STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. BUILDING _____ B. WING _____	04/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND PINES NURSING HOME	1100 N 4TH ST LONGVIEW, TX 75601

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an effective infection prevention and control program to prevent the development and transmission of communicable diseases was provided for the facility regarding COVID 19. The facility did not follow CDC guidelines and restrict LVN A from working for 14 days after being exposed to Resident #1 who displayed symptoms of COVID-19 (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older). LVN A provided an aerosolized nebulizer treatment (used to turn liquid medicine into a very fine mist that is inhaled into the lungs) to Resident #1 without an N95 mask, eye protection, and gown. Resident #1 was diagnosed with [REDACTED]. LVN A continued to work her scheduled shifts on Hall 300 after being exposed to COVID-19. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 4/25/20. While the IJ was removed on 4/26/20, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk for the transmission of COVID-19 and death. Findings included: An undated admission record dated 4/26/20 indicated Resident #1 admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The order summary report dated 4/19/20 indicated an order with a start date of 9/18/19 for [MEDICATION NAME]-[MEDICATION NAME] Solution 0.5-2.5 (3) MG/ML 1 vial inhale orally every 4 hours as needed for shortness of breath and wheezing. The MDS dated [DATE] indicated Resident #1 had intact cognition and used oxygen therapy. A care plan with a revision date of 9/19/19 indicated Resident #1 had shortness of breath, was a smoker, was receiving oxygen therapy, had altered respiratory status, and had asthma. The nurse administration record dated 4/19/20 indicated Resident #1 was to receive [MEDICATION NAME]-[MEDICATION NAME] (a medication used for the treatment of [REDACTED]. A nursing note dated 4/19/20 at 9:48 a.m. indicated LVN A found Resident #1 lethargic and short of breath in his room. LVN A checked Resident #1's oxygen saturation and found it to be 80% (normal range 95-100%) while on 2 liters of oxygen. The note indicted LVN A provided a breathing treatment and rechecked his oxygen saturation and there was no change. The note indicated LVN A increased his oxygen to 3 liters and there was no change in his oxygen saturation. The note indicated LVN A notified the nurse practitioner and the resident was sent to the hospital. During an interview on 4/27/20 at 3:51 p.m., LVN A said on 4/19/20 she entered Resident #1's room and found him lethargic. She said his oxygen level was between 80-85% and he was on 2 liters of oxygen. She said she gave him a breathing treatment through his nebulizer and stayed in the room with him for about 15 minutes. She said she wore a surgical mask and gloves and was within 3 to 5 feet of him during his breathing treatment. She said she notified the nurse practitioner of the resident's condition and sent him to the hospital. LVN A said on 4/20/20 she was notified by the facility of Resident #1's positive COVID-19 result. She said she was tested a couple of days ago and was taken off the schedule. She said there were 41 residents on the 300 hall and because she was the charge nurse, she gave direct care to all of them after her exposure to COVID-19. She said after Resident #1 was found to be positive for COVID-19, her temperature was taken every day while she was at work and the DON asked her if she was feeling well and if she was showing any signs or symptoms of COVID-19. An employee time sheet dated 4/16/20 through 4/30/20, indicated LVN A worked the day shift on 4/19/20, 4/20/20, 4/23/20 and 4/24/20. A handwritten timeline completed by the DON dated 4/20/20 at 3:25 p.m. indicated the facility received a call from the local hospital notifying Resident #1 tested positive for COVID-19. During an interview on 4/25/20 at 1:30 p.m., the DON said Resident #1 had been in the hospital since 4/19/20. She said Resident #1 was tested for COVID-19 on 4/20/20 and the positive result was sent to the facility on [DATE]. The DON said the change in Resident #1's condition happened quickly, and the facility had no reason to believe he had COVID-19 because he had no cough or fever. She said LVN A gave Resident #1 an aerosol breathing treatment and per facility policy should have stayed in the room with the resident for the entire 15-minute treatment. She said LVN A was wearing a surgical mask during the care of Resident #1, and during his breathing treatment administration. She said after the facility received Resident #1's positive COVID-19 test results from the hospital the facility requested the hospital do a blood test on Resident #1. She said the facility did not believe the resident was really positive because he had no symptoms while at the facility. She said the hospital refused to do a blood test, but the facility medical director would be calling the hospital to request a blood test for Resident #1. During an interview on 4/25/20 at 6:00 p.m., the DON said the health department was notified of Resident #1's