STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675392	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN JACINTO MANOR	206 W P ST DEER PARK, TX 77536

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to ensure that staff utilized appropriate personal protective equipment (PPE) and performed necessary hand hygiene for two of two residents (Resident (R)1 and R2) on observation status. These failures placed the 20 residents and the staff on the South hallway at risk for the spread of infections, including COVID-19 and Influenza A. Findings include: During the entrance interview on 07/17/20 at 9:30 AM, the Administrator stated there were 15 residents who tested positive for COVID-19 and are in a quarantine unit separated from the rest of the facility, with dedicated staff and equipment. The Administrator also stated that two residents currently reside in private room at the end of the South Hallway (not the COVID-19 positive quarantine unit) on observation with all necessary PPE in use. The Administrator identified that one resident (R1) went out to [MEDICAL TREATMENT] and the other resident (R2) was readmitted from the hospital. A review of the medical record for R2 revealed a 07/01/20 lab result report indicating an initial positive test for COVID-19. A second COVID-19 test on 07/08/20 was negative. On 07/07/20, R2 tested positive for Influenza A. A Hospital to Post-Acute Care Facility Transfer-COVID 19 Assessment, dated 07/08/20 identified R2 had been admitted to the hospital with [REDACTED]. R2 was subsequently readmitted to the facility on [DATE]. A 07/16/20 Nurse's Note documented, Resident return (sic) to facility . Admit . (diagnosis): Influenza-A . Resident is on droplet precautions due to Influenza. During a facility tour with the Administrator on 07/17/20, R2's room was observed at 10:00 AM. A plastic bin containing PPE was located just outside the room and a sign with a picture of binoculars was posted. The Administrator stated the sign was to alert the staff the resident was on observation status because of recent re-admission from the hospital. R2 was severely confused and was unable to be interviewed. On 07/17/20 at 12:15 PM, observed Licensed Vocational Nurse (LVN) 1 enter R2's room to deliver a water pitcher. She was wearing a gown and an N-95 mask. R2 was lying in bed and her oxygen concentrator was alarming. Upon entering the room, LVN1 did not put on a face shield/goggles or gloves. She began to touch the O2 concentrator to fix the problem. She also touched the bed control, which was lying on top of the resident's bed. She assisted the R2 to drink water, touching the resident's hand in the process. She again touched the O2 concentrator, then left the room. No hand hygiene was performed, and her gown was not removed upon exiting the room. On 07/17/20 at 12:20 PM, LVN1 stated the resident was on droplet precautions and had influenza A. When asked the facility's policy for droplet precautions, she stated she was an agency nurse and was not familiar with the facility policies. She stated this meant using a mask, goggles (which she had left at her desk), gown, and gloves. LVN1 confirmed she did not wear gloves or eye protection during the observation. On 07/17/20 at 1:20 PM, observed Certified Nurse Aide (CNA) 2 enter R2's room wearing a gown, N95 mask, and face shield to deliver lunch. CNA2 did not don gloves. R2 was lying in bed. CNA2 put the meal tray down on the overbed table. She then grabbed the bathroom door handle and attempted to enter the bathroom, but the door was locked. She removed her gown and exited the room without performing hand hygiene, then walked down the hall to the nurses' station and spoke with other staff. She was not observed to wash or sanitize her hands. During an interview, on 07/17/20 at 12:30 PM, the Administrator stated all agency staff received a four-hour orientation before they began working, and this orientation covered the COVID-19 policies, hand hygiene, and PPE use. During an interview on 07/17/20 at 12:45 PM, Infection Preventionist (IP) 1 stated R2 was recently readmitted from the hospital and was on observation. She stated staff should don PPE before entering her room and remove the PPE and wash hands before exiting the room. IP1 stated staff should use a gown, gloves, mask, and face shield. Review of Agency Staffing Checklist/Review Sheet, dated 07/12/20 revealed LVN1 signed the attendance sheet confirming she received training on infection control, including equipment cleaning, utilization of PPE, non-communal dining process, social distancing, and COVID-19 screening and procedures. Review of In-service Training document dated 06/24/20 indicated CNA2 attended a training on the COVID-19 policy. The summary of the content documented, Goal is prevent spread of (COVID-19). 'We' the staff must ware (sic) masks and googles(sic)/shield while in the facility at all times and use gowns, gloves, mask/goggles/shield - standard, droplet, airborne precautions is (sic) required. During an interview on 07/17/20 at 12:45 PM, Infection Preventionist (IP) 1 stated R2 was recently readmitted from the hospital and was on observation. She stated staff should don PPE before entering her room and remove the PPE and wash hands before exiting the room. IP1 stated staff should use a gown, gloves, mask, and face shield. IP1 added that R2 had initially tested positive for COVID-19, was sent to the hospital for respiratory distress, and subsequently tested negative for COVID-19 and positive for influenza A. Review of the medical record for R1 revealed a lab result report which indicated R1 tested negative for COVID-19 on 06/30/20. Review of the July 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. During a facility tour with the Administrator on 07/17/20 R2's room was observed at 10:00 AM. A plastic bin containing PPE was located just outside the room and a sign with a picture of binoculars was posted. R1 was severely confused and was unable to be interviewed. On 07/17/20 at 1:15 PM, CNA2 was observed entering R1's room to deliver lunch and put the meal tray down on the overbed table. CNA2 was wearing a gown, N-95 mask, and face shield. CNA2 did not put on gloves. R1 was seated in his bed. CNA2 touched the overbed table to move it for the resident. She then exited the room without disposing of the gown and sanitized her hands in the hallway. During an interview, on 07/17/20 at 1:20 PM, CNA2 stated there was no requirement to change gowns when caring for R1, as he was only on observation because he went to [MEDICAL TREATMENT] three times a week. She stated gloves should be worn when entering R1's room, and the gloves removed, and hand hygiene done, upon exiting the room. CNA2 confirmed she did not wear gloves during the observation. Review of Inservice Training Record, dated 06/24/20 indicated CNA2 attended the training. The summary of the content documented, Goal is to prevent spread of (COVID-19). 'We' the staff must ware (sic) masks and goggles/shields while in the facility (at) all times, and use gowns, gloves, mask, shield, goggles in positive/observation rooms/hall. Standard, droplet, airborne precaution (sic) is required. During an interview on 07/17/20 at 2:50 PM, the Administrator stated the facility had not been requiring staff to change their gown upon entering R1's room, as he was only on [MEDICAL TREATMENT] and not a hospital readmission. The Administrator stated, She (CNA2) still should have used gloves, but we have not been requiring them to change gowns because they (residents who go out for appointments e.g., R1 who goes to [MEDICAL TREATMENT]) get washed with antibacterial soap after return from [MEDICAL TREATMENT]. IP1 was present during the interview and nodded in agreement with the Administrator. The Administrator also stated the facility does not have a specific policy or plan that identifies the use of PPE or COVID-19 precautions that addresses residents who leave the facility for outside appoints or are readmitted following a hospitalization . The Administrator stated they follow the CDC (Center for Disease Control) guidelines and more recently the CDC Resource, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, which was last updated on 07/15/20. This resource did not directly address re-admissions and frequent outside appointments but referred the reader to additional CDC resources. Review of the 04/30/20 CDC resource, Responding to Coronavirus (COVID-19) in Nursing Homes, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, revealed the following, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in

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) a separate observation area so the resident can be monitored for evidence of COVID-19. -All recommended COVID-19 PPE (personal protective equipment) should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE.