STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE HEIGHTS REHABILITATION SUITES	6650 SOUTH SONCY ROAD AMARILLO, TX 79119

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -RN A failed to maintain proper PPE when she provided IV therapy wearing a lab coat as a gown without buttoning the lab coat, exposing her scrubs to the resident and environment. RN A was later observed wearing the same lab coat in the same manner and not wearing facial protection. -LVN B failed to maintain proper precautions when she administered medication without wearing gloves -CNA C failed to maintain proper precautions when she removed a resident's breakfast tray from his room without wearing gloves. -LVN D failed to maintain proper precautions when she was preparing medication while wearing a lab coat as a gown that was not buttoned, exposing her scrubs to the environment. -3 staff members were not maintaining proper precautions when they were noted in the hallways wearing lab coats as gowns that were not buttoned, exposing their scrubs to the environment. These deficient practices have the potential to affect all residents in the facility that is currently COVID-19 positive by exposing them to care that could lead to the spread of [MEDICAL CONDITION] infections, secondary infections, tissue breakdown, communicable diseases, and feelings of isolation related to poor hygiene. Findings include: During an observation on 9-15-2020 at 08:31 AM of a resident in room [ROOM NUMBER] who was receiving IV therapy., RN A was observed providing the resident's IV care while wearing a mask, face goggles, and a lab coat that was not buttoned with the front opened, exposing her scrubs. During an observation on 9-15-2020 at 08:39 AM of the 400 hall 7 staff were noted with lab coats on that were used for gowns. 2 of the staff members were noted with the front of the lab coat open exposing their scrubs. During an observation on 9-15-2020 at 08:40 AM the resident in room [ROOM NUMBER] was receiving her am medications from LVN B. LVN B was observed administering the medications without wearing gloves. During an interview after the medications were administered, LVN B stated that she does not wear gloves Sometimes. I am kind of allergic and tend to break out. When asked if she wore gloves for the administration of the resident in room [ROOM NUMBER]'s medication, LVN B stated, No I was not wearing gloves when I administered her meds, but I did wash my hands before I gave them and after I gave them. During an observation on 9-15-2020 at 08:48 AM CNA C was seen leaving room [ROOM NUMBER] with a resident's breakfast tray. The resident was in the room. CNA C walked down the 400-hall with the tray and placed it in the dietary cart. CNA C then returned to the resident's room. CNA C was not wearing gloves. She was wearing a lab coat, goggles, and mask. When questioned CNA C stated, Yes I brought his tray out without gloves on. I washed my hands before I picked up his tray and I plan on washing my hands now. During an observation on 9-15-2020 at 08:51 AM of LVN D who was at a medication cart with another staff member preparing medications. LVN D was dressed in a lab coat that was not buttoned exposing her scrubs. LVN D had a mask and goggles on. When questioned if the lab coat was proper PPE and being used properly LVN D stated, Probably not. I'll button it now. When questioned if LVN D was aware of the new positive COVID-19 residents in the facility she stated, Yes we do have more positive residents in the facility. During an observation on 9-15-2020 at 08:56 AM of the 200 hall a staff member was wearing her lab coat unbuttoned with her scrubs exposed. When questioned, the ICC (who was with the employee) reported that 11 residents had been determined positive for COVID-19 from testing the was done on Friday 9-11-2020. ICC stated that all the residents were currently being moved to the COVID-19 unit. The ICC reported he was handing out PPE gowns to staff and reported to this surveyor that they plan on increasing precautions until all the moves are completed. When questions concerning the staff member with the gown open the ICC reported that she was an agency staff member and he would reeducate her. During an observation on 9-15-2020 at 10:08 AM of RN A who was noted returning to her medication cart in the 400-hall. RN A was not wearing face protection and she was wearing a lab coat that was unbuttoned, exposing her scrubs. When questioned, RN A did verify that she did not have her lab coat buttoned when providing the resident in room [ROOM NUMBER]'s IV administration this am. When questioned about the lab coats providing protections for COVID-19 RN A stated, No I do not think they do. If we had to do a code or something like that I think we would be exposed but then again, I don't think any of this stuff would protect us. The rules change hourly around here anyway and the LVN that is supposed to know what he is doing about infection control doesn't have a clue. During an interview on 9-15-2020 at 08:14 AM, theadministrator stated that he was not sure on the current number of residents that were positive for COVID-19 in the facility. Administrator stated that he was not sure of the updated number of residents positives because the facility had just received results from testing completed on 9-11-2020. Administrator stated that these recent results indicated that several more residents in the general population were positive. When questioned as to the facility's current PPE policy the administrator stated that on the COVID