positive result and was consulted regarding testing LVN A and Resident #1's roommate. The DON said the facility was told not to test LVN A or Resident #1's roommate because neither person was symptomatic for COVID-19. She said the health department did not suggest quarantining LVN A and said the only changes to make were increased PPE in isolation rooms. She said trainings from the facility's corporate office stated to follow health department guidance and guidelines. During an interview on 4/25/20 at 7:00 p.m., the DON said the facility was receiving guidance from the CDC from their corporate office. She said she was not aware of the CDC guidance regarding high risk exposures. A COVID Action Plan, with a revision date of 4/21/20 indicated the following: If a staff member is exposed to the COVID 19: - The employee must inform the administrator immediately - The administrator will immediately notify SVP of Operations, SVPC, VP-Regulatory Compliance - If the employee has reported to work and they are at the screening station, they must leave the facility immediately and not return for recheck for 14 days. - If the employee is at home and report, they are not to enter the facility for 14 days and will be rescreened at that time. - If the staff member becomes ill, they must report to the facility immediately with signs and symptoms (if they mimic COVID 19, contact Local Health Department) If a staff member has presumed or confirmed COVID: - If the employee is not at work, they will be instructed to contact the local health department and will remain away from work for 14 days and the will be re-screened before returning to work. If the employee is at work, they must don a mask and leave immediately - The administrator will contact the local health department for direction. - All staff who has come in contact with this presumed or confirmed COVID staff member will have to be self-quarantined for 14 days before being rescreened. - All residents will be assessed with [REDACTED]. - Group dining will be stopped, and staff will be delivering meals to the resident rooms. - All group activities will stop until further notice. - If confirmed, admission of other potential residents will stop. The website https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take_precautions accessed on 4/28/20 indicated: .4. Take precautions when performing aerosol generating procedures. If performed, the following should occur: HCP in the room should wear N95 or higher-level respirator .eye protection, gloves, and a gown. The website https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html, updated by the CDC on 4/15/20 and accessed 4/25/20 indicated the following: . high-risk exposures refer to HCP being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, [MEDICATION NAME], nebulizer therapy, sputum induction) on patients with COVID-19 (beginning 48 hours before onset of symptoms) when the healthcare providers' eyes, nose, or mouth were not protected .III. Recommendations for Monitoring Based on COVID-19 Exposure Risk 1. High- or Medium-risk Exposure Category .HCP should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) exposure . The administrator and DON were notified on 4/25/20 at 7:00 p.m. an IJ situation was identified due to the above failures and the IJ template was provided. The facility's Plan of Removal was accepted on 4/26/20 at 2:01 p.m and included: .A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: 1. On 4/19/20 the day shift LVN was exposed to COVID- 19 through providing an aerosolized breathing treatment to an unresponsive resident while she wore a surgical mask. The resident was sent to the hospital and tested on [DATE]. Positive results were received on 04/20/2020 and the facility was notified. The LVN has since worked 3 shifts after the resident was found positive and she has not been tested 2. The LVN continued to report to work providing care to other residents and potentially exposing the residents under her care to COVID- 19 as well as other staff members which could lead to harm or death 3. The LVN in question was potentially infected with COVID-19 during the aerosolized breathing treatment that was given to the resident. The LVN has now potentially exposed the residents under her care and other staff members to COVID-19 Identify residents who could be affected Residents who were provided care for by the LVN on 300 Hall. All the residents in the 300 Hall on 04.25.2020 were assessed by the Charge Nurses and Nursing Supervisor. No resident presented with any respiratory change in condition. Identify responsible staff/ what action taken LVN was removed from the schedule on 04/25/2020. LVN has gone to the hospital on [DATE] to be tested . LVN will not be allowed back to work until test result is out and quarantined for 14 days All residents on hall 300 will be tested for COVID-19 on 4/27/2020. In-Service conducted In-service was conducted by Director of Nursing and Assistant Director of Nursing on 04.25.2020. The in-service is on Infection Control. The details of the in-service include: If a nurse must give a breathing treatment to a resident the nurse will wear an N95 Mask and be the only one in the room with door closed. Full PPE will be donned on Hall 300 Proper handwashing technique CDC risk categories regarding facility staff. The in-service was attended by licensed nurses which include; Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistants, Certified Medication Aide, Respiratory Therapy and Licensed Therapists which include; Physical Therapist, Occupational Therapist and Speech therapist. For licensed staff who are unavailable for training on this date, they will not be allowed to return to work until training is complete. This in-service will be started on 04.25.20 Implementation of Changes The changes were initiated by the Director of Nursing. The changes will be implemented effective on 04.25.20 and will be ongoing until all staff are in serviced. The Director of Nursing will ensure competency through verbalization of understanding by staff. Monitoring The Administrator/Director of Nursing/Assistant Director of Nursing will be responsible for monitoring the implementation and effectiveness of in-service on 04.25.2020. The Administrator/Director of Nursing/Assistant Director of Nursing will assess all staff members who have potentially been exposed to a suspected resident and determine the proper risk of the employee daily. Director of Nursing/Assistant Director of Nursing will monitor the administration of breathing treatments when they are deemed necessary to make sure the proper procedure daily. Administrator/Director of Nursing will consultant with the Vice President of Clinical, Vice President of Operations, Vice President of compliance and the Regional Nurse Consultant on any potential exposure related to any staff member/resident and CDC and state guidelines will be reviewed daily on the daily end of day call for 21 days after the last confirmed case. Residents will be monitored every shift for any changes of condition. Any changes of condition will be reported to the Director of Nursing and Assistant Director of Nursing immediately. Involvement of Medical Director The Medical Director was notified about the immediate Jeopardy on 04.25.2020. The Medical Director will be meeting with the Interdisciplinary team on 04.26.2020 to discuss more about the immediate Jeopardy and ways to address the alleged deficient practice. Involvement of QA An Ad Hoc QAPI meeting will be held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal. Who is responsible for implementation of process? The Director of Nursing will be responsible for implementation of New Process. The New Process/ system will be started on 04.25.2020 and no employee be able to return to work until they complete the in-service. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy verbally issued on 04.25.2020. On 4/26/20 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: During an interview on 4/25/20 at 5:05 p.m., the administrator and DON said after the facility received the positive test results for Resident #1, the staff wore N95 masks and gowns into isolation rooms, per health department recommendations. She said Resident #1's roommate was isolated and tested for COVID-19. His results were negative. During an interview on 4/25/20 at 6:00 p.m., the DON said direct care staff that previously worked on Resident #1's hall had been dedicated to that hall and would not be moved. During an observation on 4/26/20 at 11:50 a.m., an N95 mask was provided for the surveyor for entry to 300 hall. The DON and front desk staff member were wearing N95 masks. During an observation on 4/26/20 at 11:55 a.m., the DON and administrator were wearing N95 masks. During an interview on 4/26/20 at 12:00 p.m., the DON and administrator said LVN A went to the hospital on the night of 4/25/20 to be tested for COVID-19. LVN A was removed from the schedule on 4/25/20. In-services were created and staff were being trained upon arrival to work. Staff in the building were trained before clocking in, and the new rotation would be trained on 4/27/20 before clocking in. The administrator said the testing of residents would begin on the morning of 4/27/20. An untitled in-service dated 4/25/20 indicated: Food carts would be covered when delivered through the third floor, ensure masks were worn at all times and doors to kitchen were kept closed at all times. Staff were not to go onto unit 3 to retrieve carts. The carts would be delivered to the dining room for the other floors to pick up. An untitled in-service dated 4/25/20 indicated: Handwashing was the best prevention for spread of virus/disease. Staff were expected to use appropriate handwashing technique before and after any and all patient care, when entering and exiting patient care areas. When donning and doffing PPE. An untitled in-service dated 4/25/20 indicated: Respiratory assessments were to be performed in PCC per shift by the charge nurses. Temperatures and oxygen saturations were to be completed a second time per shift and entered into PCC on the weight/vital signs page. Respiratory therapy assessments were separate from this and did not count towards completion. An untitled in-service dated 4/25/20 indicated: 300 hall staff would wear full PPE for each resident's care throughout the 14 day