STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675572	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLEN ROSE NURSING AND REHAB CENTER	1019 HOLDEN ST GLEN ROSE, TX 76043

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and recorded review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #2) of 4 residents reviewed for comprehensive resident centered care plans. The facility failed to ensure Resident #2's baseline care plan included the minimum healthcare information necessary such as his need for anticoagulant therapy and use of diuretics. This failure could place newly admitted residents at risk for safety and of adverse events that could occur right after admission. Findings: Record review of Resident #2 electronic face sheet accessed on 8/1/20 revealed a [AGE] year old male admitted on [DATE] with a code status of do not resuscitate (DNR) and the following Diagnosis: [REDACTED]. Record review of Resident #2 most recent 5-day scheduled assessment dated [DATE] revealed he entered from an acute hospital stay. Resident #2 had moderate difficulty hearing but had the ability to make himself understood and could understand others. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated a severely impaired cognition and Resident #2 did not have a history of rejecting care but needed extensive assistance with most activities of daily living (ADL)s. Resident #2 also utilized a walker and wheelchair for mobility. Resident #2 was always had urinary and bowel incontinence. Resident #2 primary medical condition for admission was Debility, Cardiorespiratory conditions. Resident #2 received anticoagulant and diuretic medications and oxygen therapy while in the facility. Record review of Resident #2 electronic order recap report accessed on 8/5/20 revealed the following orders: COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to primary care provider (PCP) and director of nursing (DON) for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused respiration pattern RP:1. Within normal limits (WNL) 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount moderate amount c. large amount d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 7/10/20 with no specified end date (Note: there is no indications as to what positive findings would be). Restrict fluid intake to 1500 cc day every shift. May use oxygen at 6 liter per minute via simple mask every shift with a start date of 7/10/20 and an end date of 7/16/20. Titrate oxygen 1 - 6 liter per minute via nasal canula to keep O2 sat 90% or higher every shift with a start date of 7/16/20 with no specified end date. Vital Signs every shift with a start date of 7/8/20 with no specified end date and no parameters of when to contact the physician. Weigh patient daily one time a day with a start date of 7/10/20 with no specified end date and no parameters of weight gain or loss to notify the physician. There were several other orders to assess temperature, pulse, oxygen saturation, and varied respiratory symptoms such as lunch sound, cough, respiratory rate, respiratory pattern all with no guidance as to when and what findings to report to the physician. Record review of Resident #2 Medication Administration Record [REDACTED]#1 blood pressure had at least one abnormal reading with a systolic range of 89-168 and diastolic range of 41-94; on 7/10/20 Resident #2 started receiving respiratory assessments pre and post nebulizer treatment to assess his mental status, respiratory pattern, lung sounds, cough, heart rate, and respiratory rate only on 7/19/20 was the assessment within normal limits ((respiratory pattern should be even and constant in its pace, normal lungs sounds are air moving through the lungs on inspiration or expiration hearing wheezing, clicking, bubbling, or crackles is not normal, a normal heart rate according to the DON, a normal heart rate for an adult is 60-100 beats per minute, an normal respiratory rate is 12-20 breaths per minute, and normal blood pressure is 90/60-120/80)) and there was no parameter set for DON or physician notification. Record review of Resident #2 baseline care plan electronically accessed on 8/1/20 revealed he should receive oxygen via nasal cannula at 1-5 liter per minute. The care plan did not address any parameters as to when notification of DON and physician was warranted. The base line care plan did not address Resident #2 need for blood thinners, diuretics nor his fluid restriction of 1500 cubic centimeters (cc) of fluid daily. Resident #2 also had a comprehensive care plan that was initiated on 7/7/20 with the following focuses Depression/Anxiety related to visitation restrictions imposed by the Centers for Disease Control and Prevention (CDC) guidelines because of the COVID-19 virus and risk of exposure and at risk for alteration in Psychosocial wellbeing (including depression & Anxiety) related to restrictions on visitation do to COVID-19 there was no other areas of focus. In an interview on 7/28/20 at 2:30 pm the Administrator stated Resident #2 had passed away in the hospital on [DATE]. In an interview on 8/5/20 at 2:49 the Administrator stated care plans should reflect the current needs and condition of a resident. Record Review of facility policy dated 2/13/2007 revealed the following: Care Plans 1. The facility will develop a Base Line Care Plan within 48 hours of each resident's admission that includes but not limited to a short-term and long-term objective and timetables to meet resident's medical, nursing, and mental and psycho-social needs that are identified on admission care plan will be reviewed and approved by an R. N. The facility will develop a Comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident=s medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment. 2. The care plan must describe the following: a. Services/Interventions that are to be furnished to attain or maintain the resident=s highest practicable physical, mental, and psychosocial wellbeing. b. Problem statements to identify services that are required to maintain the resident=s highest practicable physical, mental, and psychosocial well-being. c. Short and long term goals to identify reassessment parameters for the resident=s maintenance of well-being. d. Evaluation of the interventions and goals to maintain the resident=s well-being .
