STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHAVEN NURSING AND REHABILITATION CENTER	**1855 CHEYENNE CARROLLTON, TX 75010**

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 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 store all drugs and biologicals in locked compartments for 3 (hall 400) of three medication carts reviewed for medication storage. The facility failed to lock 3 medication carts on Hall 400. This failure could affect residents by placing them at risk of not having their medications available as prescribed or possible drug diversion. Findings Included: Observation on 05/23/20 from 5:07 to 5:14 PM revealed, there were 3 medication carts unlocked and unattended on Hall 400. All drawers of the medication carts 1, 2, and 3 could be opened and the medications were easily accessible. The carts were unattended for approximately 7 minutes, before staff intervention after HHSC Surveyor opened the medication cart. Residents were observed on the 400 hall. Interview with LVN AG on 08/23/20 at 5:14 PM revealed, he asked if the surveyor was looking for something. He stated the medication cart should have been locked and that he did not know it was unlocked. He stated that the medication aide must have left the carts unlocked. Interview with MA AJ on 08/23/20 at 5:16 PM revealed she had left the carts unlocked. She stated that she had forgotten to lock it up. She stated she was in a room with a resident. She stated the residents could have accessed the medications and they could have taken them from the cart. Interview with the DON on 08/25/20 at 11:43 AM revealed the medication carts should be locked. He stated that the nurse and medication aides were in charge of ensuring that they were locked up. He stated that it was unacceptable for staff to leave the carts unlocked. Review of the facility's policy, Security of Medication Cart, dated April 2007, revealed, .the medication cart shall be secured during medication passes. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry . Medication cart must be securely locked at all times when out of the nurse's view. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure staff were wearing appropriate hair restraints while in the kitchen. 2. The facility failed to ensure food items in dry storage, refrigerator, and freezer were dated, labeled, and sealed appropriately. 3. The facility failed to maintain clean and sanitary food storage areas in the refrigerator and freezer. These failures could affect residents by placing them at risk for food contamination and food borne illness. Findings Included: 1. Observation on 08/22/20 at 4:46 PM revealed Dietary Aide K was not wearing a hair net while actively serving food on the serving line. In an interview with Dietary Aide K on 08/22/20 at 4:51 PM, he stated the reason he was not wearing his hairnet was because, he would get an allergic reaction. He stated that he should have been wearing the hair net. Review of facility policy, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated October 2008, revealed, .12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. Review of the U.S. Public Health Service Code, 2017, reflected, Hair Restraints 2-402.11. Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that as designed and work to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens, and unwrapped single-service and single-use articles. 2. Observation on 08/22/20 at 4:48 PM revealed an opened and exposed box of thickener on the kitchen rack near the handwashing sink, there was also an opened container of lemonade that was undated. There was a jug of vanilla flavoring with a makeshift top made of foil covering the top. There was a container of sugar with no top covering it, it was open and exposed to the elements. Observation of the cereal rack near the freezer on 08/22/20 at 4:53 PM revealed an open and exposed half-full bag of cereal. Observation of the facility refrigerator on 08/22/20 at 4:55 PM revealed a box of cucumbers with an open and cracked cucumber in the cardboard box with other cucumbers. The floor of the refrigerator revealed that there was green lettuce scattered on the ground, and a tray on the rack with ham wrapped in plastic wrap with no date or label on it. There was also a package of yellow deli cheese that was wrapped in plastic wrap with no label or date. Observation of the facility freezer on 08/22/20 at 5:03 PM revealed the following: - a package of dinner rolls that were opened and exposed, they were freezer burnt, there was ice crystals on the dinner rolls - a sausage link on the floor that was freezer burnt, there was ice crystals on the dinner rolls - a package of unidentifiable meat in a resealable bag with no label or date, - an open bag of sausages that was open and exposed, they were freezer burnt, there was ice crystals on the dinner rolls - 2 