STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675030	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENT CARE CENTER OF LAREDO	7001 MCPHERSON RD LAREDO, TX 78041

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation and interview the facility failed to accommodate personal privacy while providing personal care for 2 of 14 residents (Resident #7 and Resident #15) whose care was reviewed for privacy, in that: There was no privacy curtain to provide full visual privacy for Resident #7 and Resident #15 during incontinent care. This deficient practice could place residents who required assistance with incontinent at risk for embarassment, poor self-esteem, and unmet needs. The findings were: 1. Record review of Resident #7's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's MDS Quarterly assessment dated [DATE] revealed Resident #7 always had incontinent bowel and bladder. Further review revealed Resident #7 had BIM's score of 7 which indicated Resident #7 had severe cognitive impairment for daily decision making. Observation on 08/15/2020 at 2:44 PM with CNA K and CNA L revealed they provided incontinent care for Resident #7. Further observation revealed Resident #7 was lying in her bed, and there was no privacy curtain to provide visual privacy between Resident #7 and her roommate during incontinent care. Therefore, Resident #7's roommate could see CNA K and CNA L take off Resident 7's brief and wiped Resident #7's private area. Interview on 8/15/2020 at 2:50 PM with CNA K confirmed there was no privacy curtain between Resident #7 and her roommate to provide visual privacy during incontinent care. 2. Record review of Resident #15's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's MDS 5-day assessment dated [DATE] revealed Resident #15 had incontinent bowel and bladder. Record review of Resident #15's nursing progress note dated on 08/15/2020 written by LVN T revealed Resident #15 was lethargic, opened eyes spontaneously, but did not response to verbal command. LVN T documented physician was aware with order of comfort care. Observation on 8/15/2020 at 3:02 PM with CNA K and CNA L revealed they provided incontinent care for Resident #15. Further observation revealed there was no privacy curtain in place between Resident #15 and his roommate to provide visual privacy during incontinent care. Interview on 8/15/2020 at 3:07 PM with CNA K confirmed there was no privacy curtain between Resident #15 and his roommate to provide full visual privacy during incontinent care. Interview on 8/15/2020 at 3:28 PM with CNA L confirmed none of the rooms in the COVID positive unit had privacy curtains in place. Interview on 8/16/2020 at 11:50 AM the DON confirmed the privacy curtains were removed to be disinfected earlier in the week. The DON added that laundry staff became sick, so the privacy curtains had not been put back. Record review of the facility's policy titled with Bedrooms, undated, revealed 3. Each room is designed to provide full visual privacy for each resident (in the form of ceiling-suspended curtains that extended around the bed) and equipped for adequate nursing care. .
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review the facility failed to ensure residents were free from neglect for 23 of 23 COVID positive Residents (Resident #1 to Resident #23), 6 of 6 [MEDICAL TREATMENT]/suspected COVID Residents (Resident #24 to Resident #29), and 47 of 47 negative COVID Residents (Resident #30 to Resident #76) whose care was reviewed for neglect, in that: 1. The facility failed to implement processes to ensure staff follow infection prevention control procedure: a. There was no signage to identify type of precautions for [MEDICAL TREATMENT]/suspected COVID unit. b. LVN F did not wear face shield when he entered Resident #26's room in the Warm unit - [MEDICAL TREATMENT]/suspected COVID unit to inform Resident #26 that LVN F was going check Resident #26's blood sugar. c. Doors to presumptive positive Residents' rooms had left opened in Warm unit. d. Donning station in warm unit had no hand washing sink, no soap and no hand sanitizer. 2. The facility failed to implement processes to ensure staff complete COVID assessment and check Residents' vital signs every shift. a. COVID assessment and vital signs were not completed every shift for 23 of 23 positive COVID Residents. b. COVID assessment and vital were not completed every shift for 6 of 6 [MEDICAL TREATMENT]/suspected COVID Residents. c. COVID Assessment and vital signs were not completed every shift for 47 of 47 negative COVID Residents. These deficient practices affected all residents and placed residents who were positive for COVID-19 at risk for a decline in health and/or death. The findings were: 1. a. Observation on 8/15/2020 at 11:17 AM revealed the entrance of [MEDICAL TREATMENT]/suspected COVID unit had signage posted reading Warm Unit. Observation on 08/15/2020 at 11:34 AM with LVN F revealed the hallway where three residents who received [MEDICAL TREATMENT] and three presumptive COVID residents resided had no signage that indicated type of isolation. Further observation revealed there was no signage indicating type of isolation or to see staff prior to entering unit. Interview on 8/15/2020 at 11:38 AM with LVN F confirmed residents in the warm unit included residents who received [MEDICAL TREATMENT] and residents who had symptoms of elevated temperature such as 99.8 F or cough. LVN F confirmed residents received [MEDICAL TREATMENT] and symptomatic residents were put in the warm unit as a precaution. He did not know what type of isolation those residents were on because it was his first day return to work from his sick leave. LVN F confirmed there was no signage posting to indicate type of isolation for residents who received [MEDICAL TREATMENT] and symptomatic residents. LVN F confirmed the unit labeled as warm unit. Record review of the facility policy titled with COVID-19 - clinical Protocol, dated 8/7/2020, revealed There will be separate staffing teams for COVID-19 positive Residents and the quarantine (warm) unit, to the best of our ability . The residents who have symptoms will be placed on contact and droplet precaution. b. Record review of Resident #26's undated face sheet revealed an admitted on 8/26/2016 with [DIAGNOSES REDACTED]. Observation on 8/15/2020 at 11:24 AM revealed LVN F entered Resident #26's room inside the warm unit - [MEDICAL TREATMENT]/suspected COVID unit. Further observation revealed LVN F did not wear his face shield when he was inside Resident #26's room to informed Resident #26 that LVN F was going to check Resident #26's blood sugar. Interview on 8/15/2020 at 11:25 AM with LVN F confirmed he did not wear face shield when he entered Resident #26's room in the warm unit. He further confirmed he did not remember where he put his face shield. Observation of 8/15/2020 at 11:25 AM revealed LVN F exited the warm unit to look for his face shield. c. During observations made on 08/14/20 at 2:43 p.m., the doors in the Warm unit to resident rooms Rm#220, Rm#222, Rm#223, Rm#224 & Rm#225, in(NAME)Hall (warm unit) had been left open. These residents did not have any masks on while in their rooms. In an interview on 08/14/20 at 2:40 p.m., RN A (infection preventionist) stated residents in(NAME)Hall (warm unit) were residents that were symptomatic, went to [MEDICAL TREATMENT] or went out of the facility regularly for treatment and were suspect residents. RN A further stated staff removed their gowns, hung it outside the room and then put on a clean gown before entering a resident's room. Staff then provided care to the resident and removed their gown and gloves prior to leaving the residents rooms. Staff would then put on their previous gown that was left hanging on the wall. In an interview on 08/14/20 at 2:47 p.m., the DON said the resident doors in(NAME)Hall warm zone should have been closed due to the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0600