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide comprehensive person-centered care planning addressing current medical, and physical needs for 4 (Resident #1,#2, #3, and #4) of 4 residents reviewed for comprehensive and resident centered care plans. For Resident #1 the facility failed to provide a comprehensive care plan that addressed the medical needs during the COVID-19 threat. For Resident #2 the facility failed to provide a comprehensive care plan that addressed his current health condition, COVID-19, use of oxygen, and medications that require monitoring. For Resident #3 the facility failed to provide a comprehensive care plan that addressed his wounds that were requiring treatment, COVID-19, loss of his right leg above the knee, and his use of a prosthesis. For Resident #4 the facility failed to provide a comprehensive care plan that addressed the medical needs of COVID-19. This deficiency could place residents at risk of not having the nurse's role defined in the patients care and treatment, consistency of care, care driven by a

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) holistic approach, having goals met, and needs met. Findings: Record review of Resident #1 electronic face sheet accessed on 7/31/20 revealed and [AGE] year-old female admitted on [DATE] with a Do Not Resuscitate (DNR) code status and the following Diagnosis: [REDACTED]. Record review of Resident #1 most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed she had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated a severely impaired cognition. Resident #1 had minimal difficulty with hearing, unclear speech, difficulty communicating but was able if prompted or given time and she could comprehend most conversations. Resident #1 required minimum supervision for some activities of daily living up to extensive assistance with other activities of daily living. Resident #1 had frequent incontinence of urine and was occasionally incontinent of bowel. Resident #1 MDS also revealed she was on hospice while in the facility. Record review of Resident #1 electronic orders accessed on 7/31/20 Resident #1 also had the following order Monitor for elevated temperature, pulse, oxygen saturation, and respiratory symptoms three times a day. Every shift monitor client daily for respiratory symptoms or elevated temp, pulse oximetry and pulse. report any positive findings to primary care physician (pcp) and director of nursing (don) for further evaluation. (Note: there is no indications as to what positive findings would be). Record review of Resident #1 electronic care plan accessed on 7/31/20 revealed the following focus Resident #1 COVID-19 was also care planned and initiated on 3/19/20 but only addressed Resident #1 psychosocial needs and mental health needs. The care plan did not lay a baseline of physical health or parameters to indicate a change in condition for Resident #1 as related to her physical health it only addressed the effects of COVID-19 on her psychosocial health. Record review of Resident #2 electronic face sheet accessed on 8/1/20 revealed a [AGE] year old male admitted on [DATE] with a code status of DNR and the following Diagnosis: [REDACTED]. Record review of Resident #2 most recent 5-day scheduled assessment dated [DATE] revealed he entered from an acute hospital stay. Resident #2 had moderate difficulty hearing but had the ability to make himself understood and could understand others. Resident #2 had a BIMS score of 7 out of 15 which indicated a severely impaired cognition and Resident #2 did not have a history of rejecting care but needed extensive assistance with most ADLs. Resident #2 also utilized a walker and wheelchair for mobility. Resident #2 was always had urinary and bowel incontinence. Resident #2 primary medical condition for admission was Debility, Cardiorespiratory conditions. Resident #2 received anticoagulant and diuretic medications and oxygen therapy while in the facility. Record review of Resident #2 electronic order recap report accessed on 8/5/20 revealed the following orders: COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to PCP and DON for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused RP:1. WNL 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount b.mod amt c. lg amt d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 7/10/20 with no specified end date (Note: there is no indications as to what positive findings would be). Restrict fluid intake to 1500 cc day every shift. May use oxygen at 6 liter per minute via simple mask every shift with a start date of 7/10/20 and an end date of 7/16/20. Titrate oxygen 1 - 6 liter per minute via nasal canula to keep O2 sat 90% or higher every shift with a start date of 7/16/20 with no specified end date. Vital Signs every shift with a start date of 7/8/20 with no specified end date and no parameters of when to contact the physician. Weigh patient daily one time a day with a start date of 7/10/20 with no specified end date and no parameters of weight gain or loss to notify the physician. There were several other orders to assess temperature, pulse, oxygen saturation, and varied respiratory symptoms such as lunch sound, cough, respiratory rate, respiratory pattern all with no guidance as to when and what findings to report to the physician. Record review of Resident #2 base line care plan electronically accessed on 8/1/20 revealed he should receive oxygen via nasal cannula at 1-5 liter per minute. The care plan did not address any parameters as to when notification of DON and physician was warranted. The base line care plan did not address Resident #2 need for blood thinners, diuretics nor his fluid restriction of 1500 cubic centimeters (cc) of fluid daily. Resident #2 also had a comprehensive care plan that was initiated on 7/7/20 with the following focuses Depression/Anxiety related to visitation restrictions imposed by the CDC guidelines because of the COVID-19 virus and risk of exposure and at risk for alteration in Psychosocial wellbeing (including depression & Anxiety) related to restrictions on visitation do to COVID-19 there was no other areas of focus. In an interview on 7/28/20 at 2:30 pm the Administrator stated Resident #2 had passed away in the hospital on [DATE]. Record review of Resident #3 electronic face sheet accessed on 8/2/20 revealed a [AGE] year-old male admitted on [DATE] with a most recent admission of 4/22/20 with the following Diagnosis: [REDACTED]. Record review of Resident #3 