rolls of meat that were unlabeled and dated, - a package of steak meat that was not dated, - hamburger buns that were open and exposed on the rack, - an open and exposed package of green beans that were freezer burnt, there was ice crystals on the dinner rolls - a container of orange sherbet that was open and exposed, that was freezer burnt, there was ice crystals on the dinner rolls - an open and exposed package of beef and bean burritos, - an undated bag of oatmeal raisin cookies, the bag was also open and exposed, - an open and exposed package of chicken breast fillets, which were freezer burnt, there was ice crystals on the dinner rolls - an open and exposed bag of frozen pizza, - an open and exposed box of croissants, and - an open and exposed box of biscuit dough. Observation of dry storage area on 08/22/20 at 5:08 PM revealed 2 packages of chocolate chips open and exposed, 1 package of icing mixture with a hole that left it open and exposed, and 1 box of dried potatoes dented and compromised. 3. Observation of the facility freezer on 08/22/20 at 5:03 PM revealed the following: - scattered frozen corn kernels across the ground in the freezer storage area, - tater tots that were open and exposed on the freezer rack, and - a large accumulation of ice on the cooler in the freezer. Interview with the Dietary Manager on 08/25/20 at 3:06 PM revealed that she expected all of her staff to be wearing their hair nets. She stated that if staff were unable to wear a hair net then maybe they should not have been working at the facility. She stated that her expectation was that everything in the kitchen was labeled and dated after being opened. She stated when something was opened in the freezer they should have been closing it. She stated that she had conducted a cleaning after the HHSC surveyor initial tour and removed anything that was not being properly stored and cleaned. She stated that she expected her staff to be following her policies and procedures even when she was not in the building. Review of facility policy, Food Receiving and Storage, dated July 2014, revealed, 1. Food services, or other designated staff, will maintain clean food storage areas at all times .8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) date) .11. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing Review of the U.S. Public Health Service Code, 2017, reflected, Preventing Contamination from the Premises 3-305.11 Food Storage. Food shall be protected from contamination by storing the food: In a clean, dry location. Where it is not exposed to splash, dust, or other contamination; and at least 15 cm (6 inches) above the floor. Review of the U.S. Public Health Service Food Code, 2017, reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: commercially processed food, reflected, .refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a Food Processing Plant shall be clearly marked, at the time the original container is opened in a Food Establishment and if the Food is held for more than 24 hours, to indicate the date or day by which the Food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and:(1) The day the original container is opened in the Food establishment shall be counted as Day 1; and (2) The day or date marked by the Food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on Food safety. 3) Marking the date or day the original container is opened in a Food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the Regulatory Authority upon request.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and 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 for three (Halls 200, 300, and 400) of three halls reviewed and one out of one kitchen reviewed for infection control. 1. The facility failed to quarantine, Resident #2, #4, #5, and #7 who were exposed to COVID-19 and failed to ensure resident's onset of COVID-19 symptoms and quarantine dates were being tracked. 2. Facility failed to monitor Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 for signs and symptoms of COVID-19. 3. The facility failed to ensure CNA A was wearing appropriate PPE while working on the COVID-19 300 Hall and ensure staff were wearing appropriate PPE throughout the facility. 