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
residents being presumptive COVID. These residents were going to [MEDICAL TREATMENT] or residents or were pending clearance to go to a regular hall. The DON confirmed the doors to(NAME)Hall were opened at this time. DON said the Maintenance staff
were pending to put up two plastic barriers in the(NAME)Hall to separate the hall from the rest of the facility. DON stated she would put up signs that would indicate(NAME)Hall is an isolation hall and would be visible with the doors closed. d.
During observations on 08/14/20 at 3:25 p.m., Surveyor observed that Rm# 218's bathroom door had a sign that had Doffing Station taped on it. Surveyor noted that there was no hand washing sink, no soap and no hand sanitizer inside of the doffing station. In an interview on 08/14/20 at 3:30 p.m., RN A confirmed there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. In an interview on 08/14/20 at 2:47 p.m., the DON said she did not know that there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. DON said that the Donning and Doffing room in Rm# 218 was not going to be used. Interview on 8/15/2020 at 12:54 PM with the DON confirmed she had to observe staff to ensure staff wore proper PPE and hand hygiene. The DON also confirmed she reminded staff over paging system on washing hand and wearing proper PPE. The DON confirmed RN A - infection control nurse would monitor staff on proper PPE by observation and spot check. Interview on 8/15/2020 at 1:00 PM with the DON confirmed in-service provided for staff by lecture, demonstration, and computer training; the DON confirmed training on hand hygiene, proper PPE, and infection control provide to staff upon hire and quarterly. Interview on 8/16/2020 at 12:07 PM with RN A - infection control nurse, she confirmed she provided in-service and reeducated staff on infection control such as don/doff PPE and hand hygiene. RN A confirmed she did not know the cause of staff non-compliance with wearing PPE and hand hygiene. RN A confirmed she spot check for proper PPE wear and hand hygiene. she would make round during change of shift and randomly pick a staff to observe staff demonstrate on don/doff PPE and hand washing. If she noted any issue, she would verbally correct staff. RN A confirmed she did not have any documentation of monitoring for proper PPE and hand hygiene. 2. a. COVID-19 positive status Residents included Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23. Record review of Resident #1's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's nursing progress notes from 8/4/2020 to 8/7/2020 revealed Resident #1 tested positive for COVID on 8/4/2020. Further review of Resident #'s progress note revealed there 4 of 12 shifts documented Resident #1's assessment on: 8/4/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift, on 8/5/2020 during 10 PM - 6 AM shift, on 8/6/2020 during 2PM - 10 PM shift. Further review of Resident #1's progress note on 8/6/2020 during 10PM - 6 AM shift revealed there was no documentation on Resident #1's assessment besides the nurse notes regarding Resident #1's death. During 10PM - 6 AM shift on 8/6/2020, there was a nurse note written by LVN O on 8/7/2020 at 4:36 AM revealed Resident #1 was found not breathing and no pulse present; and a nurse note written by the DON on 8/7/2020 at 5:02 AM revealed (Resident #1's) death pronounce at 5 AM. Record review of Resident #1's Assessment revealed there were only two assessments documented from 7/21/2020 to 8/07/2020. Review a list of Assessment for Resident #1 from electronic chart revealed Weekly Skin assessment dated [DATE] during 6 AM - 2 PM shift and Medical Assessment - [MEDICAL CONDITION] including [MEDICAL CONDITION] infections (New Version) dated 8/7/2020 at 6:12 AM description 2 PM - 10
PM shift status in process. Record review of Resident #1's electronic record for vital signs dated from 8/1/2020 (6AM - 2PM shift) to 8/6/2020 (10 PM - 6 AM shift) there were 7 of 18 shifts documented Resident #1's vital signs. Further review revealed vital signs documented for Resident #1 on 8/1/2020 (2PM -10PM shift), on 8/03/2020 (6AM - 2PM shift), 8/4/2020 (2 PM - 10PM and 10 PM - 6 AM shift), 8/5/2020 (10 PM - 6 AM shift), and 8/6/2020 (6 AM - 2 PM and 2 PM - 10 PM shift). Interview on 8/21/2020 at 10:55 AM with LVN O confirmed she assessed Resident #1 approximately at 10:45 PM on 8/6/2020 revealed Resident #1 did not have any concern or distress. LVN O confirmed around 2:30 AM on 8/7/2020 she was with a CNA to reposition Resident #1. LVN O confirmed after 2:30 AM on 8/7/20 she did not see Resident #1 until CNA notify her to checked on Resident #1 around 4:09 AM on 8/7/20 when she found out Resident #1 was unresponsive and no vital signs. LVN O confirmed per facility policy she had to assess Resident in COVID unit by checking vital signs, signs and symptoms of COVID every 2 hours. LVN O confirmed she supposed to complete the assessment of Acute infection on the computer for residents with positive COVID every shift per facility policy. Interview on 8/21/2020 at 11:24 AM with LVN O confirmed she did not document any assessment for Resident #1 either under Acute Infection assessment or under nursing progress note because she did not have time, and she had lot of residents in the unit to take care of. Interview on 8/21/2020 at 11:31 AM with LVN O confirmed she did not have any nurse note during 10 PM - 6 AM shift, except her note at 4:00 AM. LVN O confirmed she did not document Resident #1's assessment on nursing progress note because Resident #1 did not have any symptom and did not show any distress. Interview on 8/21/2020 at 11:36 AM with LVN O confirmed there was no vital signs for Resident #1 documented during 10 PM - 6 AM shift on 8/6/2020. LVN O confirmed the CNA checked Resident #1's vital signs during 10 PM - 6 AM shift, but the CNA did not document Resident #1 vital signs in the computer. Record review of Resident #2's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's nursing progress
notes from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there was 2 of 14 shifts documented Resident #2's assessment. There was nurse note on 8/10/2020 (2 PM - 10 PM shift) and 8/14/2020 (2 PM - 10 PM shift). Record review of Resident #2's electronic record for assessments from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there were 1 of 14 assessments for COVID was documented. Further review revealed there was one assessment on 8/13/2020 was Medical Management - Acute infection (new version). Record review of Resident #2's electronic record for vital signs from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed 3 of 14 shifts documented Resident #2's vital signs. Resident #2's vital signs was documented on 8/11/2020 (10 PM - 6 AM shift), on 8/12/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's undated face sheet revealed an admitted d of 8/15/2018 with [DIAGNOSES REDACTED]. Record review of Resident #3's nursing progress notes from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 shifts documented Resident #3's assessments. Further review revealed there were nurse note regarding Resident #3's high blood sugar on 8/8/2020 (2PM - 10 PM shift) and a nurse note regarding Resident #3 had change of condition and transferred to local hospital on [DATE] (6 AM - 2 PM shift). Record review of Resident #3's Assessments from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 COVID assessments tilted with Medical Management - Acute Infection (new version) were completed on 8/9/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's electronic record for vital signs from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed there were 16 of 25 shifts documented vital signs for resident #3 as follow on 8/6/2020 (6 AM - 2 PM shift); on 8/7/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), on 8/8/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); on 8/9/2020 (10 PM - 6 AM); 8/10/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/11/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), 8/12/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift). Record review of Resident #4's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's nursing progress note from
8/4/2020 to 8/15/2020 revealed there was nurse not documented on COVID assessment every shift. Record review of Resident #4's assessment from 8/4/2020 to 8/15/2020 revealed there were 4 of 39 COVID assessments titled with Medical Management - Acute Infection (new version) completed as following on 8/8/2020 (6 AM - 2 PM shift); 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #4's vital sign record from 8/4/2020 to 8/15/2020 revealed there were 19 of 39 shifts documented vital signs for Resident #4. Record review of Resident #5's undated face sheet revealed an admitted on 11/6/2018 with [DIAGNOSES REDACTED]. Record review of Resident #5's nursing progress note from 8/1/2020 to 8/15/2020 there were two nurse notes documented for Resident #5 on 8/6/2020 and 8/15/2020. Record review of Resident #5's printed COVID assessment titled with Medical Management - Acute Infection (new version) provided by the facility revealed that not every shift had documented the COVID assessments. The assessments were completed on 8/4/2020 (10PM - 6 AM shift); 8/8/2020 (6 AM - 2PM shift), 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), 8/13/2020 (10 PM - 6 AM shift) and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #5's vital signs record from 8/1/2020 to 8/15/2020 revealed that not every shift had documented the vital signs. Further review revealed the vital sign during 10 PM - 6 AM shift were documented from 8/2/2020 to 8/9/2020. Resident #6 to Resident #23: Record review of Resident #6's undated face sheet revealed an admitted on 1/15/2019 with [DIAGNOSES REDACTED]. Record review of Resident #7's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's undated
face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's undated face sheet reveled an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #12's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #13's undated face sheet revealed an

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F 0600

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #14's undated face sheet reveal an admission
date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's undated face sheet revealed an admission date of
[DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's undated face sheet revealed an admitted on 7/1/2016
with [DIAGNOSES REDACTED]. Record review of Resident #17's undated face sheet revealed an admission date of [DATE] with
diagnose of hypertension, type 2 diabetes, and dementia. Record review of Resident #18's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #19's undated face sheet revealed an
admitted on 9/13/2018 with [DIAGNOSES REDACTED]. Record review of Resident #20's undated face sheet revealed an
admission date of
[DATE] with [DIAGNOSES REDACTED]. Record review of Resident #21's undated face sheet revealed an admission date of
[DATE]
with [DIAGNOSES REDACTED]. Record review of Resident #22's undated face sheet revealed an admission date of [DATE] with
diagnose of type 2 diabetes, hypertension, and [MEDICAL CONDITION]. Record review of Resident #23's undated face sheet
revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of nursing progress notes and assessments
titled with Medical management - acute infection (new version) for 18 positive COVID-19 status Residents ((Resident #6, #7, #8, #9,
#10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) dated from 8/1/2020 - 8/15/2020 revealed
that not every shift had documented COVID assessment. Review of vital sign record for 18 positive COVID-19 status Residents
(Resident #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) dated from 8/1/2020 -
8/15/2020 revealed that not every shift had documented vital signs. Record review of additional vital signs sheets provided by the
DON ranged from 8/1/2020 to 8/15/2020 for positive COVID-19 status Residents (Resident #1 to Resident #23) revealed
6 of 45 shifts documented vital sign as follow on 8/1/2020 (10PM - 6 AM shift), 8/4/2020 (6 AM -2 PM shift), 8/5/2020 (6 AM -2
PM shift), 8/10/2020 (2 PM - 10 PM shift), 8/13/2020 (2PM - 10 PM shift), and 8/14/2020 (2 PM - 10 PM shift). Interview
on 8/15/2020 at 1:06 PM with the DON confirmed there were two set of vital signs need to be completed for positive COVID
Residents. The DON further confirmed the first set of vital signs at the beginning of shift included blood pressure, pulse, respiratory
rate, oxygen saturation, and temperature; and the second set of vitals included temperature and oxygen
saturation need to be completed in the middle of the shift. The DON also confirmed COVID assessment needed to be completed
for positive COVID resident and documented under nursing progress note one per shift. During an interview on 8/16/2020 at
9:42 AM with the DON and RNA - infection control nurse, they confirmed licensed nurse needed to complete acute infection or
respiratory assessment per shift for COVID positive Residents. The DON and RN A also confirmed the first vital signs at
beginning of every shift needed to be done were blood pressure, temperature, respiratory rate, pulse; and oxygen
saturation; and the second set of vital signs need to be done around mid-shift were temperature and oxygen saturation.
Interview on 8/17/2020 at 4:05 PM with the DON confirmed that not every shift had documented COVID Assessment for positive
COVID-19 status Residents either under acute infection assessment or nurse progress note. The DON further confirmed if
there was no documentation on COVID assessment that meant the nurse did not do the assessment. The DON said she could not
prove if the nurse completed the assessment or not if there was no documentation. Interview on 8/17/2020 at 5:30 PM with
the DON confirmed the vital signs were not documented every shift for Residents with COVID-19 positive status residents in
either the computer or paper vital signs sheet. The DON confirmed the vital sign sheets could be put in the shredder box.
DON confirmed ideally CNAs should document the vital sign on the computer, but CNAs were so busy to turn and feed the
residents, so CNAs documented the vital signs on the paper vital sign sheet. Interview on 8/17/2020 at 5:37 PM with the DON
confirmed the vital signs documented in the computer to consider resident's record. Interview on 8/17/2020 at 5:43 PM with
DON confirmed if staff did not document the vital sign that meant they did not do the vital sign. The DON confirmed she
could not prove staff complete the vital signs every shift if there was no documentation. b. Resident #24, #25, #26, #27,
#28, are #29 were [MEDICAL TREATMENT]/suspected COVID residents resided in warm unit. Record review of Resident #24's
undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #24's
nursing
progress note from 8/1/2020 to 8/15/2020 revealed 2 of 45 shifts documented Resident#24's assessment. Further review
revealed there were assessments documented on 8/4/2020 (2 PM -10 PM shift) and 8/5/2020 (6 AM -2 PM shift). Record review
of Resident #25's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of
Resident #25's nursing progress note nursing progress note from 8/1/2020 to 8/15/2020 revealed 2 of 45 shifts documented
Resident #25's assessment. Further review revealed there were assessments documented on 8/3/2020 (6 AM - 2 PM shift) and
8/5/2020 (2 PM - 10 PM shift). Record review of Resident #26's undated face sheet revealed an admitted on 8/26/2016 with
[DIAGNOSES REDACTED]. Record review of Resident #26's nursing progress note nursing progress note from 8/1/2020 to
8/15/2020 revealed there were 7 of 45 assessments documented for Resident #26. Further review revealed assessments
documented on 8/5/2020 (6AM - 2 PM shift and 2 PM - 10 PM shift) 8/6/2020 (2 PM - 10 PM shift), 8/10/2020 (2 PM - 10 PM
shift), 8/11/2020 (2 PM - 10 PM and 10 PM - 6 AM shift), and), 8/15/2020 (2 PM - 10 PM shift). Record review of Resident
#27's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #27's
nursing progress note from 8/1/2020 to 8/15/2020 revealed there were 6 of 45 assessment documented for Resident #27.
Further review revealed assessments documented on 8/10/2020 (6AM - 2 PM shift), 8/12/2020 (10 PM - 6 AM shift), 8/13/2020
(2 PM - 10 PM shift and10 PM - 6 AM shift), 8/14/2020 (10 PM - 6 AM shift), 8/15/2020 (6 AM - 2 PM shift). Record review of
Resident #28's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of
Resident #28's nursing progress note from 8/1/2020 to 8/15 2020 revealed there were 6 of 45 assessments documented for Resident
#28. Further review revealed assessments documented on 8/8/2020 (2 PM - 10 PM shift), 8/9/2020 (2 PM - 10 PM shift and 10 PM - 6
AM shift), 8/10/2020 (2 PM - 10 PM shift), 8/11/2020 (10 PM - 6 AM shift), 8/12/2020 (10 PM - 6 AM shift) Record review of
Resident #29's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of
Resident #29's nursing progress note from 8/1/2020 to 8/15/2020 revealed there were 1 of 45 assessments documented for Resident
#29. Further review revealed assessments documented on 8/8/2020 (6AM - 2 PM shift), but other progress notes on 8/13/2020 and
8/15/2020 regarding room change and physician notification. Interview on 8/16/2020 at 9:48 AM with the DON confirmed
licensed nurse should document residents' general health under nursing progress note for Residents in warm unit - [MEDICAL
TREATMENT]/suspected COVID unit. Interview on 8/16/2020 at 2:51 PM with LVN F confirmed that he did not do COVID
assessment for Residents in warm unit - [MEDICAL TREATMENT]/suspect unit. LVN F confirmed he assessed Residents'
appearance, alertness and documented on resident's change of condition. LVN F confirmed he recently returned to work and did not
received
training on COVID assessment and documentation for residents in warm unit. Interview on 8/18/2020 at 5:35 PM with the DON
confirmed the nurse did not document COVID assessment under nursing progress note every shift for Residents in warm unit -
[MEDICAL TREATMENT]/suspected COVID unit. Record review of vital signs record from Resident #24 to Resident #29 dated
range from 8/1/2020 to 8/15/2020 revealed there was no vital signs documented every shift for Resident #24 to Resident #29.
Interview on 08/15/20 at 11:15 a.m., DON confirmed that the facility staff should be documenting vital signs every shift in the
regular halls and in the Covid Positive hall staff should be documenting vital signs twice a shift. Interview on
08/16/20 at 12:10 p.m., DON reviewed the Vital sign log sheets she had provided for the residents in(NAME)hall. DON
confirmed that she was unable to locate any documentation that her staff had done vital signs every shift as required for
these residents. DON said that she did not know that staff were not documenting vital signs every shift. c. Resident #30 to Resident
#76 were COVID-19 negative status Residents. Record review of Resident #30's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #31's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 32's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #33's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #34's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #35's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #36's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #38's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #39's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #40's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #41's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #42's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #43's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #44's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #45's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #46's undated face sheet revealed an