most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed he has a BIMS of score of 15 out of 15 indicating an intact cognition. Resident #3 had entered back to the facility after an acute hospital stay. Resident #3 has the ability to hear with minimal difficulty and can usually make himself understood and understand others and has no history of rejecting care for the quarter. Resident #3 needs supervision with eating and locomotion but requires limited assistance with most ADLs except for dressing where he requires extensive assistance. Resident #3 requires use of a walker, wheelchair, and prostheses for mobility. Resident #3 had occasional urinary incontinence but was always continent of bowel. Resident #3 active [DIAGNOSES REDACTED]. Resident #3 had also had two or more falls for the quarter. Under skin conditions nothing was marked as an area of concern. Medications received indicated Resident #3 was taking a diuretic. Record review of Resident #3 electronic orders accessed on 8/2/20 revealed the following orders: Abdominal fold treatment - Cleanse with normal saline, apply [MEDICATION NAME] and cover with adhesive [MEDICATION NAME] bandage until healed with a start date of 4/11/20 and no specified end date; Cleanse left leg with normal saline, pat dry, apply [MEDICATION NAME] and collagen mixture to any open areas, apply vitamin A&D ointment to remaining skin and wrap with kerlix and wrap with Coban. every day shift for Wound Healing with a start date of 6/27/20 with no specified date. COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to PCP and DON for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused RP:1. WNL 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount b.mod amt c. lg amt d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 6/9/20 with no specified end date (Note: there is no indications as to what positive findings would be). Resident #3 also had an order to be a full code with a start date of 5/2/20 with no specified end date. Resident #3 also had an order for [REDACTED].#3 had an order for [REDACTED].#3 electronic comprehensive care plan access on 8/2/20 did address COVID-19 with the following focuses Depression/Anxiety related to visitation restrictions imposed by the CDC guidelines because of the COVID-19 virus and risk of exposure and at risk for alteration in Psychosocial wellbeing (including depression & Anxiety) related to restrictions on visitation do to COVID-19 initiated on 3/16/20. Resident #3 care plan did not address his medical needs related to COVID-19; Resident #3 did not have his use of diuretics addressed; his need for anticoagulation therapy was not addressed; Resident #3 did not have his two wounds addressed; and there was no mention of his above the knee amputation of the right leg and his use of a prosthesis. Resident care plan did not provide a baseline for the resident or give parameters as when to notify the physician of abnormal findings. In an observation on 7/29/20 from 3:36pm till 4:30pm Resident #3 was observed through his open-door lying-in bed supine with his non-rebreather mask down at his chin, and his room was passed by nursing at least 6 times and HT at least 4 times no one tried to adjust his mask to the proper position to cover his mouth and nose. Record review of Resident #4 electronic face sheet accessed on 8/5/20 revealed an [AGE] year-old male admitted on [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #4 most recent quarterly Minimum Date Set dated 6/12/20 revealed he had a BIMS score of 2 out of 15 which indicated a severely impaired cognition. Resident #4 had minimal difficulty with hearing but could only sometimes make himself understood and could only sometimes understand others. Resident #4 only needed supervision for mobility, limited assistance with transfers and extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Resident #4 also utilized a wheelchair for mobility. Resident #4 was also always incontinent of bowel and bladder. The MDS also indicated Resident #4 had non-Alzheimer's dementia. Resident #4 had also had 1 fall with no injury and 2 falls with minor injury and had been seen by the physician once in the past quarter. Record review of Resident #4 comprehensive care plan electronically accessed on 8/5/20 did address COVID-19 with the following focuses Depression/Anxiety related to visitation restrictions imposed by the CDC guidelines because of the COVID-19 virus and risk of exposure and at risk for alteration in Psychosocial wellbeing (including depression & Anxiety) related to restrictions on visitation do to COVID-19 initiated on 3/16/20. Resident #3 care plan did not address his medical needs related to COVID-19 Record review of Resident #4 electronic orders accessed on 8/5/20 revealed the following orders: COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to PCP and DON for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused RP:1. WNL 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount b.mod amt c. lg amt d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 6/8/20 with no specified end date (Note: there is no indications as to what positive

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) findings would be). In an interview on 8/5/20 at 2:49 the Administrator stated care plans should reflect the current needs and condition of a resident. Record review of facility policy dated 2/13/2007 revealed the following: Care Plans 1. The facility will develop a Base Line Care Plan within 48 hours of each resident's admission that includes but not limited to a short-term and long-term objective and timetables to meet resident's medical, nursing, and mental and psycho-social needs that are identified on admission care plan will be reviewed and approved by an R. N. The facility will develop a Comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident=s medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment. 2. The care plan must describe the following: a. Services/Interventions that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. b. Problem statements to identify services that are required to maintain the resident=s highest practicable physical, mental, and psychosocial well-being. c. Short and long term goals to identify reassessment parameters for the resident=s maintenance of well-being. d. Evaluation of the interventions and goals to maintain the resident=s well-being. 