4. The facility failed to ensure essential visitors were screened for fever and symptoms consistent with COVID-19 prior to entering the facility. An Immediate Jeopardy (IJ) was identified on 08/23/20 at 6:15 PM. The facility was provided with the IJ template on 06/15/20 at 6:15 PM. While the IJ was removed on 08/27/20, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy and a scope of pattern because the facility was still monitoring the effectiveness of their Plan of Removal. These failures placed residents at risk for exposure to COVID-19 which could result in serious illness and/or death. Findings Included: Review of Resident #1's MDS, dated [DATE], revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #1's lab results revealed, Resident #1's [DIAGNOSES REDACTED] COVID-19 swab was collected on 08/14/20 at 8:38 PM and the positive results were detected on 08/16/20 at 12:20 PM. Review of Resident #1's progress notes revealed she was sent to the hospital the evening of 08/14/20 due to a change in condition and returned to the facility on [DATE]. Upon her return to the facility she was placed on the COVID-19 isolation unit. Review of a handwritten chart created by ADON C revealed Resident #1's roommate was Resident #2. Resident #1 and Resident #2 were roommates prior to Resident #1 being sent to the hospital and testing positive for COVID-19. Review of Resident #2's MDS, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Observations on 08/22/20 at 3:20 PM and on 08/23/20 at 2:44 PM revealed Resident #2 and Resident #4 was not quarantined. Observations revealed staff were not utilizing contact isolation after she was exposed to COVID-19 from her roommate, Resident #1 and Resident #3. There was no sign on the door that showed that residents were on contact isolation or to be directed to see the nurse before entering the room. Staff entered resident #4's room with dinner tray without wearing gown and face shield. Resident #2 handed the staff member a cup and television remote. The staff member did not practice hand hygiene and exited the room. The staff member delivered dinner trays to rooms 323 and Resident #2. The staff member did not practice hand hygiene until she finished delivering all hall trays. Interview with LVN G on 08/23/20 at 2:46 PM revealed she provided care for Resident #2. She stated Resident #2 was not being quarantined. LVN G stated she did not know residents were supposed to be quarantined due to exposure of COVID-19. LVN G stated Resident #1 and Resident #2 shared a room prior to Resident #1 being transferred to the hospital. Review of Resident #3's MDS, dated [DATE], revealed, she was a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of Lab Report for Resident #3, dated 08/13/20, revealed Resident #3 was tested for COVID-19 on 08/10/20 and it was approved on 08/12/20. The lab results reflected she was [DIAGNOSES REDACTED]-COVID-19 positive. Review of a handwritten chart created by ADON C revealed Resident #3's roommate was Resident #4. Resident #3 and Resident #4 were roommates while Resident #3 was exhibiting signs and symptoms of COVID-19 and tested positive for COVID-19 prior to being moved to the COVID-19 isolation hall. Review of Resident #4's MDS, dated [DATE], revealed that she was an [AGE] year-old- female admitted to the facility on [DATE]. Interview with CNA H on 08/24/20 at 12:45 PM revealed he provided care to Resident #2 and Resident #4. He stated he did not take care of any residents who were quarantined. He stated he N95 mask, face shield, gown, and gloves out of precaution for himself but was not mandatory. Review of Resident #5's MDS, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #5's Progress Notes , dated 07/15/20 through 08/24/20, reflected no documentation related to being exposed to COVID-19 due to his roommate (Resident #11) testing positive and no documentation about being quarantined. Observations on 08/23/20 at 4:22 PM and 08/24/20 at 3:15 PM revealed Resident #5 was not quarantined. Observations revealed staff were not utilizing contact isolation procedures after Resident #5 was exposed to COVID-19 from his roommate, Resident #11 . Resident #5 was sleeping in his bed and was unable to be interviewed. There was no sign on the door that showed that residents were on contact isolation or to be directed to see the nurse before entering the room. There was no PPE in Resident #5's room. Review of Resident #8's MDS, dated [DATE], revealed that he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #8's physician progress notes [REDACTED]. Observation on 08/24/20 3:25 PM revealed Resident #8 was not being kept on droplet isolation, staff were not utilizing contact isolation precautions. Staff were not wearing PPE in the resident's room to provide care. Interview with ADON C on 08/24/20 at 1:20 PM revealed his role entailed overseeing the nursing staff on the 300 hall and half of the 200 hall. He stated Resident #1 was experiencing a change in condition; she was lethargic and had loss of appetite. ADON C stated Resident #1 continued to decline and ADON, DON, and Physician decided to send her to the hospital. He stated during the time she was experiencing signs and symptoms of COVID-19 Resident #1 continued to reside in the same room with Resident #2. He stated once they found out Resident #1 was COVID-19 positive, they started focusing on Resident #2 (Resident #1's roommate) by monitoring her for signs and symptoms of COVID-19 for 14 days and encouraged her to stay in her room. He