STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676093	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENAISSANCE VILLA	700 DYER ST ROCKDALE, TX 76567

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 0725 **Level of harm -** Minimal harm or potential for actual harm **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.** Based on interview, observation and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of all residents residing at the facility. The facility failed to provide enough staffing so that staff were not working both COVID negative and COVID positive units. Nursing staff were working COVID positive and COVID negative sides of the facility in the same 8 or 12 hours shift. This failure could result in the spread of COVID 19 to other parts of the facility resulting in a decreased quality of life, hospitalization and death. Findings included: Review on 7/16/2020 at 1:30 PM of staff scheduled for 7/15/2020 for the 6A to 2P shift reflected 1 RN, 2 LVNs and 6 CNAs. An observation and record review on 7/15/2020 reflected 1 RN, 2 LVNs and 3 CNAs. In an interview on 7/15/2020 at 9:18 AM LVN A stated the charge nurse (LVN C) completed assessments required for the COVID unit. She stated the charge nurse is over both negative and positive residents. In an interview on 7/15/2020 at 9:44 AM PRN RN B stated assessments are completed twice per shift. I haven't been back there today. I worked there all day yesterday as the 3 CNAs in the facility refused to go back there. The staff that was back there had been there since 2 PM the day before. RN B confirmed there was no dedicated staff working the COVID unit. He stated there were at least 9 staff out sick or calling in at this time. An observation on 7/15/2020 at 10:00 AM revealed LVN C providing a treatment to Resident #1. Resident #1 resided on the cold side of the facility and is negative for COVID 19. In an interview on 7/15/2020 at 10:06 AM CNA D stated the facility was short staffed. When asked who completed assessments for residents on the COVID unit she stated the charge nurse (LVN C) comes back to the unit every few hours to assess the residents. When asked if the nurse stays on the COVID positive unit she stated no she comes to the unit as needed then returns to the COVID negative side. In an interview on 7/15/2020 at 10:19 AM LVN C stated she completed assessments on the COVID unit twice per shift and her shift is from 6 AM to 6 PM. The remainder of her time is spend providing care to the COVID negative residents. In an interview on 7/15/2020 at 10:32 AM MA E stated she administers medications to residents on the COVID unit as well as residents on the cold side. She stated the prepares individual cups of medication, takes them back to the unit, dons her PPE then administers the medication. She denied taking the med cart on the COVID unit. In an interview on 7/15/2020 at 10:38 AM CNA F stated the facility was short of staff at this time. An observation and interview on 7/15/2020 at 10:52 revealed RN B on the COVID hall. RN B stated he was completing assessments. He was observed leaving the unit with an N95 he had covered with a surgical mask. The surgical mask was handed back to CNA D, asking her to discard from him. He then went to the bathroom beyond the barrier, on the cold side to complete hand hygiene. The N95 mask was worn back to the cold side of the facility. In an interview on 7/15/2020 at 11:30 AM LVN G stated they used dedicated staffing on the COVID unit as much as possible but didn't have staff resources to keep dedicated staff on the COVID positive unit. She stated they were short of staff and were looking into hiring agency staff to assist. When asked which area they would be working she stated she didn't know at that time. In an interview on 7/15/2020 at 1:18 PM ADM verified there were 4 residents with positive COVID results and 1 resident with pending results on the COVID unit. She stated they have a contract with a staffing agency and she was able to access their website on 7/14/2020 and requested staffing assistance. She stated no one picked up shifts on 7/14/2020 or 7/15/2020 on the agency site but she had received a response for 7/16/2020 as well as 7/17/2020, 7/18/2020 and 7/19/2020. She stated she was aware staffing was an issue with staff started refusing to work on the COVID unit and some had refused to come back to the building period after starting the COVID unit. She stated, we are trying to maintain dedicated staff, but people refused to work and called in. She stated she was aware of the requirement for dedicated staffing on the COVID unit. In an interview on 7/15/2020 at 2:17 PM CNA H stated staffing is short right now. He stated they were short to the point residents scheduled for baths yesterday didn't receive their bath. When asked about today he stated there were only 3 CNAs here tonight so probably not. In an interview on 7/15/2020 at 2:30 PM Resident #1 stated she was scheduled for a bath yesterday, 7/14/2020 but the CNAs told her they didn't have enough staff. They told her they would get her a bath today (7/15/2020). In an interview on 7/15/2020 at 5:10 PM DM stated