STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675971	A. BUILDING _____ B. WING _____	04/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL CARE CENTER	507 WEST AVE SCHULENBURG, TX 78956

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is a decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii) for one (1) of four (4) residents reviewed for notification of changes. The facility failed to notify Resident #1's physician of his emergency discharge from the facility on 4/2/2020. This deficient practice could result in unsafe discharge of residents from the facility. Findings Included: Review of Resident #1's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan updated 3/12/2020 reflected resident goes out on pass late at night and the approach is for staff to monitor. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. In an interview on 4/9/2020 at 11:42 AM NP denied writing discharge orders for Resident #1. She stated she heard about the discharge but assumed he left on his own and no one had told her differently. In an interview on 4/9/2020 at 1:20 PM Corporate VP stated he spoke with ADM regarding the discharge of Resident #1. His expectation was that Resident #1 would be safely discharged . He stated at the time of their conversation it was more about the safety of the residents in the facility. In an interview on 4/21/2020 at 11:45 AM DON stated she did not notify NP of Resident #1's discharge. In an interview on 4/21/2020 at 1:20 PM ADM stated she did not notify NP of Resident #1's discharge. The facility denied having policy specific to physician notifications.
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 record review and interview, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (s)(2) of this section; and (iii) Include in the notice the items described in paragraph(c)(5) for one (1) of four (4) residents reviewed for transfer and discharge rights. (Resident #1) The facility failed to ensure Resident #1 was notified in writing and received the right to appeal his discharge. This failure could place residents at risk for not being notified of discharge appropriately and denied the right to appeal. Findings Included: Review of Resident #1's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan updated 3/12/2020 reflected resident goes out on pass late at night and the approach is for staff to monitor. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. In an interview on 4/3/2020 at 12:01 PM ADM stated she barred Resident #1 from re-entering the facility after another employee provided a signed statement that Resident #1 had been at a local hotel that was under a quarantine order for COVID 19 exposure. She stated the decision was made in conjunction with her corporate representative. She stated she took Resident #1 to the hotel of his choice so his girlfriend could pick him up the next day. In an interview on 4/8/2020 at 5:01 PM Resident #1 stated he did not know he was discharged from the facility. He thought he would be staying at a hotel for 14 days or until he could be tested for COVID 19. He stated the ADM took him to a hotel in the town where his girlfriend worked. He denied receiving anything in writing from the facility. He also denied being able to get to [MEDICAL TREATMENT] as he had no way to get there and no money. He stated his COVID 19 test came back negative this morning. In an interview on 4/8/2020 at 5:11 PM ADM stated Resident #1 was not notified in writing of his discharge. In an interview on 4/8/2020 at 5:58 PM DON stated Resident #1 was discharged [DATE]. She denied being aware of the specifics of the discharged and if discharge planning was completed. In an interview on 4/8/2020 at 6:25 PM Resident #1 stated the ADM just called him and stated he was discharged . She denied having a private room for him to be able to re-enter the facility and if he came back to the facility would have to be quarantined for 14 days. He again denied receiving anything in writing from the facility and denied signing any paperwork regarding his discharge. In an interview on 4/9/2020 at 10:43 AM ADM stated she discharged Resident #1 into his own care and that he stated he would call Medicaid transportation and give them his location for [MEDICAL TREATMENT]. In an interviewer on 4/9/2020 at 11:42 AM NP denied writing discharge orders for Resident #1. She stated she heard about the discharge but assumed he left on his own and no one had told her differently. In an interview on 4/9/2020 at 1:20 PM Corporate VP stated he spoke with ADM regarding the discharge of Resident #1. His expectation was that Resident #1 would be safely discharged . He stated at the time of their conversation it was more about the safety of the residents in the facility. In an interview on 4/9/2020 at 3:16 PM Ombudsmen stated he had received a voice mail on 4/2/2020 about a discharge but no name was provided. He stated he attempted to call back and could not reach anyone at the facility. He also stated he sent an email and had not received a response. Review of Resident #1's electronic medical chart revealed no progress notes regarding the discharge. Discharge planning documentation was not in the electronic chart. Review of facility's policy, Transfer or Discharge Notice, Policy Statement dated Revised September 2012 reflected Our facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge . Except as specified below, a resident and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility: . 2. The resident and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the discharge; c. The location to which the resident is being transferred or discharged ; d. The name, address, and telephone number of the state long-term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy or mentally ill or developmental disabled individuals (as applies); and f. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (1) of four (4) residents reviewed for transfer and discharge rights. (Resident #1) The facility failed to make arrangements for safe and orderly discharge through care planning for Resident #1. This failure could place residents at risk for not receiving care and services to

