STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676360	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RIO AT MAINLAND CENTER	**1011 MAINLAND CENTER DR TEXAS CITY, TX 77591**

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had a safe, clean, comfortable and homelike environment for 1 (Resident #1) of 7 residents reviewed for safe, clean, comfortable and homelike environment. in that, Resident #1's room had unlabeled urinals, a dinner tray left over night and the floor was dirty. This failure could put all residents at risk of infection and diminished quality of life. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male with an admitted [DATE] and re-admit of 4/21/20. [DIAGNOSES REDACTED]. Record review of Resident #1's Quarterly MDS dated [DATE] revealed BIMS score of 4 of 15 indicating cognition was severely impaired. Observation at 5:05 AM on 9/2/20 in Resident #1's room revealed resident was asleep. There was a meal tray on the bedside table. There were 2 pieces of carrot on the floor along with a spoon. The trash can had 4 urinals hanging off side, and none of them had a name or room number on them. Interview at 6:00 AM on 9/2/20 NA #1 said he usually tried to take Resident #1's tray, but he eats late and sometimes refused the tray being taken away. Yes, the tray should not have been sitting there all night. The urinals should have been labeled. She checked on residents every 2 hours. Observation at 6:47 AM on 9/2/20 in Resident #1's room found the meal tray had been removed, but the carrot and spoon were still on the floor. There was yellow liquid on floor by the trash can. Interview at 6:54 AM on 9/2/20, LVN #1 said the CNA's should have checked and cleaned up if housekeeping was not available. They should not have left the food or spilled liquid on the floor. Resident #1 does need 4 urinals, but they should have been labeled. Interview at 8:13 AM on 9/2/20, Resident #1 said some CNA's were good and some were mean. They leave my tray all night. They do not come and pick it up, but I do like to eat later. Sometimes there was greasy stuff on the floor and I am afraid I might step in it and fall. Interview at 10:35 AM on 9/2/20, DON said CNA's should check residents at least every 2 hours. CNA should look and clean up any mess they see if there was no housekeeping available. When the night shift comes on, they should remove any dinner trays that were still in the rooms. Urinals were to be labeled with name. Record review of facility policy titled, Resident Rights, revised December 2016 read in part, .These rights include the resident's right to: a dignified existence and be treated with respect, kindness, and dignity.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety, in that Food items in the nutrition refrigerator were not labeled or dated. This failure placed residents who ate the prepared and delivered snacks at risk of foodborne illnesses. Findings include: Observation at 5:25 AM on 9/2/20 of the shared nutrition refrigerator for 100, 200 and 300 halls revealed: Sandwiches with no labels 3 glasses of juice with no labels 1 Pitcher of pink lemonade with no label Opened bag of cubed cheese with no label Opened bag of peppers with no label McDonalds cup with drink and straw with no label Interview at 5:55 AM on 9/2/20, LVN #2 said the dietary department staff were responsible for the labeling of the food in the nutrition refrigerator. It should have been labeled with the date. Interview at 8:40 AM on 9/2/20, the Dietary Manager said the kitchen staff prepared the snacks and drinks for the nutrition refrigerator. All food that was made or opened should have been labeled with date made and use by date. The dietary staff should have been emptying and cleaning the refrigerator of the food. Record review of facility policy titled, Food Receiving and Storage, revised July 2014 read in part, .Food items and snacks kept on the nursing units must .placed in the refrigerator located at the nurses' station and labeled with a use by' date .all foods belonging to residents must be labeled with the resident's name, the item and the use by date
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 observations, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 3 of 12 staff (NA #1, Housekeeper, and Activities Assistant) reviewed for infection control, in that NA #1, Housekeeper and Activities Assistant were observed wearing face mask incorrectly. These failures placed residents at risk for contracting COVID-19 and other infectious diseases and a decline in health. Findings include: Observation and Interview at 5:05 AM on 9/2/20, NA #1 had his face mask under his nose. He said the mask fogs up his glasses, but it should be above his nose. Observation at 5:20 AM on 9/2/20, NA #1 still had face mask below his nose. Observation and Interview at 10:16 AM on 9/2/20, Housekeeper had a cloth mask below her nose. She said it slides down. Observation and Interview at 10:20 AM on 9/2/20, Activities Assistant was with residents in dining room for painting. Her mask was gapping on the sides and sliding down off her nose. She had to keep pulling it up. She said it was supposed to be up over her nose. Interview at 2:43 PM on 9/3/20, DON said staff was to wear surgical face masks up over the nose. We have done trainings on how to wear PPE and face masks correctly through the computer on line system. In an interview at 2:43 PM on 9/3/20 with the DON, the infection control policies related to PPE were requested Record review of documents provided by the facility revealed no information specifically related to PPE or face masks Record review of CDC guidelines on Face Mask Do's and Don'ts, dated 6/2/20, read in part: do not wear your face mask under the nose or mouth and don't touch your face mask without cleaning your hands before and after.

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.