quarantine. An untitled in-service dated 4/25/20 indicated: If a breathing treatment was given- the nurse must wear an N95 mask, be in the same room alone and have the door closed throughout the treatment. An untitled in-service dated 4/25/20 indicated: Per CDC guidelines, the facility would follow the protocol of risk categories: low, medium and high. During a record review on 4/26/20 at 1:00 p.m., Resident #s 2, 3, 4, 5, 6, and 7 had respiratory assessments performed in accordance with the facility's plan of removal on 4/25/20 and 4/26/20. Temperatures and oxygen saturations were recorded appropriately by nursing staff. During an interview on 4/26/20 at 1:10 p.m., RN B was wearing an N95 mask at the nursing station and said she had received training that morning that included usage of PPE (gloves, gowns, shoe covers) and wearing N95 masks while on the 300 hall. The facility would continue screening at the front door and taking temperatures. Nursing staff would be conducting respiratory charting twice a shift for all residents which included temperatures and oxygen saturations. She said only nurses could go into COVID pending rooms and must wear full PPE, such as gowns, gloves, and masks. During an interview on 4/26/20 at 1:15 p.m., CNA C and CNA D were both wearing N95 masks and said they had received training that morning on wearing N95 masks while in the building. They said they were also trained that when giving breathing treatments to residents, the nurses were to wear an N95 mask, be the only staff member present in the room, and have the door shut. Any staff providing care on the 300 hall would wear full PPE, such as gowns, gloves and masks. Training also included handwashing being the best way to prevent the spread of infections and to wash hands before and after resident care. During an interview on 4/26/20 at 1:25 p.m., RN D was wearing an N95 mask and said she was trained that morning on staff not being allowed on the 300 hall unless they were scheduled to work there, and those employees were to wear full PPE. She said new N95 masks were handed out by administrative staff and they were to wear those while in the building. She said if a nurse was giving a breathing treatment, only the nurse could be in the room and would wear full PPE, with the door closed. She said training covered handwashing being the best prevention for spread of viruses and staff were to wash their hands before and after any patient care. She said she received training on documentation of resident respiratory assessments, which would include temperatures and oxygen saturations. During an interview on 4/26/20 at 1:34 p.m., the RT was wearing an N95 mask and said she was trained that morning on nebulizer treatments and that the nurse, or RT, and resident were to be the only people in the room, with the door closed. She said the CDC guidelines and protocols were to be followed now because they were stricter than the health department's guidelines and protocols. She said training indicated 300 hall would be completely isolated to all staff that were not designated to work there. She said changes were made to food dispersal through the 300 hall and carts would be covered when delivered through the 300 hall and masks were to be worn. During an interview on 4/26/20 at 1:40 p.m., LVN E, who worked on hall 300, was wearing an N95 mask and said she was trained that morning on wearing masks and PPE in every room that staff would enter. She said the meal service changed, and the kitchen would start putting meals right outside of the doors to the kitchen. She said staff could not go

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) back and forth between the 300 hall and the rest of the building. She said staff had been given paper forms for clocking in and out and were not able to visit the time clock. She said administration had provided staff with paper bags to place an uncompromised N95 in at the end of their shift and were overnighting more gowns to the facility. She said the nursing staff were performing respiratory treatments to the entire 300 hall and were getting oxygen saturations and temperatures twice a day. She said she was also given training on handwashing being performed before and after resident care and when donning/doffing PPE. She said when giving breathing treatments, the nurse was to be the only person in the room with the resident, in full PPE, with the door closed. During an interview on 4/26/20 at 1:45 p.m., CMA F, who worked on the 300 hall, was wearing an N95 mask and said she was trained that morning on reporting to the 300 hall and not being able to leave to other parts of the building. She said the facility was still taking the temperatures of staff and residents. She said training included handwashing and washing hands before and after resident care. She said the facility was still encouraging social distancing between staff and residents. During an observation on 4/26/20 at 1:50 p.m., an aide performing resident care on the 300 hall, was wearing a gown, gloves, an N95 mask and eye protection. On 4/26/20 at 2:01 p.m., the administrator and DON were informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.