STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675044	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	**1100 W MINNESOTA RD PHARR, TX 78577**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs, for one Resident (R#1), of six residents reviewed for call light access. Facility staff did not place R#1's call light within her reach. This failure could place dependent residents at risk for not being able to call for assistance from staff. The findings were: Record Review of R#1's electronic physician orders [REDACTED]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Comprehensive care plan, initiated 11/14/18, revealed R#1 had an Activities of Daily Living self-care performance deficit and was at risk for not having her needs met in a timely manner. Interventions included: Encourage resident to use the call light to call for assistance before attempting any activities of daily living that resident cannot do independently. Record review of R#1's MDS assessment, dated 03/18/20, revealed R#1 was able to make herself understood and usually understood others. Observation on 05/07/20 at 7:25 a.m. revealed R#1 was in her room, sitting in her recliner. Further observation revealed R#1's call light was on the top of her bed, out of reach for R#1. In an interview at the time of the observation, R#1 said she yelled for assistance when needed. In an interview on 05/07/20 at 8:11 a.m., LVN A said R#1 knew what the call light was for and was able to use it. Observation on 05/07/20 at 8:35 a.m. revealed CNA B transferring R#1 from wheelchair to recliner. CNA B said R#1 used the call light to ask for assistance. CNA B said R#1 sometimes activated the call light unintentionally, but staff still checked to see if she needed something. In an interview on 05/07/20 at 8:37 a.m., R#1 said the call light was to ask for assistance from staff. In an interview on 05/07/20 at 10:40 a.m., the DON said call lights should be accessible to residents who could use them. Review of the facility's policy on Call light/bell response, dated 08/11/13, revealed: -Purpose: to provide an audio and, or visual system to alert staff when patient assistance is needed. -Guidelines: place call light/bell within patient's reach regardless of patient location such us: in bed, on commode, unaccompanied in sitting area.
F 0659 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with each resident's plan of care (physician's orders [REDACTED].#1) of six residents reviewed for care plans. The facility did not ensure R#1's extensive assistance for feeding was provided by a CNA. R#1's care plan called for R#1 to be fed by a CNA. This failure could place residents who required assistance with eating at risk for not receiving necessary care and services. The findings were: Record review of R#1's electronic physician orders [REDACTED]. R#1's [DIAGNOSES REDACTED]. Physician orders [REDACTED]. Record review of R#1's Comprehensive care plan, initiated 11/14/18, revealed: -R#1 was on a pureed diet, moderately thick honey consistency, and was at nutritional and hydration risk related to Dementia. Position CNA. -R#1 had an Activities of Daily Living self-care performance deficit and was at risk for not having her needs met in a timely manner. Record review of R#1's MDS assessment, dated 3/18/20, revealed R#1: - was able to make herself understood and usually understood others, - required extensive assistance for eating, and - was on a mechanical altered diet. Observation on 05/07/20 at 7:20 a.m. revealed R#1 in the dining room waiting for her breakfast. Further observation revealed the Maintenance Supervisor placed a food tray on R#1's table and sat down beside R#1. The Maintenance Supervisor proceeded to feed R#1 her pureed food. In an interview on 05/07/20 at 7:25 a.m., the Maintenance Supervisor said he was not a CNA or a Paid Feeding Assistant (individual who has successfully completed a state-approved Paid Feeding Assistant course). The Maintenance Supervisor said he was told that, if a resident was not eating and other residents were eating, he was supposed to assist the resident who was not eating. The Maintenance Supervisor said he had done that with R#1. In an interview on 05/07/20 at 9:00 a.m., the DON said nursing staff were to feed residents who required assistance with meals. The DON said she was not aware of the Maintenance Supervisor ever having been trained as a feeding assistant. The DON said staff who were not trained to feed residents should not be doing it. In an interview on 05/07/20 at 10:40 a.m., the DON said, because of COVID-19, some Supervisors were assisting in dining with setting up trays and had received training. The DON said the facility was not short-staffed, but maybe the CNAs were busy passing trays and the Maintenance Supervisor got nervous because the Surveyor was watching the residents dining. The DON said the Maintenance Supervisor was not supposed to feed residents. Record review of the Maintenance Supervisor Responsibilities revealed the responsibilities did not include feeding residents.