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

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F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) meet their needs upon discharge. Findings Included: Review of Resident #1's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan updated [DATE] reflected resident goes out on pass late at night and the approach is for staff to monitor. The Care Plan also reflected the resident is at risk for alteration in comfort and or pain R/T past auto accident and the approach included administer medications as ordered and monitor for side effects, effectiveness; assess and treat pain, discomfort as ordered by MD.; notify MD of pain unrelieved by ordered interventions; reposition frequently as needed to promote comfort. The Care Plan also reflected resident had experienced falls and approaches included don't rush resident and allow self performance with in their ability; provide assistance as needed to perform transferring as needed, document ADL performance of resident and assistance provided by staff per policy; refer to therapy PRN. The Care Plan also reflected he had the potential for complications related to [MEDICAL TREATMENT], shunt, [DIAGNOSES REDACTED]. Resident #1's care plan also reflected he had hallucinations triggered by [MEDICAL TREATMENT] and approaches included administer medication as ordered and monitor for side effects, effectiveness; intervene as needed to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to another location as needed. The Care Plan also reflected resident had potential nutritional problem as evidenced by [MEDICAL TREATMENT] and on no salt on tray diet and approaches included obtain and monitor lab/diagnostic work as ordered and report results to MD and follow up as indicated; approaches included observe, document, report to MD PRN s/sx of malnutrition and when setting up meal tray, uncover plate, assist with opening containers, pouring liquids, cutting up food, etc as needed or desired. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. In an interview on [DATE] at 12:01 PM ADM stated she barred Resident #1 from re-entering the facility after another employee provided a signed statement that Resident #1 had been at a local hotel that was under a quarantine order for COVID 19 exposure. She stated the decision was made in conjunction with her corporate representative. She stated she took Resident #1 to the hotel of his choice so his girlfriend could pick him up the next day. In an interview on [DATE] at 5:01 PM Resident #1 stated he did not know he was discharged from the facility. He thought he would be staying at a hotel for 14 days or until he could be tested for COVID 19. He stated the ADM took him to a hotel in the town where his girlfriend worked. He denied receiving anything in writing from the facility. He also denied being able to get to [MEDICAL TREATMENT] as he had no way to get there and no money. He stated his COVID 19 test came back negative this morning. In an interview on [DATE] at 5:11 PM ADM stated Resident #1 was not notified in writing of his discharge. She stated he was stopped by her at the door attempting to re-enter the facility on [DATE]. She had just received a statement from an employee who wished to remain anonymous that he had been staying at the local hotel that was under quarantine now due to COVID 19 exposure. She took him to the hotel of his choice as his girlfriend was at work and could not pick him up until the next day. He stated he had been staying at hotels but was out of money. He stated he could not go to his girlfriends house as she lived upstairs and he could not climb stairs. In an interview on [DATE] at 5:58 PM DON stated Resident #1 was discharged [DATE]. She denied being aware of the specifics of the discharged and if discharge planning was completed. In an interview on [DATE] at 6:25 PM Resident #1 stated the ADM just called him and stated he was discharged . She denied having a private room for him to be able to re-enter the facility and if he came back to the facility would have to be quarantined for 14 days. He again denied receiving anything in writing from the facility and denied signing any paperwork regarding his discharge. In an interview on [DATE] at 10:43 AM ADM stated she discharged Resident #1 into his own care and that he stated he would call Medicaid transportation and give them his location for [MEDICAL TREATMENT]. When asked if he could climb stairs she stated that would not be safe or appropriate for him. In an interviewer on [DATE] at 11:42 AM NP denied writing discharge orders for Resident #1. She stated she heard about the discharge but assumed he left on his own and no one had told her differently. She stated after missing [MEDICAL TREATMENT] for 3 - 4 days he would experience uremic frost*. Additional days of missing [MEDICAL TREATMENT] would be dangerous and even life threatening as poisons would be building up in his body with no way to exit. In an interview on [DATE] at 1:20 PM Corporate VP stated he spoke with ADM regarding the discharge of Resident #1. His expectation was that Resident #1 would be safely discharged . He stated at the time of their conversation it was more about the safety of the residents in the facility. In an interview on [DATE] at 3:16 PM Ombudsmen stated he had received a voice mail on [DATE] about a discharge but no name was provided. He stated he attempted to call back and could not reach anyone at the facility. He also stated he sent an email and had not received a response. Review of Resident #1's electronic medical chart revealed no progress notes regarding the discharge. Discharge planning documentation was not in the electronic chart. Review of facility's policy, Transfer or Discharge Notice, Policy Statement dated Revised [DATE] reflected Our facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge . Except as specified below, a resident and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility: . 2. The resident and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the discharge; c. The location to which the resident is being transferred or discharged ; d. The name, address, and telephone number of the state long-term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy or mentally ill or developmental disabled individuals (as applies); and f. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. *Uremic Frost - is the manifestation of severe azotemia where tiny, yellow-white urea crystals deposit on the skin, resulting in a frosted appearance as sweat evaporates. Reviewed website on [DATE] at 4:52 PM https://www.mayoclinicproceedings.org/article/S,[DATE](18),[DATE]/fulltext
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish a system of records or receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs was maintained and periodically reconciled for one (1) of four (4) residents reviewed for pharmacy services. (Resident #1) The facility failed to account for controlled substances for Resident #1 when medications were taken out on pass. The facility failed to reorder prescribed medications for Resident #1. This failure could put residents at risk for not having medications administered as ordered by physician. Findings Included: Review of Resident #1's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan updated 3/12/2020 reflected resident goes out on pass late at night and the approach is for staff to monitor. The Care Plan also reflected the resident is at risk for alteration in comfort and or pain R/T past auto accident and the approach included administer medications as ordered and monitor for side effects, effectiveness; assess and treat pain, discomfort as ordered by MD.; notify MD of pain unrelieved by ordered interventions; reposition frequently as needed to promote comfort. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #1's Current physician's orders [REDACTED]. Special instructions: Do not exceed 3000 mg in 24 hours. Order effective 12/6/2019 and open ended. In an interview on 4/8/2020 at 5:01 Resident #1 stated he was taken to a hotel after being turned away from the facility. He was given all his medication except for his pain medication. He doesn't know why he didn't receive the pain medication as he generally takes it out on pass with him. In an interview on 4/9/2020 at 11:42 AM NP stated she did not write discharge orders for Resident #1. She denied writing any prescriptions for a discharge. In an interview on 4/10/2020 at 10:48 AM ADM stated Resident #1 was given his pain medication at the time of discharge but did not have any left as he took too many while out on previous pass trips. In an interview on 4/10/2020 at 10:48 AM DON stated Resident #1 previously left the facility with 28 pills and returned with 7 and if they had been taken on schedule he should have returned with 15 - 18 pain pills. In an interview on 4/10/2020 at 2:14 PM DON stated when Resident #1 went out of pass he was not consistent about when he would return so he was given his entire card of pills, including pain pills. In an interview on 4/10/2020 at 2:46 PM ADM stated residents have to be given their entire card of prescriptions in case they are stopped by law enforcement to ensure they have the prescribing information for review if needed. In an interview on 4/20/2020 at 3:52 PM CMA B stated there were many times Resident #1 would return with fewer pain pills than he should have. She stated she informed ADON C on at least two occasions that Resident #1 was taking too many pain pills. In an interview on 4/20/2020 at 5:00 PM ADON C stated she was not aware that Resident #1 was taking too many pain pills until the end of March, close to the time of his discharge. She notified the DON. In an interview on 4/21/2020

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) at 9:30 AM PR D denied being contacted about problems with Resident #1's pain medication. She stated Resident #1 was eligible for a refill on or after 3/22/2020 and she's unaware why it wasn't requested. In an interview on 4/21/2020 at 11:45 AM DON stated ADON C let her know Resident #1 had returned from pass on 3/31/20 with fewer pain pills than he should have. She's not aware of any other instances this occurred. She stated, I discussed with nurses and they stated it was a common thing. He went back out of pass before I could put anything in place then we ended up discharging him a few days later. She denied completing any documented counseling, also denied notifying the physician of the shortage. When asked about the refill that was due on or around 3/22/2020 she denied knowing why his pain pills weren't refilled. In an interview on 4/21/2020 at 1:20 PM ADM stated the issue of