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	675030	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENT CARE CENTER OF LAREDO	**7001 MCPHERSON RD LAREDO, TX 78041**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #47's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #48's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #49's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #50's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #51's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #52's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #53's undated face sheet revealed an admission date of [DATE] with diagnose of gastrostomy, type 2 diabetes, hypertension, and [MEDICAL CONDITION]. Record review of Resident #54's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #55's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #56's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #57's undated face sheet revealed an admission date of [DATE] with diagnoses XREDACTED

F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review the facility failed to ensure residents were free from neglect for 23 of 23 COVID positive Residents (Resident #1 to Resident #23), 6 of 6 [MEDICAL TREATMENT]/suspected COVID Residents (Resident #24 to Resident #29), and 47 of 47 negative COVID Residents (Resident #30 to Resident #76) whose care was reviewed for neglect, in that: 1. The facility failed to implement processes to ensure staff follow infection prevention control procedure: a. There was no signage to identify type of precautions for [MEDICAL TREATMENT]/suspected COVID unit. b. LVN F did not wear face shield when he entered Resident #26's room in the Warm unit - [MEDICAL TREATMENT]/suspected COVID unit to inform Resident #26 that LVN F was going check Resident #26's blood sugar. c. Doors to presumptive positive Residents' rooms had left opened in Warm unit. d. Donning station in warm unit had no hand washing sink, no soap and no hand sanitizer. 2. The facility failed to implement processes to ensure staff complete COVID assessment and check Residents' vital signs every shift. a. COVID assessment and vital signs were not completed every shift for 23 of 23 positive COVID Residents. b. COVID assessment and vital were not completed every shift for 6 of 6 [MEDICAL TREATMENT]/suspected COVID Residents. c. COVID Assessment and vital signs were not completed every shift for 47 of 47 negative COVID Residents. These deficient practices affected all residents and placed residents who were positive for COVID-19 at risk for a decline in health and/or death. The findings were: Record review of facility policy titled with Abuse and Neglect Clinical Protocol, dated 07/2018, revealed Neglect means the failure of the facility, its employees or service provider to provide goods and services to resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. . 5. Along with other staff and management, the physician will help identify situation that might constitute or could be construed as neglect; for example, inadequate prevention or care of pressure ulcers, inattention to advance directives and inquiry into resident/patient wishes, inappropriate management of problematic behavior, recurrent failure to provide incontinent care, failure to report or evaluate significant weight loss, repeated failure to check for correct application of restraints, etc. 1. a. Observation on 8/15/2020 at 11:17 AM revealed the entrance of [MEDICAL TREATMENT]/suspected COVID unit had signage posted reading Warm Unit. Observation on 08/15/2020 at 11:34 AM with LVN F revealed the hallway where three residents who received [MEDICAL TREATMENT] and three presumptive COVID residents resided had no signage that indicated type of isolation. Further observation revealed there was no signage indicating type of isolation or to see staff prior to entering unit. Interview on 8/15/2020 at 11:38 AM with LVN F confirmed residents in the warm unit included residents who received [MEDICAL TREATMENT] and residents who had symptoms of elevated temperature such as 99.8 F or cough. LVN F confirmed residents received [MEDICAL TREATMENT] and symptomatic residents were put in the warm unit as a precaution. He did not know what type of isolation those residents were on because it was his first day return to work from his sick leave. LVN F confirmed there was no signage posting to indicate type of isolation for residents who received [MEDICAL TREATMENT] and symptomatic residents. LVN F confirmed the unit labeled as warm unit. Record review of the facility policy titled with COVID-19 - clinical Protocol, dated 8/7/2020, revealed There will be separate staffing teams for COVID-19 positive Residents and the quarantine (warm) unit, to the best of our ability . The residents who have symptoms will be placed on contact and droplet precaution. b. Record review of Resident #26's undated face sheet revealed an admitted on 8/26/2016 with [DIAGNOSES REDACTED]. Observation on 8/15/2020 at 11:24 AM revealed LVN F entered Resident #26's room inside the warm unit - [MEDICAL TREATMENT]/suspected COVID unit. Further observation revealed LVN F did not wear his face shield when he was inside Resident #26's room to informed Resident #26 that LVN F was going to check Resident #26's blood sugar. Interview on 8/15/2020 at 11:25 AM with LVN F confirmed he did not wear face shield when he entered Resident #26's room in the warm unit. He further confirmed he did not remember where he put his face shield. Observation of 8/15/2020 at 11:25 AM revealed LVN F exited the warm unit to look for his face shield. c. During observations made on 08/14/20 at 2:43 p.m., the doors in the Warm unit to resident rooms Rm#220, Rm#222, Rm#223, Rm#224 & Rm#225, in(NAME)Hall (warm unit) had been left open. These residents did not have any masks on while in their rooms. In an interview on 08/14/20 at 2:40 p.m., RN A (infection preventionist) stated residents in(NAME)Hall (warm unit) were residents that were symptomatic, went to [MEDICAL TREATMENT] or went out of the facility regularly for treatment and were suspect residents. RN A further stated staff removed their gowns, hung it outside the room and then put on a clean gown before entering a resident's room. Staff then provided care to the resident and removed their gown and gloves prior to leaving the residents rooms. Staff would then put on their previous gown that was left hanging on the wall. In an interview on 08/14/20 at 2:47 p.m., the DON said the resident doors in(NAME)Hall warm zone should have been closed due to the residents being presumptive COVID. These residents were going to [MEDICAL TREATMENT] or residents or were pending clearance to go to a regular hall. The DON confirmed the doors to(NAME)Hall were opened at this time. DON said the Maintenance staff were pending to put up two plastic barriers in the(NAME)Hall to separate the hall from the rest of the facility. DON stated she would put up signs that would indicate(NAME)Hall is an isolation hall and would be visible with the doors closed. d. During observations on 08/14/20 at 3:25 p.m., Surveyor observed that Rm# 218's bathroom door had a sign that had Doffing Station taped on it. Surveyor noted that there was no hand washing sink, no soap and no hand sanitizer inside of the doffing station. In an interview on 08/14/20 at 3:30 p.m., RN A confirmed there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. In an interview on 08/14/20 at 2:47 p.m., the DON said she did not know that there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. DON said that the Donning and Doffing room in Rm# 218 was not going to be used. Interview on 8/15/2020 at 12:54 PM with the DON confirmed she had to observe staff to ensure staff wore proper PPE and hand hygiene. The DON also confirmed she reminded staff over paging system on washing hand and wearing proper PPE. The DON confirmed RN A - infection control nurse would monitor staff on proper PPE by observation and spot check. Interview on 8/15/2020 at 1:00 PM with the DON confirmed in-service provided for staff by lecture, demonstration, and computer training; the DON confirmed training on hand hygiene, proper PPE, and infection control provide to staff upon hire and quarterly. Interview on 8/16/2020 at 12:07 PM with RN A - infection control nurse, she confirmed she provided in-service and reeducated staff on infection control such as don/doff PPE and hand hygiene. RN A confirmed she did not know the cause of staff non-compliance with wearing PPE and hand hygiene. RN A confirmed she spot check for proper PPE wear and hand hygiene. she would make round during change of shift and randomly pick a staff to observe staff demonstrate on don/doff PPE and hand washing. If she noted any issue, she would verbally correct staff. RN A confirmed she did not have any documentation of monitoring for proper PPE and hand hygiene. 2. a. COVID-19 positive status Residents included Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23. Record review of Resident #1's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's nursing progress notes from 8/4/2020 to 8/7/2020 revealed Resident #1 tested positive for COVID on 8/4/2020. Further review of Resident #'s progress note revealed there 4 of 12 shifts documented Resident #1's assessment on: 8/4/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift, on 8/5/2020 during 10 PM - 6 AM shift, on 8/6/2020 during 2PM - 10 PM shift. Further review of Resident #1's progress note on 8/6/2020 during 10PM - 6 AM shift revealed there was no documentation on Resident #1's assessment besides the nurse notes regarding Resident #1's death. During 10PM - 6 AM shift on 8/6/2020, there was a nurse note written by LVN O on 8/7/2020 at 4:36 AM revealed Resident #1 was found not breathing and no pulse present; and a nurse note written by the DON on 8/7/2020 at 5:02 AM revealed (Resident #1's) death pronounce at 5 AM. Record review of Resident #1's Assessment