3. The comprehensive care plan must be developed within seven days after completion of the comprehensive assessment. It will be prepared by an care plan team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and with the resident, resident's family or legal representative. Documentation will be maintained in the resident's clinical record of the Care Plan meeting.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure 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 well-being of each resident for 2 (Residents #2, and #3) of 4 residents assessed for competent nursing staff. For Resident #2 the facility failed to deliver oxygen as ordered, failed to follow Resident #2 fluid restriction, identify a change in respiratory status, and to timely seek medical attention when the resident's respiratory rate increased. For Resident #3 the facility failed to have an order for [REDACTED]. Findings: Record review of Resident #2 electronic face sheet accessed on 8/1/20 revealed a [AGE] year old male admitted on [DATE] with a code status of DNR and the following Diagnosis: [REDACTED]. Record review of Resident #2 most recent 5-day scheduled assessment dated [DATE] revealed he entered from an acute hospital stay. Resident #2 had moderate difficulty hearing but had the ability to make himself understood and could understand others. Resident #2 had a BIMS score of 7 out of 15 which indicated a severely impaired cognition and Resident #2 did not have a history of rejecting care but needed extensive assistance with most ADLs. Resident #2 also utilized a walker and wheelchair for mobility. Resident #2 was always had urinary and bowel incontinence. Resident #2 primary medical condition for admission was Debility, Cardiorespiratory conditions. Resident #2 received anticoagulant and diuretic medications and oxygen therapy while in the facility. The MDS also indicated the resident had not received a physical examination by the physician in the review period. Record review of Resident #2 electronic order recap report accessed on 8/5/20 revealed the following orders: COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to PCP and DON for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused RP:1. WNL 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount b.mod amt c. lg amt d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 7/10/20 with no specified end date (Note: there is no indications as to what positive findings would be). Restrict fluid intake to 1500 cc day every shift. May use oxygen at 6 liter per minute via simple mask every shift with a start date of 7/10/20 and an end date of 7/16/20. Titrate oxygen 1 - 6 liter per minute via nasal canula to keep O2 sat 90% or higher every shift with a start date of 7/16/20 with no specified end date. Vital Signs every shift with a start date of 7/8/20 with no specified end date and no parameters of when to contact the physician. Weigh patient daily one time a day with a start date of 7/10/20 with no specified end date and no parameters of weight gain or loss to notify the physician. There were several other orders to assess temperature, pulse, oxygen saturation, and varied respiratory symptoms such as lung sound, cough, respiratory rate, respiratory pattern all with no guidance as to when and what findings to report to the physician. Record review of Resident #2 Medication Administration Record [REDACTED]#2 started receiving respiratory assessments pre and post nebulizer treatment to assess his mental status, respiratory pattern, lung sounds, cough, heart rate, and respiratory rate only on 7/19/20 was the assessment within normal limits (respiratory pattern should be even and constant in its pace, normal lungs sounds are air moving through the lungs on inspiration or expiration hearing wheezing, clicking, bubbling, or crackles is not normal, a normal heart rate according to the DON, a normal heart rate for an adult is 60-100 beats per minute, an normal respiratory rate is 12-20 breaths per minute) and there was no parameter set for DON or physician notification. Record review of Resident #2 weights and vitals summary revealed resident was receiving oxygen via nasal cannula on 7/8/20 and 7/9/20 but he had no order for oxygen until 7/10/20 and that was to use oxygen with a simple mask. Resident #1 also received oxygen via nasal cannula on 7/8/20,7/9/20, 7/10/20, 7/11/20, 7/12/20, 7/13/20, 7/14/20, 7/15/20, but there was no order to receive oxygen via nasal cannula until 7/16/20. Record review of Resident #2 baseline care plan electronically accessed on 8/1/20 revealed he should receive oxygen via nasal cannula at 1-5 liter per minute. The care plan did not address any parameters as to when notification of DON and physician was warranted. Resident #2 also had a care plan that was initiated on 7/7/20 with the following focuses Depression/Anxiety related to visitation restrictions imposed by the CDC guidelines because of the COVID-19 virus and risk of exposure and at risk for alteration in Psychosocial wellbeing (including depression & Anxiety) related to restrictions on visitation do to COVID-19 there was no other areas of focus. Record review of Resident #2 daily skilled nursing notes revealed on 7/14/20 he was receiving oxygen via nasal cannula at 2-6 liter per minute when he had no order to receive oxygen via nasal canula and the facility policy is to deliver oxygen via nasal canula at a flow rate under 6 liters per minute with nasal canula. Record review of Resident #2 progress notes from 7/20/20 revealed at 11:30 am Resident #2 had a respiratory rate of 40 breath per minute with diminished/absent lung sound in the right middle and lower lobe along with left lower lobe. Resident #2 was breathing tachypneic, labored, and with use of accessory muscle with shortness of breath. At 4:00 pm Resident #2 had respiration between 32-48 breaths per minute and was using accessory muscles. (Four and half hours after findings at 11:30 am he was sent to the emergency room .) In an interview on 7/28/20 at 2:30 pm the Administrator stated Resident #1 had passed away in the hospital 7/28/20. (Note: two attempts with the Administrator to determine when death occurred and cause of death and one attempt with the interim DON and neither provided the following information). Record review of Resident #3 electronic face sheet accessed on 8/2/20 revealed a [AGE] year-old male admitted on [DATE] with a most recent admission of 4/22/20 with the following Diagnosis: [REDACTED]. Record review of Resident #3 most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed he has a BIMS