STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676028	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN SPECIALTY REHAB & NURSING	4320 W 19TH ST LUBBOCK, TX 79407

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and the resident's representative(s) of the discharge and the reasons for the move in writing and in a language and manner they understand, in that: a) the facility failed to notify the resident and the resident's representative(s) of the discharge and the reasons for the move in writing and in a language and manner they understand for 1 of 2 residents discharged from the facility during a hospital stay (Resident #11). These problems could result in residents being discharged without notification and not being informed of their discharge and other resident rights. The findings include: Record review of the clinical record for Resident #11 revealed that he was admitted to the facility on [DATE] and was [AGE] years old. Further record review revealed that the resident had [DIAGNOSES REDACTED]. Psychotic Features. Record review of the facility's Admission/Discharge To/From Report with Discharges From 5/5/20 To 8/5/20 revealed that Resident #11 was discharged to the hospital on [DATE]. Further documentation of the form revealed that Resident #11 did not return to the facility after hospitalization . On 8/5/20 at 2:10 PM an interview was conducted with the Administrator regarding recent discharges from the facility. Regarding Resident #11, he stated, I don't know where he is. He was autistic prior to the MVA (motor vehicle accident). He further stated that the resident had exhibited sexual related behaviors, bit the end of his [DEVICE] and tried to go out the door. He added, This happened all at the same time. He was Physician #1's patient. His Nurse Practitioner #1 gave an order to send him to the hospital for a psych eval. He was beyond what we could take care of. He was on 24-hour watch the entire stay. The hospital was asking us to bring him back and we can't handle it. His fianc was local, and his mother was not. He was 6'2and walked. He would run. We tried to state school, but they would not take him. The Administrator further stated, Before he came here he was taken off of psychoactive medications and they said that he was doing wonderful. We sent discharge paperwork to the state school. The Administrator was then asked about notification of to discharge to the responsible party and resident. He stated, His girlfriend and mother and Ombudsman were notified and the physician. We just notified over the phone. The physician told them to send him to the hospital. At this time Admissions Staff #1 stated, I spoke to the ER social worker. They called, and we told them we are not taking him back. She said that he was not showing psych behaviors but TBI ([MEDICAL CONDITION]) issues. The Administrator talked to the mother and girlfriend about the discharge. It's in the progress notes. On 8/5/20 at 2:55 PM an interview was conducted with Family Member #1 (Responsible Party, per record review of the face sheet). She stated, I was told he was not able to come back to the nursing facility due to his behaviors and they said he was going to the hospital. They could not deal with his behaviors. He was ADHD (Attention Deficit [MEDICAL CONDITION] Disorder). She was then asked if she had received any discharge letter. She stated, They called but never sent me a letter or email. I got a call from the hospital after the surgery on his knee. He got released to his Significant Other A. He was on a waiting list for another facility. She was then asked about the resident's admission process in the facility. She stated, Significant Other A was there when he was placed in the nursing facility. She and I filled out the (admission) paperwork. We were on speakerphone. On 8/5/20 at 3:03 PM an interview was conducted with Significant Other A. She stated, I haven't received a letter or email from the facility (regarding discharge). (The hospital) told me. Social services did not tell me. Yes, I was the one that filled out everything on admission. He's been living with me since 7/7/20. On 8/5/20 at 4:05 PM Admissions Staff #1 was asked about discharges from the facility and paperwork. Regarding Resident #11 she stated, We called the family. We send discharge letters when it is a planned discharge. He was only here 4 days. On 8/5/20 at 5:40 PM the Administrator was interviewed regarding the High Alert Email. He stated, If a resident is sent out of the building for any reason, Ltac, another facility etc. it's sent to the responsible party. Record review of the High Alert Email for Resident #11, presented by the Administrator, revealed that it documented a transfer to the hospital and not a discharge from the facility. The email documented, 6/23/20 10:37 AM. Type: Transfer Notification. Note Text: (Resident #11) was transferred to a hospital on [DATE] 10:39 AM related to new order to have resident sent to (a hospital) for psych evaluation. This is intended to serve as notice of an emergency transfer. This notice was provided to . Via . on (date) . Author: LVN #2. Policy: Record review of the facility policy labeled Nursing Policy and Procedure Manual, AD03 - 1.0 revealed the following documentation, discharged or Transferred To Another Facility . Emergent transfers to acute care. Residents who are sent emergently to the hospital are considered facility-initiated transfers because the residents return is generally expected. Residents who are sent to the emergency room , will be permitted to return to the facility, unless the resident meets one of the criteria under which the facility can initiate discharge . Notification of Discharges. For facility-initiated transfer or discharge of a resident, the facility will notify the resident and the resident representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand . Emergency Transfers. When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be provided to the resident and resident representative as soon as practicable . In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 and to help prevent the development and transmission of communicable diseases and infections, in that: a) One of 3 LVNs (LVN #1) failed to conduct blood sugar testing in a manner to prevent the spread of infections. LVN #1 tested Resident #4's blood sugar and then placed the glucometer, with used test strip, on his bed. b) Laundry personnel failed to handle, store, and process linens to prevent the spread of infection. Laundry staff #1 failed to wash her hands between