unit the staff were expected to wear full PPE. Administrator stated that in the general population if the staff were not involved in care such as with himself or office staff then a mask was acceptable. If the staff were involved in care or direct care they were to wear a mask, gown, and face shield. If they touched a resident or were in contact, they were to use gloves and proper hand washing. The administrator reported that the 400 hall is a step down/quarantine hall where they place the new residents who have been admitted or the resident who may have been out of the facility on an appointment. During an interview on 9-15-2020 at 9:29 AM, ICC stated that each lab coat is used for the day, it is washed, then reused the next day. The ICC stated, They are used as a barrier to prevent the spread of spores, germs, or any other thing like that. When questioned the ICC reported that at this time they have enough PPE and that the facility is currently utilizing the STAR program. During an interview on 9-15-2020 at 10:49 AM with the DON who reported when asked about the effectiveness of the lab coats for COVID prevents stated, They were in the beginning, but we are evaluating, and I think we are going to change everyone to regular gowns. When asked what the lab coats are supposed to do the DON stated, They are supposed to protect the resident if the staff member had anything such as the COVID on their clothes. When asked about other precautions the DON stated, staff are to wear masks at all times, they are to wear face shields or goggles when within 6 feet of a resident and they are to wear gloves and wash their hands when they are in a resident's room, when working with a resident, or when providing any resident care. When asked if she felt that if a staff member was working with a lab coat that was unbuttoned exposing their cloths was appropriate precautions the DON stated, No, coats should be closed. When asked if staff can remove a residents dining tray from their room or if administering medications without wearing gloves was appropriate precautions the DON stated, No they should have gloves on. The DON then reported that from this morning results they had 11 more resident positive for COVID-19. The DON verified that the 11 residents were in the general population for 4 days before it was discovered that they were positive. During an interview on 9-15-2020 at 12:51pm with the administrator, who when asked if a staff member should work with the lab coat buttoned he stated, I think they should have it buttoned. That is to protect from transmission. When asked if staff should wear gloves when providing resident care, the administrator stated, They should be. Record review of facility provided PPE tracking form dated 9-14-2020 revealed the facility had the following: How many items are remaining at the start of the day? Gowns-1360 Gloves Boxes-191 N-95-2770 Record review of facility provided policy titled Nursing Policies and Procedures dated 2020, revealed the following: Subject: Staffing, nursing department in pandemic Procedures: The facility will provide appropriate Personal

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) Protective Equipment (PPE) to the staff according to the need of the established unit. All facility staff will wear a facemask while in the facility covering their nose and mouth. Staff that are caring for COVID-19 positive and unknown COVID-19 status will wear a respirator mask, gown, gloves and goggles or face shield. Record review of facility provided policy titled Infection Prevention and Control Policies and Procedures dated 3-6-2020 revealed the following: Subject: Coronavirus Disease 2019 (COVID-19) Because [DIAGNOSES REDACTED]-Co-1/COVID-19 is an emerging disease the severity of its transmissibility is unknown. It is a rapidly evolving situation and facilities should refer to the Center for Disease Control and Prevention (CDC) . Procedure: 1. Facility staff should avoid exposure to [MEDICAL CONDITION] by maintaining a safe distance from persons exhibiting symptoms and/or infected with [MEDICAL CONDITION] and by using appropriate personal protective equipment (PPE) when appropriate. Record review of Centers for Disease Control and Prevention (CDC) titled Strategies for Optimizing the Supply of Isolation Gowns dated 3-17-2020 revealed the following: When No Gowns Are Available Consider using gown alternatives that have not been evaluated as effective. In situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients as single use. However, none of these options can be considered PPE, since their capability to protect HCP is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured. o Disposable laboratory coats o Reusable (washable) patient gowns o Reusable (washable) laboratory coats o Disposable aprons o Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available: ? Long sleeve aprons in combination with long sleeve patient gowns or laboratory coats ? Open back gowns with long sleeve patient gowns or laboratory coats ? Sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats Reusable patient gowns and lab coats can be safely laundered according to routine procedures. o Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles o Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties) and replace reusable gowns when needed (e.g., when they are thin or ripped) This surveyor requested on 4 separate occasion a policy for PPE to be implemented by all staff to include direct care staff in the general population with no adequate policy provided.