stated she was currently being monitored but she was not on quarantine He stated when residents have been exposed to COVID-19 due to their roommate testing positive they did not place them on quarantine or use any special PPE because they would have to place everyone in the facility on a quarantine. ADON C stated Resident #3 had spiked a temperature and had diarrhea so they notified the doctor. He stated he did not remember when Resident #3 had a temperature and diarrhea. He stated a COVID-19 test was ordered. He stated Resident #3's test result came back positive. He stated once the positive COVID-19 test result was received Resident #3 was moved from her room to the 300 hall COVID-19 isolation unit. He stated they continued to monitor Resident #3's roommate, Resident #4, but they did not place Resident #4 on quarantine. ADON C stated Resident #3 was not isolated once she started exhibiting signs and symptoms, because at the time the staff did not know for sure that she had COVID-19, so they continued to monitor her until they got the test result back. ADON C stated once they got the labs back they moved Resident #3 immediately. He stated they did not initiate quarantine or isolation precautions for Residents #2 and #4 but would do whatever the doctor ordered them to do. ADON C stated if they had to quarantine every resident who was exposed to COVID-19, by their roommate, they would have to isolate everyone in the facility. ADON C stated it was a case by case basis regarding isolating residents who were experiencing signs and symptoms of COVID-19. ADON C stated if they knew for a fact a resident had COVID-19 they were placed on isolation. He stated when a resident was on quarantine they were observed and they ensured the resident stayed in their room. He stated if a resident's COVID-19 status was unknown, they would continuously monitor every day because they did not know if that resident was positive. ADON C stated he was trained by the DON and he was trained on the facility's policy regarding infection control and COVID-19. Interview with DON on 08/25/20 at 11:02 AM revealed COVID-19 was a [MEDICAL CONDITION] infection which the facility was currently dealing with. He stated signs and symptoms of COVID-19 consisted of elevated temperature, shortness of breath, difficulty breathing, and sore throat. He stated the meaning of isolation was to monitor residents for precautions regarding COVID -19. He stated

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) residents showing signs and symptoms of COVID-19 were isolated. He stated staff had been trained on isolation precautions. He stated quarantine consisted of observation and keeping the resident in their room. The DON stated when a resident was quarantined they would be on close monitoring for signs and symptoms of COVID-19. He stated if a resident resided on a hall where another resident tested positive the whole hall was placed on quarantine. He stated when someone was on quarantine the direct care staff must wear full PPE which consisted of a N95 mask, gown, face shield or goggles, and gloves. The DON stated if a resident was exposed to COVID-19the physician would be contacted, the room would be cleaned and disinfected, resident closely monitored, isolated, and staff would use full PPE. He stated Resident #5 and Resident #2 were being monitored for exposure to COVID-19 by their roommates. He stated ADON C, ADON D, and he would implement full PPE to provide care to the residents. The DON stated staff would wear PPE in the room and take off the PPE in the room for the residents who had been exposed to COVID-19 by their roommate. He stated PPE was kept in the resident's bathroom. He stated after 10 days residents were not considered positive for COVID-19 and 10 days was how long residents were kept in quarantine. He stated full PPE was no longer required for Resident #4 (exposed to COVID-19 by roommate Resident #3) because it had been 10 days since expose to COVID-19. He stated Resident #4's quarantine ended on 08/23/20. The DON stated Resident #3 (Resident #4's roommate) was tested for COVID-19 because the doctor requested the test due to her being weak and having diarrhea. He stated Resident #3 was not exhibiting a fever and the resident was fine and there were no concerns regarding COVID-19. He stated diarrhea was a sign and symptom of COVID-19 but that it was an uncommon one. The DON stated Resident #3 was quarantined with her roommate, Resident #4, because she was not showing initial signs of COVID-19. He stated residents were isolated at the time of their COVID-19 test was conducted if they were symptomatic. He stated Resident #3 was isolated with her roommate, Resident #4, and then she was transferred to the 300 hall COVID-19 Unit once the positive result came back . The DON stated Resident #3 should have been moved when she started