STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675557	A. BUILDING _____ B. WING _____	07/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSONG CARE CENTER	3400 E WALNUT PEARLAND, TX 77581

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 follow guidance for prevention and management of COVID 19 to prevent the spread of infection and provide a safe and sanitary environment and to handle, store, process, and transport linens so as to prevent the spread of infection for 10 sampled residents and on 1 of 5 halls (Flamingo Hall) reviewed for infection control. -The facility failed to follow CMS guidance to cancel all communal indoor and outdoor activities to prevent or limit exposure and spread of COVID 19 in residents that attend activities. -CNA A removed linens from a resident room and placed them back on the clean linen cart. These failures placed all residents at risk of exposure to infection and re-infection of COVID-19 and other infectious disease. Findings include: Record review of intake # 5 revealed that the facility continued to have group activities after being advised that indoor and outdoor activities should be canceled to avoid and prevent the spread of COVID 19. The activities were posted on a social media outlet to include a concert outside of the building and painting on the patio activities. Residents and or staff were noted without wearing mask during the events. The concern was that due to the facility failing to follow guidance to cancel group activities that the residents were exposed and susceptible to spreading or contracting COVID 19. On 5/20/2020 observation of a media outlet revealed a post, dated April 21, 2020 of the Painting with a Twist on The Patio caption. There was a total of 8 pictures of residents outside. 2 residents were seated at the same table, all other residents were seated at individual tables with painting projects. On 5/20/2020 observation of a media outlet revealed a post, dated April 22 at 9:30 am of the concert/party held outside of the facility there was a video from a local news media showing 2 musicians in their staging area, distanced away from the residents. Residents were observed listening to music, clapping and enjoying music. The residents appeared to be social-distanced. The staff were observed to have on mask. The musicians were interviewed and said that they wanted to come and play music, keeping in mind social distancing and they felt that they did, offering entertainment for the residents. On 5/20/2020 at 12:22 pm, a telephone interview with the Administrator regarding the social media and television reports revealed that some of the dates on the pictures weren't the actual dates the activities occurred and that she would get the Activity Director to help assist in getting actual dates and attendees. She said that there were 2 musicians present for the concert and their stage was 20 to 30 feet away from the residents, they did not come into the facility. She also said that with both activities the residents were spaced 7-8 feet apart and there is always less than 10, at most times 6 people in the settings. activities and they were parted into groups. The Activity Director transported some out in their wheelchair one at a time except for those who could go on their own. She said that the 2 residents seated together in the painting on the patio activity are a married couple. On 4/7 in version 2.2 from Texas Health and Human Services were told that group activities should be canceled, but it went onto say that no more than 10 people, maintaining at least 6 ft. apart of separation in a room at any time. Record review of email correspondence from the Administrator dated 5/20/20 revealed that The Activity Director was the only staff member transporting resident's most of the residents who went outside were able to take themselves. Staff have been wearing mask since late in March, if they transported a resident anywhere they were wearing their mask and using sanitizer. Painting outside was a last-minute thought, because it was so beautiful outside, it was on 4/9. On 4/7 in version 2.2 from Texas Health and Human Services were told that group activities should be canceled, but it went onto say that no more than 10 people, maintaining at least 6 ft. apart of separation in a room at any time. We felt outdoor small activities was safe with proper social distancing. I believe 4/9 was the last thing we did besides in rooms and Zoom. The concert was 4/8. We didn't write a policy for the activities during COVID. Record review of email correspondence from the Administrator dated 5/20/20 read in part . we started having the resident's wear mask on 4/20 or 4/21 . the pictures that are posted on social media weren't always posted on the day they were taken. If you need specific dates for certain events, let me know and I can try to get someone to provide them. In this situation, we did what we felt we could safely do with keeping at least 6 feet apart and no large group activities. Record review of email correspondence from the Administrator dated 5/21/20 read in part .The concert and the party on the patio are the same event, it was 4/8, the news aired it a few weeks later. I took the pictures they used. We rotated the resident's all of them were not there at the same time Painting on the patio, the Activity Director did in 2 groups. During an interview on 5/21/20 at 12:22 p.m. with the Vice President of Operations, he said the same