STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VAL VERDE NURSING AND REHABILITATION CENTER	100 HERMANN DR DEL RIO, TX 78840

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 5 of 9 residents (Resident #1, #3, #7, #8, #9) reviewed for medication administration, in that: 1. Resident #1's temperature had not been documented in the resident's permanent medical record since 11/21/19. 2. Resident #3's temperature, pulse or respirations had not been documented in the resident's permanent medical record since 9/9/2018. 3. Resident #7's temperature had not been documented in the resident's permanent medical record since 7/2/19. 4. Resident #8's temperature had not been documented in the resident's permanent medical record since 9/1/19. 5. Resident #9's temperature had not been documented in the resident's permanent medical record since 2/13/20. These deficient practices could place residents at risk for inaccurate documentation of vital signs and prevent the accurate assessment of baseline vital signs which could result in a decline in health. The findings were: 1. Review of Resident #1's face sheet, dated 4/17/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7 which indicated a severe cognitive impairment. Review of Resident #1's vital sign documentation in the medical record revealed a temperature had not been documented since 11/21/2019. 2. Review of Resident #3's face sheet, dated 4/17/20 revealed an admission date of [DATE] and a readmission of 3/17/17 with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS could not be assessed which indicated a severe cognitive impairment. Review of Resident #3's vital sign documentation in the medical record revealed the resident's temperature, pulse or respirations had not been documented since 9/9/2018. 3. Review of Resident #7's face sheet dated 4/17/20 revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of an annual MDS dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment. Review of Resident #7's vital signs documentation revealed the last temperature recorded was taken on 7/2/19. 4. Review of Resident #8's face sheet dated 4/17/20 revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #8's quarterly MDS dated [DATE] revealed the BIMS could not be assessed which indicated a severe cognitive impairment. Review of Resident #8's vital signs documentation in the medical record revealed the last temperature recorded was documented 9/1/19. 5. Review of Resident #9's face sheet dated 4/17/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's quarterly MDS dated ,[DATE]/ revealed BIMS was unable to be assessed which indicated a severe cognitive impairment. Review of Resident #9's vital sign documentation in the medical record revealed the temperature had not been documented since 2/13/20. Review of paper documentation of vital signs dated 4/1/20-4/14/20 provided by the DON revealed the temperature, pulse, respirations, blood pressure and oxygen saturation were being taken by staff and documented on their paper Shift Assignment Sheets. In an interview on 4/17/20 at approximately 4:10 PM the DON revealed all residents in the facility were receiving vital signs at least once every shift (every 8 hours) since the COVID-19 Pandemic began. The DON indicated the vitals are reviewed by the charge nurses for any deviation from normal and the documentation was then discarded. The DON confirmed the vital signs were not being recorded in the residents' medical records. At the time of exit, the facility did not provide a policy on documentation of vital signs in the medical records.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 10 of 10 Residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) observed for infection control, in that: 1. CNA did not disinfect a blood pressure cuff, thermometer and pulse oximeter between resident use for Resident's #1, 2, 3, 4, 5 and 6. 2. Facility staff (CNAs A, C and E, and MA D) did not ask Residents (#6, 7, 8, 9 and 10) to cover their mouths and noses with tissues or place masks on residents when providing resident care. These deficient practices could place residents, staff and visitors at risk of transmission of communicable diseases and infections, including COVID-19. The findings were: 1. Review of Resident #1's face sheet, dated 4/17/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7 which indicated a severe cognitive impairment. Review of Resident #2's face sheet, dated 4/17/20 revealed an admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's 5-day Medicare MDS dated [DATE] revealed a BIMS of 10 which indicated a moderate cognitive impairment. Review of Resident #3's face sheet, dated 4/17/20 revealed an admission date of [DATE] and a readmission of 3/17/17 with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS could not be assessed which indicated a severe cognitive impairment. Review of Resident #4's face sheet, dated 4/17/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS of 9 which indicated a moderate cognitive impairment. Review of Resident #5's face sheet, dated 4/17/20 