of score of 15 out of 15 indicating an intact cognition. Resident #3 had entered back to the facility after an acute hospital stay. Resident #3 has the ability to hear with minimal difficulty and can usually make himself understood and understand others and has no history of rejecting care for the quarter. Resident #3 needs supervision with eating and locomotion but requires limited assistance with most ADLs except for dressing where he requires extensive assistance. Resident #3 requires use of a walker, wheelchair, and prostheses for mobility. Resident #3 had occasional urinary incontinence but was always continent of bowel. Resident #3 active [DIAGNOSES REDACTED]. Resident #3 had also had two or more falls for the quarter. Under skin conditions nothing was marked as an area of concern. Medications received indicated Resident #3 was taking a diuretic. Record review of Resident #3 electronic orders accessed on 8/2/20 revealed the following orders: Abdominal fold treatment - Cleanse with normal saline, apply [MEDICATION NAME] and cover with adhesive [MEDICATION NAME] bandage until healed with a start date of 4/11/20 and no specified end date; Cleanse left leg with normal saline, pat dry, apply [MEDICATION NAME] and collagen mixture to any open areas, apply vitamin A&D ointment to remaining skin and wrap with kerlix and wrap with Coban. every day shift for Wound Healing with a start date of 6/27/20 with no specified date. COVID-19 resident screening assessment every shift. Mental status, respiratory pattern, cough. report any positive findings to PCP and DON for further evaluation every shift Mental status: 1. within normal limits (WNL) 2. Anxious 3. Restless 4. Lethargic 5. Confused RP:1. WNL 2. Hyperventilation 3. Irregular 4. Labored 5. Shallow COUGH: n. no cough a. small amount b.mod amt c. lg amt d. thin e. thick f. clear g. white h. yellow i. green j. bloody with a start date of 6/9/20 with no specified end date (Note: there is no indications as to what positive findings would be). Resident

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) #3 also had an order to be a full code with a start date of 5/2/20 with no specified end date. Resident #3 also had an order for [REDACTED].#3 had an order for [REDACTED].#3 July Medication Administration Record [REDACTED]. Resident #3 had also received treatment to his abdominal fold wound every day but two (7/2/20 and 7/9/20) and left leg every day. Per the Medication Administration Record [REDACTED]. In an interview on 8/4/20 at 3:47 pm the DON stated Resident #3 non-rebreather should have been covering his nose and mouth. In an interview on 7/4/20 at 3:47 pm the DON stated for a nurse to obtain a baseline set of vital signs a nurse would need to go to weights and vitals summary and review all the weights and vitals to determine what a resident's baseline would be. The DON also stated they do not set parameters for vital signs as a facility or for each resident unless that a resident is on blood pressure medications, and her expectation is for nursing to identify a change of condition when vitals are outside the average normal for adults (Note normal rage for adults is a respiration rate of 12-20 breaths per minute, an Sp02 rate of 90% or above, a body temperature of 97-99 degrees Fahrenheit, and heart rate of 60-100 beats per minute, and a blood pressure of 90/60-120/80). The DON also expects nursing to do a comprehensive assessment when abnormal findings are noted, report to the physician, and document. Record review of facility policy dated 2/13/2007 revealed the following: Oxygen Administration Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by [MEDICAL CONDITION] or [MEDICAL CONDITION]. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician . Goals 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen . Procedure . 7. Place nasal cannula, usually used for flow rate under 6L/min, in the nares with the prongs straight or curving downward and around the ear and under the chin. Adjust to a snug fit and pad nares on the face and ears with gauze to protect from pressure of the tubing . 9. Place non-rebreather, usually reserved for rates over 8L/min, over the nose and mouth and adjust elastic band for a snug fit, pad areas on face with gauze to protect from pressure . Record review of facility policy dated 3/11/2013 revealed the following: Notifying the Physician of Significant Change in Status The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires Immediate notification of the physician or Non-immediate/Report on Next Workday notification of the physician. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record . 4. If the physician does not return the call within a reasonable amount of time, the nurse will attempt to contact the physician a second time. If the situation is an emergency, and the physician does not call back within a reasonable amount of time, the nurse will contact the Medical Director or the nearest ambulance service for assistance. The nurse will document all attempts to contact the physician in the resident's clinical record . 6. The nurse will monitor and reassess the resident's status and response to interventions. Physicians should develop a working [DIAGNOSES REDACTED]. Record review of the U.S. National Library of Medicine Medline Plus accessed on 8/5/20 revealed the following: Hypoxemia- Hypoxemia is a below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or circulation, and may result in various symptoms, such as shortness of breath . It can also be estimated by measuring the oxygen saturation of your blood using a pulse oximeter - a small device that clips to your finger . Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low. Record review of facility policy dated 2/13/2007 revealed the following: Oxygen Administration Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by [MEDICAL CONDITION] or [MEDICAL CONDITION]. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician . Goals 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen . Procedure . 7. Place nasal cannula, usually used for flow rate under 6L/min, in the nares with the prongs straight or curving downward and around the ear and under the chin. Adjust to a snug fit and pad nares on the face and ears with gauze to protect from pressure of the tubing . 9. Place non-rebreather, usually reserved for rates over 8L/min, over the nose and mouth and adjust elastic band for a snug fit, pad areas on face with gauze to protect from pressure .
