STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676461	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTRO COUNTY HOSPITAL DISTRICT DBA COUNTRY VIEW L	**701 BUTLER BLVD. DIMMITT, TX 79027**

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. - LVN A did not alert the facility that she had a family member living in the same house test positive for COVID-19 - LVN A did not answer the screening sheet correctly when asked if she had come in close contact with a person who was COVID positive. These failures have the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections. Findings include: Record review of facility screening sheets reflected in part: On 8-27-2020, 8-30-2020, 8-31-2020, 9-2-2020, 9-4-2020, and 9-5-2020, LVN A answered the last column of the questionnaire, Exposure to facilities with confirmed COVID-19 cases (Y/N), no on all dates. During an interview with ADM on 9-14-2020 at 1:45 PM, she confirmed that the LVN was exposed to three family members who were COVID positive in August of 2020. ADM was asked if she knew that the LVN A was exposed to COVID before LVN A tested positive. ADM stated that she was not aware that LVN A had been exposed to COVID until she tested positive for COVID on 9-4-2020. ADM stated that she then asked LVN how she thought that she had got COVID and LVN told her that her granddaughter, daughter and husband had all tested positive. ADM stated that she then asked LVN why she did not alert the facility to known exposure, LVN replied that her husband's doctor said that he was ok to work so she assumed that she was too. ADM stated that LVN A's husband does not work in healthcare. ADM was then asked if she had provided education to all staff about reporting in to the facility if exposed to COVID. ADM stated that she had done education with all staff and that LVN A was receiving a write up as soon as she was back at work. During a phone interview with LVN A on 9-14-2020 at 2:14 PM, she confirmed that her granddaughter, daughter and husband had all tested positive for COVID. She stated that her granddaughter tested positive on 8-11-2020. LVN A stated that she alerted the facility after her granddaughter and daughter tested positive and was told that as long as she was having no signs or symptoms she was ok to work. LVN A did not remember who had told her that she could return to work. LVN A stated that she spoke with DON about her husband testing positive for COVID and was told that as long as she had no symptoms she was ok to work. She stated that she was tested on [DATE] as a part of the facility wide testing, and then received her results on 9-5-2020 while she was at work. She confirmed that she left the facility immediately. During an interview with DON on 9-14-2020 at 2:24 PM, she was asked if LVN A called her and told her that her husband was COVID positive. DON stated she did not recall ever receiving a phone call from LVN A telling her that her husband had tested positive, nor any other family member. During an interview with ADM on 9-14-2020 at 2:54 PM, ADM was asked if it was her expectation that staff members who have family members test positive for COVID answer yes to this question. She responded that it was her expectation that staff members who come in close contact with anyone who is COVID positive to answer yes to that question. Record review of facility investigation sheet titled Positive Employers Root Cause Analysis, not dated, reflected in part: LVN A, Day LVN - Positive test on 9-4-2020 - Employee last worked 9-5-2020. She was tested with the facility wide testing. No symptoms or signs of COVID-19. Employee was sent home immediately of learning of her test results. She was asked if she knew where she may have contracted COVID-19. Employee stated that he granddaughter tested positive on 8-10, her daughter tested positive on 8-13, and her husband tested positive on 8-24. She stated that Dr. Rohm told her husband that he probably had it already for a while ant here was no need to quarantine and to just return to work immediately. She stated that she thought because he was cleared to work she was too. She stated that she did not tell anyone at (facility) that her husband was positive. Record review of facility provided policy titled COVID-19 Testing, not dated, reflected in part: Employee Testing - Will notify Administrator or Director of Nursing with any questions, regarding concerns about COVID-19. If a temp or an answer of yes on the questionnaire, employee will don a facemask and exit the facility and notify charge nurse via phone. If they suspect illness or exposure, employee is to call prior to entering building. Record review of facility provided policy titled Infection Control, dated 1-20-2013, reflected in part: POLICY: - Employees exposed, or believed to have been exposed, to any communicable diseases shall report the incident promptly to their immediate supervisor and /or the Infection Control Practitioner RESPONSIBILITIES: - The employee has the responsibility for promptly reporting exposure to communicable disease incident to his/her immediate supervisor Record review of an in service titled: COVID-19 Illness Reporting and Memo dated 4-28-2020, revealed the LVN A received training on facility policy titled infection Control listed above. Record review of Nursing Facility COVID-19 Response Emergency Rule, not dated, reflected in part: (c) A nursing facility must screen all residents, staff, and people who come to the facility for the following criteria: (4) contact in the last 14 days, unless to provide critical assistance, with someone who has a confirmed [DIAGNOSES REDACTED].

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.