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 maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for one Resident (R#2) of five residents observed for infection control practices, in that: 1) CNA C's facemask was untied while assisting two unidentified residents with feeding. 2) CNA D's facemask did not cover her nose and mouth during incontinent care for R#2. 3) LVN E did not perform hand hygiene before donning gloves when providing care to R#2. 4) a) CNA B did not change gloves during R#2's incontinent care or wash her hands before leaving R#2's room. These failures could affect residents dependent upon staff for care and place them at risk for inadequate care and healthcare associated cross-contamination and infections. The findings included: 1) In an observation of 05/07/20 at 7:30 a.m., CNA C was in the dining room assisting an unidentified male resident with feeding. Further observation revealed CNA C's facemask was not tied and the bottom strings of her facemask were loose and hanging under her shoulders. CNA C finished with assisting the male resident, washed her hands, and sat down at another table with an unidentified female resident to assist with feeding. CNA C's facemask was not tied and the bottom strings of her facemask were loose and hanging under her shoulders. In an interview on 05/07/20 at 7:45 a.m., CNA C said she had not noticed that the strings from the facemask were not tightened to the back. She said the facemask needed to be tightened in the back, including the lower strings. In an interview on 05/08/20 at 9:13 a.m., CNA C said she had received training on how to wear a facemask. She said the facility had given staff facemasks that had elastic that went around the ears, but she was wearing a facemask from home that had strings because she had blisters on the backs of her ears due to the elastic. CNA C said she was aware of the importance of wearing a facemask the correct way as a prevention for transmitting infections to residents. 2) Record Review of R#2's electronic physician orders [REDACTED]. R#2 had [DIAGNOSES REDACTED]. Record review of R#2's Comprehensive care plan, initiated 09/03/19, revealed R#2 was incontinent of bowel/bladder related to activity intolerance. Record review of R#2's MDS assessment, dated 01/27/20, revealed R#2: -was rarely/never understood by others, -required total care for all Activities of Daily Living, and -had a feeding tube. In an observation on 05/11/20 at 10:55 a.m., CNA D, accompanied by an unidentified CNA, entered R#2's room. CNA D had her facemask positioned under her nose. The CNAs performed incontinent care for R#2. During the care, CNA D had her facemask positioned under her nose. In an interview on 05/11/20 at 11:05 a.m., CNA D said she had not noticed that her facemask was under her nose. CNA D said she had been

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) in-serviced on how to wear a facemask and that the facemask should cover the nose and mouth. 3) In an observation on 05/11/20 at 11: 20 a.m., LVN E entered R#2's room, accompanied by surveyor. Without sanitizing or washing her hands, LVN E donned gloves, removed R#2's bed covers and gown, and touched the skin around R#2's [DEVICE] (gastrostomy tube) area. In an interview on 05/11/20 at 11:25 a.m., LVN E said had forgotten to wash her hands before assisting R#2. She said she was aware of the importance of hand hygiene to prevent the spread of infections. 4) Review of a video recording dated 05/05/20 from 7:15 p.m. to 7:19 p.m., revealed CNA B did not perform hand hygiene during incontinent care for R#2 and did not wash her hands before leaving R#2's room. In an interview on 05/14/20 at 4:03 p.m., CNA B said she did not know why she did not follow the routine of hygiene while assisting R#2 with incontinent care. CNA B said she was aware of how important it was to use proper hand hygiene to prevent infections while assisting residents. Record review of the facility's policy on hand hygiene, dated 11/12/17, revealed: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent spread of infection to other personnel, resident, and visitors. Record review of the facility's policy on Infection control and prevention; Surveillance Plan: Infection control surveillance COVID-19, revision date 04/02/20 revealed: Policy: to minimize exposures and spread of respiratory pathogens including COVID-19 . employees; for the duration of the state of emergency, all staff should wear facemask while in the facility.