exhibiting signs and symptoms of COVID-19. He stated Resident #3 had exhibited unusual symptoms. The DON stated Resident # 1 received a COVID-19 test on 08/10/20 and the result was negative. He stated Resident #1 continued to show signs and symptoms of COVID-19 and was in the room with her roommate, Resident #2. He stated he had in-serviced his ADONs on the difference of quarantine and isolation constantly. He stated the ADONs report to him during the meetings regarding residents needing quarantine and isolation . He stated he dropped the ball regarding Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #7 regarding quarantine, isolation, and monitoring for signs and symptoms of COVID-19. Interview with the MD I on 08/25/20 at 2:51 PM revealed he expected the facility to place anyone who was starting to exhibit signs and symptoms of COVID-19 to be placed on isolation and removed from their roommate. Record Review of the Facility Infection Control Isolation tracking log, undated, revealed the facility was not currently tracking the six of the seven residents who were currently on isolation. The tracking log was provided on 08/24/20. Interview with the DON on 08/25/20 at 11:43 AM revealed he did not know why the new COVID-19 cases are not on the tracking log. He stated he would provide it. No additional tracking logs were provided prior to exit. Record Review of facility policy, Surveillance for Infections, dated 07/2017, revealed, The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. Review of U.S Department of Health and Human Services Commission public health and safety site, accessed on 09/02/20, from https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html, titled, What is the difference between isolation and quarantine?, dated 07/22/20, revealed, Isolation and quarantine are public health practices used to protect the public by preventing exposure to people who have or may have a contagious disease. Isolation: separates sick people with a contagious disease from people who are not sick. Quarantine: separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. 2. Review of Resident #2's Progress Notes and TARs for August 2020 revealed the resident's temperature was checked routinely each shift, but there was no documentation the resident was monitored for any other signs or symptoms related to COVID-19. Resident #2's Progress Notes reflected no documented evidence she was exposed to COVID-19 due to her roommate Resident #1 testing positive for COVID-19 . Review of Resident #3's progress notes for 07/25/20 through 08/08/20 revealed no documentation the resident was monitored each shift for signs and symptoms of COVID-19. Resident #3 was moved to the COVID isolation unit on 08/13/20. Review of Resident #4's Progress Notes and TARs for 07/25/20 through 08/23/20 revealed the resident's temperature was checked routinely each shift, but there was no documentation the resident was monitored for any other signs or symptoms related to COVID-19. Resident #4's roommate, Resident #3, was moved to the COVID isolation unit on 08/13/20. Review of Resident #5's TAR and Progress Notes for 07/15/20 through 08/21/20 revealed Resident #5's temperature was monitored every shift, but there was no documentation of Resident #5 being monitored for other signs or symptoms of COVID-19. Resident #5's Progress Notes reflected no documentation related to being exposed to COCVID-19 due to his roommate (Resident #11) testing positive. Review of Resident #6's MDS, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #7's Progress Notes and TAR for 08/16/20 through 08/24/20, revealed the resident's temperature was monitored every shift, but there was no documentation of Resident #7 being monitored for other signs or symptoms of COVID-19. The progress notes did not contain any documentation regarding Resident #7 being exposed to COVID-19 through his roommate, Resident #6, who tested positive or about being placed on quarantine. Review of Resident #8's Progress Notes and TAR for 07/07/20 through 08/21/20, revealed the resident's temperature was monitored every shift, but there was no documentation of Resident #7 being monitored for other signs or symptoms of COVID-19. Review of Resident #9's MDS, dated [DATE], revealed that he was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #9's Progress Notes, dated 07/05/20 through 08/21/20, revealed there was no documentation regarding monitoring for signs and symptoms of COVID-19. Review of Resident #10's MDS, dated [DATE], revealed that he was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #10's Progress Notes for 07/03/20 through 08/21/20, revealed there was no documentation regarding monitoring for signs and symptoms of COVID-19 physician progress notes [REDACTED]. Review off Resident #11's MDS, dated [DATE], revealed that he was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #11's