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F 0607

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 4)
revealed there were only two assessments documented from 7/21/2020 to 8/07/2020. Review a list of Assessment for Resident #1 from electronic chart revealed Weekly Skin assessment dated [DATE] during 6 AM - 2 PM shift and Medical Assessment - [MEDICAL CONDITION] including [MEDICAL CONDITION] infections (New Version) dated 8/7/2020 at 6:12 AM description 2 PM - 10
PM shift status in process. Record review of Resident #1's electronic record for vital signs dated from 8/1/2020 (6AM - 2PM shift) to 8/6/2020 (10 PM - 6 AM shift) there were 7 of 18 shifts documented Resident #1's vital signs. Further review revealed vital signs documented for Resident #1 on 8/1/2020 (2PM -10PM shift), on 8/03/2020 (6AM - 2PM shift), 8/4/2020 (2 PM - 10PM and 10 PM - 6 AM shift), 8/5/2020 (10 PM - 6 AM shift), and 8/6/2020 (6 AM - 2 PM and 2 PM - 10 PM shift). Interview on 8/21/2020 at 10:55 AM with LVN O confirmed she assessed Resident #1 approximately at 10:45 PM on 8/6/2020 revealed Resident #1 did not have any concern or distress. LVN O confirmed around 2:30 AM on 8/7/2020 she was with a CNA to reposition Resident #1. LVN O confirmed after 2:30 AM on 8/7/20 she did not see Resident #1 until CNA notify her to checked on Resident #1 around 4:09 AM on 8/7/20 when she found out Resident #1 was unresponsive and no vital signs. LVN O confirmed per facility policy she had to assess Resident in COVID unit by checking vital signs, signs and symptoms of COVID every 2 hours. LVN O confirmed she supposed to complete the assessment of Acute infection on the computer for residents with positive COVID every shift per facility policy. Interview on 8/21/2020 at 11:24 AM with LVN O confirmed she did not document any assessment for Resident #1 either under Acute Infection assessment or under nursing progress note because she did not have time, and she had lot of residents in the unit to take care of. Interview on 8/21/2020 at 11:31 AM with LVN O confirmed she did not have any nurse note during 10 PM - 6 AM shift, except her note at 4:00 AM. LVN O confirmed she did not document Resident #1's assessment on nursing progress note because Resident #1 did not have any symptom and did not show any distress. Interview on 8/21/2020 at 11:36 AM with LVN O confirmed there was no vital signs for Resident #1 documented during 10 PM - 6 AM shift on 8/6/2020. LVN O confirmed the CNA checked Resident #1's vital signs during 10 PM - 6 AM shift, but the CNA did not document Resident #1 vital signs in the computer. Record review of Resident #2's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's nursing progress
notes from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there was 2 of 14 shifts documented Resident #2's assessment. There was nurse note on 8/10/2020 (2 PM - 10 PM shift) and 8/14/2020 (2 PM - 10 PM shift). Record review of Resident #2's electronic record for assessments from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there were 1 of 14 assessments for COVID was documented. Further review revealed there was one assessment on 8/13/2020 was Medical Management - Acute infection (new version). Record review of Resident #2's electronic record for vital signs from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed 3 of 14 shifts documented Resident #2's vital signs. Resident #2's vital signs was documented on 8/11/2020 (10 PM - 6 AM shift), on 8/12/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's undated face sheet revealed an admitted d of 8/15/2018 with [DIAGNOSES REDACTED]. Record review of Resident #3's nursing progress notes from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 shifts documented Resident #3's assessments. Further review revealed there were nurse note regarding Resident #3's high blood sugar on 8/8/2020 (2PM - 10 PM shift) and a nurse note regarding Resident #3 had change of condition and transferred to local hospital on [DATE] (6 AM - 2 PM shift). Record review of Resident #3's Assessments from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 COVID assessments tilted with Medical Management - Acute Infection (new version) were completed on 8/9/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's electronic record for vital signs from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed there were 16 of 25 shifts documented vital signs for resident #3 as follow on 8/6/2020 (6 AM - 2 PM shift); on 8/7/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), on 8/8/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); on 8/9/2020 (10 PM - 6 AM); 8/10/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/11/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), 8/12/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift). Record review of Resident #4's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's nursing progress note from
8/4/2020 to 8/15/2020 revealed there was nurse not documented on COVID assessment every shift. Record review of Resident #4's assessment from 8/4/2020 to 8/15/2020 revealed there were 4 of 39 COVID assessments titled with Medical Management - Acute Infection (new version) completed as following on 8/8/2020 (6 AM - 2 PM shift); 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #4's vital sign record from 8/4/2020 to 8/15/2020 revealed there were 19 of 39 shifts documented vital signs for Resident #4. Record review of Resident #5's undated face sheet revealed an admitted on 11/6/2018 with [DIAGNOSES REDACTED]. Record review of Resident #5's nursing progress note from 8/1/2020 to 8/15/2020 there were two nurse notes documented for Resident #5 on 8/6/2020 and 8/15/2020. Record review of Resident #5's printed COVID assessment titled with Medical Management - Acute Infection (new version) provided by the facility revealed that not every shift had documented the COVID assessments. The assessments were completed on 8/4/2020 (10PM - 6 AM shift); 8/8/2020 (6 AM - 2PM shift), 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), 8/13/2020 (10 PM - 6 AM shift) and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #5's vital signs record from 8/1/2020 to 8/15/2020 revealed that not every shift had documented the vital signs. Further review revealed the vital sign during 10 PM - 6 AM shift were documented from 8/2/2020 to 8/9/2020. Resident #6 to Resident #23: Record review of Resident #6's undated face sheet revealed an admitted on 1/15/2019 with [DIAGNOSES REDACTED]. Record review of Resident #7's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's undated
face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's undated face sheet reveled an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #12's undated face sheet revealed an
admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #13's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #14's undated face sheet reveal an admission
date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's undated face sheet revealed an admission date of
[DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's undated face sheet revealed an admitted on 7/1/2016 with [DIAGNOSES REDACTED]. Record review of Resident #17's undated face sheet revealed an admission date of [DATE] with diagnose of hypertension, type 2 diabetes, and dementia. Record review of Resident #18's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #19's undated face sheet revealed an admitted on 9/13/2018 with [DIAGNOSES REDACTED]. Record review of Resident #20's undated face sheet revealed an admission date of
[DATE] with [DIAGNOSES REDACTED]. Record review of Resident #21's undated face sheet revealed an admission date of [DATE]
with [DIAGNOSES REDACTED]. Record review of Resident #22's undated face sheet revealed an admission date of [DATE] with diagnose of type 2 diabetes, hypertension, and [MEDICAL CONDITION]. Record review of Resident #23's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of nursing progress notes and assessments titled with Medical management - acute infection (new version) for 18 positive COVID-19 status Residents ((Resident #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) dated from 8/1/2020 - 8/15/2020 revealed that not every shift had documented COVID assessment. Review of vital sign record for 18 positive COVID-19 status Residents (Resident #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23) dated from 8/1/2020 - 8/15/2020 revealed that not every shift had documented vital signs. Record review of additional vital signs sheets provided by the DON ranged from 8/1/2020 to 8/15/2020 for positive COVID-19 status Residents (Resident #1 to Resident #23) revealed 6 of 45 shifts documented vital sign as follow on 8/1/2020 (10PM - 6 AM shift), 8/4/2020 (6 AM -2 PM shift), 8/5/2020 (6 AM -2 PM shift), 8/10/2020 (2 PM - 10 PM shift), 8/13/2020 (2PM - 10 PM shift), and 8/14/2020 (2 PM - 10 PM shift). Interview on 8/15/2020 at 1:06 PM with the DON confirmed there were two set of vital signs need to be completed for positive COVID Residents. The DON further confirmed the first set of vital signs at the beginning of shift included blood pressure, pulse, respiratory rate, oxygen saturation, and temperature; and the second set of vitals included temperature and oxygen
saturation need to be completed in the middle of the shift. The DON also confirmed COVID assessment needed to be completed for positive COVID resident and documented under nursing progress note one per shift. During an interview on 8/16/2020 at 9:42 AM with the DON and RNA - infection control nurse, they confirmed licensed nurse needed to complete acute infection or respiratory assessment per shift for COVID positive Residents. The DON and RN A also confirmed the first vital signs at beginning of every shift needed to be done were blood pressure, temperature, respiratory rate, pulse; and oxygen saturation; and the second set of vital signs need to be done around mid-shift were temperature and oxygen saturation. Interview on 8/17/2020 at 4:05 PM with the DON confirmed that not every shift had documented COVID Assessment for positive COVID-19 status Residents either under acute infection assessment or nurse progress note. The DON further confirmed if

