STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORT WORTH TRANSITIONAL CARE CENTER	**850 12TH AVENUE FORT WORTH, TX 76104**

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.** Based on observation, interview, and record review, the facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained for the facility. 1. The facility failed to ensure CNA G and Housekeeper EE appropriately utilized PPE while performing their job duties. 2. The facility failed to have residents practice social distancing and wear PPE appropriately to prevent the spread of COVID-19. The failures placed residents at risk for exposure to and development of COVID-19. The findings included: 1. Observation and interview on 04/23/20 at 9:00 AM revealed the facility was a three story building and residents resided on the second and third floor. The second floor was their short term skilled unit and the third floor was occupied by long term residents. Interview with the Administrator and DON revealed they had reserved a short hall on the second floor as their isolation area for COVID-19. They further stated the COVID-19 outbreak had occurred on the third floor and as residents were showing symptoms, they were being moved to the second floor for isolation. Administrator and DON stated they currently had 18 COVID-19 residents on the third floor, 3 residents on the second floor in the isolation area and eight positive staff members that were quarantining at home. Record review of the facility's census provided by the DON on which she had handwritten residents' COVID-19 testing status revealed the facility had 11 rooms with COVID-19 positive residents. Observation on 04/24/20 at 2:00 PM revealed CNA G was seen interacting with residents with his mask on in a COVID-19 negative room. While still in the room he pulled the mask down below his mouth as he continued to interact with the residents in the room. He then exited the COVID-19 negative room. CNA G stated he knew he should not have pulled down his mask and should remain over his nose and mouth with each resident. Observation on 04/24/20 at 3:45 PM revealed CNA G walking down the hallway with no mask covering his face. He stated he had just taken it off to get a drink and should have put it back on. He stated he was aware it needed to be worn at all times. Observation on 04/25/20 at 11:15 AM revealed Housekeeper EE was seen cleaning an empty room and pulled her mask down below her chin. Interview with the Regional VPO revealed Housekeeper EE had admitted to pulling her mask below her chin so he had her go get a new mask to put on. Record review of the CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic accessed on 04/23/20 found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, reflected the following: .place a patient with known or suspected COVID-19 in a single-person room with the door closed .As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with known or suspected COVID-19 .only patients with the same respiratory pathogen may be housed in the same room .Limit transport and movement of the patient outside of the room to medically essential purposes .To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers) .Patients should wear a facemask or cloth face covering to contain secretions during transport. If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room. Personnel entering the room should use PPE as described above. Whenever possible, perform procedures/tests in the patient's room .Patients and visitors should, ideally, be wearing their own cloth face covering upon arrival to the facility. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room . 2. Observation on 04/23/20 at 9:05 AM revealed Resident #1 sitting in his wheelchair just outside the elevator doors on the first floor. Resident #1 was observed wearing a soiled face mask which was not covering the resident's nose. Observation on 04/23/20 at 11:10 AM revealed Residents #2, #3, and #4 along with PT B and PTA C inside the therapy gym on the first floor. Residents #2, #3, and #4 were not wearing face masks or face coverings and were observed to be within six feet of one another. PT B and PTA C were observed wearing face masks. Interview with PT DD on 04/24/20 at 1:26 PM revealed they were currently not providing therapy to COVID-19 positive residents and residents on the second floor that were not showing symptoms were receiving therapy in the gym on the first floor. She said they had just been made aware the residents in the therapy gym yesterday (04/23/20) should have been wearing masks as they were interacting with them during therapy. Record review of the CDC guidance Preparing for COVID-19 in Nursing Homes accessed on 04/23/20 found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html reflected the following: . Enforce social distancing among residents. Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments .If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop .Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene .

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