Progress Notes, dated 07/16/20 through 08/21/20, revealed there was documented monitoring for signs and symptoms of COVID-19 on 08/13/20 and 08/20/20 but for no other dates during the reviewed time frame. for signs and symptoms of COVID-19. Physician note, dated 08/14/20, reflected the physician wanted Resident #11 monitored for shortness of breath, cough/congestion, fatigue/muscles aches, and sore throat. Nurse note, dated 08/17/20, revealed Resident #11 tested positive for COVID-19. Interview with ADON C and ADON D on 08/23/20 at 2:01 PM revealed the staff should be monitoring all residents every shift for signs and symptoms of COVID-19 . They stated the ADONs and DON would follow up to ensure staff were conducting their monitoring once a shift. They stated nurses were to document in the resident's electronic chart. They stated they did not know when the last time nurses were trained on monitoring for signs and symptoms of COVID-19. They stated their expectation was that nurses should document and monitor every shift. They stated if they are not documenting and monitoring the residents for signs and symptoms of COVID-19, they could miss someone who is showing signs and symptoms, which could cause more residents to get sick. ADON C stated if the resident wass showing signs and symptoms of COVID-19 the nurse had been educated to document if residents were showing signs, and to document if they were not showing signs as well. ADON D stated monitoring is required for residents who were exposed to COVID-19 by their roommate. ADON D stated they would place COVID-19 positive residents on the 300 hall COVID-19 Unit, and clean and disinfect their prior room. ADON D stated both residents would be monitored for 14 days. ADON C and ADON D stated they were tracking quarantine periods on the tracking log, to ensure residents were being tracked for 14 days after quarantine . ADON D stated full PPE was required to be worn when caring for residents who were quarantined and had been exposed to COVID-19. Interview with DON on 08/23/20 at 4:11 PM revealed his expectation for monitoring residents for signs and symptoms of COVID-19 was that the nurses were to monitor, and if the resident was showing signs and symptoms of COVID-19 that was communicated to the DON, MD/NP, and POA. He stated staff were to document the monitoring even if the resident was not showing signs and symptoms. He stated monitoring was conducted every shift. The DON stated if there was no documentation of signs and symptoms it was because the resident did not have any signs and symptoms of COVID-19. He stated they monitored residents for signs and symptoms of COVID-19 but that it was not documented. The DON stated nurses were monitoring for signs and symptoms of COVID-19 even though they were not documenting the monitoring. He stated when the nurse took the resident's temperature they were screening for signs and symptoms of COVID-19 during that time. He stated he did not watch every nurse during that time to ensure they were doing the screening;he just knew they were doing it. The DON stated beginning 08/22/20 all staff would document the monitoring every shift even if the resident was not showing signs and symptoms of COVID-19. 3. Observation on 08/22/20 at 10:55 AM revealed CNA A was wearing a surgical mask on the 300 hall COVID-19 hall while

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) providing resident care from room to room . She was also observed speaking to the DON. Interview with CNA A on 08/23/20 at 1:32 PM revealed she acknowledged she was wearing a surgical mask, gown, goggles, and gloves while working the 300 hall COVID-19 hall on 08/22/20 when she was observed. She stated she was providing care to all residents during that time. She stated she did not see a N95 mask in the PPE cart so she put on a surgical mask. She stated she did not ask LVN J for a N95 mask at the beginning of her shift, she stated that she did ask LVN J for a N95 in the middle of her shift and was given a mask. CNA A stated the risk of wearing any mask besides the N95 could cause herself to get infected or infect others. She stated facility policy regarding the type of mask to be worn on the COVID-19 isolation hall was a N95. She stated she was trained about a week ago on the proper PPE usage on the COVID-19 hall. Observation on 08/22/20 at 4:13 PM revealed the Hall 200 nurse, LVN M, was wearing a loose fitting KN95 mask on the hall. CNA N was observed wearing a N95 mask and full PPE. Observation of MA O was wearing a KN95 mask while passing medications to residents. Interview with LVN M on 08/22/20 at 4:15 PM revealed she was given the mask by the facility. She stated she was trained to wear the KN95 and N95 mask at the facility. LVN M stated she was not fit tested for her mask. LVN M stated her mask was loose due to