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) there was no documentation on COVID assessment that meant the nurse did not do the assessment. The DON said she could not prove if the nurse completed the assessment or not if there was no documentation. Interview on 8/17/2020 at 5:30 PM with the DON confirmed the vital signs were not documented every shift for Residents with COVID-19 positive status residents in either the computer or paper vital signs sheet. The DON confirmed the vital sign sheets could be put in the shredder box. DON confirmed ideally CNAs should document the vital sign on the computer, but CNAs were so busy to turn and feed the residents, so CNAs documented the vital signs on the paper vital sign sheet. Interview on 8/17/2020 at 5:37 PM with the DON confirmed the vital signs documented in the computer to consider resident's record. Interview on 8/17/2020 at 5:43 PM with DON confirmed if staff did not document the vital sign that meant they did not do the vital sign. The DON confirmed she could not prove staff complete the vital signs every shift if there was no documentation. b. Resident #24, #25, #26, #27, #28, are #29 were [MEDICAL TREATMENT]/suspected COVID residents resided in warm unit. Record review of Resident #24's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #24's nursing progress note from 8/1/2020 to 8/15/2020 revealed 2 of 45 shifts documented Resident#24's assessment. Further review revealed there were assessments documented on 8/4/2020 (2 PM -10 PM shift) and 8/5/2020 (6 AM -2 PM shift). Record review of Resident #25's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25's nursing progress note nursing progress note from 8/1/2020 to 8/15/2020 revealed 2 of 45 shifts documented Resident #25's assessment. Further review revealed there were assessments documented on 8/3/2020 (6 AM - 2 PM shift) and 8/5/2020 (2 PM - 10 PM shift). Record review of Resident #26's undated face sheet revealed an admitted on 8/26/2016 with [DIAGNOSES REDACTED]. Record review of Resident #26's nursing progress note nursing progress note from 8/1/2020 to 8/15/2020 revealed there were 7 of 45 assessments documented for Resident #26. Further review revealed assessments documented on 8/5/2020 (6AM - 2 PM shift and 2 PM - 10 PM shift) 8/6/2020 (2 PM - 10 PM shift), 8/10/2020 (2 PM - 10 PM shift), 8/11/2020 (2 PM - 10 PM and 10 PM - 6 AM shift), and), 8/15/2020 (2 PM - 10 PM shift). Record review of Resident #27's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #27's nursing progress note from 8/1/2020 to 8/15/2020 revealed there were 6 of 45 assessment documented for Resident #27. Further review revealed assessments documented on 8/10/2020 (6AM - 2 PM shift), 8/12/2020 (10 PM - 6 AM shift), 8/13/2020 (2 PM - 10 PM shift and10 PM - 6 AM shift), 8/14/2020 (10 PM - 6 AM shift), 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #28's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #28's nursing progress note from 8/1/2020 to 8/15 2020 revealed there were 6 of 45 assessments documented for Resident #28. Further review revealed assessments documented on 8/8/2020 (2 PM - 10 PM shift), 8/9/2020 (2 PM - 10 PM shift and 10 PM - 6 AM shift), 8/10/2020 (2 PM - 10 PM shift), 8/11/2020 (10 PM - 6 AM shift), 8/12/2020 (10 PM - 6 AM shift) Record review of Resident #29's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #29's nursing progress note from 8/1/2020 to 8/15/2020 revealed there were 1 of 45 assessments documented for Resident #29. Further review revealed assessments documented on 8/8/2020 (6AM - 2 PM shift), but other progress notes on 8/13/2020 and 8/15/2020 regarding room change and physician notification. Interview on 8/16/2020 at 9:48 AM with the DON confirmed licensed nurse should document residents' general health under nursing progress note for Residents in warm unit - [MEDICAL TREATMENT]/suspected COVID unit. Interview on 8/16/2020 at 2:51 PM with LVN F confirmed that he did not do COVID assessment for Residents in warm unit - [MEDICAL TREATMENT]/suspect unit. LVN F confirmed he assessed Residents' appearance, alertness and documented on resident's change of condition. LVN F confirmed he recently returned to work and did not received training on COVID assessment and documentation for residents in warm unit. Interview on 8/18/2020 at 5:35 PM with the DON confirmed the nurse did not document COVID assessment under nursing progress note every shift for Residents in warm unit - [MEDICAL TREATMENT]/suspected COVID unit. Record review of vital signs record from Resident #24 to Resident #29 dated range from 8/1/2020 to 8/15/2020 revealed there was no vital signs documented every shift for Resident #24 to Resident #29. Interview on 08/15/20 at 11:15 a.m., DON confirmed that the facility staff should be documenting vital signs every shift in the regular halls and in the Covid Positive hall staff should be documenting vital signs twice a shift. Interview on 08/16/20 at 12:10 p.m., DON reviewed the Vital sign log sheets she had provided for the residents in(NAME)hall. DON confirmed that she was unable to locate any documentation that her staff had done vital signs every shift as required for these residents. DON said that she did not know that staff were not documenting vital signs every shift. c. Resident #30 to Resident #76 were COVID-19 negative status Residents. Record review of Resident #30's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #31's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 32's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #33's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #34's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #35's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #36's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #37's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #38's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #39's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #40's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #41's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #42's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #43's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #44's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #45's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #46's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #47's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #48's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #49's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #50's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #51's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #52's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record rev
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 develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet the resident's mental and psychosocial needs, for three Residents (R#26, R#25 and R#24) of six residents reviewed for care plans. R#26, R#25 and R#24 were placed in isolation (Rosa Hall). R#26, R#25, R#24 did not have MD orders for and had not been care planned for isolation placement. This failure could place residents at risk for infection and not receiving the necessary care and services required. The findings were: Record review of R#26 's Face Sheet un-dated, revealed R#26 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#26 's [DIAGNOSES REDACTED]. Record review of R#26 's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#26: -had clear speech, -was understood by others, -was able to understand others, -had moderately impaired cognition. -required extensive assistance from staff for bed mobility, transfers, -totally dependent with dressing, bathing and personal hygiene, -required limited assistance for eating and toilet use, Record review of R#26's care plan, dated 08/15/20, revealed R#26: There was no Care Planning for Droplet precautions in the residents Care Plan and no indication that this resident was under any type of isolation. Problem: R#26 has [DIAGNOSES REDACTED]. Goal: R#26 will remain free from shortness of breath, chest pains, [MEDICAL CONDITION], or elevated blood pressure; Approach: Staff to arrange for [MEDICAL TREATMENT] as ordered, provide good personal hygiene. Monitor access area for redness or pain and report promptly. Notify Physician if [MEDICAL CONDITION], chest pain, elevated blood pressure or shortness of breath or bleeding occurs. Resident is to wear a face mask and disposable gown while out to [MEDICAL TREATMENT] due to Covid-19 pandemic. Problem: R#26 had potential nasal congestion, sneezing, watery itchy eyes, cough and wheezing d/t Diagnosis: [REDACTED]. Goal: Resident will minimize symptoms and

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) allergens that might aggravate condition daily and ongoing through next care plan review. Approach: Check history and physical for any stated allergies [REDACTED]. Record review of R#25 's Face Sheet un-dated, revealed R#25 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#25's [DIAGNOSES REDACTED]. Record review of R#25's Minimum Data Set (MDS) assessment, dated 07/27/20, revealed R#25: -had clear speech, -was understood by others, -was able to understand others, -was cognitively intact, -required supervision assistance from staff for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing. Record review of R#25 's care plan, dated 08/15/20, revealed R#25: There was no care plan for droplet precautions in the residents care plan and no indication that this resident was under any type of isolation. Problem: R#25 is at risk for infection or risk for spreading infection related to Covid-19 Pandemic. Goal: R#25 will minimize risk for infection daily and ongoing over next care plan review. Approach: Check temperature q shift and PRN. Encourage social distancing. Explain to resident and family of procedure. Face cloth cover mask placed when leaving room. Give verbal reminders to cover mouth and nose with cloth/mask. Monitor for signs and symptoms of infection and report immediately. Resident needs to wear a face mask and disposable gown while out to [MEDICAL TREATMENT] due to Covid-19 pandemic. Problem: at risk for shortness of breath due to [DIAGNOSES REDACTED]. Goal: R#25 will minimize episodes of shortness of breath and ongoing over the next care plan review. Approach: 1500 ml fluid restriction as ordered, encourage resident to be out of bed daily and exercise. Have oxygen available if needed, notify physician if any [MEDICAL CONDITION] or shortness of breath. [MEDICATION NAME] as ordered, monitor for and be present to render support to prevent anxiety if episode of shortness of breath occurs. Problem: R#25 had potential nasal congestion, sneezing, watery itchy eyes, cough and wheezing d/t Diagnosis: [REDACTED]. Goal: Resident will minimize symptoms and allergens that might aggravate condition daily and ongoing through next care plan review. Approach: [MEDICATION NAME] as ordered, [MEDICATION NAME] propionate nasal suspension as ordered, Vitamin C as ordered. Check history and physical for any stated allergies [REDACTED].#24's Face Sheet un-dated, revealed R#24 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#24's [DIAGNOSES REDACTED]. Record review of R#24's Minimum Data Set (MDS) assessment, dated 08/11/20, revealed R#24: -had clear speech, -was understood by others, -was able to understand others, -was cognitively intact. -required extensive assistance from staff for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing, -required limited assistance for eating, Record review of R#24's care plan, dated 08/15/20, revealed R#24: There was no care plan for droplet precautions in the residents care plan and no indication that this resident was under any type of isolation. Problem: R#24 is at risk for shortness of breath due to [DIAGNOSES REDACTED]. Goal: Will minimize episodes of shortness of breath daily and ongoing over the next care plan. Approach: [MEDICATION NAME] as ordered; notify physician if [MEDICAL CONDITION] or shortness of breath occurs. Monitor for episodes of shortness of breath and implement interventions as ordered. Monitor feet and hands for warmth, color or [MEDICAL CONDITION]. Encourage resident to get out of bed daily and exercise. Monitor for and be present to render support to prevent anxiety if episode of shortness of breath occurs. Have oxygen available if needed. Problem: R#24 had potential nasal congestion, sneezing and cough d/t Diagnosis: [REDACTED]. Goal: Resident will minimize the risk of upper respiratory infection daily and ongoing over the next care plan review. Approach: [MEDICATION NAME] as ordered, notify if MD if treatment is not effective. Assess lung sounds as needed. [MEDICATION NAME] as ordered, [MEDICATION NAME] as ordered. Monitor for shortness of breath and report to MD. Observe resident for adverse side effects, document and report to physician. In an interview on 08/14/20 at 2:40 p.m. RN A said(NAME)Hall was the suspect hall. She said the residents in this hall are either symptomatic with Covid-19 symptoms, [MEDICAL TREATMENT] patients or other residents that leave the facility regularly for treatments. These residents were on isolation because of these concerns. During observations on 08/14/20 at 2:43 p.m., surveyor noted that the doors in(NAME)Hall for Rm# 220, Rm# 222, Rm# 223, Rm# 224, Rm# 225 were all open. In an interview at the time of observation on 08/14/20 at 2:43 p.m., RN A said that the residents in(NAME)Hall did not have a care plan on Droplet Isolation and had no MD orders for isolation. In an interview on 08/15/20 at 11:00 a.m., RN MDS Nurse R said the she was responsible to update the care plans. She said that the staff nurse taking care of the residents in(NAME)Hall should notify the MDS nurse when a resident has been moved to an isolation hall. She states that the residents in that hall had been moved recently and no one had notified her that these residents were moved into the isolation hall(NAME)Hall. She said that she did not know that some of the residents in(NAME)Hall had not been care planned for Covid-19 Droplet isolation and had no MD orders for isolation. In an interview on 08/15/20 at 11:15 a.m., DON said that she did not know why the [MEDICAL TREATMENT] residents in(NAME)Hall did not have a care plan on Droplet Isolation and had no MD orders for isolation. Record review of the facility policy titled, Care Plans- Comprehensive, with 08/06/20 date, revealed: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems;
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, for four residents (R#26, R#27, R#28, R#29) of six residents reviewed for physician services. 1) The facility did not ensure R#26 was seen by their attending physician at least once every 30 days for the first 90 days after admission. 2) The facility did not ensure R#27 was seen by their attending physician at least once every 60 days. 3) The facility did not ensure R#28 was seen by their attending physician at least once every 60 days. 4) The facility did not ensure R#29 was seen by their attending physician at least once every 60 days. This failure could place residents at risk for not receiving provided adequate medical care. Findings were: 1) Record review of R#26's Face Sheet un-dated, revealed R#26 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#26's [DIAGNOSES REDACTED]. Record review of R#26's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#26: -had clear speech, -was understood by others, -was able to understand others, -had moderately impaired cognition. -required extensive assistance from staff for bed mobility, transfers, -totally dependent with dressing, bathing and personal hygiene, -required limited assistance for eating and toilet use, Record review of R#26s electronic medical record (WellSky) revealed R#26 had last been seen by a MD on 03/12/20, 04/09/20 and 07/14/20. 2) Record review of R#27's Face Sheet un-dated, revealed R#27 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#27's [DIAGNOSES REDACTED]. Record review of R#27's Minimum Data Set (MDS) assessment, dated 07/09/20, revealed R#27: -had clear speech, -was usually understood by others, -was able to usually understand others, -had moderately impaired cognition. -required extensive assistance from staff for bed mobility, -Independent with eating, -totally dependent with personal hygiene, Review of R#27s electronic medical record in WellSky revealed R#27 had last been seen by a MD on 04/01/20 and by a Podiatrist; 06/10/20 and 08/12/20. Record review of R#27's care plan, dated 08/15/20, revealed R#27: 3) Record review of R#28's Face Sheet un-dated, revealed R#26 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#28's [DIAGNOSES REDACTED]. Record review of R#28's Minimum Data Set (MDS) assessment, dated 07/09/20, revealed R#28: -had clear speech, -was usually understood by others, -was able to usually understand others, -had severely impaired cognition. -required limited assistance from staff for bed mobility, transfer, walk in room, -required extensive assistance from staff with dressing, toilet use, personal hygiene -required limited assistance for eating, Review of R#28s electronic medical record in WellSky revealed R#28 had last been seen by a MD on 11/21/19 and by a Podiatrist; 01/21/20 and 04/09/20. 4) Record review of R#29's Face Sheet un-dated, revealed R#29 was admitted to the facility on [DATE] and re-admitted on [DATE]. R#29's [DIAGNOSES REDACTED]. Record review of R#29's Minimum Data Set (MDS) assessment, dated 03/26/20, revealed R#29: -had clear speech, -was understood by others, -was able to understand others, -had moderately impaired cognition. -required extensive assistance from staff for bed mobility, transfers, -totally dependent with dressing, bathing and personal hygiene, -required limited assistance for eating and toilet use, Record review of R#29s electronic medical record (WellSky) revealed R#28 had last been seen by a MD on 03/12/20, 04/09/20 and 07/14/20. In an interview on 08/15/20 at 3:26 p.m., the DON said most MD's are seeing their residents via Virtual Visits and usually every two weeks. She said that the facility Medical Director was doing Virtual Visits for the Covid Positive residents on a weekly basis. DON said that there should be physician progress notes [REDACTED]. Surveyor asked for any documentation the facility had that the residents in(NAME)Hall had been seen by an MD as required. In an interview on 08/16/20 at 12:10 p.m., the DON said the facility did not have any documentation to show the resident's MD had seen the residents in the(NAME)Hall(warm unit) q month. DON said the facility had no documentation to show the facility attempted to contact residents physician and have them see the