on 6/27/2020 she left the kitchen and assisted CNAs with resident care as there wasn't enough CNAs to get residents up for breakfast. An observation and interview on 7/15/2020 at 6:30 PM revealed LVN I administering medications on the cold side of the building. When asked if she was going to pass medications on the COVID unit she stated she was, but she would do that last. Review of Daily Team Member Sign-in/Assignment Sheet reflected the following: 7/14/2020 staff assigned to COVID hall called in sick as well as another staff on the same shift. There was a total of 7 call in's by CNAs this date. 7/15/2020 staff assigned to COVID hall call in sick as well as another staff on the same shift. There was a total of 3 call in's by CNAs this date. Review of facility policy, Contingency Plan for Staffing Shortages, dated 7/15/2020 reflected, The facility will respond to staffing shortages by adjusting staff schedules, hiring additional healthcare personnel (HCP), and rotating HCP to positions that support patient care activities. Review of facility policy, Renaissance Villa Novel Coronavirus Prevention and Response dated 4/1/2020 and Revised 6/22/2020 reflected 7. Procedure when COVID-19 is suspected or confirmed: .f. Implement standard, contact, and droplet precautions. Wear gloves, glows, goggles/face shields, and masks upon entering room and when caring for the resident. . h. Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of care. Clean and disinfect all other equipment used for care. . l. Facility will evaluate staffing needs and design schedule to cover the resident with dedicated staff if possible. Depending upon resident needs, facility will assign a nurse to perform all duties for the resident in lieu of an aide. . m. Emergency Staffing actions will include: i. Changing shifts times (such as changing to 12 hour shifts) to better utilize a smaller number of staff to care for residents. Ii. Optimize use of our part time employees that do not work other jobs.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on interview, observation 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 to help prevent the development and transmission of communicable diseases and infection for the residents in the facility for 4 of 13 staff reviewed. (RN B, LVN C, Medication Aide E and LVN I). The facility failed to assign dedicated staff on the assigned COVID unit(RN B, LVN C, Med Aid and LVN I). Nursing staff and medication aids were working both COVID positive and COVID negative sides of the facility in the same shift. The LVN I and RN B failed to ensure PPE used on the COVID unit was discarded or left on the COVID unit before returning to the COVID negative side of the facility. These failures resulted in an Immediate Jeopardy (IJ) situation on 07/15/2020. While the IJ was removed on 07/16/2020 at 5:43 PM, 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 pattern due to staff needing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676093	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENAISSANCE VILLA	**700 DYER ST ROCKDALE, TX 76567**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) more time to monitor the plan of removal for effectiveness. This failure could result in the spread of COVID 19 to other parts of the facility resulting in a decreased quality of life, hospitalization and death. Findings included: In an interview on 7/15/2020 at 9:18 AM LVN A stated the charge nurse (LVC C) completes assessments required for the COVID unit. She stated the charge nurse is oversees care to both negative and positive residents. In an interview on 7/15/2020 at 9:44 AM RN B stated assessments are completed twice per shift. I haven't been back there today. I worked there all day yesterday as the 3 CNAs in the facility refused to go back there. The staff that was back there had been there since 2 PM the day before. RN B confirmed there was no dedicated staff assigned to the COVID unit. An observation on 7/15/2020 at 10:00 AM revealed LVN C providing a treatment to Resident #1. Resident #1 resided on the cold side of the facility and is negative for COVID 19. In an interview on 7/15/2020 at 10:19 AM LVN C stated she completed assessments on the COVID unit twice per shift and her shift is from 6 AM to 6 PM. In an interview on 7/15/2020 at 10:06 AM CNA D stated LVN C completed assessments for residents on the COVID unit and she stated the LVN C (charge nurse) comes back to the unit every few hours to assess the residents. When asked if the charge nurse remained on the COVID unit for her shift, she stated no; she returns to the COVID negative side to provide resident care. In an interview on 7/15/2020 at 10:32 AM MA E stated she administers medications to residents on the COVID unit as well as residents on the COVID negative side. She stated she prepares individual cups of medication, takes them back to the unit, dons her PPE then administers the medication. She denied taking the med cart on the COVID unit. An observation and interview on 7/15/2020 at 10:52 revealed RN B on the COVID hall. RN B stated he was completing assessments. He was observed leaving the unit with an N95 he had