Resident #1 taking too many pain pills while out on pass was never brought to her attention. She denied knowing when he left and returned or what was going on with his medication. She stated her expectation would be for the DON or herself to contact his physician letting them know what was going on. She would also expect for a care plan meeting to take place to counsel the resident that he wasn't taking his pain medication appropriately. In an interview on 4/21/2020 at 2:38 PM ADON E denied anyone telling her Resident #1 was returning with too few pain pills. She stated if there was a discrepancy it should have been brought to her attention. In an interview on 4/21/2020 at 3:26 PM CMA F stated she had noted Resident #1 returning with too few pain pills on two occasions she could remember. She stated the medication aide wouldn't count the controlled substances back in, a nurse would have to to do that. When asked about reordering medication for Resident #1 she stated ADON C told her she couldn't do his order but didn't know why. Review of Resident #1 electronic health records reflected the following progress notes: 3/30/2020 1:46 PM resident return (sic)from OOP with meds at this time no c/o pain or discomfort and no s/s of distress temp 97.6. will continue to monitor 3/23/2020 1:12 PM Resident return (sic) to facility at approx. 12noon with meds. temp 97.4 no s/s of distress and no c/o pain or discomfort. will continue to monitor. 3/15/2020 6:49 PM Resident left from [MEDICAL TREATMENT] on Friday has not been in facility all weekend. created by ADON E 3/12/2020 12:32 PM resident return (sic)from OOP at approx 11 am was seen by NP and had chest Xray done by Radiology Company and back OOP x 72 hr with meds per personal vehicle. no c/o pain or discomfort and no s/s of distress. 2/28/2020 1:15 PM Resident is OOP with meds. Denies any pain or discomfort. 2/13/2020 9:22 AM Resident OOP per personal vehicle. No complaints of pain or discomfort. Review of Resident #1's Individual Patient's Narcotic Record reflected the medication [MEDICATION NAME]-Acetamin 10-3 [MEDICATION NAME] 10-325 Tablet was available for reorder after 3/22/2020. Review of Resident #1's Individual Patient's Narcotic Record reflected he left OOP on 2/28/2020 with 22 [MEDICATION NAME] and returned 3/1/2020 with 7 [MEDICATION NAME]. Per review of doctor's orders of 2 tablets, 3 times per day he should have ingested 12 tablets but 15 were missing. Review of Resident #1's Individual Patient's Narcotic Record reflected he left OOP on 3/18/2020 with 18 [MEDICATION NAME] and returned 3/23/2020 with 0 [MEDICATION NAME]. Per review of doctor's orders of 2 tablets, 3 times per day he should have ingested 30 tablets but 18 were missing. Review of facility's Release of Responsibility for Leave of Absence and Medication Released on Leave of Absence dated 3/18/2020, 10:25 PM signed by Resident #1 and Charge Nurse reflected 18 [MEDICATION NAME] were released to Resident #1 this day. Review of Resident #1's Individual Patient's Narcotic Record reflected he left OOP on 3/27/2020 with 27 [MEDICATION NAME] and returned 3/30/2020 with 7. Per review of doctor's orders of 2 tables, 3 times per day he should have ingested 14 tablets but 17 were missing. Review of facility's Release of Responsibility for Leave of Absence and Medication Released on Leave of Absence dated 4/2/2020, 11:50 AM signed by Resident #1 and DON reflected no [MEDICATION NAME] were released to Resident #1 this day. Review of facility policy, Discharge Medication dated Revised December 2012 stated, Unless otherwise specified by facility policy, or contrary to current law or regulation, medication shall be sent with the resident upon discharge. Controlled substances may not be released to the resident upon discharge . A Physician must be contacted for an order to discharge a resident with medications before they will be dispensed.controlled substances shall not be released upon discharge or to the resident unless permitted by current stated law governing the release of controlled substances and a authorized (in writing) by the resident's attending physician .The Nurse shall complete the medication disposition record including: a. the resident's name; B. the name of the person who will be assisting or administering the medication after discharge; c. the date of discharge; d. the name of each medication; e. the prescription (Rx) number of each medication; f. the quantity of each medication ; g. the strength of each medication; h. any special instructions; i. telephone numbers for the physician, pharmacy and facility; j. the signature of the person receiving the medication; k. the signature of the nurse releasing the medication. Review of facility policy, Medication Storage, Controlled Medication Storage dated 11/17 reflected 6. . Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. The director nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies while nurses remain on duty. The director of nursing, in a report to the administrator, documents irreconcilable discrepancies. Review of facility policy, Disposal of Medications, Syringes and Needles - Discharge Medications dated 11/17 reflected 1. Medications, including controlled substances, may be sent with the resident upon discharge if the prescriber has authorized this, it is allowed per payor source and permitted by state law. . 6. Discharge medication information is entered on the discharge instruction form or continuity of care form. 9. Medications may not be sent with the resident upon discharge if: a. The resident leave or is discharged without a prescriber's order or approval.