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F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) residents. In an interview on 08/18/20 at 4:35 p.m., the Medical Director said the residents primary MD was responsible for doing any physician progress notes [REDACTED]. Medical Director said that physicians have access to the computerized charting in WellSky. Medical Director said that he would do the documentation from his office for any visits that he does. Medical Director said that the residents should be seen by their primary MD as needed. Medical Director states that he did not know if the facility was monitoring whether there was any documentation of when the visits are done by the primary MD. During exit conference on 08/21/20 the Administrator and DON were asked to provide any further documentation that was related to any of the preliminary tags and no further documentation was provided at the time of exit conference. Record review of the facility's policy on Physician Services was the Texas Administrative Code- Title 40, Part 1, Chapter 19, Subchapter M- Rule 19.1203, amended March 24, 2020, revealed: Physician visits must conform to the following schedule: (1) Licensed-only facility. Each resident must have a medical examination at least annually by the resident's physician and as necessary to meet the needs of the resident. Physician orders [REDACTED]. record, a different schedule for each review and revision. (2) Medicaid-certified facilities and Medicare skilled nursing facilities. (A) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (B) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments, for one medication cart (Rosa Hall medication cart) of three medication carts observed. One medication cart in the(NAME)Hall was left with key in the lock and unattended. This failure could place residents at risk for drug diversion or accidental ingestion. The findings were: During observation on 08/19/20 at 10:25 a.m., surveyor walked into(NAME)Hall and noted the medication cart had the key in the lock of the medication cart. This hall had a plastic barrier separating it from the hall and had to be opened using a zipper the closed it off. Surveyor noted that there was no staff in the hall at this time and no staff were noted to be in residents room. During observation on 08/19/20 at 10:40 a.m., surveyor observed two staff walking into(NAME)Hall through the plastic barrier by unzipping it. Surveyor asked them if they were the staff working in(NAME)Hall. LVN U and CNA W said they were the only staff working in the hall. In an interview on 08/19/20 at 10:45 a.m., LVN U said she was only working in(NAME)Hall (warm unit). LVN U said the medication cart in(NAME)Hall was the cart she was responsible for. LVN U said she did not know she had left the keys inside of the lock of the medication cart. LVN U said she should not have left the keys in the lock of the medication cart. LVN U said that anyone could have walked by and taken medications from it. In an interview on 08/20/20 at 12:45 p.m., DON said the medication cart keys should never be left in the lock of the medication cart. DON said that the keys should always be with the nurse that has the medication cart assigned to them. She said that the nurse should not have left the keys in the medication cart for the safety of the residents in that hall. She said a resident could remove medications from the medication cart that are not prescribed to them and hurt themselves. Record review of the facility policy titled, Security of Medication Cart, with revised date 04/12/18, revealed: Policy Statement: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the residents room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with the doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all time when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room.
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 designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 23 of 23 COVID positive Residents (Resident #1 to Resident #23), 6 of 6 [MEDICAL TREATMENT]/suspected COVID Residents (Resident #24 to Resident #29), and 47 of 47 COVID negative Residents (Resident #30 to Resident #76), review for infection control in that: 1. Transmission-Based Precaution was not appropriately implemented for warm unit - [MEDICAL TREATMENT]/suspected COVID unit and COVID unit: a. There was no signage to identify type of precautions for [MEDICAL TREATMENT]/suspected COVID unit. b.N95 masks were unlabled and hanging on a wall in the warm unit and COVID unit. c. Doors to presumptive positive Residents' rooms had left opened in the Warm unit. d. Donning station in warm unit had no hand washing sink, no soap and no hand sanitizer. e. Medication Aide E - MA E did not wear gown and gloves to put a label on the wall in Resident #24's and Resident #25's rooms in the [MEDICAL TREATMENT]/suspected COVID unit. e.LVN F did not wear face shield when he entered Resident #26's room in the Warm unit - [MEDICAL TREATMENT]/suspected COVID unit to inform Resident #26 that LVN F was going check Resident #26's blood sugar. g. CNA K and CNA L entered COVID unit without N95 masks. 2. Staff did not appropriately implement hand hygiene, PPE usage, and environmental cleaning and disinfection. a. CNA C wore N95 mask under her chin and did not cover her nose and mouth when working in negative COVID hallway. b. Laundry staff S did not know the contact time of the disinfectant solution while attempting to disinfect the side rail. c. MA E did not change gloves and perform hand hygiene before administering the eye drop for Resident #55. d. CNA K did not change gloves and perform hand hygiene after providing incontinent care and before applying clean pad and brief for Resident #7. e. CNA L did not change gloves and perform hand hygiene after providing incontinent care and before applying clean pad, brief, and hospital gown for Resident #15. f. CNA L did not remove gloves and perform hand hygiene before exiting Resident #15's room. 3. Staff did not complete COVID assessment and did not check Residents' vital signs every shift a. COVID assessment and vital signs were not completed every shift for 23 of 23 COVID-19 positive status Residents. b. COVID assessment and vital signs were not completed every shift for 6 of 6 [MEDICAL TREATMENT]/suspected COVID-19 status Residents. c. COVID Assessment and vital signs were not completed every shift for 47 of 47 COVID-19 negative status Residents. These deficient practices could affect residents at the facility and place them at risk of infection from transmission of communicable diseases and at risk for declining in health and/or death. The findings were: 1. a. Observation on 8/15/2020 at 11:17 AM revealed the entrance of [MEDICAL TREATMENT]/suspected COVID unit had signage posted reading Warm Unit. Observation on 08/15/2020 at 11:34 AM with LVN F revealed the hallway where three residents who received [MEDICAL TREATMENT] and three presumptive COVID residents resided had no signage that indicated type of isolation. Further observation revealed there was no signage indicating type of isolation or to see staff prior to entering unit. Interview on 8/15/2020 at 11:38 AM with LVN F confirmed residents in the warm unit included residents who received [MEDICAL TREATMENT] and residents who had symptoms of elevated temperature such as 99.8 F or cough. LVN F confirmed residents received [MEDICAL TREATMENT] and symptomatic residents were put in the warm unit as a precaution. He did not know what type of isolation those residents were on because it was his first day return to work from his sick leave. LVN F confirmed there was no signage posting to indicate type of isolation for residents who received [MEDICAL TREATMENT] and symptomatic residents. LVN F confirmed the unit labeled as warm unit. Record review of the facility policy titled with COVID-19 - clinical Protocol, dated 8/7/2020, revealed There will be separate staffing teams for COVID-19 positive Residents and the quarantine (warm) unit, to the best of our ability . The residents who have symptoms will be placed on contact and droplet precaution. b. During observations of the facility, on 08/14/20 at 3:22 p.m., revealed: An empty resident room [ROOM NUMBER] had a sign taped to the door that read Donning Station. Surveyor walked into Rm#218 and