revealed an admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS of 12 which indicated the resident was cognitively intact. Review of a face sheet for Resident #6 dated 4/17/20 revealed an admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly MDS dated [DATE] revealed a BIMS score of 13 which indicated the resident was cognitively intact. Observation on 4/16/20 at 3:33 PM revealed CNA A went from room to room performing vital sign checks using a thermometer, pulse oximeter and blood pressure cuff while carrying the items on a clip board. CNA A entered a resident room to obtain vital signs for Resident #1, Resident #2 and Resident #3. Further observation revealed CNA A washed her hands and exited the room but she did not disinfect all the equipment. Observation on 4/16/20 at 3:40 PM revealed CNA A entered Resident #4's room, placed the clipboard on the resident's bed and obtained vital signs. CNA A did not clean the equipment after resident use. Observation on 4/16/20 at 3:43 PM revealed CNA A entered Resident #5's room and performed vital signs. CNA A did not disinfect the equipment after resident use. Observation on 4/16/20 at 3:47 PM revealed CNA A entered Resident #6's room with the clipboard, blood pressure cuff, thermometer and pulse oximeter with the intent to perform vital signs until surveyor intervention. Interview on 4/16/20 at 3:47 PM with CNA A confirmed she had not disinfected the blood pressure cuff, thermometer, pulse oximeter or clip board after contact with residents either before or after use. CNA A confirmed she had been trained to clean the equipment with a sanitizing wipe between use. Interview on 4/16/20 at 3:50 PM with RN B confirmed staff should be disinfecting equipment between resident use. 2. Review of Resident #7's face sheet dated 4/17/20 revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's annual MDS dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment. Review of Resident #8's face sheet

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) dated 4/17/20 revealed an admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #8's quarterly MDS dated [DATE] revealed the BIMS could not be assessed which indicated a severe cognitive impairment. Review of Resident #9's face sheet dated 4/17/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's quarterly MDS dated [DATE] the BIMS was unable to be assessed which indicated a severe cognitive impairment. Observation on 4/16/20 at 2:20 PM revealed CNA C entered Resident # 6's room while not maintaining social distancing and watched TV with resident. Upon entry to Resident #6's room CNA C did not ask Resident #6 to cover the mouth and nose while she was in the room and the resident was not wearing a mask. Observation on 4/16/20 at 2:26 PM revealed CNA C entered Resident #7's room to drop off supplies. CNA C approached the resident's bedside without asking the resident to cover his mouth or nose. Observation on 4/16/20 at 2:29 PM revealed CNA C entered Resident #8 and #9's room without asking the residents to cover their mouths or noses while staff was in the room. Observation on 4/16/20 at 2:36 PM revealed MA D entered Resident #7's room to administer medications and did not ask the resident to cover their mouth or nose while staff was in the room. Observation on 4/16/20 at 2:38 PM revealed CNA C entered Resident #10's room without asking the resident to cover his mouth or nose with tissues. Observation on 4/16/20 at 3:00 PM revealed CNA E performed incontinent care to Resident #7 without asking the resident to cover his mouth and nose during care. Observation on 4/16/20 at 3:33 PM revealed CNA A performed vital signs on Resident #1, #2 and #3. CNA A did not ask any of the residents in the resident room (Resident #1, #2, and #3) to cover their mouths or noses while staff was in the room and performing care. Observation on 4/16/20 at 3:40 PM revealed CNA A entered Resident #4's room to perform vital signs and did not request that the resident cover the mouth and nose while staff was performing care. Interview on 4/16/20 at 2:44 PM with MA D revealed staff had not been trained to ask resident to cover their mouth and nose when while staff were in resident rooms and providing care. Interview on 4/16/20 at 3:10 PM with CNA E revealed she had not been trained or instructed to ask residents to cover their mouth and nose while staff was in the room and performing care. Interview on 4/16/20 at 4:00 PM with the DON confirmed she didn't know staff was supposed to ask residents to cover their mouths and noses when staff entered the resident rooms and when providing resident care. The DON stated she was familiar with CMS guidelines and had been keeping track of the frequent CMS letters. The DON confirmed staff should be disinfecting equipment between resident use. Review of a facility policy, titled Cleaning and Disinfection of Resident Care Items and Equipment as part of the Infection Control Manual dated January 2018 revealed, Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and OSHA Bloodborne Pathogens Standard.