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 interview, observation and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection during lunch service for two (2) of four (4) residents reviewed for infection control. (Residents #2 and #3). A. BOM failed to offer hand sanitizer or other form or hand hygiene to Resident #3 when serving his lunch in his room. BOM also failed to don PPE when entering Resident #3's room which was on isolation precautions. B. Resident #2 denied anyone offered him hand hygiene prior to eating his lunch. This failure could result in the spread of communicable diseases and put residents at risk for contracting a communicable disease. Findings Included: A. Review of Resident #3's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's Care Plan last updated 3/26/2020 reflected resident was at risk for pressure ulcer due to bedfast / mobility. Review of Resident #3's Admission MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #4's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4 Admission - Baseline Care Plan dated 3/27/2020 reflected resident #4 required supervision with meals and required one staff to assist with all ADLs In an interview on 4/3/2020 at 12:01 PM ADM stated she is unaware if Resident #4 was exposed to COVID 19 while at the hospital. When he returned from the hospital on [DATE] he was put in the room with his roommate, Resident #3. The facility was notified later that day of policy change that required all residents admitted or readmitted from the hospital to be quarantined 14 days. At that point, we quarantined both residents and placed a quarintine notice on their door. In an observation on 4/3/2020 at 12:43 PM Resident #3 was served his lunch tray by BOM. She did not offer to sanitize his hands. BOM entered the room, which was designated as being under isolation, without doning PPE. In an interview on 4/3/2020 at 12:45 PM BOM stated she had just delivered Resident #3's lunch and did not assist him with sanitizing his hands. She turned back towards Resident #3 and stated, be sure to wash your hands before you eat. B. Review of Resident #2's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's Care Plan updated 3/12/2020 reflected an actual fall with approaches of call bell to be in reach, resident instructed to use call bell and await assistance and PT to evaluate and treat. Resident like to keep meal trays in his room till he gets ready to eat them. Sometimes it can be an hour or more after trays are served. resident wants it kept in his room, not somewhere else. Review of Resident #2's Quarterly MDS dated [DATE] reflected a BIMS score of 11 indicating mild cognitive impairment. In an interview on 4/3/2020 at 12:40 PM Resident #2 denied anyone washing his hands or offering him hand sanitizer prior to his lunch being served. In an interview on 4/3/2020 at 4:35 PM ADM stated her expectation was for staff to assist residents with hand washing prior to meals being served. Her expectation for staff entering a room on isolation was for them to use the appropriate PPE equipment. Review of facility policy, COVID 19 Policy and Procedure v1 dated March 2020 reflected Staff should remind residents to practice social distancing and perform frequent hand hygiene. Under the section of General Guidelines, Standard and Transmission Based Precautions must be adhered to for every resident and especially for any new or readmitted resident. and Hand Hygiene should be performed before and after all resident contact, contact with potentially infections material, and before putting on and after removing PPE, including gloves. Review of facility policy, Infection Control Guidelines Resident Admission, verbally dated 4/1/2020 per the Administrator reflected, All residents admitted or readmitted to the facility will be restricted to their room and isolation

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) procedures will be initiated for at least 14 days . The resident will be placed in a private room with PPE supplies placed outside of the door, a receptacle for discarding PPE and trash in the room, and a sign placed on the door noting the isolation precautions in place . If the resident must leave their room for any reason, they will be required to wear a mask at all times, remain at least 6 feet from other residents, and practice hand hygiene as necessary.