covered with a surgical mask. The surgical mask was handed back to CNA D, asking her to discard for him. He then went to the bathroom beyond the barrier, on the COVID negative side to complete hand hygiene. The N95 mask was worn back to the COVID negative side of the facility. In an interview on 7/15/2020 at 11:30 AM LVN G stated they used dedicated staffing on the COVID unit as much as possible but didn't have staff resources to keep dedicated staff on the COVID unit. She stated they were short of staff and were looking into hiring agency staff to assist. When asked which area they would be working she stated she didn't know at that time. In an interview on 7/15/2020 at 1:18 PM ADM verified there were 4 residents with positive COVID results and 1 resident with pending results on the COVID unit. She stated she was aware staffing was an issue when staff started refusing to work on the COVID unit and some had refused to come back to the building period after starting the COVID unit. She stated, we are trying to maintain dedicated staff, but people refused to work and called in. She stated she was aware of the requirement for dedicated staffing on the COVID unit. An observation and interview on 7/15/2020 at 6:30 PM revealed LVN I administering medications on the cold side of the building. When asked if she was going to pass medications on the COVID unit she stated she was, but she would do that last. When asked about her procedure she stated she leaves the cart outside the unit, prepared the medication in clean disposable cups, takes them back to the COVID unit , dons her PPE then administers the medication. When asked specifically about her mask she stated she covers her N95 with a surgical mask prior to administering medication. She then discards the surgical mask prior to leaving the COVID unit. When asked if she wore the N95 the remainder of the shift, she stated she did. In an interview on 7/15/2020 at 6:41 PM LVN G as well as LVN J were told about the interview with LVN I. They both agreed their expectation was for the N95 mask used on the COVID hall to only be used with COVID positive residents. They stated the LVN should have placed her N95 in a bag to be used the next time she was needed on the COVID unit. Review of facility policy, Renaissance Villa Novel Coronavirus Prevention and Response dated 4/1/2020 and Revised 6/22/2020 reflected 7. Procedure when COVID-19 is suspected or confirmed: .f. Implement standard, contact, and droplet precautions. Wear gloves, glows, goggles/face shields, and masks upon entering room and when caring for the resident. . h. Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of care. Clean and disinfect all other equipment used for care. . l. Facility will evaluate staffing needs and design schedule to cover the resident with dedicated staff if possible. Depending upon resident needs, facility will assign a nurse to perform all duties for the resident in lieu of an aide. . m. Emergency Staffing actions will include: i. Changing shifts times (such as changing to 12-hour shifts) to better utilize a smaller number of staff to care for residents. ii. Optimize use of our part time employees that do not work other jobs. On 7/15/2020 at 3:50 PM the Administrator was notified the facility had an IJ situation for the above failures. The facility's first Plan of Removal (POR) was submitted by the Administrator on 7/15/2020 at 6:23 PM. The final POR was accepted by the survey team on 7/16/2020 at 5:43 PM. Accepted Plan of Removal: F880 DON/ADON will assign dedicated nurse 7 days a week to work on the COVID unit for each shift; to administer medications and conduct treatments on the unit. DON/ADON will monitor unit staffing; ensuring dedicated staff sign in shift assignments in advance; and will have alternate replacement with management staff or agency to work the shifts at the facility in the general population and on the COVID unit daily. Monitoring for the plan of removal began on 7/16/2020 at 3:48 PM. Two (2) LVN's were interviewed for understanding regarding not wearing the same N95 on and off the COVID Unit. It was also verified through observation and the interviews of two (2) CNA's that agency staff had been on site and were still on site assisting with Resident care. In an in interview on 7/16/2020 at 5:03 PM CNA L (agency staff) stated she was working only on the COVID unit. She stated today was her first shift, but she had picked up several shifts at this facility. In an interview on 7/16/2020 at 5:05 PM LVN I stated she was inserviced regarding having dedicated PPE on the COVID unit. She stated there was now a dedicated nurse on the COVID unit and she wouldn't be going back there but she understood about the PPE. In an interview on 7/16/2020 at 5:07 PM CNA H stated there were 4 CNAs on his shift. He stated resident care assignments should be back to normal and they could resume showers. He confirmed there was the normal numbers of CNAs checking out from the 6A to 2P shift when he arrived at 2 PM. On 7/16/2020 at 5:43 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 pattern due to the facility requiring time to monitor their plan of removal.