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) saw there was an N95 mask hanging on the wall to the left of the room that was not put away in a bag or container. Surveyor also observed 4 other N95 masks put away in separate plastic ziploc bags that had been labeled with names. During observations on 08/14/20 at 3:25 p.m., Surveyor observed that Rm# 218's bathroom door had a sign that had Doffing Station taped on it. Surveyor noted that there was no hand washing sink, no soap and no hand sanitizer inside of the doffing station. In an interview on 08/14/20 at 3:30 p.m., RN A said that any N95 masks in the Donning area must be stored inside of a plastic bag to prevent any contamination from a used N95 mask. RN A confirmed there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. Observation of the donning station in the COVID positive unit on 8/14/2020 at 6:18 PM revealed a N95 mask with stretched and twisted straps as had been used was hung on top of a face shield on the wall by itself without being stored inside the paper bag. Interview on 8/14/2020 at 6:28 PM RN D confirmed the N95 mask should not be hung on top of the face shield on the wall in the donning station because N95 mask which had been used and should be discarded at the end of shift. Interview on 8/16/2020 with 11:28 AM with RN A, she confirmed N95 mask should not be hung by itself. RN A confirmed N95 mask should be thrown away in biohazard bag or kept in the paper bag. RN A confirmed staff should have known about storing or discarding N95 mask because she provided in-service for staff regarding N95 mask when the COVID outbreak occurred in the facility. Record review of the in-service record dated 8/11/2020 titled with Use of PPE: use of gown per patient, when providing care, the entire shift, discard at the end of shift, N95 mask use only for that shift discard at the end of shift. Returned correct demonstration. c. During observations made on 08/14/20 at 2:43 p.m., the doors in the Warm unit to resident rooms Rm#220, Rm#222, Rm#223, Rm#224 & Rm#225, in Rosa Hall(warm unit) had been left open. These residents did not have any masks on while in their rooms. In an interview on 08/14/20 at 2:40 p.m., RN A (infection preventionist) stated residents in Rosa Hall (warm unit) were residents that were symptomatic, went to [MEDICAL TREATMENT] or went out of the facility regularly for treatment and were suspect residents. RN A further stated staff removed their gowns, hung it outside the room and then put on a clean gown before entering a resident's room. Staff then provided care to the resident and removed their gown and gloves prior to leaving the residents rooms. Staff would then put on their previous gown that was left hanging on the wall. In an interview on 08/14/20 at 2:47 p.m., the DON said the resident doors in Rosa Hall warm zone should have been closed due to the residents being presumptive COVID. These residents were going to [MEDICAL TREATMENT] or residents or were pending clearance to go to a regular hall. The DON confirmed the doors to Rosa Hall were opened at this time. DON said the Maintenance staff were pending to put up two plastic barriers in the Rosa Hall to separate the hall from the rest of the facility. DON stated she would put up signs that would indicate Rosa Hall is an isolation hall and would be visible with the doors closed. d. During observations on 08/14/20 at 3:25 p.m., Surveyor observed that Rm# 218's bathroom door had a sign that had Doffing Station taped on it. Surveyor noted that there was no hand washing sink, no soap and no hand sanitizer inside of the doffing station. In an interview on 08/14/20 at 3:30 p.m., RN A confirmed there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. In an interview on 08/14/20 at 2:47 p.m., the DON said she did not know that there was no hand washing sink, no soap and no hand sanitizer in the bathroom that was being used as a doffing station. DON said that the Donning and Doffing room in Rm# 218 was not going to be used. e. Record review of Resident #24's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #24's physician order dated 8/1/2020 to 8/31/2020 revealed and order of [MEDICAL TREATMENT] on Tuesday, Thursday, and Saturday. Record review of Resident #25's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 8/15/2020 at 8:44 AM revealed Resident #25 was sitting on his wheel chair in his room in the warm unit. Further observation, MA E entered Resident #25's room to put a label and a hook on his wall without wearing gloves and gown. Observation on 8/15/2020 at 8:48 AM revealed without wearing gloves and gown, MA E exiting Resident #25's room and entered Resident #24's room to put a label on the wall. Interview on 8/15/2020 at 8:48 AM with MA E, he confirmed he did not wear gown and gloves when he put a label and a hook on the wall inside Resident #25's room in the warm unit. Interview 8/15/2020 at 8:50 AM with MA E, he confirmed he did not wear gown and gloves when he put the label on the wall inside Resident #24's room. Interview on 8/15/2020 at 12:48 PM with the DON, she confirmed MA E needed to wear gown when he put on the labels in resident #24's and Resident #25' rooms in the warm unit. f. Record review of Resident #26's undated face sheet revealed an admitted on 8/26/2016 with [DIAGNOSES REDACTED]. Observation on 8/15/2020 at 11:24 AM revealed LVN F entered Resident #26's room inside the warm unit - [MEDICAL TREATMENT]/suspected COVID unit. Further observation revealed LVN F did not wear his face shield when he was inside Resident #26's room to informed Resident #26 that LVN F was going to check Resident #26's blood sugar. Interview on 8/15/2020 at 11:25 AM with LVN F confirmed he did not wear face shield when he entered Resident #26's room in the warm unit. He further confirmed he did not remember where he put his face shield. Observation of 8/15/2020 at 11:25 AM revealed LVN F exited the warm unit to look for his face shield. g. Observation of COVID positive unit on 8/15/2020 at 1:35 PM revealed on the first room on the right was employee break room and a donning station located in the back of the employee breakroom, and the first room on the left was the doffing room once enter the COVID unit. Further observation revealed the employee break room, doffing room, and 10 of 15 doors to Residents' rooms in COVID unit left opened. Observation 8/15/2020 at 2:02 PM revealed CNA K entered COVID unit with regular scrub and with no face covering - no surgical mask or N95 mask on. CNA K got a gown from a bin in front of the employee break room. Further observation at 2:03 PM CNA K walked to the donning station located in the back of the employee breakroom to put on PPE. Interview on 8/15/2020 at 2:19 PM with CNA K confirmed she entered the COVID unit with no face covering before going to the donning station because there was nothing outside the COVID unit for her to put on. Observation on 8/15/2020 at 2:07 PM revealed CNA L wore a surgical mask when he entered COVID unit before entering the donning station inside the COVID unit to don PPE. Interview on 8/16/2020 at 11:26 AM with RN A - infection control nurse confirmed staff need to wear N95 mask when entering the COVID unit before going to the donning station. RN A further confirmed CNA K and CNA L should not enter the COVID unit without face covering or with surgical mask. 2. a. Observation on 8/14/2020 at 5:41 PM revealed CNA C carried two dirty meal trays from the end of the negative hallway and observed CNA C's N95 mask which was under her chin did not cover her nose and mouth. Interview on 8/14/2020 5:44 PM with CNA C, she confirmed her N95 mask was under her chin because the straps that held the N95 mask was slid down and she cannot put back while she was holding two dirty meal trays. Interview on 8/15/2020 at 12:30 PM with the DON, she confirmed she checked CNA C's N95 mask which was not loose. DON confirmed CNA C was corporate staff from a sister facility. On 8/15/2020 at 12:35 PM the DON further confirmed CNA C should have received training on wearing proper PPE before working at the facility because corporate needed to send qualified CNAs to work at the facility. Record review of the facility's policy titled with Sequence for putting on (don) personal protective equipment (PPE) gear, undated, revealed Do not wear respirator/facemask under chin or store in scrubs pocket between patients. b. Laundry staff S did not know the contact time of the disinfectant solution and disinfectant the side rail improperly. During observations on 08/15/20 at 1:18 p.m., Surveyor observed a staff member that was cleaning the hand rails at the entrance to Verde Hall and to right side of the nurses station. Surveyor observed Laundry Attendant S spraying the hand rails and then immediately wiping the hand rails with a rag. Laundry Attendant S was not allowing any time for the chemicals to stay on the hand rails. During an interview on 08/15/20 at 1:24 p.m., DON said that the facility Housekeeping Supervisor was out sick and that she was supervising that department. She said that staff helping with Housekeeping are in-serviced on the chemical they are to use In an interview at the time of observation, surveyor spoke with Laundry Attendant S who said that she was helping out Housekeeping due to increased work and less staff available. Laundry Attendant S said that she did not know how long she was supposed to wait after spraying the DC-33 chemical before she was supposed to wipe it off. The bottle that she was using had hand written DC-33 written on it with a marker and had no label with how long it was supposed to be left on prior to wiping off. Surveyor asked the DON for a copy of the DC-33 material data sheet. In an interview on 08/15/20 at 1:50 pm, Laundry Attendant S said that she had a new label on her spray bottle of DC-33. Laundry Attendant S showed the surveyor the label and observed that it had that the chemical needed to stay in contact with the surface for at least 10 minutes after spraying the DC-33 before wiping it off. Record review of the facility policy titled, Cleaning and Disinfecting Resident's Rooms dated 07/2020, revealed: Purpose: The purpose of this procedure is to provide guidelines for cleaning and disinfecting resident's rooms. 3. Manufacturer's instructions will be followed for proper use of disinfection products including: a. Recommended use-dilution b. Material compatibility c. Storage d. Shelf-life e. Safe use and disposal c. Record review of Resident #55's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #55's physician order dated 8/1/2020 - 8/31/2020 revealed an order of [MEDICATION NAME] Balance Ophthalmic Solution 0.6 % give 1 drop to each eye QID - four times per day. Record review of Resident #55's Medication Administration Record [REDACTED]. Observation on 8/15/2020 at 10:20 AM revealed MA E grabbed a bottle of water on Resident #55's bedside table and administered oral medication. With gloves on, MA E took

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	675030	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENT CARE CENTER OF LAREDO	7001 MCPHERSON RD LAREDO, TX 78041

