being properly deep cleaned. [DATE]th while assisting another staff member to identify which test results that were received on [DATE]th were staff members and residents so that she could notify family members of test results. I noticed that there was a COVID positive resident on the south unit and a COVID negative patient on the isolation unit. The VPO instructed staff who needed to be moved and to where. I brought this to his attention. After sitting back down at my computer I overheard him ask the RNC how to move the residents without the state surveyors noticing. At this time the NP asked me for a resident room roster, I walked into the admissions office for a roster at that time and the Admissions Director told me that the VPO had instructed her to NOT give anyone from the state a room roster . In an interview on [DATE] at 12:20 PM the facility NP stated she had made a timeline of events that occurred at the facility and would provide a written statement. The NP stated she had been at the facility everyday since the outbreak started and witnessed facility failures first hand. Review of the facility's NP written statement dated [DATE] reflected This is the statement of events personally witnessed to the best of my recollection at the facility from [DATE]th through 27th 2020. On [DATE] the facility was instructed to close all doors, stop all therapy room to room, and have all staff tested by myself and the LHA (local health authority) MD. This was disregarded by the facility. Again, staff were recommended to be tested , therapy stopped, and doors closed on [DATE] after additional positives were found. Again, this was disregarded by the facility. Again, staff were recommended therapy stopped, and doors closed on [DATE] after additional positives were found. Again, this was disregarded by the facility . It was also requested in writing by the facility MD to keep same staff to isolation hallway- not mix with non-isolation hallway, stop therapy .This again was disregarded . On [DATE] at the direction of LHA MD a true isolation unit was recommended. It was said this would be done ASAP at that time . Therapy continued until [DATE]. Doors remained open until [DATE]. 100 and 200 hall shared one ,[DATE] nurse until [DATE]. Staff took care of positive and negative patients till [DATE]. The residents were all tested at my direction with swabs from state on [DATE], [DATE], [DATE]. I personally witnessed staff asking for additional outside staffing help as early as [DATE]. They were disregarded. I personally witnessed staff entering isolation rooms with masks only on. I also was notified by one family that they did not know their family member was positive for > 48 hrs. post diagnosis. PPE was not adequately stocked outside of isolation rooms and bins were not in rooms to dispose of PPE. Patients with positive results were kept in rooms with negative patients for > 18 hrs. post diagnosis. In an interview on [DATE] at 3:45 PM the VPO came to the surveyor and stated he made a mistake and moved the wrong resident last night and placed a negative resident on the COVID unit and a positive resident remained on the negative side. Observation on [DATE] at 8:25 PM on the isolation unit revealed a trash bag with various contents on the floor outside room [ROOM NUMBER]. Review of the census reflected room [ROOM NUMBER] had housed Resident #6 prior to her going out to hospital this evening (Resident progress notes reflected she left at 6:37 pm. Further observation revealed the double glass doors at the end of 100 hall had a large trash bag outside. This was the second night in a row trash was observed outside this door. The staff are breaking containment to remove trash. A written statement from a facility staff member was received by email on [DATE] at 2:09 AM. The staff member stated they wanted to remain anonymous to protect her job. .Up until [DATE] , no effort from Corporate offices were made to fit test N95's for the employees. The only available PPE we had were surgical masks, the yellow disposable gowns, Medium N95 masks, gloves, Hair covers and clear glasses that didn't wrap around our eyes to protect them from the side. No foot covers available at this time. A concern made to the Administrator regarding inappropriate clear glasses, no new clear goggles or face shields made available to staff in facility . [DATE] the VPO and RNC came to facility to provide lunch for facility staff members. Neither one of them entered the facility to assess how protocols were being followed. .[DATE] .the VPO and RNC have finally arrived at the facility and entered our building after 18 days of having multiple residents and staff members positive for the novel coronavirus and 4 days since notifying the RNC of the need for extra staff. Observation/Interview on [DATE] at 9:05 AM during rounds with the Epidemiologist revealed he stated he still had concerns regarding items in the hallways and alcoves, and resident belongings in the halls (which were potentially contaminated). He further stated the house keeping staff need to pick up the pace on getting rooms cleaned out that are empty that had COVID positive residents in them. In an interview on [DATE] at 8:00 AM the ADON stated she would like to provide a statement. Review of the statement dated [DATE] from the ADON reflected . I just have a lot of concerns regarding the VOP and his decisions he's making. In the very beginning we had little PPE to wear, he even said at one point we can wear the N95 masks for 5 days before discarding. Recently I asked if it was safe for me to do wound care on both sides of the building, I try to get south side (negative side) done first but it doesn't always happen this way. I spoke to the VOP and asked if this was safe for the residents and he reassured me it was as long as I wasn't continuously working on the COVID side, which I'm there every day. I'm still very leery of this and wanted clarification Review of the facility's policy Outbreak of Novel Coronavirus (2019-nCoV) dated [DATE] reflected Suspected outbreaks of Novel Coronavirus within the facility will be promptly identified and appropriately handled per the CDC recommendations. The Administrator or Director of Nursing (DON) will notify the local health department in case of an outbreak. Personal Protective equipment (e.g., gowns, gloves, NOISH-certified disposable N95 respirators) will be provided to our employees . Review of the facility's policy Reportable Diseases dated [DATE] reflected .Should any residents or staff suspected or diagnosed as having a reportable communicable/infectious disease according to State-Specific criteria, such information shall be promptly reported to appropriate local and/ or state health department officials . On [DATE] at 6:40 PM the VPO, Administrator and RNC were notified the facility had an IJ situation for the above failures. The facility's first Plan of Removal (POR) was submitted by the VPO on [DATE] at 8:20 PM. The final POR was accepted by the survey team on [DATE] at 2:00 PM. Accepted Plan of Removal: Plan of Removal On [DATE], a complaint survey was initiated at |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 12)<br>Brenham Nursing and Rehabilitation Center at 400 E Sayles Street, Brenham TX . On [DATE] |