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 and interview 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 and to help prevent the development and transmission of communicable diseases such as COVID-19 and infections. The facility failed to actively verify absence of fever and respiratory symptoms when employees report to work. The facility failed to restrict visitation of all visitors and non-essential health care personnel. The facility failed to ensure employees followed hand-hygiene practices, staff did not use Alcohol Based Hand Sanitizer (ABHS) before and after all resident contact. The facility failed to ensure employees disinfected shared medical equipment before use on another resident. The facility failed to minimize exposures to respiratory pathogens by not frequently disinfecting commonly touched surfaces. The facility failed to ensure employees with a positive COVID-19 test results were excluded from work for a minimum of 10 days from the first positive results and/or until they had two negative results no greater than 24 hours apart. The facility failed to provide a single area for donning of Personnel Protective Equipment (PPE) on the COVID-19 wing. These failures could place residents at risk of infections and communicable diseases including COVID-19. Findings: In an observation and interview on 7/28/20 at 12:00 pm four females were coming out the facility's only laundry area two had on mask and two did not. During this surveyor's entrance screening the two ladies with mask from the laundry area entered the screening areas as well. The Marketing Director (MD) was working the screening table. The MD took my temperature, had this surveyor complete a COVID-19 Screening Questionnaire Access to Building form then had this surveyor place the questionnaire in a box with no review of the from by MD. The MD never requested this surveyor to complete hand hygiene and the MD never gave this surveyor any instruction on cough etiquette, hand-hygiene practices or anything related to best practice during this COVID-19 threat. The MD could not tell this surveyor given answers to this surveyor's questionnaire and given those answers if entry could be allowed. MD stated she has only been working for the facility for two weeks and today is her first day to do screening and she has not had any in servicing for being a screener. In an observation on 7/28/20 at 12:00 pm during the screening process the foyer was observed to have no supplies to disinfect the area or it's equipment. There was two small tables in the area both holding items for screening and both tables where sticky with grime and one table had visible circles on it as if a cup had sat and leaked a dark liquid. The MD stated she had nothing to disinfect the area or nothing to use to disinfect the pens and equipment used. Interview on 7/28/20 at 12:00 pm the Housekeeping Supervisor (HKS) and Housekeeper A (HK) stated the two ladies in laundry were HK A's daughters and they acknowledged the ladies did not have on a mask while in the laundry area and had not been screened before entering the laundry area. HKS stated it was against her facilities policy to have non-essential person in the facility during this COVID-19 threat. During observation and interview, on 7/28/20 at 12:10 pm, the House Keeping Supervisor (HKS) took me to a second entry to enter the non COVID side of the building in the foyer sat a book with COVID-19 Screening Questionnaire Access to Building forms and a thermometer with no visible supplies to disinfect this screening area. The HKS stated this area is for staff to self-screen before entering the building, but she cannot remember if they have been in serviced on the proper way to screen themselves. In an interview on 7/28/20 at 12:22 pm the Administrator stated they have housekeeping from 7 am to 3 pm 7 days a week and she has no one assigned to clean commonly touched surfaces after housekeeping has left for the day. The Administrator also stated she has 3 entries into the building. The Administrated stated she has a screening station in a foyer just off the habilitation wing were employees for the COVID free unit are to screen then they are to walk around to another door on the side of the building and enter the COVID free unit. Both the COVID warm and COVID hot halls have their own door that staff are to enter, screen, and exit from. The Administrator stated staff were supposed to be using the buddy system to do their screenings, but she discovered this was not happening. The Administrator also stated she was not aware of a screening station at the door the HKS took this surveyor to enter the building. Record review with Human Resources (HR) of staff punch in and punch out times for 7/17/20 revealed 54 employees utilized the punch in and out time clock and of the 54, 14 (which is equal to 25.9%) COVID-19 Screening Questionnaire Access to Building forms were not accounted for. Of the 14 employees that did not complete a Screening Questionnaire Access to Building form, 2 were Certified Nurse Assistance (CNA), 3 were Dietary Aides (DA), 1 was a Certified Medication Aide (CMA), 1 was an Licenses Vocational Nurse (LVN), 2 were from the Habilitation Therapy (HT)

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	675572	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLEN ROSE NURSING AND REHAB CENTER	1019 HOLDEN ST GLEN ROSE, TX 76043

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) department, 1 was a Laundry Aide (LA), 1 was an Activity Director (AD), and 3 had been terminated. Record review of the staff punch in and punch out time sheet for 7/28/20 revealed 39 employees utilized the punch in and out time clock and of the 39, 4 (which is equal to 10.25%) Screening Questionnaire Access to Building forms were not accounted for. Of the 4 missing Screening Questionnaire Access to Building forms 1 was a CNA, 1 was an LVN, 1 was a CMA, and 1 was from HT. 1 CNA was a repeat offender for both reviews. In an observation on 7/28/20 at 2:15 pm the Administrator was on the phone talking with her mask down at her chin and partially eaten pizza was on her desk. There were several offices down the same hall with drinks on their desk. In an interview on 7/28/20 the Administrator stated their first case of COVID-19 which was Habilitation Therapy (HT) A was tested [DATE]th, 2020 and received the results on July 20th, 2020. She stated Habilitation Therapy (HT) A had worked her last day July 17, 2020 she was not feeling herself that day but thought it was allergies [REDACTED]. The Administrator stated they had 15 positive residents, 2 currently in the hospital and one that had passed in the hospital. The Administrator stated 14 staff had tested positive for COVID-19 some have signs and symptoms, but none are currently working. The administrator stated since it was proven