weight-loss. Observation of the kitchen on 08/22/20 at 4:46 PM revealed three dietary aides, Dietary Aide K, Dietary Aide F, and Dietary Aide L, were preparing meal trays. The dietary aides were not wearing masks. Observation of the trays being loaded and put on the cart and moved out of the kitchen. Observation of the kitchen on 08/22/20 at 4:50 PM revealed Dietary Aide F, Dietary Aide K, and Dietary Aide L put on a surgical face mask, however, Dietary Aide F and Dietary Aide K were wearing their surgical masks below their nose. Interview and observation with Dietary Aide K on 08/23/20 at 5:54 PM revealed he was wearing an N95 mask and the bottom strap of the mask was dangling. He stated he was trained on how to wear a mask and that a mask must be worn while working in the kitchen. He stated he did not have the mask on during the observation made on 08/22/20 at 4:46 PM because it moved his beard restraint around. He stated that the correct way to wear a mask was that it covered the nose and mouth. He stated he did not know why he had his mask below his nose. He stated he was trained to wear any type of mask. Dietary Aide K stated he was trained by the DON. Interview with Dietary Aide L on 08/23/20 at 5:56 PM revealed the mask irritated the skin under her chin and she took it off for a second. She stated she was wearing a KN95 mask. She stated she could get a mask from the Administrator but brought her own to work. She stated the Administrator said they had to wear a KN95 mask and a surgical mask was no longer allowed since the COVID-19 outbreak. Dietary Aide L stated she received an in-service regarding masks on 8/18/20 and then again 8/23/20. She stated it was important to wear a mask during food preparation to prevent any type of germ spread. Interview with Dietary Aide F on 08/23/20 at 6:06PM revealed that she was wearing a N95 mask. She stated she was trained to wear the N95 mask. She stated she had the mask down below her nose because she had to speak to Dietary Aide L. She stated the facility policy was that they wear the mask and that it needed to cover their nose and mouth. Dietary Aide F stated she was trained by the DON on how to wear the mask and he provided her with the N95 mask. Observation and interview on 08/23/20 at 11:50 AM revealed that CNA P was observed wearing a KN95 mask. CNA P stated she was wearing a N95 mask and the mask was given to her by ADON C two to three days ago. She stated she was trained by the DON on the proper mask to wear at the facility. Observation and interview on 08/23/20 at 11:55 AM revealed CNA Q was wearing an KN95 mask and a surgical mask underneath. She stated she wore the surgical mask underneath the KN95 mask because the KN95 was loose on her face. She stated the facility policy was that she had to have the KN95 mask on before walking into the facility and starting work. She stated the facility would provide her with a KN95 or N95 mask. She stated that she was trained by the DON regarding the proper mask to wear at the facility. Observation and interview on 08/23/20 at 12:17 PM revealed LVN R was wearing a KN95 mask. He stated he got the mask from the front office that morning. He stated he was given the mask by his weekend supervisor, LVN E. LVN R stated it was the facility policy that he had to wear a KN95 or N95 mask. He stated that he was trained by the DON regarding masks. During an interview with ADON C and ADON D on 08/23/20 at 2:00 PM revealed since there was COVID-19 in the building everyone had to wear a N95 or KN95 mask. They stated they trained staff on how to properly wear the masks. They stated the DON trained staff, on a weekly basis, on masks and PPE usage. ADON C stated staff should not be wearing a surgical mask on the COVID unit because the risk for contracting COVID-19 from residents was high. ADON C and ADON D both stated the kitchen staff should be wearing a N95 mask. Interview with Weekend Supervisor, LVN E, on 08/23/20 at 2:57 PM revealed masks should be worn in the building and the preference was the N95 mask. She stated sometimes staff would wear surgical masks. LVN E stated there was no specific mask that needed to be worn. She stated staff had been trained on wearing a N95 mask. LVN E stated the purpose of the N95 mask was to mitigate the spread of [MEDICAL CONDITION]. She stated the risk of wearing a surgical mask on the COVID-19 unit was it could cause the staff to become infected and spread the illness. She stated that masks should be worn by all the staff in the building. Interview with DON on 08/23/20 at 4:11 PM revealed every employee in the facility should be wearing a mask. He stated facility staff were required to wear the N95 mask but that it was not mandatory. He stated that they recommended the N95 masks but they would accept the surgical mask. He stated on the 300 hall COVID-19 unit staff had to wear the