soiled and clean duties and wear nonabsorbent protective clothing when handling soiled linens. Linens were not processed and stored in a manner to effectively prevent air from the soiled side entering the clean side of the laundry. The soiled side was not under relative negative air pressure . These problems could result in spread of transmission-based infections in the facility. The findings include: >Glucometer Use: -On 8/5/20 at 11:10 AM LVN #1 was observed conducting blood sugar testing on hall 300 in rooms 302 (Resident #4), 306 (Resident #5) and 313 (Resident #2). At 11:28 AM, she entered room [ROOM NUMBER], tested the resident's blood sugar (Resident #4) and then placed the glucometer on the resident's bed with the test strip still in it and stated 258 at 11:29 AM. She then picked up the glucometer, left the room and put it on the medication cart On 8/5/20 at 5:45 PM an interview was conducted with the DON regarding the handling of glucometers during blood sugar testing. He stated, What I do, I keep it (glucometer) in my hand, then remove the strip and wrap it in my glove. Then I dispose of it

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) (test strip) in a sharps container. On 8/7/20 at 8:35 AM an interview was conducted with the DON regarding any previous glucometer training for staff. He stated, We have yearly evaluations and the glucometer is covered. It's also covered on orientation. >Linen Infection Control: On 8/5/20 at 12:20 PM an observation was made of the laundry. There was soiled laundry in the bins and the bins were uncovered. The washers were in operation and going. There was no exhaust (relative negative air pressure) turned on for the soiled side. On 8/5/20 at 12:29 PM an interview was conducted with Laundry Staff #1. She was asked if there was an exhaust fan operational on the soiled side. She was not aware of the need for an exhaust fan being on for the soiled side. She said that she had been working in the laundry a month or two Observation at this time revealed that there were two exhaust vents and one ceiling vent on the soiled side and one ceiling vent in the chemical room with the closet door closed. The 4 ceiling vents were tested and there was no negative air pressure provided on the soiled side to effectively ensure that soiled area air did not flow into the clean area. On 8/5/20 at 12:53 PM an observation was made in the laundry of Laundry Staff #1 handling soiled and clean linens. She donned a cloth gown that had long sleeves and was made of an absorbent material. She did not tie the gown at the waist. She donned gloves and put on a face shield. She loaded soiled linens into a washer labeled isolation. She was leaning into the washer and soiled linen bin. After loading the washer, she removed her gloves, face shield and cloth gown. She then went to the clean side and touched the dryer front and started folding clean linens. She folded a pillowcase which contacted her chest and arms when she was folding it. She failed to wash her hands between soiled and cleaned operations. Laundry staff #1 was then asked about her training and orientation for the laundry. She stated, The first day we run the machines, sort and run the dryers and folding. Orientation was a half day. I was already a housekeeper. I had a girl tell me what to do. I worked in a laundry at another nursing home. On 8/5/20 at 3:29 PM an interview was conducted with Regional Maintenance Supervisor. He stated, We are having electrical issues in that area meaning laundry area. He added, We did not notice the fan being broken until last night. It was never put in Maintenance Care (system). I found it last night after 5 PM. If it's not in Maintenance Care, I won't see it. On 8/5/20 at 4:46 PM an interview was conducted with the Housekeeping/Laundry Supervisor regarding laundry training. She stated, Laundry training consisted of PPE, and laundry handling and it takes about 35 to 45 minutes. Orientation is three days before they are out on their own. She was then asked how long the exhaust fan had been out. She stated I'm not sure. I guess the girls don't notice it. She was also asked about the absorbent cloth gown worn by the laundry staff when handling soiled laundry. She stated, We also had a raincoat we use. She should have been wearing the raincoat. It's to be use when you're on the soiled side for loading soiled laundry. Policy: Record review of the facility policy label Nursing Policy and Procedure Manual 2003 Revised February 13, 2007, GPMC03 - 3.0, Glucometer, revealed the following documentation, . 4. Maintenance. 1. Clean and inspect meter exterior with each use. 2. Meter will be cleaned with a germicidal and allowed to air dry between patient testing . Record review the facility policy labeled Infection Control Policy and Procedure Manual 2019 AD03 - 4.0 revealed the following documentation, Surveillance. Essential elements of a surveillance system . Two types of surveillance process and outcome will be used in the facilities. Process surveillance . Examples of this type of surveillance include monitoring of compliance with transmission-based precautions, proper hand hygiene, and the use and disposal of gloves. Process surveillance determines, for example, whether the facility . Uses appropriate hand hygiene prior to and after all procedures . Ensure that reusable equipment is appropriately cleaned, disinfected, or reprocessed; and uses single use medication vials and other single use items appropriately (proper disposal after every single use) . Record review the facility policy Labeled Infection Control Policy and Procedure Manual 2018, LN03 - 1.3, revealed the following documentation, Linens . 9. Laundry staff will have adequate handwashing facilities and products, as well as appropriate PPE (i.e. Gloves, gowns) to wear while sorting linens . 13. Clean and soiled linens will be stored in separate areas. Employees will ensure that hands are clean and dry before handling clean linen . 15. All employees will use standard precautions in handling soiled linens. Record review the facility policy labeled Infection Control Policy and Procedure Manual 2019, AD0 3-8.0 revealed the following documentation, Fundamentals of Infection Control Precautions . A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. 1. Hand hygiene. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . After handling soiled or used linens, dressings, bed pans, catheters and urinals . Consistent use for staff of proper hygienic practices and techniques is critical to preventing the spread of infections .