that using the buddy system to screen employees at entry was not being done she got approval to hire a screener, but no one has applied. The Administrator also stated it is not appropriate for staff to have family in the building for any reason. (Note: Request for HT A COVID-19 Screening Questionnaire Access to Building form was requested on 7/29/20 and was not provided by exit.) Record review of a list of COVID-19 positive resident and staff provided by the Administrator on 7/29/20 revealed HT A had contact with at least 9 of the 15 positive residents and she had contact with at least 5 of the 13 positive staff two of those five also worked in habilitation therapies. In an observation and interview on 7/28/20 at 3:16 pm HK B stated they are to clean commonly touched surfaces every two hours, but they are not signing any documentation on what and when they are cleaning and as far as she knows you just clean what is in your assigned hall. HB stated she is unaware of what the procedure is for cleaning commonly touched surfaces once housekeeping leaves for the day. HK B also had a white Styrofoam cup with a lid and straw on her cleaning cart. HK B stated they are not allowed and threw the cup in her trash receptacle on the cart. In an observation and interview on 7/28/20 at 3:33 pm LVN C was observed going from room to room on the non COVID unit taking temps, pulse, and peripheral capillary oxygen saturations (Sp02). LVN C was using a rolling bedside table with the following supplies at hand: documentation sheet, a pen, thermometer, peripheral capillary oxygen saturation (Sp02) meter, glucometer, blood glucose test strips, insulin, insulin syringes, and alcohol prep pads. (Note: LVN C did not have any disinfecting wipes, bag for trash, or a sharps container.) LVN C was observed taking temperature, pulse, and Sp02 on approximately 7 residents. LVN C assessed 5 residents before attempting hand hygiene assessed 2 more residents and completed hand hygiene again. LVN C would wipe down the finger pads to the Sp02 meter between residents with an alcohol prep pads but did not wipe down the whole Sp02 monitor and she did not use any kind of disinfecting wipe or cleaning product on the community medical equipment. LVN C stated not wiping down the community equipment is acceptable because they did not touch the resident or items in their room and not doing hand hygiene between each room is ok because she is not touching item in the room. In an interview on 7/29/20 at 9:40 am the Administrator stated she expects her staff to follow the policy for hand hygiene and encourages them to do so after leaving a resident room because you may never know when you touched something in their room. The Administrator stated staff should be using the purple top wipes for shared medical equipment between each resident. Record review of an in service dated 7/10/20 covering the following topic Disinfection Product and Applied kill time address the kill times of purple, black, and red wipes, K-quat kill time and what items need to be disinfected such as high traffic areas, handrails, light switches, doorknobs, and nurse station to be done 4 times a day, but it does not cover disinfection of community medical equipment. This in service was not signed by LVN C and only had 11 signatures when the facility employees over a hundred people according to the employee roster provided by Human Resources (HR). In an observation on 7/29/20 at 3:21 pm two female staff and male staff were sitting at the nurse station all staff had drinks with in arms reach and at least one had food with in arms reach. LVN E was seen with his mask down at his chin to take a drink of his soda. In an observation on 7/29/20 at 3:36 pm entry into the COVID hot wing revealed an outside door used for entry and at that door is a rolling bedside table to do screenings. To the right a resident room has been turned into a doffing room and to the left a resident room has been turned into a donning room. There was no barrier to provide a warm zone for entry and exit thus allowing persons who may not pass screening to fully expose the wing. In the donning room, pizza boxes were sitting on a table. There was a cart sitting by the fire doors with clean linens and they were not covered. HT B was talking on his cell phone with gloves on and went into a male resident room, came out of the room with no gloves, still on his cell phone, put his phone down to don a new pair of gloves, retrieved his cell phone and kept talking. HT B then proceeded to a female resident room still having his cell phone in hand, he then let the female resident hold and talk on his cell phone. After HT B and the female resident was done talking on the cell phone he placed it in his pocket and went on about his work. In an interview on 7/29/20 at 8:39 pm Social Worker (SW) stated that before this week they would take their own temperatures and do their own questionnaires and it was a buddy system. In an interview on 7/30/20 at 10:08 am Registered Nurse (RN) A stated non-essential personal has been an issue the Administrator has been allowing vending machine vendors in the building to restock the vending machines. RN A stated the last time she has seen a vendor in the building was 7/10/20. In an interview on 7/30/20 at 2:27 pm LVN A stated the Administrator had been allowing vendors in the building and the last day she had seen a vendor was 7/10/20 when they had a visit from Special Infection Control Assessments (SICA) team. LVN A stated the Administrator got worried because the vendor had left approximately 10 minutes before the arrival of the SICA team and the Administrator went and pulled the screening sheet so the SICA team would not see the vendor had been allowed in the building, because he had put vending on his screening sheet. LVN A also stated that they were screening themselves when reporting for work. LVN A stated she knows of two families that have been allowed to enter the building to view bodies after death. LVN A overheard the Human Resources (HR) person on the phone with Resident #1 daughter arranging to view the body and she believes this was allowed because the family of Resident #1 has personal ties to facility employees. LVN A also knew of one other family allowed entry to see his living wife after becoming very upset over not being able to visit his wife. LVN A stated it was very common to see staff eating and drinking in offices, the nurse station, and even having drinks on the medication carts. LVN A stated she addressed it with the Administrator and was told to pick her battles that it was not hurting anybody. Record review of Resident #1 electronic face sheet accessed on 7/31/20 revealed and [AGE] year-old female admitted on [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #1 most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed she had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated a severely impaired cognition. Resident #1 MDS also revealed she was on hospice while in the facility. Record review of Resident #1 progress notes revealed Resident #1 passed away on 7/10/20 at 1:50 pm and at 4:03 pm the daughter and grandson were allowed into room [ROOM NUMBER] to view the body and allowed to cut her mother's hair and place in a bag. Record review of Resident #3 electronic face sheet accessed on 8/2/20 revealed a [AGE] year-old male admitted on [DATE] with a most recent admission of 4/22/20 with the following Diagnosis: [REDACTED]. Record review of Resident #3 most recent quarterly Minimum Data Set ((MDS) dated [DATE] revealed he has a BIMS of score of 15 out of 15 indicating an intact cognition. Record review of Resident #4 electronic face sheet accessed on 8/5/20 revealed an [AGE] year-old make admitted on [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #4 most recent quarterly Minimum Date Set dated 6/12/20 revealed he had a BIMS score of 2 out of 15 which indicated a severely impaired cognition. Record review of Resident #4 progress notes revealed he passed away 7/8/20 at 9:45 pm. Resident #4 progress notes also revealed on 7/8/20 at 10:30 pm family is traveling from Fort Worth to the nursing home to view the body prior to release. On 7/9/20 at 1:09 am University of Texas South West Medical Center arrived to remove Resident #4's body and 2 family members were present at the time of removal. In an interview on 7/31/20 at 10:39 am HT A stated she has seen the vending machine man in the building since COVID-19. HT A stated she is aware of at least one family being allowed in the facility to view a body once the resident had passed. HT A had also seen coworkers with drinks and food at their desk and medication carts as well. In an interview on 7/31/20 at 1:42 pm RN A stated she was aware of Resident #1 family being allowed an extended amount of time with Resident #1 body after death, but it was handled by a corporate RN with the approval of corporate. RN A recalls this happening on 7/10/20 the day the SICA team was present. RN A stated that the Administrator told her viewing bodies after death is part of [MEDICATION NAME] care, but RN A felt the rules where not the same for everyone in the eyes of the Administrator. In an interview on 8/5/20 at 11:18 am LVN D stated she is 99% faithful about doing her screenings when reporting to work, but she is not as good about doing her screening when she leaves for the day. LVN D also stated she has seen non-essential persons in the building and she personally screened Resident #4 family when they came to view his body after his death. LVN D also stated she has been working ever since finding out she was COVID-19 positive, but she has only been working on the COVID hall and she believes they also

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) have a house keeper who tested positive working the COVID hall as well. Record review of staff who have tested positive since 7/28/20 provided by the Administrator on 8/4/20 revealed LVN D had tested positive for COVID-19. Record review of Resident #3 July Medication Administration Record [REDACTED]. Record review of Resident #3 August Medication Administration Record [REDACTED]. In an interview on 8/5/20 at 2:32 pm HKS stated that the facility is using a COVID positive housekeeper on the COVID unit. Record review of facility policy dated 5/27/20 revealed the following: Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID 19) . Policy: It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Federal and State/Local recommendations . Note: All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements. Check the following link regularly for critical updates, such as updates to guidance for using PPE: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html . Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact . Dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19 . Screening Employees: Facility will actively verify absence of fever and respiratory symptoms when employees report to work-beginning of their shift. Document temperature, absence of shortness of breath, new or change in cough and sore throat and other criteria as identified by State guidance. If employee is ill, employee will put on a facemask, immediately leave the facility and self-isolate at home . The facility will re-educate employees and reinforce: Strong hand-hygiene practices . Employee Return to Work Criteria . ASYMPTOMATIC CASES Time Based Strategy, must be isolated and excluded from work for a minimum of 10 days have passed since the date of the first positive test, assuming that have not subsequently developed symptoms since the positive result. If the Healthcare Provider develops symptoms, they should follow instructions for symptomatic cases . ASYMPTOMATIC CASES Time Based Strategy, Must be isolated and excluded from work after receiving negative results of an FDA Emergency Use Authorized molecular assay for COVID19 from at least 2 consecutive respiratory specimens collected greater than 24 hours apart (total of 2 negative specimens) If the HCP develops symptoms, they should follow instructions above for symptomatic cases . Visitor Restrictions The facility will restrict visitation of all visitors and non-essential health care personnel, except for certain [MEDICATION NAME] care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only . Visitors will be reminded to frequently perform hand hygiene. Prior to entry to the facility, visitor will be instructed on: Hand Hygiene, limiting surfaces touched, Use of PPE, Refrain from physical contact with residents and others in the facility, (practice social distancing by remaining 6 feet apart from others and not handshaking, hugging, etc.) . Vendors will not be permitted in the facility. Vendors will be instructed to drop off supplies at a dedicated location (loading dock). Record review of a facility in services all dated 7/10/20 revealed the following. Increased Surveillance Related to Potential Exposure . All building must remain on high alert related and adhere to all policy implementation related to COVID19, due to the potential exposure we must increase monitoring of clients and staff. 1. Continue security of building (doors must be secured and accessed only if essential) 2. Continue: NO VISITORS .; Fundamentals of infection control all departments policy proper handwashing protect yourself and others . Hand Hygiene . Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pule or blood pressure, and lifting a resident) . Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections . Resident care equipment and articles . 3. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant . All of the in service signature sheets had the same 11 signatures.