N95 mask. He stated according to the CDC that staff could wear surgical masks throughout the facility. He stated the Administrator, ADON C, ADON D, and himself promote the N95 mask but staff could wear any type of face mask. He stated that for the COVID-19 unit it was mandatory for staff to wear the N95 mask. The DON stated his did not promote that staff wear a surgical mask on the COVID-19 unit. He stated when he was on the 300 hall COVID-19 Unit on 08/22/20 at 11:30 AM he did not notice CNA A was wearing a surgical mask and not a N95. He stated he trained the staff on the proper PPE to wear when working on the COVID-19 hall. He stated that everybody has been trained regarding masks including, Dietary, Therapy, Maintenance, Housekeeping, Nursing, and Administrative staff. He stated his last in-service on masks was 08/02/20. 4. Observation on 8/22/20 at 10:30 AM revealed the facility failed to properly screen the HHSC surveyor upon entering the facility. LVN AG only took the HHSC surveyor's temperature then proceeded to allow entrance into the facility. The HHSC surveyor toured the facility for two hours until temperature was re-checked and questionnaire was completed for COVID-19 by LVN E. Interview with Weekend Supervisor, LVN E, on 08/23/20 at 2:57PM revealed staff should conduct the screening on visitors. She stated she screened visitors on the weekend. LVN E stated she was not trained by administrative staff on how to screen visitors and staff. She stated HHSC surveyors are considered essential visitors and need to be screened too. She stated essential visitors need to be screened because you do not know where they have been on the outside or if they have been exposed. Interview with DON on 08/23/20 at 4:11 PM revealed on the weekends the LVN E was in charge of conducting the screenings of staff and any essential visitors who come into the building. He stated LVN E should have had the HHSC surveyor fill out the COVID-19 screening questionnaire because it helped them screen people who may have been exposed to COVID-19. He stated his expectation was when someone came into the facility they were screened; temperature taken and given the questionnaire. The DON stated the residents were put at risk because they had not screened someone who walked into the building. Review of facility policy, Coronavirus/COVID-19, 08/08/20, revealed, The facility follows current guidelines and recommendations for the prevention and control of [MEDICAL CONDITION]. The facility should contact their local health department if they have questions or suspect a resident of the nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposure among residents, personnel, and visitors . 4. Source control, which involves having the infected person wear a cloth face covering or facemask over their mouth and nose to contain their respiratory secretions, might help reduce the risk of transmission of [DIAGNOSES REDACTED] CoV-2 from both symptomatic and asymptomatic people . Facilities may not allow entry unless the visitor meets the criteria of emergency personnel, necessary visits by the resident physician, or a state surveyor. Document name, reason for visit, job title, and temperature of each visitor. All persons that enter are to be screened for temperature and symptoms, and either given a mask or to provide their own mask . COVID-19 Control. 1. MD/PCP will notified of symptomatic residents and the resident will be required to take appropriate measures including Contact and Droplet Precautions and remaining in their room until assessed by PCP or orders are received for testing and test results are received . 2. Staff caring for a resident who is presumptive for COVID-19 will wear personal protective equipment while providing care. 3. If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED]. Temperature measurement may also be required to determine appropriateness of staff or visitors to be at the facility .15. All residents will have temperature monitored and recorded three times per shift Review of facility policy, Infection Control, dated 10/2018, revealed, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections . 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility . e. Maintain records of incidents and corrective actions related to infections . Review of HHSC COVID-19 Response for Nursing Facilities Version 3.5, dated 08/18/20, revealed, For the duration of the state of emergency, all NF personnel should wear a facemask while in the facility. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHAVEN NURSING AND REHABILITATION CENTER	**1855 CHEYENNE CARROLLTON, TX 75010**

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) who are have been appropriately trained and fit-tested can use N95 respirators. Staff who are caring for residents with COVID-19 or caring for residents in a building with widespread COVID