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 9) the empty medication cup which held by Resident #55 and threw into the trash can. Further observation, without changing gloves and performing hand hygiene, MA E opened the vial of eye drop medication and administered to Resident #55' both eyes. During an interview on 8/15/2020 at 10:30 AM with MA E, he confirmed he did not remove his gloves and did not sanitize or wash his hands before administering the eye drop medication to Resident #55. He further confirmed he wore the same gloves which he wore before he entered Resident #55's room to administer oral medication to Resident #55. During an interview on 8/16/2020 at 12:15 PM with RN A and the DON, they confirmed MA E should have changed gloves and washed his hands before administering eye drop for Resident #55. Record review of the facility's policy titled with Instillation of Eye Drops, undated, revealed Steps in the Procedure: 1. Place the equipment on the bed side table or over the bed table. arrange the supplies so they can be easily reached. 2 wash and dry your hands thoroughly. 3. Put on gloves. d. Record review of Resident #7's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's MDS Quarterly assessment dated [DATE] revealed Resident #7 always had incontinent bowel and bladder. Observation on 08/15/2020 at 2:44 PM with CNA K and CNA L revealed they provided incontinent care for Resident #7. CNA K used disposable wash cloth to wipe Resident #7's perineum and buttocks which were soiled with feces. Without changing gloves and performing hand hygiene, CNA K wore the same soiled gloves to put on clean pad and brief for Resident #7. Interview on 8/15/2020 at 3:21 PM with CNA K, she confirmed she did not remove soiled gloves which were used to provide incontinent care for Resident #7, and she did not wash or sanitize her hands before applying clean pad and new brief for Resident #7. e. Record review of Resident #15's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's MDS 5-day assessment dated [DATE] revealed Resident #15 had incontinent bowel and bladder. Observation on 8/15/2020 at 3:02 PM with CNA K and CNA L revealed they provided incontinent care for Resident #15 who was soiled with urine. CNA L used the disposable wash cloth to wipe Resident #15's perineum and buttocks. Then, CNA L removed the soiled brief and soiled pad. Without changing gloves and performing hand hygiene, CNA L put on new pad and new brief for Resident #15. Further observation, CNA L removed the Resident #15's soiled hospital gown and put on the new hospital gown for Resident #15 by using the same soiled gloves which were used to provide incontinent care for Resident #15. Interview on 8/15/2020 at 3:23 PM with CNA L confirmed he did not change his gloves and did not sanitize or wash hands after providing incontinent care and before applying clean pad, brief, and hospital gown for Resident #15. Interview on 8/16/2020 at 11:57 AM with RN A and the DON, they confirmed staff should remove their gloves, wash hands and put on new gloves after incontinence care and before applying new pad and brief for the residents. f. Observation on 8/15/2020 at 3:06 PM revealed CNA L put on new gloves upon entrance Resident#15's room. With gloves on CNA L repositioned Resident #15 and opened the window blinds in Resident #15's room. Further observation, CNA L exited Resident #15's room without removing his gloves. CNA L walked across the hall from Resident #15's room to apply hand sanitizer on his gloved hands and get clean linen from the linen cart. Interview on 8/15/2020 at 3:24 PM with CNA L confirmed he did not remove his gloves and wash his hands before exiting Resident #15's room and before getting clean linen from the linen cart. Interview on 8/16/2020 at11:57 AM with RN A and the DON, they confirmed CNA L should remove his gloves and sanitize his hand before exiting Resident #15's room. Interview on 8/15/2020 at 12:54 PM with the DON confirmed she had to observe staff to ensure staff wore proper PPE and hand hygiene. The DON also confirmed she reminded staff over paging system on washing hand and wearing proper PPE. The DON confirmed RN A - infection control nurse would monitor staff on proper PPE by observation and spot check. Interview on 8/15/2020 at 1:00 PM with the DON confirmed in-service provided for staff by lecture, demonstration, and computer training; the DON confirmed training on hand hygiene, proper PPE, and infection control provide to staff upon hire and quarterly. Interview on 8/16/2020 at 12:07 PM with RN A - infection control nurse, she confirmed she provided in-service and reeducated staff on infection control such as don/doff PPE and hand hygiene. RN A confirmed she did not know the cause of staff non-compliance with wearing PPE and hand hygiene. RN A confirmed she spot check for proper PPE wear and hand hygiene. she would make round during change of shift and randomly pick a staff to observe staff demonstrate on don/doff PPE and hand washing. If she noted any issue, she would verbally correct staff. RN A confirmed she did not have any documentation of monitoring for proper PPE and hand hygiene. Record review of the facility's policy titled with Active Management Process for COVID 19 dated 8/6/2020 revealed Per the CDC, standard precaution, such as those listed below, are the most effective way to prevent the spread of COVID- 19. Proper hand hygiene before and after contact with patient, after contact with contaminated surfaces or equipment, after removing personal protective equipment. Daily use of disinfectants that are hospital grade and listed on the approve EPA list N to clean surface. 3. a. COVID-19 postitive status Residents included Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23. Record review of Resident #1's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's nursing progress notes from 8/4/2020 to 8/7/2020 revealed Resident #1 tested positive for COVID on 8/4/2020. Further review of Resident #'s progress note revealed there 4 of 12 shifts documented Resident #1's assessment on: 8/4/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift, on 8/5/2020 during 10 PM - 6 AM shift, on 8/6/2020 during 2PM - 10 PM shift. Further review of Resident #1's progress note on 8/6/2020 during 10PM - 6 AM shift revealed there was no documentation on Resident #1's assessment besides the nurse notes regarding Resident #1's death. During 10PM - 6 AM shift on 8/6/2020, there was a nurse note written by LVN O on 8/7/2020 at 4:36 AM revealed Resident #1 was found not breathing and no pulse present; and a nurse note written by the DON on 8/7/2020 at 5:02 AM revealed (Resident #1's) death pronounce at 5 AM. Record review of Resident #1's Assessment revealed there were only two assessments documented from 7/21/2020 to 8/07/2020. Review a list of Assessment for Resident #1 from electronic chart revealed Weekly Skin assessment dated [DATE] during 6 AM - 2 PM shift and Medical Assessment - [MEDICAL CONDITION] including [MEDICAL CONDITION] infections (New Version) dated 8/7/2020 at 6:12 AM description 2 PM - 10 PM shift status in process. Record review of Resident #1's electronic record for vital signs dated from 8/1/2020 (6AM - 2PM shift) to 8/6/2020 (10 PM - 6 AM shift) there were 7 of 18 shifts documented Resident #1's vital signs. Further review revealed vital signs documented for Resident #1 on 8/1/2020 (2PM -10PM shift), on 8/03/2020 (6AM - 2PM shift), 8/4/2020 (2 PM - 10PM and 10 PM - 6 AM shift), 8/5/2020 (10 PM - 6 AM shift), and 8/6/2020 (6 AM - 2 PM and 2 PM - 10 PM shift). Interview on 8/21/2020 at 10:55 AM with LVN O confirmed she assessed Resident #1 approximately at 10:45 PM on 8/6/2020 revealed Resident #1 did not have any concern or distress. LVN O confirmed around 2:30 AM on 8/7/2020 she was with a CNA to reposition Resident #1. LVN O confirmed after 2:30 AM on 8/7/20 she did not see Resident #1 until CNA notify her to checked on Resident #1 around 4:09 AM on 8/7/20 when she found out Resident #1 was unresponsive and no vital signs. LVN O confirmed per facility policy she had to assess Resident in COVID unit by checking vital signs, signs and symptoms of COVID every 2 hours. LVN O confirmed she supposed to complete the assessment of Acute infection on the computer for residents with positive COVID every shift per facility policy. Interview on 8/21/2020 at 11:24 AM with LVN O confirmed she did not document any assessment for Resident #1 either under Acute Infection assessment or under nursing progress note because she did not have time, and she had lot of residents in the unit to take care of. Interview on 8/21/2020 at 11:31 AM with LVN O confirmed she did not have any nurse note during 10 PM - 6 AM shift, except her note at 4:00 AM. LVN O confirmed she did not document Resident #1's assessment on nursing progress note because Resident #1 did not have any symptom and did not show any distress. Interview on 8/21/2020 at 11:36 AM with LVN O confirmed there was no vital signs for Resident #1 documented during 10 PM - 6 AM shift on 8/6/2020. LVN O confirmed the CNA checked Resident #1's vital signs during 10 PM - 6 AM shift, but the CNA did not document Resident #1 vital signs in the computer. Record review of Resident #2's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's nursing progress notes from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there was 2 of 14 shifts documented Resident #2's assessment. There was nurse note on 8/10/2020 (2 PM - 10 PM shift) and 8/14/2020 (2 PM - 10 PM shift). Record review of Resident #2's electronic record for assessments from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed there were 1 of 14 assessments for COVID was documented. Further review revealed there was one assessment on 8/13/2020 was Medical Management - Acute infection (new version). Record review of Resident #2's electronic record for vital signs from 8/10/2020 (6AM - 2 PM shift) to 8/14/2020 (2PM - 10 PM shift) revealed 3 of 14 shifts documented Resident #2's vital signs. Resident #2's vital signs was documented on 8/11/2020 (10 PM - 6 AM shift), on 8/12/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's undated face sheet revealed an admitted d of 8/15/2018 with [DIAGNOSES REDACTED]. Record review of Resident #3's nursing progress notes from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 shifts documented Resident #3's assessments. Further review revealed there were nurse note regarding Resident #3's high blood sugar on 8/8/2020 (2PM - 10 PM shift) and a nurse note regarding Resident #3 had change of condition and transferred to local hospital on [DATE] (6 AM - 2 PM shift). Record review of Resident #3's Assessments from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed 2 of 25 COVID assessments tilted with Medical Management - Acute Infection (new

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	675030	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENT CARE CENTER OF LAREDO	**7001 MCPHERSON RD LAREDO, TX 78041**

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 10) version) were completed on 8/9/2020 (10 PM - 6 AM shift), and on 8/13/2020 (10 PM - 6 AM shift). Record review of Resident #3's electronic record for vital signs from 8/6/2020 (6 AM - 2 PM shift) to 8/14/2020 (6 AM - 2 PM) revealed there were 16 of 25 shifts documented vital signs for resident #3 as follow on 8/6/2020 (6 AM - 2 PM shift); on 8/7/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), on 8/8/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); on 8/9/2020 (10 PM - 6 AM); 8/10/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/11/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift), 8/12/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift); 8/13/2020 (6 AM - 2 PM shift and 10 PM - 6 AM shift). Record review of Resident #4's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's nursing progress note from 8/4/2020 to 8/15/2020 revealed there was nurse not documented on COVID assessment every shift. Record review of Resident #4's assessment from 8/4/2020 to 8/15/2020 revealed there were 4 of 39 COVID assessments titled with Medical Management - Acute Infection (new version) completed as following on 8/8/2020 (6 AM - 2 PM shift); 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #4's vital sign record from 8/4/2020 to 8/15/2020 revealed there were 19 of 39 shifts documented vital signs for Resident #4. Record review of Resident #5's undated face sheet revealed an admitted on 11/6/2018 with [DIAGNOSES REDACTED]. Record review of Resident #5's nursing progress note from 8/1/2020 to 8/15/2020 there were two nurse notes documented for Resident #5 on 8/6/2020 and 8/15/2020. Record review of Resident #5's printed COVID assessment titled with Medical Management - Acute Infection (new version) provided by the facility revealed that not every shift had documented the COVID assessments. The assessments were completed on 8/4/2020 (10PM - 6 AM shift); 8/8/2020 (6 AM - 2PM shift), 8/9/2020 (6 AM - 10 PM shift and 10 PM - 6 AM shift), 8/13/2020 (10 PM - 6 AM shift) and 8/15/2020 (6 AM - 2 PM shift). Record review of Resident #5's vital signs record from 8/1/2020 to 8/15/2020 revealed that not every shift had documented the vital signs. Further review revealed the vital sign during 10 PM - 6 AM shift were documented from 8/2/2020 to 8/9/2020. Resident #6 to Resident #23: Record review of Resident #6's undated face sheet revealed an admitted on 1/15/2019 with [DIAGNOSES REDACTED]. Record review of Resident #7's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's undated face sheet reveled an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #11's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #12's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #13's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #14's undated face sheet reveal an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #15's undated face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's undated face sheet revealed an admitted on 7/1/2016 with [DIAGNOSES REDACTED]. Record review of Resident #17's undated f