band played twice, once in the open area by the parking lot where residents could see them through their windows and once in the patio area. He said they only brought 10 residents out at a time, but acknowledged that they did not include the staff in the count. He said the musicians were set up approximately 25 feet away from the residents. When asked if the musicians had been screened and whether their COVID-19 testing status was known, he said no. He said the musicians did not come into the facility and they felt they could social distance outside. On 5/28/2020 at approximately 4:00 pm a telephone interview with the Activity Director, she said that she did transport the residents to the activities and she could not remember how many groups she transported to the activities, she added they were social distanced. She said she had in-services on COVID 19 and infection prevention. Record review of documentation of attendees to the concert outside on 4/8/2020 revealed that there were 9 residents that attended, and residents were rotated to attend, not all were there during the same time. Also, the residents were distanced over 6 feet apart. Record review of documentation of attendees to the painting on the patio on 4/8/2020 revealed that the activity was done in two groups, not at the same time. The first group had 4 resident attendees, the second group had 4 resident attendees. Record review of an email from the Administrator dated 5/26/2020 revealed the Musicians, didn't come in or get close to anyone they sat up on their own and stayed far from everyone, so we did not do the screening. We only screen people who come in. Record review of the ATTACHMENT 3: Interim Guidance for Prevention, Management, and Reporting of Coronavirus Disease 2019 (COVID-19) Outbreaks in Long-Term Care Facilities and Other Communal Living Settings revealed the following: Immediate Prevention Measures Visitor restriction - On March 13, 2020, the Centers for Medicare and Medicaid Services (CMS) released a memorandum directing all nursing homes to restrict visitors except those medically necessary. This is an important measure to prevent the introduction of [MEDICAL CONDITION] that causes COVID-19 into LTCFs. The Texas Department of State Health Services (DSHS) recommends all LTCFs restrict visitation except in end-of-life care. Social distancing - Remind residents to practice social distancing and perform frequent hand hygiene. Social distancing means avoiding unnecessary physical contact and keeping a distance of at least 6 feet from other people. Cancel communal dining and all group activities, such as internal and external activities. Record review of the documentation from the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group dated March 13, 2020 read in part . Additional guidance: 1. Cancel communal dining and all group activities, such as internal and external group activities. Record review of the Long-Term Care Regulatory Provider Letter, PL 20-11 dated, March 20, 2020 read in part . Prohibition of Nonessential Visitors .Per the Texas Governor's March 19, 2020, Executive Order No. 3, NF providers must prohibit all visitors not providing critical assistance given the significant health and safety risk to medically fragile residents posed by COVID-19 (coronavirus). LINENS: Observation on 5/1/20 at 11:39 a.m. revealed CNA A was in occupied resident room [ROOM NUMBER]. There was a chair in the room that held a folded set of linens. She had not performed hand

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) hygiene after removing the gloves she had on. CNA A picked up the folded linens off the resident's chair, carried them out of the room, and placed them back onto the clean linen cart in the hallway. During an interview and observation on 5/1/20 at 11:39 a.m. with CNA A she was asked why she carried the linens out of the room and if she was supposed to do that. She was also asked if she was supposed to perform hand hygiene after removing her gloves and before leaving the resident room. CNA A then went to take the linens back off of the cart. She said she was supposed to have washed her hands before she left the room and that she was aware of that. Related to the linens, she just kept saying, But they are clean? During an interview on 5/1/20 at 11:40 a.m. with RN A, she confirmed the linens were not supposed to be removed from a room once taken into the room regardless of whether they had been used. Record review of a facility undated REMINDERS form read in part, .WASH HANDS/USE SANITIZER BEFORE ENTERING ROOMS AND WHEN LEAVING ROOMS AND BEFORE AND AFTER PROVIDING CARE AND WHEN LEAVING OFF HALL. . Record review of the facility policy and procedure revised August 2012 for Infection Control Guidelines for All Nursing Procedures read in part, .2. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .m. After removing gloves; . Record review of the facility policy and procedure for Departmental (Environmental Services) -Laundry and Linen revised January 2014 revealed this policy did not address directive to not remove linens once taken into a resident room. Record review of the facility policy and procedure for Laundry and Bedding-Soiled read in part, .Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. . The policy and procedure did not contain clarification instructions that laundry taken into a resident room was to be considered soiled and not removed back out of the room and placed with clean linens.